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1 Executive Summary

This report covers the period 2009-April 2010. The economic and financial crisis, which introduced itself in full during the second half of 2008, had a major impact on the discussions regarding pensions and health care. This was not because the recession introduced new aspects in this discussion, but rather because it speeded up aspects in the discussion, which were already under debate before the crisis appeared: the recession just added a kind of urgency.

In the Netherlands, the retirement age of 65 has been under debate for quite some time because of infringement of the state budget and the expected greying population in the years to come. The recession made it possible for the Government to propose to raise the retirement age by two years to 67. However, in March 2010 the Government fell and new elections will take place the 9th of June 2010. As a consequence the raise of the retirement age to 67 is under debate in the election campaign. Looking at the political landscape it seems that it is a matter of time when a retirment age of 67 instead of 65 will become effective. Nearly all political parties agree that such a measure is inevitable. The slight recovery of the economy at the end of 2009 focused the debate more on the conditions and the time frame then the financial crises. Moreover not only the first pillar but also the second and to a lesser extend the third pillar are under discussion as well. Several committees were installed to provide advise on the future of the Dutch pension system and in preparation of measures to be taken in order to reduce the budget deficit 20 working groups were installed of which two concentrated on social protection, more specific the situation on the labour market and the possible reform of the unemployment benefit scheme.

Besides the raising of the retirement age in relation to the first pillar especially the sustainability of the second pillar came under discussion in 2009. The economic crisis illustrated the vulnerability of the second pillar pension funds. Their coverage rate declined substantially because of losses on the stock markets and the low long-term interest rate. The coverage rate is the main indicator for the capacity of the pension funds to maintain their pension obligations for the future. In a way this coverage rate indicator can be seen as a guarantee that pensions will be paid, also in the future. The Minister of Social Affairs and Employment needed to draft a special law in order to make it possible for pension funds to restore their coverage rate to 105% again. Instead of three years funds were permitted to have their coverage rates in order by 5 years accompanied with a detailed restoration plan. A pension fund has several options to restore its coverage rate like raising contributions, lowering the pension benefits or not indexate the pension benefits (not following the inflation rate). The only measures taken by the funds were not indexating the pension benefits. The recovery of stock exchange markets in 2009 contributed the rest and most funds are well on track to reach a coverage rate of 105%. However the warning of what can happen with the pension system because of a severe economic crisis was enough to install a Committee on the sustainability of second pillar pensions. The conclusions of this committee Goudzwaard will provide input for the future debate on the second pillar pension scheme. People will have to lower their pension expectations or accept a higher risk profile of their pension fund. The height of the pension benefit will be then more insecure. The third-pillar pension schemes also suffered from the recession for the same reasons that applies to the pension funds: losses on the stock market and a low long term interest rate. As a result persons, such as, for example, the self-employed, who are mainly dependent on the first and third pillar will risk considerable lower pension benefits and risk falling into a poverty trap. Especially with regard

to self-employment this has speeded up the discussion as to whether pension provisions for the self-employed should be obligatory and collectively organised.

Given the situation in the Dutch pension system, the Dutch Government is trying to increase participation and avoid the use of early-retirement schemes. Indeed a decline in the use of early-retirement schemes could be noted but the economic crises can frustrate this development, as the labour market situation for elderly workers is bad. By using the unemployment benefit scheme on a part-time basis and investing in schooling and education the Government is attempting to avoid the loss of elderly workers from the labour market. Given the last figures on unemployment in the Netherlands this approach seems to be succesfull.

The heart of the Dutch health-care system is to provide high-quality, affordable and accessible care. Life expectancy has risen steadily over the years. As a result the affordability of care in particular will be under discussion in the coming years. Here, too, the economic crisis has speeded up this debate. For 2010 the Dutch Government has set her priorities on quality, innovation and prevention. In order to reach these objectives the Government will do so by:

- providing access to care and preventing that the need of care leads to poverty and financial dependency, and addressing inequality in access to care as well as results;
- guaranteeing and investing in the quality of care and long-term care and adjusting care to changing needs by setting quality guidelines and indicators, by handing more responsibilities to professionals and patients, as well as invest in innovation and prevention;
- guaranteeing sustainable care through stimulating policies, good governance, proper alignment between public and private care institutions, sound human resource policy in the care sector and promoting a healthy way of living.

The major reform of the Dutch health system made insurance mandatory and assured access to care. Since its introduction several amendments have been introduced, especially to realise savings. Certain medical treatments have been excluded from insurance or reimbursed to a lesser extent. Moreover a personal risk contribution was introduced and, last but not least, prevention came high on the list of priorities.

2 Current Status, Political and Scientific Discourse during 2009–April 2010

This Annual National Report covers the period 2009 until April 2010. In the last quarter of 2008 and the beginning of 2009, the world economy entered a state of turmoil. Instead of economic growth, a recession began, and social protection also felt its influence. At the end of 2009 a slight recovery of the economy could be noticed although much insecurity still exists. The Dutch economy experienced an historic economic recession of 4% in 2009. For 2010 the Central Planning Agency predicted an economic growth for 2010 of 1.5% and for 2011 of 2%[1]. In the analyses for the Central Economic Plan 2010 it became apparent that the state budget took the severest blow of the crisis. Budget deficit is expected to rise to 6.3% in 2010 and 4,9% in 2011[2]. The flexibility of the Dutch labour market and the considerable increase of the number of self employed resulted in a modest increase of unemployment to 6.5% in 2010-2011[3]. The debate on pensions and health care is dominated by how to survive the impact of the economic crises by maintaining sound public financial sustainability in the longer term and a sound social protection system for the future.

2.1 Pensions

The Dutch pension system contains of three pillars:

- the first pillar providing a monthly pension for every citizen reaching the retirement age of 65 and paid from the state budget;
- the second pillar, which contains supplementary capital based pension funds, which are obligatory and collectively organised;
- the third-pillar pension schemes, which are concluded by beneficiaries on an individual basis.

It should be no surprise that the financial crisis and the accompanying loss of value in the stock markets had major influence on the Dutch pension system, especially the second and third pillars. The first pillar is under discussion as well because sustainable public finance conflicts with the increasing greying population and the expected growth in the expenditure on first pillar pensions. The substantial financial support for the financial sector plus the necessary investment in the economy infringed the Dutch state budget. From a 1% surplus, the state budget showed a shortfall to 5.3% in 2009 and is expected to further grow to 6.3% in 2010. Debt has increased from 42% to 62% of GDP over just one year and is expected to be 66% at the end of 2010[4].

