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1 Executive Summary

This report covers the period 2010 until April 2011. In this period the Dutch economy slowly recovered from the economic and financial crisis and social partners and government were in the middle of the discussion on how to make the Dutch pension system more sustainable. As such, the Dutch pension system can be defined as a good basic public pillar supplemented with a well performing occupational system.

Although the Dutch system can be considered as one of the best in the world, the economic and financial crisis unveiled that the system faces some serious challenges:

- The financial sustainability of the pension funds in the search of finding a new balance between security and risk management;
- The demographic change of the Dutch population;
- The infringement of the state budget because of the measures taken necessary to overcome the crisis.

One of the main successes of the pension system has been the good cooperation between and among social partners and government. This cooperation made the structure and achievements of the current system possible. It is therefore encouraging that all parties involved again take their responsibility to discuss future sustainability of the Dutch pension system realising that change is necessary. This report with regard to pensions reflects on the search for change introducing a new and more sustainable pension system, keeping a three-pillar pension house including collectivity, solidarity and mandatory participation. The challenge is to find a new balance between security of pension benefits and risk management of pension funds as taking capital risks is necessary to provide a better chance for indexation of pension benefits in the future.

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. A key issue is that various market making decisions still have to be taken, for instance concerning the scope of free pricing, the lifting of the ban on for-profit hospital care and the abolishment of various ex-post risk equalisation arrangements in health insurance. The new government announced in its Coalition Agreement, that it will further follow the market reform. In its view, a half-way implementation of the reform would mean a health care system that is even more hybrid than the previous one. It would also fail in terms of efficiency, innovation and patient-centredness. The further implementation of the market reform is not easy, however, not only from a technical perspective, but also and in particular from a political perspective. There is also a fundamental tension in the reform: On the one hand, the government wants to introduce market competition, but on the other hand it also wants to retain a 'classic' instrument to control costs, namely imposing a global budget for public health care expenditures.

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 number of services once covered by the Exceptional Medical Expenses scheme (AWBZ) have been or will be shifted to the package of the Social Support Act (WMO). As a consequence, the role of local government (charged with the implementation of the WMO) in long-term care is significantly upgraded. Another measure is to extend the scope of the new Health Insurance Act by transferring various health services from the AWBZ. As a consequence, the role of health insurers in long-term care is upgraded. In its Coalition Agreement, the government also opts

for greater (financial) self-responsibility in long-term care. What was said bout health care also applies to long-term care. Its reform will not be easy, not only from a technical point of view, but also from a political perspective.

A new development that can be observed both in health care and in long-term care is the development of performance measurement by means of valid indicators and the communication of performance information to the wider public. The 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.

2 Current Status, Reforms and the Political and Scientific Discourse during the previous Year (2010 until May 2011)

2.1 Overarching developments

Every major crisis has its own reforms. In the 1990s this was the reform of the invalidity pension scheme; at the beginning of the new century the health care reforms, and now, with the last crisis slowly passing, the reform of the pension system. Because of the budget deficit, however, not only the pension system is under revision but also the so-termed regulations at the lower end of the labour market. More specificly, the regulation for young disabled (WAJONG), the regulations on sheltered workplaces (WSW), and social assistance (WWB). The government wants to merge all three regulations into one new regulation, the "Work Capacity Act", in order to increase the effectiveness of policies by implementing the new act at municipality level. The budget for the new regulation should be reduced by 1.8 billion euros. The new act will, according to the government, enable municicpalities to get more people into work, make more targeted and effective use of their budgets and cut costs. The total budget for the new act will be 2.6 billion euros in 2015. The WAJONG act will only continue to exist for young disabled who are completely and permanently unable to work due to their disability or medical problems.[1]

With this new act the government speculates on the future shortages of labour supply which will make it possible also for vulnerable groups to participate in the labour market. The usage of reintegration funds by municipalities will be reduced and used selectively, which makes the reduction of reintegration budgets possible. The labour market performance during the crisis feeds the idea that the Netherlands will face serious labour market shortages in the near future when the economy grows substantially. In April 2011, the unemployment rate was at 5.1% showing a declining trend since the end of 2009.[2]

The main topic in the debate regarding the new act concerns serious budget cuts, which makes municipalities hesitant to implement the new law. Municipalities will face full responsibility for the implementation of the new act and, therefore, the integration of all people at the lower end of the labour market. They are thus fearing there are not enough financial means to be succesful. Also parties on the left side of the political spectrum critisise the new act as being socialy unacceptable. In the Netherlands, labour market policies and socal protection are more and more interwoven. In a way, work is considerend to be the best social protection people can have. If this is also the case for vulnerable groups like young disabled persons and people working at sheltered work places remains to be seen. The demographic trend of a greying

[1] The National Reform Programme 2011, Ministry of Economic Affairs, Agriculture and Innovation, April 2011.

[2] Figures on unemployment rates by the Dutch Statistical Agency CBS.

population and future shortages of labour supply have to be solved as well, although it is questionable if people at the lower end of the labour market will be a serious part of the solution. If not, then the new social protection law will be no more than an instrument to reduce the budget deficit.

With regard to the budget deficit the Netherlands have always been a strong supporter of the Growth and Stability Pact criteria when introducing the Euro. Just like other countries the economic and financial crisis infringed the state budget and raised the gross national debt towards 66% by the end of 2011.[3] The reforms and policy ambitions of the current government are regarded as consistent with the stability programme in order to return as quickly as possible to the criteria of the Stability and Growth Pact. The Dutch government in that respect regards the Euro Plus Pact in line with its own economic reform agenda. Sustainability of public finances and employment are important elements of this agenda - explaining the speeding up of the pension reform debate and such measures like the Work Capacity Act.

2.2 Pensions

2.2.1 The system's characteristics and reforms

First pillar

The current Dutch pension system consists of three pillars. The basic state old-age pension under a statutory insurance scheme (AOW) and the supplementary pension schemes by virtue of the employer and the private savings 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 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 State Budget. Entitlement to AOW is accumulated at a rate of 2% for each year of insurance i.e. 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 of each person). Since the end of the last century, the number of AOW benefits paid has been steadily increasing, illustrating the greying trend of the Dutch society. At the end of 2008, 2.7 million people were receiving AOW pension benefits, in February 2011, this number was already 2.8 million.[4] 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 not sufficient to pay all benefits. By the end of 2060, the gross public pension expenditure is expected to be 10.6% of GDP which is an increase of 4% in the period 2007-2060.[5]

[3] http://www.rijksoverheid.nl/documenten-en-publicaties/persberichten/2010/09/21/nationale-schuld-2011-staatsschuld-en-rentelasten-nemen-toe.html.

[4] Figures from CBS on number of AOW benefits.

[5] 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.

Second pillar

The second pillar consists of 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.[6] The second pillar serves to supplement the first one. The Dutch supplementary pension system consisted of 495 pension funds in the first quarter 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 had existed.[7] 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 decided by trade unions and employers 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 taken 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 in 2008, this percentage was reduced to 1% with 87% having a career-average scheme.[8]

The legal framework of occupational pensions consists of the Pensions Act in which it is stated that occupational schemes are subject to negotiations between employers associations and trade unions. The government's role is to ensure that pension entitlements are actually fulfilled. Other acts which are of importance are the Mandatory Participation in an Industry-wide Pension Fund Act in which it is regulated to declare a collective pension agreement 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 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

[6] 0.5% of the total member population; http://www.statistics.dnb.nl/index.cgi?lang=nl&todo=PenReg.
[7] http://www.statistics.dnb.nl/index.cgi?lang=nl&todo=PenReg.
[8] Source: Dutch National Bank Statistics Bulletin December 2008.

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%.[9]

Third pillar

The third pillar 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 who depend on the third pillar for their pension provisions as a supplement to the first pillar AOW. Currently, about 10% of the total pension provisions in the Netherlands are covered by the third pillar.[10] The increasing importance of individual pensions also fueled 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 depend on the first and third one. The growth in the number of self-employed 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 and recommends to study on this problem in order to create more possibilities for this vulnerable group.[11]

Developments

The Dutch three pillar system as such is not up for discussion. However, three developments make reforms necessary, reforms which are now thoroughly debated. The economic and financial crisis caused serious problems for the financial sustainability of the pension funds. The crisis led to severe asset losses and created a state budget deficit of 5.4% in 2010[12] and in the longer term the demographic change calls the sustainability of especially the second pillar pension schemes into question. The debate on reforming the pension system has not been finalised yet and will be reflected on in the next paragraph. What is sure is that the retirement age will be most probably connected to the life expectancy of the population. Every five years the life expectancy will be monitored and the retirement age adapted accordingly. The first step is to raise the retirement age from 65 to 66 in 2020. The government recently launched a legislative proposal in this direction, which is now in the Dutch Second Chamber for debate.[13] Given the minority situation in both chambers of Parliament it is not sure that the proposal will reach the legislative status unharmed. There is, however, a common agreement that the retirement age should be raised and connected to life expectancy.

An important change that has been introduced is that contributions to voluntary early retirement schemes and pre-funded flexible pension schemes are no longer deductible from taxable income. A transition period applies and it is sill possible to leave the labour market before reaching the age of 65 but only at one's own expense. Furthermore, financial incentives were introduced to retire after the age of 65 in terms of tax reductions and by the fact that no social contributions have to be paid after 65, which results in a higher net income

[9] Dutch National Bank, working paper 258, August 2010.
[10] Prof. dr. G.J.B. Dietforst: can the Third Pillar perform better? Interpolis Pensioenlezing December 2008.
[11] ZZP'ers in beeld, SER advies 10/04 October 2010.
[12] Figures Eurostat 60/2011 - 26 April 2011.
[13] Law on rasing the pensionable age to 66, legislative proposal of the Minister of Social Affairs and Employment 10 May 2011. http://www.rijksoverheid.nl/ministeries/szw/documenten-en-publicaties/kamerstukken/2011/05/10/wetsvoorstel-en-memorie-van-toelichting.html.

effect. The effect of these incentives are, however, limited because the approval of the employer is needed to work longer and the involved pension scheme should support longer working which is not yet the case for every pension fund. Under Dutch law it is not possible to work longer then until the age of 70 in order to build up pension rights. It was also made possible to combine the receipt of old-age state pension (AOW) benefit with work. The after tax earnings for this group of people is higher then for people under 65 because this group is not compulsorily insured anymore for the insurance schemes of employees, which gives a positive net income tax effect.

2.2.2 Debates and political discourse

The Goudzwaard Committee

The debate on the Dutch pension system started already before the economic and financial crisis. The greying population and the risk sharing between younger and elder generations made this debate inevitable. Two committees played an important role regarding the future of the Dutch pension system: the Goudzwaard and the Frijns committee. The Dutch Minister for Social Affairs and Employment installed both committees.[14] The Goudzwaard Committee reflected on the sustainability of the second pillar pensions presenting an inventory of possible solutions. The main conclusion of Goudzwaard was that doing nothing is no option starting from the unique features and core values of the second pillar namely collectivity, solidarity and wide coverage through mandatory participation. The increasing life expectancy, ageing, increasing mobility and decreasing capital coverage ratios threaten the sustainability of the system. Therefore, social partners need to find a new balance between ambition, security and costs.[15]

The Frijns Committee

The Frijns Committee investigated the risk and investment management of pension funds as well as the governance of these funds. The conclusions were that the pension funds did not pay enough attention to risk management and the quality of their investments. Furthermore, social entrepreneurship[16] is not an integral part of the risk and investment management of the funds. In its recommendations Frijns pleas for durable investment policies, the determination and willingness of participants to accept risks and last but not least that the real objective of the fund must be a real pension that maintains its purchasing power. It is important for pension funds to ensure sufficient expertise in the board in order to be able to initiate policies in the field of risk management, investment management and execution.[17]

The Pension Accord of Social Partners

Although critical remarks on the work of both committees can be made, the economic and financial crisis made the recommendations and options for solutions more manifest. The real value of both reports is that most of the conclusions are shared broadly by the main players in the field, namely social partners and the government. In June 2010, social partners concluded

[14] Goudzwaard Committee consisted of Prof. Beetsma, Nijman and Schnabel chaired by Prof. Goudzwaard. The Frijns Committee consisted of Prof. Scholtens and Mr. Nijsen, chaired by Prof. Frijns. Both committees were installed for a limited time and completed their work in January 2010.

[15] Report Committee Goudzwaard: A strong Second Pillar: Towards a sustainable system of supplementary pension provisions.

[16] A social entrepreneur recognises a social problem and uses entrepreneurial principles to organise, create and manage a venture to achieve social change (a social venture).

[17] Report Committee Frijns: “Pensioen: onzekere zekerheid”.

a pension accord underlining the main conclusions of both committees stating that the main features of the occupational pensions in the second pillar, i.e. collectivity, solidarity, and compulsory membership, should be maintained. The pension accord 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. As a result, the first step will be 66 in 2020 and 67 in 2025. Social partners also propose to introduce a penalty and award system into the first pillar rewarding persons who work longer and penalising persons who work shorter. As a result it is still possible to retire at 65 but a reduction of the AOW will then be included. A sensitive point introduced in the agreement with regard to the first pillar is the proposal that the state pension benefit should be linked to developments in earned income.[18] This point is sensitive because of the uncertainties it entails with regard to the consequences for the state budget. Moreover, the pension agreement reflects on the necessity to improve the labour market position of older employees. The positive development started in recent years. Due to changes in social security and early retirement, regulations need to be strengthened by additional policy measures in the field of mobility of older workers and HRM-management measures like age-conscious staff policies, recruitment and selection etc.[19]

One of the main successes of the pension system has been the good cooperation between and among social partners and government. This cooperation made the structure and achievements of the current system possible. It is therefore encouraging that all parties involved again take their responsibility to discuss the future sustainability of the Dutch pension system realising that change is necessary. The debate among social partners and between social partners and the government is still progressing, however, not without difficulty. In particular, the discussion on risk sharing between employers and employees with regard to the profit or losses of pension funds on the stock markets is a difficult topic to solve. 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 Dutch pension funds experienced considerable asset losses during the crisis, which made a debate on good financial governance and restoration of coverage ratios very urgent. The demographic transition towards an older population predicts an increase in public pension expenditure and, last but not least, third pillar private pension products are at their best an additional benefit, but less than expected. Compensation by raising the first pillar AOW benefit could be a solution, but as stated above the public finance situation makes this option also very difficult. Certainly, increasing the pensionable age and connecting it with life expectancy of the population will give relief, but only under the condition that the labour participation especially of women and older workers will further increase. With regard to the labour participation of women the number of limited working hours (average between 20 and 23 hours per week) is a problem as many women work part time. For older workers the raise of the actual retirement age is of importance. The government took several measures especially in tax policy to discourage early retirement and encourage working longer. The effects of these measures have been positive as the effective retirement age shifted from 59.3 in 2007 to 63.2 years in 2008.

The debate on the Pension Accord is particularly difficult within the largest trade union federation FNV. The main topic is the division of risks between employers and employees at

[18] Salaries comprise the employee's contract salary and incidental remuneration.
[19] Labour Foudation: Pension Accord Spring 2010, 4 June 2010.

the moment of profit losses of pension funds. The largest trade unions want to take less risk then the federation board of FNV. Moreover, there is debate on the level of guaranteed pension benefits (nominal rights) in relation to indexation of these benefits. It becomes more and more apparent that indexation of pensions is only possible when taking risks at capital markets. Nominal rights are characterised by a low (very volatile) risk-free discount rate, increasing buffers, or with a risk-free investment policy. The declining coverage ratios over the last ten years show that increasing buffers and return to coverage ratios above 170% is not realistic any more.[20] To put pressure on the discussion the Minister for Social Affairs forwarded already a legislative proposal to raise the pensionable age to 66 in 2020, not discussing at the moment the request of social partners to connect the first pillar state pension to earned income. A positive signal in this direction could ease the pressure on the risk and indexation discussion.

Labour market participation of elderly

The discussion on pensions is closely connected to the discussion on labour market participation of elderly workers. Also in the Pension Accord this topic was prominently mentioned. 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 63.2 years (2008).[21] At present, a debate is going on concerning the relation between the statutory retirement age and effective retirement. A more gradual rise of the statutory retirement age gives people the possibility to get used to the idea of working longer. Others state that the quicker the retirement age rises, the quicker the actual age of leaving the labour market will rise as well as people adapt more rapidly because of income changes.[22] Although the trend goes in the right direction there is common agreement that more effort is needed to increase the percentage of labour market participation of elderly and to raise the average exit age in order to make the pension system more sustainable.

The missing 10%

A last element to be mentioned in the debate and political discourse is the problem of the 10% of the working population which has no adequate additional pension provisions. As stated above, the number of self-employed is increasing and analyses of the labour market during the economic and financial crisis show that self-employed provided the necessary flexibility to keep unemployment figures relatively low.[23] Self-employed persons mainly absorbed the shock on the labour market.[24] Until recently, the third pillar was considered as an extra provision for employees in order to top up the pension benefits from the first and second pillars. For the growing group of self-employed, however, the third pillar is, in combination with some tax credits, the only supplementary pension provision available. Therefore, proposals are made to make it possible for self-employed to enter the pension funds under the second pillar in order to increase collectivity. Other options are the foundation of a second

[20] Dutch Bureau for Economic Policy Analysis (CPB) on coverage ratio's pension funds. CPB Memorandum by Jan Bonenkamp and Harry ter Rele, February 2009.
See also Prof. Dr. L. Bovenberg on the Pension Accord calling the agreement a courageous agreement, Volkskrant 24, March 2011; Ibid. Jan Nijssen: Pointing directions to future affordability of Dutch pensions, 12 April 2011, EU peer review Dutch pension system.

[21] 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.

[22] https://intranet.tudelft.nl/live/pagina.jsp?id=389a52ff-0ece-4f2e-8d21-91bd0792ece2&lang=nl.

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

[24] ibid. The social economic position of self-employed.

pillar pension fund for self-employed in which contributions are paid by every self-employed person.[25] For the levying of these contributions several options are possible like payments through the VAT system. With the quarterly payment of VAT also the contribution for pensions could be levied.