2.1.1 First pension pillar: AOW

The General Old Age Pensions Act (AOW) is a basic pension for people aged 65 and over. It is a collective-based first pillar pension being approximately EUR 8,800 per year, EUR 12,800 per year for a single person. Every year a person living in the Netherlands between the

1 Figures CPB http://www.cpb.nl/nl/news/2010_13.html.
2 Ibid.
3 Ibid.
4 Figures CPB. Newsletter 2009 March/April.

age of 15 and 65 builds up 2% of the first pillar pension. Dutch nationals working abroad can still build up the AOW pension on a voluntary basis. At the age of 65 the AOW is expected to be 70% of the minimum wage for a single person and for married couples or persons living together 50% of the minimum wage of each person. The AOW pension is paid by the Social Insurance Bank (SVB) and contributions are levied by the tax authorities. It covers 50% of the total pensionsystem[5].

With regard to the AOW we will discuss first the debate on the sustainability of the Dutch first pillar system and the related discussions to raise the retirement age to 67 and increasing labour participation, especially of elderly persons. Increasing labour participation is of course closely connected to the prevention of the use of early-retirement schemes. To that extent a new law VPL was introduced in 2006. The effects of this law will be described as well.

Sustainability of the AOW

A debate has been going on about the sustainability of the Dutch first pillar pension scheme in the light of the greying population for over 25 years. The pressure on the state budget is considered to be too high. At the hight of the greying population in 2038 about 4 miljon people will depend on a pension. The ratio 1 pensioner to 4 working persons now will shift over the period 2008-2038 to 2 to 1 making the burden for the working population nearly unbearable[6]. The debate on the sustainability intensified with the advice of the Commission Labour Participation in June 2008.

The Commission Labour Participation advised the Government to raise retirement age to 67 not only because of the financial sustainability of pensions but also because of the foreseen shortage of employees on the Dutch labour market. In the report of the commission it is calculated that the retirement age of 65 no longer matches current life expectancy[7]. Raising the retirement age to 67 would have a positive effect on labour participation of between 0.8 and 2.5%[8]. In its first reaction to the advice of the commission the Dutch Government explicitly stated that it would try to prevent the necessity of raising the retirement age to 67, which could be clearly seen as a political statement as the debate of rising the retirement age is a very sensitive political issue closely connected to the labour participation of the elderly above the age of 50 in the labour market.

Figures show that the participation of the elderly above the age of 50 was steadily increasing, especially for women[9]. As explanation the Dutch Planning Agency (CPB) stated that the new law VPL and the accompanying transitional provisions encouraged people to work longer. Early retirment was disencouraged by the introduction of fiscal arrangements that had a positive effect indeed. The law VPL (Fiscal Aid for Working Longer) contains a transitional period of 10 years for the group of people who were 55 years of age or older on 31 December 2005. This group of people can still retire early while keeping certain fiscal privileges. However, the law also contains a stimulus for this group of workers to work longer, until the age of 65. The fiscal benefit will be larger than using an early-retirement arrangement. According to the OECD a more rapid implementation of these measures would provide better incentives to work longer[10].

5 Figures CPB: the Dutch Economy 2008.
6 Figures CPB: the Dutch Economy 2008 page 171.
7 78.3 years for males and 82.3 for females in 2008 CBS Webmagazine, 27 January 2010.
8 Calculations CPB annex 2 Report Commission Labour Participation.
9 CPB Memorandum: the growth of labour participation of elderly men unravelled (2009). See also figures labour participation in the NSR.
10 Economic Survey of the Netherlands, OECD 2008.

VPL came into force on 1 January 2006, abolishing fiscal advantages regarding pre-pension arrangements and introducing a fiscally advantageous life course. Young and old alike have the possibility to save in order to leave work on a temporary basis (e.g. to look after a newborn child). In 2008, the Dutch Government announced that working longer than 62 will be rewarded with a financial bonus on wages[11]. With this measure the Government is following the advice of the Commission Labour Participation. The Central Planning Agency (CPB) calculated that this measure would have a budgetary effect of EUR 1.1 billon, resulting in a higher participation effect of 30,000 persons[12]. It should be noted that for those working over the age of 65 problems will occur with other social security laws like the Health Insurance Act. Employers cannot insure employees for sickness benefits when they are over 65[13]. The Commission Labour participation in addition advises an exemption for contributions regarding unemployment and disability insurance[14].

The effect of the economic recession

This new laws and initiatives on the sustainability of AOW were introduced before the economic recession and the Dutch Government still agrees with the policy of more labour participation for elderly people working longer despite the increase in unemployment as a result of the crises. The main reasons are the financial sustainability of the first pillar pension scheme and the structural labour shortages in some sectors, such as education and health care. According to the Dutch Government, increasing labour participation and preventing early-retirement exit pathways remain necessary in the long run. Recent figures of CBS show that especially in the last quarter of 2009 unemployment among workers older then 45 increased rapidly. This effect is explained mostly because elderly stay longer unemployed then younger job seekers[15]. In its policy response to the recession therefore, the Dutch Government states that despite the economic crisis and recession, structural problems like a greying population require undiminished attention[16]. Despite the first response to the Commission Labour Participation not to raise the retirement age to 67, under the influence of the recession the decision was made that an increase of the retirement age to 67 instead of 65 is unavoidable, a measure which is expected to have a positive effect on the budget of 0.7% of GDP[17]. In its government declaration the Dutch Government stressed that both measures will contribute to:

- the solution as to confront the greying population;
- the financial sustainability of the first pillar pension scheme;
- avoiding a decrease in the pensions of the current pensioners.

However, before a proposal could be send to Parliament the Government fell over the Afghanistan dossier and the retirement age is now an important element in the election campaigns of political parties. In general all political parties agree that a raise of the retirement age is necessary except the Peoples Freedom Party (PVV) and the Socialist Party (SP). The PVV stresses the importance of other measures to combat the budget deficit. The SP highlights the importance of the problems of the labourt market for elderly people. In their opinion it is no use to raise the retirement age without improving the labour market position of persons above the age of 50.

11 Official Government Declaration, 16 September 2008.
12 CPB calculations annex 2 report Commission Labour Participation.
13 Economic Survey of the Netherlands, OECD 2008.
14 Commission Labour Participation (Commission Bakker) paragraph, 4 April 2008
15 Figures on unemployment CBS January 2010.
16 Work together, live together, government declaration March 2009.
17 Ibid.

Of course the policy of the Government with regard to the retirement age provoked debate on the effect of the proposed measures. The debate intensified because of the election campaigns. The first aspect to be discussed is the demographic assumptions regarding the greying population. The Dutch Government assumes that overall people will become older and healthier. Indeed, life expectancy has risen from 1950 till now by eight years, from 70 to 78 for a man. However, what counts according to demographic scientists is the life expectancy of a man of 65. According to the Central Bureau of Statistics, in 1950 the remaining time of living for a man of 65 was 14 years, and this rose in 2007 to 17 years[18]. The difference therefore is three years and not eight. As a result, raising the retirement age to 67 is regarded as arbitrary. Moreover, the healthy life expectancy is not taken into account at all. The healthy life expectancy is defined as living without chronic disease or other physical limitations. The period of healthy living after reaching the retirement age has increased as well because of better medical care[19]. More then 80.6% of the Dutch population consider their health situation as very good and good[20]. Another aspect mentioned is the difference in life expectancy with regard to educational levels and certain professions. A difference is measured of seven years between the highest and lowest educational levels. All the aspects mentioned in the discussion argue for a more differentiated approach instead of raising the retirement age in a general way. According to the demographic trends it is better to differentiate according to the length of working life instead of life expectancy[21].