2.2.3 Impact of EU social policies on the national level

Response on the Green Paper

The Dutch government response to the Green Paper on Pensions has been closely cooperated with the Dutch Parliament (first and second chamber). The main topic of the response is that in the view of the Netherlands, Member States should be responsible of their own pension system. Moreover, the Netherlands attaches closely to its own pension system, in particular the second pillar schemes. The role of the EU should be primarily the focus on the protection of sustainable pension provisions and financial stability. The Growth and Stability Pact should play an important role in this respect. In its response, the Dutch government reflects on the value of the Dutch debate on pensions including the role of social partners. It stresses the different aspects of security in relation to risk management and is not against European legislation in this respect, provided that Member States can choose how to deal with the risk management of their pension systems. The government also states the importance of the OMC to discuss the pension policies of the Member States in order to learn from each other and implement best practices. In that way, the importance of collectivity within pensions should be more stressed.[26]

Other reactions to the Green Paper concern the shift from DB to DC systems, which should be considered as a factual circumstance in which the EU should not interfere. Also, the remark that own initiative with regard to pensions should be stimulated is not always received positive as it undermines the pay-as-you-go schemes that are still very important for many pensioners. Furthermore, the Dutch experiences with the third pillar products are not that positive. Last but not least, some responses state that the there is a lack of the social dimension in the Green Paper. In their opinion, it focuses too much on the economic dimension and on the internal market approach.[27]

The EU2020 Strategy

Reflecting on the EU2020 Strategy and the main problems for the Netherlands as set by the Council in June 2008, the Dutch government has endorsed the recommendations adopted by the European Council adding that the ten broad policy recommendations in the Annual Growth Survey of the European Commission should be seen in the light of the current economic climate. The Dutch government stresses the importance of using the full potential of the labour market in the light of a greying population, a tighter labour market in the near future, and increasing economic dynamics. It is the ambition of the Dutch government to increase gross labour market participation to 80% by 2020. The NRP report reflects in more detail on the key problems mentioned by the Council, i.e. full use of labour potential and the fact that the total number of working hours in the Netherlands is the lowest in the EU. It is in this part of the NRP that labour market measures and labour market participation are

[25] ZZP'ers in beeld, SER advies 10/04 October 2010. Also ZZp'ers en hun marktpositie, N. van den Berg, J.W.M. Mevissen, N. Tijsmans, Raad voor Werk en Inkomen, November 2009.

[26] Letter of the Dutch government to Parliament concerning the response on the Green Paper on Pensions, 11 October 2010.

[27] The most important responses can be read on the following site: http://www.npn-online.com/.

connected with the pension system. The raising of the retirement age to 66 and the proposal to connect the retirement age with life expectancy is an example of this connection. Another one concerns keeping elderly workers in the job, to promote measures with regard to lifelong learning in order to make longer participation in the labour market possible and create a new vitality programme[28] to make downgrading or part time pensions feasible. With regard to the sustainability of the Dutch pension system the thought behind these measures is to further improve the labour participation of older workers in order to increase the period of contribution payments for pensions.

2012 - The European year for active ageing

There are not many activities planned yet with regard to the year of active ageing. On local level and provincial levels 2012 as year of active ageing is mentioned, nothing more and nothing less. Some initiatives that are mentioned concern Groningen as City of Healthy Ageing, the development of a website on active ageing, and some reports on the practice of active ageing.[29]

In December 2005, the lifelong learning action programme was launched, and in 2007, the action plan for adult education.[30] Both plans aim at higher employability of elderly, reducing their vulnerability in the labour market. Furthermore, social partners are invited to enter labour agreements on measures concerning lifelong learning. Most labour conditions nowadays contain possibility for further training and education of employees. The Committee Bakker on labour participation recommended the introduction of a personal budget to be used for educational and schooling purposes. The aim should be to make employees more sustainable striving for work security instead of job security.[31] Although the Bakker report resulted in intense discussions many of its recommendations have not yet been implemented. The government wants to introduce a Vitality Fund which has characteristics of the mentioned personal budget.

2.2.4 Impact assessment

The financial sustainability of the Dutch pension systems in the first and second pillar needs further improvement. The main challenge for sustainability is how to handle financial uncertainty and demographic change. Within the world of scientific pension experts most of them agree that the pension ambition should be lowered and indexation of pensions secured, higher risk taking by participants in pension funds is necessary.[32] The debate focuses more on the question of balancing risk and security, between a DB, DC or mixed type of scheme.[33] The Dutch pension system is at the moment quite capable of providing retirees with sufficient income. With the recovery of the asset market and the current rising trend of the long interest rates the coverage rates of Dutch pension funds recovered as well. Indexation of benefits comes therefore back in the picture after having been partly deferred during the

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

[29] Active Ageing from policy to practice by Prof.Mr. L.C.J.Sprengers, November 2006.

[30] National Action Programme, A life long learning, Ministry of Eduction 2005, Action plan for adult eduction, Ministry of Education 2007.

[31] Committee Labour participation: Towards a future that works, June 2008.

[32] Prof. Dr. L. Bovenberg, Dutch pensions in an international context, Jan Nijssen pointing directions to future affordability of Dutch pensions and others.

[33] Balancing the security and affordability of funded pension schemes - The Netherlands' supplementary occupational pension plans, by Edward Palmer, 12 April 2011.

economic/financial crisis. However the sense of urgency that in the longer term change is necessary is undisputed.

Clearly, the Dutch pension system stands out among national pension systems in its level of generosity. The gross replacement rate is 88.9% for a worker with median earnings and 88% for a worker with average earnings. The net replacement rate is about 100%. As a result, only 2-3% of persons 65 and older live in relative poverty in the Netherlands.[34] The key indicator of persons at risk of poverty or exclusion aged over 65 as a percentage of the total population shows a considerable rise from 6.4% (2005) to 9.7% in 2008. In 2009, the indicator showed a decline by 1.6 percentage points to 8.1%, which can be clarified of the fading effect of the inflation rate. In 2008 and 2009, many pensions were not indexed by inflation, which explains the steep rise of the risk of the poverty indicator in 2008. Over 2009, the inflation figures decreased. In 2008, inflation was 2.25% (in 2007 1.49%) and in 2009 1.96%.[35]

Specifying the figures of poverty by gender illustrates that males as well as females contributed to the steep rise although the rise in 2007/2008 for males was much sharper than for females. The decline from 2008 to 2009 followed the same pattern from 9.5% in 2008 to 7.9% in 2009 for females and from 10.1% to 8.3% respectively for males.

It is obvious that the economic and financial crisis had an impact on the discussion regarding the Dutch pension system. Not in the sense that a new debate occurred, but in the sense that more urgency for change became apparent. Thinking about pensions is thinking about the long term and in great numbers. The fact that the economic and financial crisis harmed seriously the state budget and coverage rates of the pension funds has lead to an enhanced attention towards the longer term in which other financial and economic crises might hit again.

2.2.5 Critical assessment of reforms, discussions and research carried out

The Dutch pension reform is at the moment in a critical stage. Interests are soaring and negotiations therefore tough. Positive is that both social partners and the government are aware that change is necessary. The economic and financial crisis speeded up the debate about the sustainability of the Dutch pension system. The Dutch system is regarded as one of the best pension systems in the world providing pensioners with high benefits, which becomes obvious when looking at replacement rates. In that sense, the Dutch system fulfils the objectives of the OMC. It provides adequate retirement incomes and access to pensions for most of the population. Concerns are in place regarding the remaining 10% who depend on the first and third pillar under which a growing group of self-employed persons.

The key notion in the debate is future sustainability. Pensions are about large numbers and long-term perspectives. This makes the sustainability debate urgent regarding the balance between risks and security, raising the retirement age, the relation between the first pillar state pension and the second pillar supplementary schemes and the labour market perspectives for elderly workers. Linking the AOW benefits with the developments of earned income can be helpful in finding an agreement for balancing risks and security in the second pillar. At the moment, the Dutch government is hesitant because of the increasing state budget effects to be expected when raising AOW benefits. For the employers it is obvious that gaining security in pension benefits by increasing the contribution levels is no option any more. As a result, the

[34] Pensions at a glance, OECD 2009, and Growing unequal?, OECD 2008.
[35] Figures on inflation CPI index by CBS. http://www.homefinance.nl/economie/inflatie/inflatie-nederland-cpi.asp.

trade unions are confronted with the dilemma of, on the one hand, accepting higher risks in asset management of the funds and, on the other hand, the grass roots of the unions who demand more security in a DB way. Common agreement exists with regard to the connection of the retirement age with life expectancy and the urgency to improve the labour market situation for elderly workers.

The labour market position of elderly workers is improving due to fiscal measures of the government and the fact that the Dutch labour market was rather tight in recent years. The main challenge for the near future is to let especially women make more working hours as women work mostly part time especially when children are involved. The Pension Accord of social partners and the Dutch NRP therefore focus on creating possibilities for better combinations of work, care, free time etc. It is questionable, however, if the proposed vitality arrangement which combines some older arrangements[36] from the past will be successful. The older arrangements did not work well either although the new arrangement seems to provide more flexibility. The future will tell if the vitality arrangement will meet the challenge of working hours. Other experiments like promoting more home work, teleworking and further informatisation could increase flexibility as well.

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 population. As a consequence, the fraction of public health care expenditures (HCE) jumped by 1.4% from 7.1% in 2005 to 8.5% in 2006.[37]

To spur competition, every resident has the formal right to switch to another insurer by the end of the year. Employed residents pay a state-set contribution (7.75%) of their income with a maximum of 2,600 euros a year) plus a flatrate premium set by each insurer separately (on average about 1,150 euros in 2011). The state pays for children under 18. Since 2008, there is also a mandatory deductible (170 euros in 2011) with an exemption clause for General Practitioner (GP) care, mother and child care 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 (ban on risk selection); (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 flatrate 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

[36] The two most important older arrangements are the saving fund in which employees can save on a monthly basis a fiscal-friendly maximum amount of their salary, and the course-of-life fund with which employees can take extra days of e.g. learning or care tasks at home (children, elderly).