Other demographic scientists argue that the greying population in the Netherlands is no financial problem at all due to the fact that this greying population is accompanied by declining fertility rates. According to this opinion the ageing of the Dutch population started as early as around 1900 when life expectancy increased and birth rates declined. Within 100 years, life expectancy increased by 56% and fertility by 64%. For the state budget young people are more costly than the elderly because of education and other supportive needs and measures. The effect will be a shift of costs from the young to the elderly, which results in a more modest budgetary pressure than expected. In addition, in this vision a differentiated approach is defended because of the life expectancy and the arbitration of 65 as retirement age[22].

Another theme in the debate is the presumption that people will work longer. This is easier said than done. Research shows that ⅔ of the working population stops working earlier than planned[23]. The CPB figures show that the participation of the elderly above the age of 50 is steadily increasing, especially for women. It cannot be denied that the trend has been changed especially in the age category between 55 and 59 years. The labour participation for the age between 60 and 64 is still very limited. In the age category of 60–64 only 42% of the men and 23% of the women are still working for more than 12 hours per week. Compared with the age category of 55–59 these percentages are 83% and 56%[24] respectively. Only a fraction of the workers reaches the official retirement age of 65[25]. Recent figures of CBS show that in 2007 the average retirement age was 62 for men and women nearly alike, men 62.1 and women

[18] Gezondheid en zorg in cijfers 2008 CBS. (health and care in figures)

[19] Although there are no concrete figures available also because of definition questions what to regard as healthy living.

[20] Gezondheid en zorg in cijfers 2009 health condition of the Dutch population.

[21] Gijs Beets of the National Interdisciplinary Demographic Institute (NIDI) The Hague in NRC Handelsblad 3 April 2009. Theo van Engelen: from 2 to 16 million people (2009).

[22] Theo van Engelen: from 2 to 16 million people (2009).

[23] Hanna van Solingen, Kene Henskens and Harry van Dalen, the diminishing border between pension and working, The Hague NIDI (2009).

[24] Ibid.

[25] CPB Memorandum: the growth of labour participation of elderly men unravelled (2009). See also figures labour participation in the NSR.

62.6 a difference of half a year. Compared with 2006, more than 10,000 persons worked longer than their 60th birthday especially in the public sectors[26]. It is too soon to judge the real effect of the governmental measures but it is also obvious that it will not be easy to let people work until they are 67. Therefore it is questionable whether the positive effects on labour participation and budget will be achieved in full. The economic crisis showed a rapid increase of elderly unemployed[27].

Since nearly all political parties agree that a raise of the retirement age to 67 is necessary other aspects entered the debate. First, the aspect on the heavy professions. It is agreed that in a heavy profession it is nearly impossible to reach the retirement age of 67 healthy when staying in the same overloaded job. Question is then how to define heavy profession? Should besides physical aspects also psychological aspects be taken into account? From the debate so far it becomes apparent that defining heavy professions and connect such definition with the retirement age will be very difficult and most probably impossible to implement in practise[28]. As a result a more differentiated approach is necessary.[29] Furthermore it is stressed that raising the retirement age for the first pillar not necessarily means a raise for the second pillar as well. To achieve this the retirement age for both pillars should be increased to 67. Others opt to leave the choice with persons concerned. The second pillar scheme can then be used as an early retirement scheme to overbridge the period between a certain age and 67. More and more it becomes obvious in the debate that the reform of the pension system to make it more sustainable for the future and other crises to come, is closely connected with the functioning of the labour market. The tendency in the direction of more work security instead of job security as noted by the Labour Market Commission demands probably a more flexible differentiated pension system as well in which people make theire own choice when and how they want to enjoy their pensions. Forcing people to quit their job because of reaching the retirement age will be then outdated. However also in this respect the differentiation in job categories plays an important role especially with regard to the solidarity principle. Some professions will be able to afford earlier retirement on their own expense more then other professions or for some professions it is easier to work longer[30]. Studies show there is a relation between the level of education and early retirement. Low levels of education and skills result to more early retirement patterns[31]. These aspects have to be taken into account.

2.1.2 Second pillar

The second pillar is supplementary to the first pillar and covers 91% of the working population, which is a very high coverage rate. All supplementary pension contributions together cover 10% of the GDP. Participation in a supplementary pension fund is obligatory and collectively organised (e.g. through collective labour agreements) covering nearly all sectors like the public sector (APB) and health care sectors (PGGM). The new Pension Law, which was introduced on 1 January 2007, guarantees the possibility of participating in a supplementary pension scheme from the age of 21 instead of 25. Together with the first pillar the second pillar provides pensioners with a substantial income, which assures a reasonable

[26] Employees retire later, CBS 2010 http://www.cbs.nl/nl-NL/menu/themas/inkomen-bestedingen/publicaties/artikelen/archief/2010/2010-023-pb.htm.

[27] Figures on unemployment CBS January 2010.

[28] Interview with Fatma Koser Kaya from the magazine Pensioen, Bestuur en Management, 17 February 2010.

[29] Bernard van Praag, 2009, "Pensioenleeftijd naar 67 lost huidige crisis niet op", *Me Judice*, year 2, 25 March 2009. Raising the retirement age to 67 does not solve the crisis.

[30] Ibid.

[31] Rethinking retirement, from participation to allocation by Rob Euwals, Ruud de Mooij, Daniel van Vuuren. CPB April 2009.

living standard of 70% of the average earned wage. An important feature with regard to the supplementary second-pillar system, which is based on capital coverage, is that the supplementary pension funds are under the supervision of the Dutch National Bank. Every fund has to fulfil obligations with regard to financial reserves and sound financial policies. The second pillar pension covers 45% of the total Dutch pension system[32].

The main problems faced by the pension system in the Netherlands as a result of the recession concern the second pillar. Because of the lower stock markets and long-term interest rates the pension funds lost over EUR 18 billion, a decline of 2%[33]. In the 1st quarter of 2008, the performance of pension funds resulted in a negative profitability on investments of -8%. In the 2nd and 3rd quarters this was -1.9 and -6.2% respectively. The severest blow came in the 4th quarter, with losses of 17%. It is remarkable that the losses on investments in the stock market had already occurred before the crisis revealed itself in the second half of 2008. Therefore all pension funds were already under stricter supervision of the Dutch Central Bank. In 2009, some recovery could be noted in line with the recovery of the stock markets. What is of imperative importance here is the so-called coverage rate, which is set by law. For pension funds this coverage rate should be a minimum of 105%. Because of the losses the coverage rate declined to an average of 95%, which means that the pension funds can only comply with 95% of their obligations, which is not acceptable by law[34]. The law prescribes that a pension fund with a lower coverage rate than 105% gets three years to recover its coverage rate[35]. For that purpose a recovery plan should be forwarded to the Dutch Central Bank. A pension fund can in fact implement three measures to recover:

- lower the pensions of the pensioners;
- stop indexation of the pensions to keep in track with the inflation rate;
- raise the contributions.