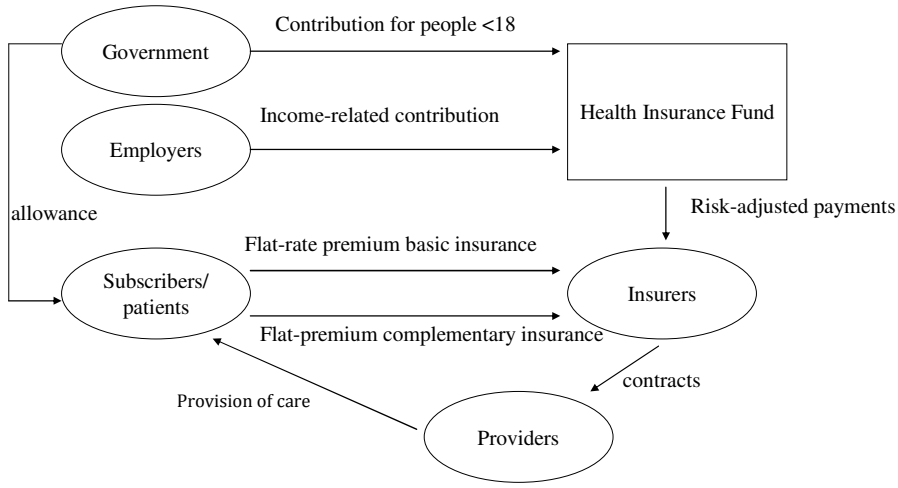
[37] CPB (2010). Macro Economische Verkenning 2011; www.cpb.nl.

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 current policy issue is whether to permit hospitals to go for profit. The new government, in office since October 2010, declared that it will 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. However, the introduction of for-profit hospital care remains controversial. To build a political majority, the government opted in its Coalition Agreement for what was termed 'regulated for-profit hospital care'.

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, orthopedic surgery,

radiology, neurology, and cardiology. Some centres can be best described as a small specialised hospital. The rise of independent centers 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 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. At the same time, however, the budget plan includes an extra raise of 0.9 billion to enhance the workforce in long-term care. The structural impact of the austerity measures on health care expenditures in 2015 is as follows (in Euro):[38]

Table 1:

Expenditure in CURE	-1.4 billion
Expenditure in CARE (including LTC)	-0.7 billion
Extra expenditures in LTC	+0.9 billion
TOTAL	-1.2 billion

Another austerity measure is to target the state health insurance allowance at only those persons 'who really need financial state support' to purchase a basic health insurance policy. The budgetary impact in 2015 of this measure is estimated at -2.1 billion euros.

2.3.2 Debates and political discourse[39]

There is much debate about the future course of the market reform in Dutch health care. Two topics stand out here. The first topic concerns the further introduction of market competition in health care, in particular by widening the scope of competition in hospital care and some other areas of health care. The market reform is explicitly supported by the Liberal Party (*VVD)* and the Christian-Democrats (*CDA*). Both parties acknowledge that competition requires intensive regulation to preserve universal access and improve the quality of care. The Democrats (*D'66*) also opt for the market reform; they particularly emphasise that competition requires patients to make their own choices. The Labour Party (*PvdA*) is critical about competition and opts for a temporary standstill as regards the market reform in hospital care. The Labour Party also opposes the introduction of for-profit hospital medicine. The Christian Union (*CU*) tends to support managed competition in health care, but further steps require a careful evaluation of its effects on quality, access and costs et cetera. The Green Party (*Groen Links*) is critical about the market reform. Yet, it supports the further introduction of competition, but rejects the lifting of the ban on for-profit hospital medicine. The Socialist Party (*SP)* has consistently manifested itself as an opponent to the market reform. The position of the Party for Freedom (*PVV*) is unclear. The party has declared itself as an opponent of the market reform. But as a quasi-member of the current government it is uncertain what position the party will take, if new market making decisions are discussed in the Parliament. This brief overview indicates that the market reform is still controversial in

[38] Bijlage Regeerakkoord Vrijheid en Verantwoordelijkheid (*Annex to Coalition Agreement Freedom and Responsibility*) (2010).

[39] Information for this section was retrieved from the websites of the political parties mentioned.

Dutch health care. Yet, our assessment is that opposition is not so strong that the reform will be terminated or revoked.

Another key topic concerns the balance between the income dependent contribution rate, set by the government, and the flatrate premium, set by each insurer separately (competition). HIA regulates that the balance between contributions and the state grant for children under 18 on the one hand, and the flatrate premium on the other hand, must be 50:50. Several political parties including the Labour Party, the Green Party, the Christian Union call for a significant raise of the income dependent contribution rate together with a significant decrease of the flatrate premium. They reason that this measure will not only strengthen income solidarity, but also make the present system of state allowances to compensate persons on low income superfluous and reduce administrative costs. The Socialist Party favours a complete abolition of flatrate premiums.

2.3.3 Impact of EU policies at the national level

Debate on the OMC in the field of health care

The contribution of the Netherlands to this debate has been limited in 2010. The Annual National Report 2010 does not discuss health care either. The explanation for this state of affairs is the fall of the previous coalition government in March 2010. After the elections in June it lasted until October 2010 for the new government to take office.

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 HCE, the introduction of new innovative technologies in medical care, the full use of the workforce, et cetera.

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 also put an end to the labyrinth of private health insurance consisting not only of pure private health insurance schemes, but also of state-regulated private health insurance and some specific private schemes for categories of public servants.

The integration of the sickness fund scheme and private health insurance in a single scheme has reinforced solidarity. However, the premium charge (including the employer's part) is significantly lower for persons on high income (100,000 euros) than for people on low income (10,000 euros); the percentages are about 7% and 25% respectively. The premium charge for persons with an income of 20.000 euros is estimated at about 22%; for persons with an income of 40.000 euros at about 18%; and for persons with an income of 60,000 euros at about 12%.[40] The state allowance to compensate people on low income is included in these

[40] W. Vermeend & R. van Boxtel (2010). Uitdagingen voor een gezonde zorg (*Challenges to a healthy health care)*. Amsterdam: Lebowski Publishers.

estimations. How to assess these differences in premium charge is of course a matter of political appreciation.

The market reform enhanced consumer choice because of their yearly switching (exit) option. However, there are good reasons for not overstating the enhancement of 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 because of the centralised decision making model. Furthermore, there are many practical restrictions to consumer choice, such as lack of transparency, high transaction costs of switching, and market structure.

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, signaling 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.[41]

Since the 2006 reform the number of insurers has significantly dropped from almost 57 to 29 in 2010.[42] However, these figures obscure the concentrated structure of the health insurance market because four major companies (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).[43] The growth of total expenditures for outpatient prescription drugs has also been rather modest over the past few years. Over the period 2006-2009 expenditures grew by 10.7%, which is significantly less than the 19.4% growth of total HCE.

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 about 33% in 2009. The stepwise and cautious extension of free pricing was not only intended to build up experience, but also echoes the continuous need of political compromising. Generally speaking, price increases in the free pricing segment are 1-2% lower than in the segment where prices are still regulated by the Netherlands Health Care Authority.[44]

Over the period 2006-2011, the income-dependent contribution rate grew from 6.5% to 7.75%, and the flatrate premium, corrected for the transition from the no-claim arrangement to the mandatory deductible arrangement in 2008, by 38%, from an average of 795 euros per person in 2006 to an average of about 1,100 euros in 2011.

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41 Vektis (2011). Verzekerden in beweging (*Mobility in health insurance)*; www.vektis.nl (accessed 1 May 2011).

42 Vektis (2010). Zorgverzekeraars en zorgfinanciering (*Health insurers and health care financing*); www.vektis.nl (accessed 1 May 2011).

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

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

Over the period 2006-2009 total HCE rose by 19.4% compared to 16% over the period 2002-2005.[45]

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.[46] This was due to the drop of 3.9% in GDP.[47] Health care cannot be exempted from austerity programmes to restore the financial balance and meet the requirements of the EU Stabilisation Pact (see Table 1 for more details).

Groups not covered by the health system

HIA regulates that only persons who are a legal resident of the Netherlands can enroll. Another regulation is that any person who fails to purchase a basic health insurance policy, is uninsured by implication. The total number of uninsured persons was estimated at 152,000 (reference period May 2009), but this number has fallen to 136,000 (May 2010).[48] Uninsured persons must be distinguished from persons with insurance who fail to pay their premium. The total number of defaulters – defined as persons with insurance who failed to pay their premium over a period of at least six months – was estimated at 318,000 in December 2009. Using a new definition this number dropped to 244,000 in December 2010, which equals about 1.9% of the adult population.[49]

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 what it termed 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.

Assessment of health outcomes

Quality of care, in particular measured by health outcomes, has become a hot issue in health care. Though much figures point to high quality of care and the great majority of the people perceives the quality of care as good or even excellent,[50] there are various indications that the quality of care can and should be improved. An important development in this respect

[45] http://statline.cbs.nl (accessed 1 May 2011.
[46] CPB (2010). Macro Economische Verkenning 2011 (*Macro Economic Enquiry 2011*).
[47] CPB (2010). Macro Economische Verkenning 2011 (*Macro Economic Enquiry 2011).*
[48] CBS (2011). Persbericht: 10% minder onverzekerden tegen ziektekosten in 2010 (*Press release: 10% fewer uninsured*); www.cbs.nl (accessed 1 May 2011).
[49] CBS (2011). Persbericht: 10% minder onverzekerden tegen ziektekosten in 2010; www.cbs.nl (accessed 1 May 2011).
[50] See for instance the RIVM report Prestaties van de Nederlaandse zorg (Performances of Dutch health care). Bilthoven 2010.

concerns the growing emphasis on the quality of health care, not only in terms of input and process indicators but also in terms of health outcomes and patient/client satisfaction. Since the early 2000s, a lot of energy has been given to the development of valid indicators to compile 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 improvements 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.

The quality of health care is no longer taken for granted and left merely to health professionals. The external dimension in assessing health outcomes has gained in importance. For instance, the Medical Inspectorate has adopted a much more activist and critical attitude than in the past. Patients and clients are frequently asked for their assessment of quality of care and their judgments are accessible on the internet. Patient/client organisations are also increasingly involved in the development of quality indicators. Insurers are active in this field, too (see critical assessment).

The current emphasis upon quality measurement and its role in performance-related payment has also been criticised. There are concerns about the administrative costs involved, the logic of escalation[51] (ever more indicators) and the danger of perverse effects (e.g. gaming by provider organisations). On a more fundamental level there is a critical debate on the limits to quality measurement (given the complexity of care) and its impact on consumer choice. Nevertheless, it is evident that quality measurement marks a new era in health care. It is impossible to imagine future health care without.

2.3.5 Critical assessment of reforms, discussions and research carried out

In 2011, the new Minister for Health alluded to nine priorities grouped in three categories in her policy document entitled "Care that works" (*Zorg die werkt*):

A. *The presence of primary care and sports facilities in the neighborhood*

Primary care facilities including GP care, pharmacy, physiotherapy, dentistry, community nursing, and mental health care should be directly available in the neighborhood. Insurers are expected to play a key role by rewarding initiatives that improve access to primary care.

There is a need for safe sports facilities for young and old people in the neighborhood.

B. *More value for money*

Health care funding will be based upon performance. The most important measure here is the extension of free pricing in hospital care and the introduction of a new case-based payment

[51] C. Pollitt, S. Harrison, G. Dowswell, S. Jerak-Zuiderent, R. Bal (2010). Performance regimes in health care: institutions, critical junctures and the logic of escalation in England and the Netherlands. *Evaluation*, 16/1; 13-29.

system. The current 30,000 hospital products in the form of diagnosis treatment combinations (*diagnosebehandelingscombinatie/DBC*) will be replaced by a system of about 3,000 hospital products, termed DOTs (*DBC's Op weg naar Transparantie).* Another important measure concerns the abolishment of ex-post risk equalisation arrangements in health insurance in order to stimulate insurers to achieve better results in health care purchasing.

The pursuit of improving the quality of care, including its safety, and transparency of care will be continued. The Medical Inspectorate will work according to the principle of high trust and high penalty. Medical communities are expected to formulate standards for high quality care. These standards must also include volume norms for frequent complex care. Insurers are expected to use these norms in purchasing health care.

Activities will be undertaken to increase and optimise the workforce for health care. The numerus fixus will be gradually abolished. Task substitution by specialist nurses will be encouraged.

C. *Enhancing the freedom of choice of consumers and health care entrepreneurs*

The delivery of optimal care requires better coordination between health care providers, but this coordination should not restrict freedom of choice. The approval procedure of consolidations should also be quality-based. Consolidations of insurers with provider organisations (vertical integration) will be forbidden by law.

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 behavior including a healthy living environment are warranted.

The room for entrepreneurial behavior will be increased. Innovation in health care requires active public-private partnerships. To encourage such partnerships the traditional ban on for-profit hospital care will be replaced with a model of regulated for-profit hospital care. More room for entrepreneurship also implies more self-responsibility.

There is a strong need for reducing administrative costs

Many of these priorities indicate that the market reform will be continued and that the scope of market competition will be enhanced. This is an important point because, in contrary to the rhetoric of competition, the scope of competition in health care delivery has remained restricted so far. Free pricing in hospital care is limited to about 33% of hospital revenues. Maximum prices (set by the Health Care Authority) are widely used in long-term care. The tariffs of self-employed specialists (fixed hourly rate) and, for the major part, general practitioners are regulated by the Health Care Authority. Extra billing is forbidden by law.

There are several complementary explanations for this restricted scope. To a great extent it is the result of the government's cautious implementation strategy to create opportunities for policy learning and, more importantly, avoid market distortions. But politics has always played an important role, too. The controversial nature of market competition made a radical approach impossible. An incremental approach was the only way to move forward.

The gradual implementation strategy is not without disadvantages, however. Firstly, it creates uncertainty about the further course and 'ultimate' shape of the market reform among all stakeholders involved. This may have a negative impact on strategy development. Secondly, one cannot but conclude that the gradual implementation strategy has brought about a health care system that in several respects is even more hybrid than it was before. Hospital care is a case in point. The current funding model implies the coexistence of two different regimes: the regulations and incentives in the A-segment (no free pricing, collective bargaining, and no

incentive to increase production because of the budget ceiling) are different from the regulations and incentives in the B-segment (free pricing, bilateral bargaining, incentive to increase production). This is not only highly confusing but also a source of administrative complexity and costs. The new Minister for Health described the present situation in hospital funding as 'stuck in the middle'.

Her list of priorities indicates a choice for more competition, for instance by increasing the scope of free pricing in hospital care to 70%. Only hospital services for which free pricing is considered to be unfeasible or undesirable should be funded by means of a fixed budget (e.g. trauma care, some top clinical care types, donor teams, helicopter services). Free pricing will also be introduced in some other areas of health care, e.g. dentistry. Other market making decisions concern the abolition of ex-post risk equalisation (which requires further improvement of the already sophisticated system of ex-ante risk equalisation) and the introduction of regulated for-profit hospital care. On the other hand, she intends to forbid vertical integration in order to preserve consumer choice.

The extent to which this 'leap forward' will be successful, is uncertain. The transition from the current situation to the new situation (termed 'end model') is complicated from a technical perspective, the more so because it will be combined with the replacement of DBCs with DOTs. Extensive temporary regulation is held to be required to ensure a 'smooth' transition and avoid destabilising effects. Hospitals are skeptic about the temporal nature of these measures and insurers have casted doubt about the feasibility of the trajectory. Medical specialists will be eager to retain their revenues.

Furthermore, one should not forget the political context. It is uncertain whether the government manages to build a political majority for plan. Skepticism about the impact of market reforms and privatisation, not only in health care, but in other public policy sectors as well, is on the rise. Politicians fear that they have ever less to say in health care, because decision making is increasingly shifted away from the political arena to the expert world of the Health Care Authority and the commercial world of insurers and/or provider organisations. They are well aware of the political sensitivity of health care.

In this respect, it is not only interesting but also confusing to see how the language of market competition tends to be gradually replaced with the language of collaboration. This suggests that, at least in the view of many, the 'logic of market competition' must be supplanted by the 'logic of care'. The call of insurers for more specialisation, differentiation and concentration in hospital care also fits in this new policy trend.

Cost control will remain a key issue in health care policy making. The growth of health care expenditure (HCE) is expected to be twice the expected GDP growth (4% versus 2%). Hard measures will therefore be required to reign in the future growth of HCE. Without these measures, the current solidarity arrangements in health care financing will no longer be sustainable. An uncontrolled growth of HCE will also mean a serious threat to universal access to health care. Furthermore, it is evident that an uncontrolled growth will have far-reaching implications for the wider economy and public spending in general (crowding out).

As said earlier, the records of the market reform in cost control have not been impressive so far. In this respect, it is hardly surprising that the government does not rely solely upon market competition to effectuate cost control. It also wants to retain a 'classic' instrument for cost control, namely setting a global fixed budget for health care and its sectors. Just like in the past, cost overruns will be offset by government-imposed tariff cuts (or other policy measures). However, this creates a fundamental tension in the market reform. On the one

hand, the government strives for market competition (free pricing, volume contracting, et cetera). On the other hand, however, it wants to control total public HCE by upholding the global budget instrument (*budgettair kader zorg/BKZ*). This double-edged strategy looks a little bit like 'squaring the circle' and will, beyond any doubt, turn out to be a source of great complexity and continuous conflicts in the future.