Most of the pension funds opted for an indexation stop. Furthermore, the Government decided to change the law by Minsterial decision and extended the recovery period by another two years to a temporary total of five years in order to allow the funds more time[36]. The other two possible measures have not yet been used because they would negatively influence the spending capacity of Dutch citizens. For the Dutch Government it is important to keep domestic demand at a substantial level. If the indexation stop and the lengthening of the recovery period is not enough for recovery, the Dutch National Bank can force pension funds to take other measures to recover their coverage rate. The measures taken and the recovery on the stock markets had a positive effect on the coverage rate of the pension funds in 2009. At the end of 2009 the number of pension funds with a coverage rate higher then 105% raised from 92 in the last quarter of 2008 to 234 in the last quarter in 2009[37]. Also the indexation stop had a positive effect to these results. The effect on the pensioners' income was very modest as inflation was very modest in 2009.

The situation as described above launched a more fundamental debate on the sustainability of the Dutch pension system and the role of the second-pillar pension schemes. The first element of the debate is in connection with the raising of the retirement age under the first pillar to 67. This measure is regarded as profitable for the second-pillar pension funds, too, as it saves the

[32] CPB: the Dutch economy 2008.
[33] Central Agency of Statistics: Pension funds and Insurers lose on the stock market, 5 April 2009.
[34] Law of 7 December 2006 concerning rules for pensions (Pension Law).
[35] It should be noted that the figures used are average figures as the situation can differ from pension fund to pension fund.
[36] Ministerial decision to temporarily deviate from art. 142 Pension Law, letter of the Minister of Social Affairs and Employment to the Second Chamber 20 February 2009.
[37] Toezichtgegevens pesnionefondsen Dutch National Bank, statistics April 2010.

funds a substantial amount of money, provided that the retirement age of 67 is also applicable to the second pillar pensions. The savings are estimated at several billion Euro[38]. A second element that arises in the debate is the obligation to participate in a second-pillar pension scheme that is regulated collectively in collective labour agreements. It is argued that bad performance of pension funds should give the participants the possibility to change to another fund, which conflicts with the collective approach of second-pillar pension funds. Furthermore it is in doubt whether obligatory participation really contributes to the performance of the pension funds[39]. The other side of the coin points at the high coverage of the second-pillar pension scheme and the fact that people are not aware of their choices regarding pensions and the consequences of their choices. A third element in the debate points at the temporary character of every economic crisis. The function of the long-term interest rate is of particular importance in this respect. Pension funds have to calculate their financial reserves on the bases of the long-term interest rate and this rate is at a historically low level. This fact contributes to the current position of the pension funds according to the law. Performing the calculations with average interest rates over a certain period of time could contribute to a more realistic view of the financial reserves of pension funds[40]. Together with the new Pension law also the new "Financial Toetsingskader" (FTK) was adopted in 2007, which is more in line with the new International Financial Reporting Standards. The main purpose of the FTK is to keep pension funds financially healthy in order to be able to sustain its obligations now and in the future. The FTK, among others, implementents the prudent person principle, which comes from the European Pension Directive[41]. This principle guarantees the quality of the investement policy of the pension fund taking safety, quality, liquidity and profits into account.

A fourth element to deliberate on concerns the coverage rate itself initiated by the Fellowship of Actuaries[42]. In their opinion, the coverage rate as stated in the law is rather arbitrary, and they argue for a flexible coverage rate. A fund with young participants for instance can have a lower coverage rate, as they will pay into pension schemes over a longer period of time. Such "younger" funds can take more time to build up the necessary capital. The same goes for a fund of a stable economic sector such as the public sector. It is to be expected that the public sector will continue to exist and receive contributions for over 100 years. Social partners, too, argue for a more flexible coverage rate. Those opposing this viewpoint are in particular the insured individuals and pensioners who want safety for everything. The expectations of their pension are high and it is politically unpopular to discuss the coverage rate of the pension funds and its connectivity with high and safe pensions, even if this safety is relative. A last more fundamental element in the debate that should be mentioned is the question of whether the Dutch pension system does not depend too much on the capitalised 2nd pillar scheme. As an answer it is suggested that the role of pension funds should be limited and the part of the first pillar in the total pension system be increased. Defenders of the current system state that increasing the first pillar pension would infringe upon the public finance system. It would simply be too costly. As a consequence of this debate a Committee was initiated reporting on

38 Estimate of the Association of Pension Funds. Also here, the debate on the real savings when raising the retirement age is of importance. See also the debate on demographic trends in the paragraph on the first pillar pension scheme.

39 Drs. L. Blom: Discussing the obligation of pension funds SDU 2006. This book introduced another method of calculating the profitability of pension funds taking into account the societal function of pension funds, which differs from e.g. insurance companies.

40 According to Prof. Nijman, director of Netspar (international centre of expertise for the greying population) and professor of econometrics and financial markets at the University of Tilburg. interview Trouw on 9 December 2008.

41 European Pension Directive 2003/41/EG, OJ L235/10 of 23 September 2003.

42 Van Gaalen: article for the Fellowship of Actuaries FTK and IFRS: killing pension funds, 2008.

the sustainablility of the second pillar in the light of the ageing population. In their report[43] the Committee advised a more sober pension system in order to challenge the problem of a greying population. In their view the increase of contributions will not be the answer to strengthen the financial position of the pension funds. Raising contributions would seriously damage the economic position of the Netherlands. The Committee advised to take into consideration three options:

- to lower the ambitions in the sense that workers should be informed that their pension could be considerably lower than expected. In most cases pensioners will not receive 70% of their average earned wage,
- or to raise the retirement age further
- or to take more risks at the stock markets.

The report of the Committee Goudzwaard provoked much response. The conclusion that the Dutch pension system is too expensive is generally shared. Also the idea that pensioners have to expect less then 70% of their average earned wage becomes more acceptable. Especially when taking into account that many people own houses. When pensioners succeed to have their mortgage paid when retiring, less then 70% of their average earned wage is indeed needed. With the conclusions of the report also the classical contradiction between trade unions and employers-assocations became apparent. Employers agree in general with the conclusions of the Committee that the second pillar pension scheme is too expensive and burdens the economy, while the trade unions state that the conclusions are too pessimistic[44]. In their view a raise of the contributions should at least be seriously discussed because otherwise the price for the expensive second pillar would only be at the expense of the insured persons. Another point of criticism is that the Committee did not take into account the governance of pension funds especially in relation to the results of bad investments[45].