A final comment concerns the role of health insurers. The priorities in the policy document '*Zorg die werkt'* indicate a strong reliance on the role of the insurers. Effective market competition in health insurance requires insurers to act as prudent purchasers of health care on behalf of their customers. They are assumed to negotiate with provider organisations on prices, volume of care, and quality of care. Furthermore, they are expected to play a key role in restructuring health care by means of specialisation, differentiation and concentration of care. Insurers and other financial stakeholders (banks) will also have to bear the financial risk of bankruptcies. Only in case of situations beyond one's control the government will remain responsible for the continuity of care in the field of patient transport (ambulances), obstetrics, emergency care, crisis intervention for persons with mental disorders and what is termed 'crucial long-term care'.[52]

It remains to be seen to what extent insurers will fulfill these expectations. Managed care by selective contracting and patient steering are largely in their infancy. Selective contracting hardly exists yet. Nevertheless, some interesting developments can be observed. In 2010, one insurer (CZ) made public that it would no longer contract four hospitals for breast cancer surgery, because their quality of care, measured by capacity, volume (number of operations) and patient satisfaction, did not meet the minimum standard. An interesting effect of this remarkable initiative was that it prompted the Society of Surgeons to publish quality standards for some surgical procedures. The Society clearly wants to remain in the driving seat as regards the definition and control of the standards of quality of care which it sees as its exclusive area of expertise. In the meantime, another big insurer (Achmea) announced to use these standards in hospital contracting. So, it may well be that selective contracting comes off the ground and that hospitals will be forced to reconsider their portfolio. A fundamental question remains of course, how patients will assess these new developments in terms of freedom of choice and access to care.

As regards patient steering, so far insurers have mainly used soft instruments to influence patients, in particular by giving them information on the waiting times of hospitals. Patients also increasingly ask insurers for information about the quality of care. Some insurers use positive incentives by exempting patients from paying the mandatory deductible if they visit a certain hospital, and some insurance policies require patients to visit preselected providers for non-acute care. Patient steering by requiring patients to co-pay for health care in a hospital without a contract hardly exists yet.

In summary, we can conclude that the government has opted for the further marketisation of health care. However, it does not solely rely on competition to reign in health care expenditures. The implementation of the steps outlined is complicated, not only for technical but also for political reasons. The future course of the market reform as well as its effect upon HCE and other issues remain uncertain.

[52] Policy Letter to the Parliament on Safeguards for continuity of care (*Waarborgen voor continuïteit van zorg*).

2.4 Long-term care

2.4.1 The system's characteristics and reforms

Long-term care (LTC) is mainly provided by not-for-profit provider organisations, in particular nursing homes, houses for residential care and home care delivery organisations. Clients can also apply for a cash-benefit (direct-to-client payment) to purchase LTC. Until the mid-1990s needs assessment was still performed by provider organisations. Since then, the government's policy has been to standardise needs assessments by the development of universal and objective criteria. This process of centralisation culminated in 2005 in the creation of a specific national agency for needs assessment (the *Centraal Indicatieorgaan Zorg/CIZ*). The CIZ is in charge of developing criteria to determine who is entitled to LTC, for which type of LTC, and for how much LTC. Assessment of the needs of individual applicants is made by CIZ's regional branches. Over the past few years, the trend has been to make the provider organisations responsible again for needs assessment and to transform the CIZ from an assessment agency into an agency in charge of the supervision of the assessment of provider organisations. The reassessment of clients and the assessment of clients with complex problems will remain a task for the CIZ. The purpose of this partial decentralisation of needs assessment is to reduce bureaucracy and reinforce the professional self-responsibility of provider organisations.

There are two main regimes for financing LTC. The first regime is the Exceptional Medical Expenses Act *(Algemene Wet Bijzondere Ziektekosten/AWBZ).* The AWBZ is a mandatory social health insurance scheme, in place since 1968, covering the entire population. The contribution rate is 12.25% of income with a maximum of 3,920 euros a year. The scheme pays, among others, for nursing home care, care in houses for residential care and community nursing. Clients are required to co-pay. The size of the co-payment depends on age, income and living situation. Personal budgets for LTC are also financed through the AWBZ. The AWBZ covers about 70% of the expenditures; 25% of the remaining 30% is tax-financed and 5% by co-payments.

The second financing regime concerns the Social Support Act (*Wet Maatschappelijke Ondersteuning/WMO*) which has been in place since 2007. This regime made municipalities responsible for social care to clients who need support. The WMO also charged municipalities with the funding and delivery of household services (domestic care). For this task they receive a budget from the government (tax financing). Prior to the WMO, the funding of household services formed part of the AWBZ. Unlike the AWBZ, the WMO is not an insurance scheme defining a right to care, but instead a budget scheme. Municipalities are not obligated to fund and deliver household services, if their WMO budget is exhausted.

Whereas municipalities are charged with the implementation of the WMO, the AWBZ is implemented by health insurers. In theory, each insurer must implement the AWBZ for their subscribers. Practice is different, however. For each region the government has designated one insurer to implement the AWBZ on behalf of all other insurers (representation model). The designated insurer runs the regional care office (*zorgkantoor*) which is in charge of the contracting and funding of provider organisations, financial control, et cetera. Health insurers do not incur a financial risk in the AWBZ. It is often argued that the absence of such a risk does not motivate them to make the best of it.

Currently, there is much debate about the future of the AWBZ. With the introduction of the WMO various services, in particular household services, were shifted from the package of the AWBZ to the working area of municipalities. This policy will be continued by making

municipalities responsible also for the delivery of other LTC services including welfare support once covered by the AWBZ. As a consequence, one may speak of a substantial upgrading of the role of municipalities in LTC. The rationale of this strategy is that municipalities are best capable to deliver tailor-made LTC services to their inhabitants. LTC requires an integrated strategy, not only including LTC, but also housing, welfare, activities to stimulate social participation, and so on. Municipalities are already responsible for policy making in these areas. Decentralisation of health services to municiplaties is also assumed to be an effective instrument to increase efficiency. Therefore, it is combined with substantial expenditure cuts.

A second reform concerns the shifting of various types of health services from the AWBZ package to the benefit package of services covered by the new health insurance scheme (HIA). Examples are rehabilitation care and community nursing. The purpose of this package shifting is to encourage and enable health insurers to develop integrated care pathways for their clients. The coexistence of two separate funding schemes (HIA and AWBZ) is considered to be a major stumble block to develop such pathways.

The gradual dismantling of the AWBZ raises the question of what to do with nursing home care and other forms of real LTC for the elderly. The current position of the government is to make health insurers responsible for these services by shifting them to the benefit package of HIA. This is a complicated process, however. It requires a substantial extension of the ex-ante risk equalisation scheme to compensate health insurers for the specific risk profile of their insured population.

Health care expenditures for LTC

It would be misleading to consider the AWBZ expenses as expenses for LTC for elderly people. This is due to the fact that the AWBZ scheme covers many other health services than LTC such as the care for people with mental retardation and long-term psychiatric care. Young people with socio-medical problems also make increasingly use of AWBZ-funded health services.

Table 2: Expenditures for long-term care, 1998-2009 (in billion euros)

	1998	2000	2002	2004	2006	2008	2009
LTC-AWBZ	7.6	8.7	11.2	12.3	13.4	14.8	15.5
WMO	--	--	--	--	--	1.3	1.3
Total	11.7	14.5	18.5	21.1	23.1	21.6*	23.0

Source: CBS for LTC-AWBZ (http://statline.cbs.nl) and SCP for WMO (www.scp.nl). * The decrease of expenditures is caused by the shifting of the household services from the AWBZ to the WMO.

Table 2 shows that expenditures for LTC covered by the AWBZ have more than doubled over the period 1998-2009 (104%) and even more, if the WMO expenditures are included (121%). The LTC expenditures per capita 65+ grew from 3,621 euros in 1998 to 6,262 euros in 2009. The sharp increase of expenditures in the period 2000-2002 is largely explained by the government's policy to reduce waiting times for LTC.

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.[53] However, the take-up is low. "In the Netherlands", according to Bettio and Plantenga[54], "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).[55] 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.[56] 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. A distinction can be made between the AWBZ and the WMO. For the AWBZ the most important measures were:

- Stricter guidelines for needs assessment;
- Delisting of some LTC services from the benefit package of the AWBZ;
- Care offices negotiate with provider organisations on the price and quality of care. Agreed prices are lower than the maximum prices set by the Netherlands Health Care Authority;
- Introduction of a new performance-based funding model. Funding is client-based and depends upon his/her severity of need. There are ten severity-of-need categories. The new funding is assumed to improve efficiency.

As regards the WMO municipalities have sought to curb the demand for LTC by the introduction of strict criteria. Municipalities may cooperate for needs assessment with the CIZ, but they are not required to do so. As a consequence, there is some variation in the criteria applied. Some municipalities currently consider the introduction of an income ceiling. Applicants whose earnings exceed this ceiling do no longer qualify for WMO-funded services (means testing). Municipalities also organise competitive bidding to contract provider organisations. This procedure has led to several bankruptcies of provider organisations.

2.4.2 Debates and political discourse

There has been an intensive debate on the future of the LTC in the Netherlands over the past few years. Several bodies including the Social-Economic Council (*Sociaal-Economische*

[53] E. Mot (2010). The Dutch system of long-term care. CPB-document, no. 204; www.cpb.nl.
[54] F. Bettio, J. Plantenga (2004). Comparing care regimes in Europe. *Feminist Economics* 10(1): 85-113.
[55] E. Mot (2010). The Dutch system of long-term care. CPB-document, no. 204; www.cpb.nl.
[56] 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.

Raad), the Council for Public Health and Care (*Raad voor de Volksgezondheid en Zorg*), the Health Insurance Board (*College voor de Zorgverzekeringen*), and several consumer/patient organisations have expressed their view. LTC has also become an important topic on the political agenda. It was even explicitly given attention in the Coalition Agreement of the new government. The general opinion holds that a reform of LTC is needed, not only to improve its quality and efficiency, but also to restructure its funding. Various participants in the debate argue that a substantial part of the services covered by the AWBZ should be shifted to the benefit package of the basic health insurance scheme. Such a shift is seen as essential for the development of an integrated and patient-centred supply of health services. In addition, various services directed at activation and social participation of clients should be shifted to the local government which is assumed to be in a better position than health insurers to develop tailor-made services to empower people who require LTC.