2.1.3 Third pillar

Third-pillar pension insurances are in many cases concluded because people lost pension rights when they changed to another supplementary pension fund or became self-employed. Although the transfer of pension rights to another fund is easier now, it is still possible to lose pension rights. For this reason many employees concluded private capital-based pension insurance schemes. The number of third-pillar pensions is still increasing despite the fact that the Government has reduced the tax deduction. In total the third pillar includes 5% of the total pension system[46]. Others concluded such insurance schemes as extra income in the pension period. In the past years there have been many questions regarding the sustainability of these pension products as the insurers calculated the costs too high, which is lowering the profitability of these pension insurances. Moreover these products were regarded as too complex and therefore not transparent. Negotiations between insurers and consumer organisations regarding a deduction of the costs have been successful last year. Agreements

[43] A strong second pillar, towards a sustainable supplementary pension system, committee Goudzwaard, 27 October 2010.

[44] For example response of VNO-NCW, AWVN (employers) and ABVA/KABO FNV (trade unions) to the report of the Committee Goudzwaard. Committee Goudzwaard is too negative about the pension funds by Edith Snoey February 2010 http://www.abvakabofnv.nl/nieuws/weblogedithsnoey/commissie-goudswaard-te-negatief-over-toekomst-pensioenfondsen. Official press statement VNO-NCW http://vno-ncw.nl/Pers/Persberichten/Pages/VNONCW_en_MKBNederland_grens_pensioenkosten_bereikt__340.aspx?source=%2Fpers%2FPersberichten%2FPages%2Fdefault.aspx.

[45] Dutch Association of Pension Interests, 29 January 2010.

[46] A strong second pillar, towards a sustainable supplementary pension system, committee Goudzwaard, 27 October 2010.

were reached with several large insurance companies to compensate for the cost component in some of the pension products. Even though it is not the direct responsibility of the Government, this situation can negatively affect the income position of pensioners and people's trust in third-pillar pension products. The Authority Financial Markets (AFM) supervises third-pillar pension products and measures are taken to create more openness in these pension products, especially with regard to the cost structures of the different products. The Dutch ombudsman concluded that the cost calculation of the insurers is not adequate and should be adjusted. In total there are 6.5 million products sold on the basis of investments covering EUR 60 billion on contributions[47]. Not all of these products are third-pillar pension products and it is unknown how many of these products will be used for pensions.

The debate on the results of third-pillar pension schemes intensified because of the economic and financial crises. Insurers who offer third-pillar pension products lost in the first and second quarter of 2009 5.1% and 5.9% respectively. In the last two quarters of 2008 the loss was 11.3 and 13.8% respectively. Because of the difference in the investment portfolio the insurers performed better than the pension funds in the 1st and 4th quarters of 2008. In the 2nd and 3rd quarters the pension funds performed better[48]. What can be concluded from the figures is that insurers who offer third-pillar pension products also face considerable problems, which are similar to the problems of the pension funds. The difference is the aspect of collectivity and the fact that insurers don't have to fulfil the obligations regarding the coverage rate. The risk is in fact completely borne by the insured person. It is difficult to foresee what effect the crisis will have for persons who are building up supplementary pensions under the third-pillar pension scheme. As most of the Dutch population is covered by the first and second pillar, the effects of the losses in the third pillar will probably be modest, presuming that the measures taken by the Government to recover the coverage rate in the second pillar will have a positive effect. Furthermore the strength of collectivity will do its work. However, persons who are dependent only on the first and third pension pillars will probably face considerably lower pensions than expected and even risk falling into a poverty trap when reaching retirement age. The measure to raise the retirement age to 67 is also expected to have a positive effect for the third pillar because an insured person will pay contributions for a longer period of time. In this respect the discussion regarding early retirement becomes interesting.

2.1.4 Early retirement

Comparing figures over a period from 2006 to 2008 it can be concluded that from 2006 to 2007 the number of persons leaving the labour market with an early retirement pension increased by 36,000. From 2007 to 2008 the number decreased from 467,000 to 458,000[49]. Fewer men made use of early-retirement schemes, while women showed a slight increase of the use of such schemes. Figures for 2009 are not available yet. The use of early retirement schemes is rapidly discouraged by several fiscal measures like taxing early retirement pensions. The best effect on preventing early retirement is however the financial crisis. Pensions funds are, as stated above, interested in receiving as much contributions as possible for a longer period of time. Early retirement is simply not affordable any more on the longer term.

It is maybe too early to conclude that there is a declining trend in the use of early-retirement schemes as it is not clear yet what the effect of the recession will be. For elderly workers it is

47 Estimated figures by several foundations protecting the rights of costumers who bought third-pillar pension products.

48 Figures CBS, 6 April 2009.

49 Source: CBS figures early retirement published April 2009.

still difficult to obtain a job when becoming unemployed. In order to increase labour participation of this vulnerable group more mobility and flexibility on the labour market is necessary. The use of part-time unemployment benefit arrangements in combination with training and educational provisions aims at keeping workers on the job as long as possible[50]. This seems to be especially important for elderly workers. Investment in training and education can make them more flexible and increases their chances on the labour market when the recession is over. A shortage of labour is still to be expected when the economy starts growing again. Keeping elderly workers active and participating is therefore of importance in the future and is to be expected that the use of early-retirement schemes as an early exit pathway will be avoided. Together with the Fiscal Aid for Working Longer (VPL) clear incentives have been introduced to keep people in the labour market. This trend will be further strengthened by the negative investment results of the insurers and pension funds, avoiding early retirement because this cannot be afforded financially.

2.1.5 Position of self-employed

The economic and financial recession draw the attention to the position of self employed in the labour market. When unemployment increased it became obvious that self-employed provided flexibility in the labour market preventing unemployment figures increasing explosively. As a result part of the price for the crisis on the labour market was paid by self-employed. This also stimulated the debate about the social security position of self-employed. From figures of the CBS it became apparent that the growth of the number of self-employed came to a stand still because of the crisis. In the third quarter of 2008 650,000 self-employed were active on the Dutch labour market. The third quarter of 2009 this number declined with 20,000 to 630,000 self-employed. Striking is that from the self-employed that stopped only 0.5% became unemployed. More than 2% started as employee again and the rest left the labour market[51]. The most important motives to start as self-employed is the autonomy and freedom not to be connected to an organisation or company anymore. Most of the starting self-employed are experienced professionals of an older age. This matches also the reflections on the difficult position of elderly workers and the more difficult use of early-retirement schemes. Self-employment is seen as an escape route for those who do not find a new job after getting dismissed. Dutch legislation even makes it possible to start as self-employed from a position of receiving social benefits. The benefits then help with starting up.

The position of self-employed on the Dutch labour market in relation to the crisis made the questions regarding pensions and other social security arrangements more urgent. Many self-employed are not insured for disability or unemployment and do not build up any pension, which makes them dependent on only the first pillar and a part of a supplementary pension they built up when working as an employee[52]. The Government offers fiscal opportunities for the self-employed to save for a pension provision. However, the general trend is that self-employed people are underinsured with regard to the building up of their pensions. The crisis even had a more negative effect on this underinsurance.