The political debate also concerns the financing of LTC. 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.

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 (see further below).

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.[57]

Impact of the EU2020 strategy on LTC

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.

2.4.4 Impact assessment

Indicators to assess the quantity and quality of LTC

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.

Data collection for category 1 indicators takes place every year, for category 2 indicators every two years. Much attention is given to the further development of indicators, including the proper correction of case mixes and the development of indicators for specific client groups (clients with dementia, rehabilitation patients, and clients with non-congenital brain damage).

Recent developments with regard to the costs of LTC

The expected growth of expenditures for LTC is a source of great concern. Over the last decade, expenditures have been increasing rapidly. The government's policy to reduce waiting times around the turn of the century plus the extension of the benefit package of the AWBZ by generously including social support and guiding services caused an extra growth of

[57] 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.

expenditures (it is recalled that not only elderly people but also persons at young age have benefitted from this extension of the benefit package). Policy makers realised that the terms of entitlement were not always well defined; as a consequence, the demand for these services turned out to be much higher than expected. To handle expenditure growth, the criteria for needs assessment have been made stricter than they were in the past.

Another source of budgetary concern is the exponential growth of personal budgets. This programme started in the mid-1990s. Initially, its costs were less than 100 million euros. In 2010, however, total costs were about 2.2 billion. The introduction of stricter criteria has hardly had any significant effect so far. The instrument of personal budgets has become quite popular, because they enable people to purchase health care themselves which is assumed to make care more client-centred. Personal budgets may not only be used for purchasing benefits in kind of established provider organisations including nursing homes or home care delivery provider organisations, but also to purchase informal care (the so-termed monetarisation of informal care). The exponential growth of the expenditures for personal budgets was not followed by a declining demand for institutional care. Personal budgets have evolved as an extra pipeline in funding LTC.

In her recent programme letter on long-term care (June 2011), the State Secretary for Health announced a drastic retrenchment programme. Only persons who have been assessed as eligible for a stay in a home for long-term residential care (e.g. nursing) can opt for a personal budget to purchase care privately. All other persons will lose their personal budget. In practice this means that the great majority of the current budget holders (about 90%) will loose their personal budget. How to guarantee them access to care remains somewhat unclear, but the State Secretary strives for more self-responsibility and an extension of informal care. The personal budget of the persons who qualify for it will be raised by 5%. Furthermore, a personal budget will become a legal right.[58]

Shortage of medical and nursing staff in LTC

In her recent Labour Market Letter (*Arbeidsmarktbrief*) the new Minister for Health announced 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.

[58] Programme letter to the Parliament on long-term care (Programmabrief langdurige zorg) (2011).

Impact of increasing needs of LTC on family members

As said before, the government's policy is to direct LTC at only those people who really need it. This strategy will increase the demand for informal care by family members. The government presently considers policy measures to support informal caregivers.

The demand for LTC may change in the future, not only because more elderly people will live longer in healthy conditions (healthy ageing), but also because they want to live in their personal environment as long as possible and direct the LTC they need themselves, for instance by mobilising or setting up social networks and forming cooperatives to purchase LTC (see also section on estimates of the future demand of LTC).

Information gaps

The government provides funds for various national programmes to develop and evaluate new instruments for LTC. Two examples are the "In for Care Programme" (In voor Zorg programma) that collects and disseminates information on pratical experiences with innovations in LTC, and the "National Programme on Elderly Care" sponsored by the research organisation ZonMw. Furthermore, much energy is given to the measurement of the quality of LTC.

Estimates with regard to the future demand for LTC, expenditures, facilities, staff, services

There is discussion about the growth of LTC demand. According to the Office for Social and Cultural Planning (*Sociaal en Cultureel Planbureau*) the average annual growth of 1.8% over the period 1985-2005 cannot be simply extrapolated to the future. It's growth for the period 2010-2030 is estimated at only 1.2% because of healthy ageing.

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). In this respect, it is interesting to note that the Party for Freedom (PVV) has chosen LTC as a key element of their programme.

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. In this respect one should take into account, that the current percentage of 15.3% of people aged 65 and older is expected to increase to 17.5% in 2015 and 23.7% in 2030. The percentage of people aged 80 and older is expected to increase rapidly after 2025; in 2050 four out of ten persons aged 65 and older will be aged 80 and older.

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 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.

3 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] Disability

[L] Long-term care

[R] Pensions

[R1] BOVENBERG, Lans, Moedig pensionakkoord benoemt risico's. "Courageous pension agreement points out the risks", March 2011, Tilburg.

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.

[R2] COMMITTEE FRIJNS: "Pensioen:onzekere zekerheid", Pension not for sure, January 2010, the Hague

The report of the Committee Frijns discusses the risk and investment management of pension funds as well as the governance of these funds. The conclusions were that the pension funds did not pay enough attention to risk management and the quality of their investments. Furthermore social entrepreneurship is not an integral part of the risk and investment management of the funds. In its recommendations Frijns pleas for durable investment policies, the determination and willingness of participants to accept risks and last but not least that the real objective of the fund must be a real pension that maintains its purchasing power. It is important for pension funds to ensure sufficient expertise in the board in order to be able to initiate policies in the field of risk management, investment management and execution.

[R2] COMMITTEE GOUDZWAARD: "A strong second pillar, towards a sustainable supplementary pension system", 2010

The report of the Committee Goudzwaard discusses the future of the second pillar pension system. The committee advised to take three options into consideration: lowering ambitions, increasing contributions or to take more investment risks. The report was asked by the Dutch government and its results will play an important part in the discussion regarding the future of the Dutch pension system.

[R1] DUTCH GOVERNMENT response to the Green Paper towards adequate, sustainable and safe European pension systems, 14 October 2010

The main topic, which was stressed in the response, is that in the view of the Netherlands, Member States should be responsible for their own pension system. Moreover the Netherlands attaches closely to its own pension system in particular the second pillar schemes. The role of the EU should be primarily focus on the protection of sustainable pension provisions and financial stability. The Growth and Stability Pact should play an important role in this respect. In its response the Dutch government reflects on the value of the Dutch debate on pensions including the role of social partners. It stresses the different aspects of security in relation to risk management and is not against European legislation in this respect provided Member States can choose how to deal with the risk management of their pension systems. The government states also the importance of OMC to discuss the pension policies of the Member States in order to learn from each other and implement best practises. In that way the importance of collectivity within pensions should be more stressed

[R3] DUTCH GOVERNMENT, Wet verhoging pensioenleeftijd naar 66 jaar. "Law on the raise of the pesionable age to 66", May 2011.

This law entails the raise of the pensionable age to 66 in 2020. This draft law is now in parliament for debate.

[R2; R3; R4] LABOUR FOUNDATION, Pension Accord Spring 2010, June 2010

The Pension Accord is the basis for the current negotiations between social partners and government on the sustainability of the Dutch pension system. The accord reflects on the retirement age, the labour market perspective of elderly workers and the financial sustainability of pension funds.

[R1] LABOUR FOUNDATION, response to the Green Paper towards adequate, sustainable and safe European pension systems, November 2010

The Dutch Labour Foudation endorses the response of the Dutch government.

[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; R2] PALMER, Edward, Balancing the Security and Affordibility of Funded Pension Schemes-The Netherlands Suppementary occupational pension plans, April 2011, Uppsala

In his article Mr. Palmer reflects on the sustainability of Dutch supplementary pension plans. His answer to this question is positive although fine tuning of the system is necessary taking into account a long-term period to even out economic crisis and financial shocks.

[R1] REGEERACCOORD, Vrijheid en verantwoordelijkheid. October 2010.

"Coalition Agreement, Freedom and Responsibility"

This document is the basis for the government policies for the current government period of four years. The main measures regarding pensions concern the raise of the retirement age to 66 in 2020 and the reduction of the budget deficit.

[R2; R3] SOCIAL ECONOMIC COUNCIL (SER), Self-employed in the picture, October 2010

Until recent the third pillar was considered as an extra provision for employees in order to top up the pension benefits from the first and second pillars. For the growing group of self-employed however the third pillar is in combination with some tax credits the only supplementary pension provision available. Therefore proposals are made to make it possible for self-employed to enter the pension funds under the second pillar in order to increase collectivity.

[R3] SVB, Brochure: the AOW pension. 2011

The brochure explains for pensioners the rules with regard to the AOW pension. It provides information on the level of benefits, living situation etc.

[H] Health

[H1] BESSELING. Health spending and public finance: what will bring the future? April 2011 (Centraal Planbureau, Netherlands Bureau for Economic Policy Analysis).

This report states that the current 4% growth rate of spending will lead to a doubling of the share of health care in GDP in the decades to come. Ceteris paribus, this growth would require much more than a doubling of the redistribution, which would in turn lead to either a crowding out of other government services and social security or a considerable loss in GDP.

[H4] BOONEN & SCHUT. Preferred providers and the credible commitment problem in health insurance: first experiences with the implementation of managed competition in the Dutch health care system. Health Economics, Policy and Law, 2010 (online).

This article gives a brief overview of developments in the area of managed care in the Dutch health care system since the 2006 reform. It also discusses the credible commitment problem of insurers.