The social security system is based on the employer-employee relationship and is not able to cope with the third category of self-employed people. With regard to pensions in general two sides of the debate can be categorised:

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50 Part-time unemployment in order to keep skilled workers on the job, introduced on 1 April 2009. Conditions for making use of this measure are that the company should be in principle a healthy company and that the company should invest in training and education for the time the workers are not working for the company.

51 CBS webmagazine, Wednesday 20 January 2010 http://www.cbs.nl/nl-NL/menu/themas/arbeid-sociale-zekerheid/publicaties/artikelen/archief/2010/2010-3029-wm.htm.

52 Social Economic Council Bulletin April 2009.

- the self-employed should themselves be responsible for their pension provisions;
- the social security system, including pension provisions, should be adapted to the situation that the Dutch labour market contains more and more self-employed people.

The strongest advocates of adaptation of the social security system even argue for obligatory social security arrangements including pensions. The argument is that if employees are obliged to participate in a second-pillar pension scheme, why not the self-employed? The advocates of the first vision state that the self-employed should manage their own social security. Figures illustrate that self-employed people with high income are perfectly capable of providing their own social security arrangements. The real problem occurs with self-employed people with a low income[53]. Research shows that the income of the self-employed is comparable with that of employees. A full-time self-employed person works an average 41 hours per week and earns EUR 85,000 per year[54]. It seems that especially for self-employed people with lower incomes social security and pension arrangements should be provided on a collective basis to keep the costs low. Trades unions and other professional organisations already offer such collective arrangements but they cover only a small number of self-employed people. This drops the question whether legal measures are necessary. The crisis made the answer to this question even more urgent as many self-employed had to use their financial reserves to survive in the market. Reserves they built up for for instance pensions were now used for other purposes. Self-employed lost as average 12% of their income in 2009[55].

2.1.6 Conclusions

The developments last year can be seen as a wake-up call for the Dutch pension system. Before the financial crisis discussion on the principles of the system, which are based on the capitalised second pillar pension schemes, hardly took place. The crisis changed that, as described in this report. It can be questioned if the Dutch pension system is a financial sound and sustainable system. With the recoverage of the stock exchange markets, as happened in 2009, or economic recovery also the coverage rate of the pension funds will recuperate. Therefore the question is more interesting whether the system is sustainable in the light of the greying population. The intended measure of the Dutch cabinet to extend the retirement age to 67 has to be seen in this light. The crisis created the opportunity for the Government to propose this unpopular measure. The common opinion among the majority is that raising the retirement age is inevitable and that the pension system is closely connected to the labour market. Raising the retirement age means also that people have to work longer and the Dutch labour market is not yet ready to achieve this.

Problematic is the situation of the people who depend solely on the first and third pillar schemes like self employed persons. It is calculated that these third pillar private schemes will not provide sufficient income for the pensioner because the considerable percentage of costs is calculated over the contributions. Positive is that people who are in the possession of these products are now organised and negotiate with banks and insurance companies to have these costs compensated. In some cases these negotiations are already successful and it is expected that more success will follow. However the pension situation of self-employed is still a concern and organising more collective arrangements for self-employed could be an important step forward. The crisis made this even more evident as many self-employed used

53 The drivers of career success of the job-hopping professional, dr. Arjen van den Born (2009).
54 ibid.
55 Article Pieter Hilhorst in the Volkskrant 12 January 2010: More space for self-employed.

their financial reserves to survive on the market. Reserves, which were meant for pension provisions.

2.2 Health

The main challenges and goals of the Dutch health and long-term care sectors are quality, innovation and prevention. Priorities set by the Dutch Government in 2010 to accomplish these challenges are[56]:

- functional and efficient care;
- defrayment of care based upon performance;
- guaranteeing the solidarity of the system;
- mental care;
- emergency care;
- policy on medicine;
- medical specialists.

The heart of the Dutch policy is to provide high-quality, affordable and accessible care. In the Netherlands most initiatives and policies are applicable for health as well as long-term care. This approach stresses the interfaces and similarities in challenges of both. The Dutch Government even anticipates a more extensive interaction by acknowledging that health and care are also interconnected with socio-economic and social inclusion issues that need a broader scope and approach to the challenge.

2.2.1 Public health

Life expectancy at birth in the Netherlands is high. In 2007, this was 78.3 years for men and 82.3 years for women. In the past five years life expectancy has risen, most importantly due to a reduced risk of dying of coronary heart disease.[57] The RIVM expects life expectancy to rise further to 83.2 years of age for men and 85.5 years of age for women in 2050. Between 2003 and 2007 over 25% of the Dutch population (4.5 million) has one or multiple chronic disease(s) like asthma, depression, diabetes or coronary heart disease. Most of these patients are male and most are of older age.[58]

The actual *experience* of health differs in the various regions in the Netherlands. Over the years 2004–2007, 19.5% of the Dutch population experienced their health as "less well". People from the southern part of Limburg and from the bigger cities (Amsterdam excluded) feel significantly less healthy than people in other parts of the country. People from Eemland, IJssel-Vecht and Holland Midden (these are the regions in the centre of the Netherlands)

[56] Ministry of Health, 'Beleidsagenda 2010', The Hague, September 2009.
[57] Figures from RIVM (retrieved on 15 May 2009 from http://www.rivm.nl/vtv/object_document/o2314n18838.html).
[58] Figures from RIVM (retrieved on 01 June 2010 from: http://www.vtv2010.nl/kernrapport/).

experience their health as significantly better than the Dutch average[59]. This remained roughly the same in the period 2005 – 2008[60].

In spring 2010 the RIVM presented its Future Public Health Research.This report concludes that despite the fact that 25% of the Dutch population has a chronic disease, the experience of insalubrity or physical constraints does not rise. Smoking is still the number one cause for most loss of health, followed by being overweight. For most determinants (factors influencing health), trends are favourable or at least steady. However, people with lower social economic status, are worse off in general. This is influenced by physical and social circumstances.[61]

2.2.2 Current status and changes in the Dutch health-care system

Passing the Insurer Act in 2006 launched the reform of the Dutch health-care system. It integrates the former sickness fund scheme and private health insurance into a single mandatory insurance for all residents. Also, regardless to gender, age, health condition or socio-economic status, access to health care is assured[62].

The main objectives of the reform were to make health care more consumer-driven, to strengthen solidarity arrangements, to make health care more efficient and innovative and to improve quality of health care. The main incentives used to achieve these objectives are market competition, enhancing room for contracting between insurer and provider agents, enhancing consumer choice, risk-pooling by means of adjusted capitation payments to health insurers to achieve fair market competition, measuring the performance of health-care providers and insurers and government regulation used to ensure universal access to health insurance[63].