[H3] CENTRAAL BURAU VOOR DE STATSTIEK, Tien procent minder onverzekerden tegen ziekkosten in 2010.

"Ten percent LESS people without health insurance"

In this bulletin the number of people without insurance has fallen from 152,000 persons (reference period May 2009) to 136,000 (May 2010). The total number of defaulters – defined as persons with insurance who failed to pay their premium over a period of at least six months – was estimated at 318,000 in December 2009. Using a new definition this number dropped to 244,000 in December 2010 which equals about 1.9% of the adult population.

[H4] MAARSE, J. Markthervorming in de zorg. Een analyse vanuit het perspectief van de keuzevrijheid, solidariteit, toegankelijkheid, kwaliteit van zorg en betaalbaarheid. Maastricht, Mei 2011. Datawyse.

"Market reform in health care. An analysis from the perspective of freedom of choice, solidarity, accessibility, quality of care and affordability"

This study gives an overview of the market reform in Dutch health care. There are two leading questions: (a) what is the impact of freedom of choice, solidarity, accessibility, quality of care and affordability upon the shape of the market reform and, conversely,(b) what is the impact of the reform upon these values? The analysis contains a short description of the background of each value, its translation in regulations and policies, the meaning of each value in the 'real world' of health insurance and health care provision and a speculative assessment of the long-term impact of the reform upon each value.

[H1] MINISTERIE VAN FINANCIEN, Nota over de toestand van 's Rijks Financiën 2011. September 2010.

"Note on the situation of the state's finance"

This document gives an overview of the public revenues and expenditures including health care

[H1] MINISTERIE VAN FINANCIEN, Rapport curatieve zorg. April 2010.

"Report on Curative medicine"

This report of the working group on cure presents an analysis of the performance of the Dutch health care system. It outlines two alternative proposals for a substantial expenditure cutback programme (6.35 billion euros) in health care. The report was prepared for the new government as a tool to decide on expenditure cuts in health care as part of its general policy to restore public finance.

[H1] MINISTERIE VAN FINANCIEN, Rapport langdurige zorg. April 2010.

"Report on long-term care"

This report of the working group on long-term care combines proposals for expenditure cuts of about 4.2 billion euros with three alternatives for a redesign of long-term care to improve

its efficiency. The report was prepared for the new government as a tool to decide on expenditure cuts in health care as part of its general policy to restore public finance.

[H2] MINISTER VAN VOLKSGEZONDHEID, WELZIJN EN SPORT. Zorg die werkt. Letter to the Parliament, January 26, 2011.

"Health care that works"

In this letter the new Minister of Health gives as her opinion that people are self-responsible for their lifestyle. She does not want to punish an unhealthy lifestyle. Mass media campaigns about a health lifestyle will be terminated. But the choice for a healthy lifestyle needs to be facilitated.

[H4] MINISTER VAN VOLKSGEZONDHEID, WELZIJN EN SPORT. Zorg die werkt. Letter to the Parliament, January 26, 2011.

"Health care that works"

In this policy document the Minister of Health outlines her key policy ideas. The main objectives of her plans are: (a) facilities for primary care and sports should be available in the neighborhood, (b) more value for money and (c) the enhancement of the freedom of choice of consumers and health care entrepreneurs.

[H5] MINISTER VAN VOLKSGEZONDHEID, WELZIJN EN SPORT. Waarborgen voor de continuïteit van zorg. Letter to the Parliament, April 27 2011.

"Safeguards for the continuity of care"

The basic message in this letter is, that the government will no longer guarantee the continuity of individual provider organisations, but only in emergency situations the continuity of what is termed 'crucial care' in the field of ambulance care, emergency care, acute obstetrics and emergency care in psychiatric care. Health insurers are given a prominent role in avoiding bankruptcies.

[H5] MINISTER VAN VOLKSGEZONDHEID, WELZIJN EN SPORT, Zorg die loont. Letter to the Parliament, March 14, 2011.

"Care that pays off"

In this letter the new Minister of Health outlines her plans to extend the freely negotiable part in hospital care from 33% presently to about 70% in 2012. The letter also includes measures to guarantee a smooth transition process. Other topics concern the switch from DBCs tot DOTs in hospital funding, expensive medicines and capital investments.

[H2] MINISTRY OF HEALTH, WELFARE AND SPORTS. Handreiking gezonde gemeente, April 2011.

"Assistance for healthy city"

This document gives an overview of the role of municipalities in creating a healthy city. It discusses the government's public health priorities and outlines a number of themes for action (smoking, overweight, depression, sexual health). Municipalities are also informed about the evidence of preventive interventions.

[H5] NEDERLANDSE ZORGAUTORITEIT.

The NETHERLANDS Health Care Autorithy (NZa) regularly publishes monitors that give an overview of recent developments on the health Insurance market and health care provision (see www.nza.nl).

[H1] REGEERACCOORD, Vrijheid en verantwoordelijkheid. October 2010.

"Coalition Agreement, Freedom and Responsibility"

The annex to this agreement announces a number of policy measures to implement expenditure cuts in health care. The structural impact of the expenditure cuts in cure will be -2 billion euros in 2015 and in long-term care -0.7 billion euros in 2015. The annex also contains measures for extra investments in long-term care(+0.9 billion euros). The budgetary impact of measures to target the state health insurance allowance at only those persons who really need financial support is estimated at -2.1 billion euros in 2015.

[H2] RIJKSINSTITUUT VOOR VOLKSGEZONDHEID EN MILIEU, Towards better health, 2011. Bilthoven.

This report gives a summary of a number of reports on public health developments in the Netherlands. It concludes, among others, that life expectancy is still on the rise. Another conclusion is that there is more disease, but also an increase of healthy life expectancy. Other themes concern living a healthy life in a healthy environment are the 'health gap' (inequalities in health), the effects and further potential of prevention and the so-called health-and-wealth theme.

[H3] RIJKSINSTITUUT VOOR VOLKSGEZONDHEDI EN MILIEU, Towards better health, 2011. Bilthoven.

This summary report contains an overview of the current state of affairs as regards health inequalities. 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 expectation 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.

[H4] SCHUT & VAN DE VEN. Effects of purchaser competition in the Dutch health system: is the glass half full or half empty? Health Economics, Policy and Law, 2011 (6): 109-123.

This article argues that purchaser competition has already significantly affected the provision of hospital care, pharmaceuticals and primary care, as well as efforts to gather and

disseminate information about the quality of care. From this perspective the glass is half full. However, based on the crude performance indicators available, the reforms have not yet demonstrated significant effects on the performance of the Dutch health care system. From this perspective the glass is half empty.

[H6] STICHTING FARMACEUTISCHE KENGETALLEN (SFK). Den Haag. Data en feiten 2009.

"Data and facts 2009"

This report gives an extensive overview on pharmaceutical spending in the Netherlands, the consumption of pharmaceutical drugs, developments in the market of pharmacies and the effects of various government measures to curb the growth of pharmaceutical spending.

[H5] VEKTIS

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

[L] Long-term care

[L] GRADUS & VAN ASSELT. De langdurige zorg vergeleken in Nederland en Duitsland. Economisch-Statistische Berichten, 1 April, 2011, 202-204.

"A comparison of long-term care in The Netherlands and Germany"

Long-term care in the Netherlands is expensive compared to Germany. Higher copayments combined with a stronger emphasis upon self-management will contribute to the affordability of long-term care.

[L] MINISTERIE VAN FINANCIEN, Rapport langdurige zorg. April 2010

"Report on long-term care"

This report of the working group on long-term care presents an analysis of the performance of the Dutch system of long-term care. It outlines four alternative proposals for a substantial expenditure cutback programme (4.2 billion euros) in long-term care. The report was prepared for the new government as a tool to decide on expenditure cuts in health care as part of its general policy to restore public finance.

[L] MOT. The Dutch system of long-term care. March 2010 (Centraal Planbureau, Netherlands Bureau for Economic Policy Analysis, The Hague)

This report describes the Dutch system of long-term care for the elderly and gives an overview of LTC policy in the Netherlands. The report is part of the first stage of the European project ANCIEN (Assessing Needs of Care in European Nations), commissioned by the European Commission under FP7.

[L] STAATSSECRETARIS VOLKSGEZONDHEID, Vertrouwen in de zorg. Letter to the Parliament, January 2011.

"Trust in care"

In this policy letter the new State-Secretary of Health, Mrs. M. Veldhuijzen van Zanten-Hyllner, outlines her policy intentions concerning long-term care. The main objectives of her plans are: (a) the creation of better and affordable care, (b) emphasis upon the utilisation of human power as well as the protection and valuation of the working force in long-term care, and (c) carefulness in the neighborhood.

[L] VAN CAMPEN (ED). Kwetsbare ouderen. Landelijk beeld van de groeiende groep ouderen met meervoudige gezondheidsproblemen. February 2011 (Office for Social and Cultural Planning, The Hague).

"Vulnerable elderly. Country overview of the increasing Group of elderly people with multiple health problems".

This research document describes the characteristic of vulnerable elderly and how vulnerability develops in the last stage of life. Vulnerability leads to care dependency. A timely diagnosis may help to avoid admission into a nursing home or home for residential care. The report contains an estimation of the present and future number of vulnerable elderly as well as a number of recommendations for public policymaking.

4 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. NIVELs' 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 6566 666
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