The mandatory insurance covers basic needs and people can complement this with an additional insurance policy. Also, a new Health Insurance Income Support Law compensates lower-income groups for the substantial increase of the nominal premium rate they must pay. That way, income solidarity in health insurance is preserved. The actual height of the support depends on the income. The lower the income, the higher the support. In 2010, the maximum of the support is set on EUR 735 for a single household. In case there is a partner, the support is maximised at EUR 1.548. The financial crisis has triggered the discussion on the height of the compensation[64]. Economisation in the compensation expenditures is an important topic in the 2010 election debate.

The basic insurance package consists of medical care provided by general practitioners (GPs), hospitals, medical specialists and obstetricians, medication, IVF up to three times, maternity assistance, medical aids, paramedical care (physiotherapy, speech, ergo therapy, dietary

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59 Experience of health shows the subjective well-being of people and relates to physical as well as mental illnesses. Regional variations in age and gender have been corrected in these figures. Experienced health has proved to be an important predictor of mortality. RIVM (retrieved on 15 May 2009 from http://www.rivm.nl/vtv/object_document/o1078n18744.html).

60 Information from the Figure 2.27 of the RIVM "Future Public Health Research, part 'Health and Determinants''', p. 45 figure 2.27, Bilthoven, May 2010.

61 Information on the RIVM 'Future Public Health Research, part 'Health and Determinants'', (retrieved on 3 June 2010 from http://www.vtv2010.nl/deelrapporten/gezondheid--determinanten).

62 Three groups are excluded: soldiers on active duty, foreigners who do not have a residence permit, and principal objectors of insuring.

63 Maarse, Hans, 'Health Insurance Reform 2006', Health Policy Monitor, March 2006 (retrieved on 15 May 2009 from www.hpm.org/survey/nl/a7/1).

64 Information retrieved from http://www.rijksoverheid.nl/onderwerpen/veranderingen-in-de-zorg-in-2010/zorgverzekering#zorgtoeslag on 03 June 2010.

advice), dental care up to the age of 22, specialist dental care and dentures, hospitalisation, patient transport.

In 2009, the Government slightly amended this basic health insurance package. Compensation for sleeping pills and tranquillisers was reduced and special chairs used to stand up more easily[65] and allergen-free mattress covers are no longer being compensated. Expected savings are EUR 124 million in 2009. Payment for medication for erectile malfunction has also been terminated, as well as for faxes for the deaf. Furthermore investment will be made in better quality of methadone treatment, and children from the age of seven or eight can claim investigation into and treatment of dyslexia[66]. The individual contribution for psychotherapy has also been ended. In 2010, the maximum reimbursement for wigs was raised and a device to breathe in bemused medicine was added to the basic insurance package, as well as defrayment for examination concerning sleep apnea.

In May 2008 around 171,000 people did not have insurance. CBS shows that this number slightly decreased to 152,000 in May 2009. Even though this means a decline compared to the years before, this number is still too high. In 2008, two thirds of this group were immigrants, of which the share of those from the new EU countries was prominent[67]. In 2009, the number of uninsured natives decreased while the number of immigrants rose. Overall the percentage of uninsured first-generation immigrants is still much higher than that of the second generation. The number of uninsured second-generation immigrants declined[68]. In order to properly address this problem, in September 2009 a bill has been submitted to the House of Representatives in which regulations have been laid down to fine uninsured citizens. Before this act will be enacted, known groups of uninsured will be informed. The act provides rules to trace the uninsured people by coupling files. Once traced, this person will first be persuaded to arrange insurance. If one does not comply, he or she will be fined[69].

The no-claim refund[70] was abolished as of January 2008, and has been replaced by a mandatory "personal risk" regulation (mandatory deductible) of EUR 150 for insured people aged 18 years or older per year (this is EUR 103 for people with chronic illnesses). In 2010, this rate has been raised to EUR 165. The compensation to the chronically ill has been set on EUR 54. The main purposes of the mandatory deductible are to undo the perceived unfairness within the no-claim arrangement, to increase individual responsibility of patients with regard to health care and to increase efficiency by avoiding unnecessary medical consumption. The mandatory deductible has resulted in a minor overall increase of costs for the citizens. However, some argue that the decrease in medical consumption will only be short term and expect that the mandatory deductible will be set at a higher level every year[71].

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65 The so-called 'sta-op-stoelen'.

66 Ministry of Health, 'Beleidsagenda 2009', The Hague, 2009, p.11.

67 Information from CBS, press release of 15 April 2009: "Ruim 170 duizend onverzekerde tegen ziektekosten" (retrieved on 15 May 2009 from www.cbs.nl/nl-NL/menu/themas/gezondheid-welzijn/publicaties/artikelen/archief/2009/2009-028-pb.htm).

68 Information from CBS, press release of March 31rst 2010, "Aantal onverzekerden ziektekosten stabiliseert" (retrieved on 22 April 2010 from http://www.cbs.nl/nl-NL/menu/themas/gezondheid-welzijn/publicaties/artikelen/archief/2010/2010-3087-wm.htm).

69 Information retrieved from http://www.rijksoverheid.nl/onderwerpen/zorgverzekering/onverzekerden on 22 April 2010.

70 This arrangement provided a refund up to a maximum of EUR 255 per year to people that had not incurred many care expenses. The purpose was to decrease spending on care, but it proved to be an ineffective and, in terms of administration, a highly complex instrument. In addition, critics claimed that it was unfair to people suffering ill health, as they could never claim any refund.

71 Maarsse, Hans, Mandatory deductible in basic health insurance, Health Policy Monitor, April 2008 (retrieved on 15 May 2009 from www.hpm.org/en/Surveys/BEOZ_Maastricht/11/Mandatory_deductible_in_basic_health_insurance.html?se

Reforms in legislation

The Dutch Government is highly dedicated to the improvement of the health-care system. Many law amendments are still being introduced to achieve the high standards of quality, affordability and access to health care and long-term care.

- *Exceptional Medical Expenses Act (AWBZ)*: The reform of long-term care and mental care targets a decrease in costs and a return to its core objectives. A new financial system has been introduced: defrayment based on accomplishments rather than on available capacity. Also patients will have more freedom to decide on the treatment and care they receive, and where they want to receive it. Some care has been removed from the AWBZ and added to the responsibilities of the local government, support (supporting clients in their daily activities) being one of these. In addition, the indications of the Centres for Care Assessment (CIZ) will be improved in order to prevent incorrect inflow and relieve the pressure on the AWBZ[72].
- *Social Support Act (WMO)*: With the passing of this act in 2007 the local government became responsible for providing social support to their citizens. This act is based on people's self-reliance. As the number of volunteers and informal caretakers is expected to decline, Government supports municipalities in stimulating new volunteers and carers. The implementation of the Social Support Act has challenged the local government. Many of them struggle with items concerning the actual purchase of care (putting out to tender). Poor cooperation with the CIZ has made many municipalities decide to provide care themselves. The future position of the CIZ remains to be seen. On April14th, 2009 Parliament approved a legislative change in the WMO in order better guarantee the position of Dutch citizens. This has been introduced in 2010.
- *Act on public health* was passed in autumn 2008. This act makes it easier to internationally address (the threat of) contagious outbreaks, such as SARS.
- *Act on allowance for the chronically ill and disabled (Wtcg)*: this 2009 act arranges general allowances for the chronically ill and disabled, including a reduction of the mandatory deductible for the AWBZ and WMO, and new fiscal legislation for the costs of specific care. In addition, arrangements have been made to compensate older people and those unable to work in their financial expenses.
- *Act on client rights care (Wcz):* this bill combines current regulations on complaints and quality and aims to strengthen the positions of clients. The cabinet has approved the bill in July 2009, the House of Representatives will view it shortly.

The most important developments in Dutch health care are based on the three main challenges: quality, innovation and prevention.

2.2.3 Quality

The Insurer Act of 2006 heralded the reform of the health-care system. Due to the Dutch objective to provide a high-quality, affordable and accessible health-care system, the Government is continually anticipating the changing needs. Nonetheless, due to its political system, proper and timely anticipation is still work in progress. Transparency, quality and

arch=start+search&p_c:254=254&content_id=251&a=sh&search.x=17&p_i=0&language=en&search.y=5#Headline1).

72 Ministry of Health, 'Beleidsagenda kabinet 2009', The Hague, 2009, p.15.

increase of patients' (being consumers) influence are still in development and being improved. Obviously these are very much interconnected.

- *Transparent and measurable quality of care*: All care institutions have to employ transparency in results and quality by 2011. An example of improving transparency of quality is the multi-annual action programme Quicker Better. This programme consisted of three pillars: awareness and the sharing of knowledge, indicators for safer and better care – for improving the method of scrutiny, and increasing patient safety and logistics in hospitals. In this last pillar 20% of Dutch hospitals participated, and it was rounded off in 2008. In this period 24 hospitals undertook improvement projects on decubitus, postoperative wound infections, blame-free reporting systems, process refurbishment, and work without waiting lists. Also, board and staff members have been supported with a leadership network in order to strengthen and amplify further progress internally. In addition, an externally amplifying influence was aimed at, based on a belief in the stimulating effect on other hospitals to match up to their level of quality.

  The results of the Quicker Better programme (third pillar) have been evaluated by NIVEL. This evaluation shows that all hospitals involved have increased their quality on these issues, however not all ambitions have been achieved[73]. Probably the most important result is that amplifying the development and stimulating further process internally and externally has definitely been implemented successfully[74]. Furthermore, the hospitals have taken structural measures to spread logistical- and security projects. In time it should become evident whether the results have also improved the patients well being.

Transparency in care is necessary in order to guarantee good, affordable, safe and innovative care. The new care payment system, "Diagnosis treatment combination" (Diagnosebehandelcombinatie: DBC), introduced in hospitals and mental-care institutions in 2005 contributes to this. A DBC reflects the total of hospital (or mental-care institution) activities for one patient, based on diagnosis, type of care, care requested and treatment. The DBC defines the amount reimbursed by the insurer. As for some DBCs (the so-called B-segment, 34%) hospitals and insurers can negotiate prices and quality, this new system will promote competition and allow more free-market contracts of insurers and hospitals[75]. The first insights (based on 2005–2008) in the effect of the DBC on quality, accessibility and cost containment show moderate positive results. The focus on quality during the negotiations has increased; however quality is not yet a "binding condition". However, recommendations and expectations are that this will develop in negotiations in the coming year. Concerning accessibility, waiting time seems to follow the slight downward trend. As for the effect of cost containment within the percentage of free price negotiation, the price level in 2005–2006 remained nominally equal. 2006–2007 showed an increase in nominal prices of 2.1%[76]. For 2007-2008 a the price level raised with 3.1%.[77] Some oppose the system of DBC's as the implementation turned out to be very complex. For example problems occur when one patient has two different DBCs. Also some professionals' argue that this system violates patients' privacy[78].

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73 For the exact results and figures, see the NIVEL evaluation, p. 46 and further. www.nivel.nl/oc2/page.asp?pageid=11084.

74 Vos, Leti, Michel Duckers and Cordula Wagner, Evaluatie Sneller Beter pijler 3: Resultaten van een verbeterprogramma voor ziekenhuizen, NIVEL Utrecht 2008.

75 Information retrieved on 17 May 2009 from www.dbconderhoud.nl. Also more information can be found there.

76 Nza, ,Monitor ziekenhuiszorg 2008. Een analyse van de marktontwikkelingen in het B-segment 2008.' Utrecht, 2008.

77 Hospital monitor, NZa, 2009.

78 For example, see: www.dbcvrij.nl.

Learning during its development and implementation, further improvement of the system is needed. Therefore the plan 'DBC's on the road to transparancy' (DOT) has been designed, focusing on recognisability, stability, user convenience, innovation and access to information. After a delay of nearly a year, in 2010 the structure of about 30,000 DBC's will be replaced by a structure of around 3,000 care products[79].

- *Enhancing the influence of patients*: This means that their rights are clearly formulated and occupy a central position in the care process. The influence of patients is expanding ever more in relation to improving health quality. Moreover, some believe it will develop into one of the leading performance indicators of care quality. The Dutch Government aims to increase the patient's liberty to decide on what care he or she will receive and where by introducing personal budgets, and their influence on quality will continue to grow due to the open-market system. Several research documents from 2006 reveal gaps in patient's rights. For example the Board for Public health and care (Raad voor Volksgezondheid en Zorg: RVZ) states a.o. that patient rights are inaccessible and it is insufficiently known among clients how to express complaints[80]. Also the Inspectorate for Public Health (Inspectie voor de Gezondheidszorg: IGZ) reports several bottlenecks in the application of patient rights, the alignment of care being one of these[81]. These signals have made the Dutch Government decide to investigate improvement through the Programme "Seven rights for the patient in care. Investment in care relation". Instruments to achieve these seven rights are: association with field partners for better insight in quality and patient experiences; strengthening the position of organisations representing clients' interests; and anchoring a better client position within our legislation. The programme's aim is to achieve its goals by 2011[82]. It is expected that patients will emphasise the need for integrated care, like care and welfare, offered on local scales. Some municipalities already offer integrated services in so-called residential-care service desks. Integrating care from different areas like care, long-term care and informal care, will greatly increase the efficiency and affordability of care.

  In July 2009 the cabinet approved the bill on client rights care (Wcz). It combines current regulations on complaints and quality and aims to strengthen the positions of clients. After enactment of the bill the information on performances of hospitals and care centers will be more transparent, also filing complaints will become easier and more effective. And information during a complaint will be improved. This way the individual and collective patient rights are strengthened, and the act stresses the responsibility of care suppliers concerning the quality of care[83]. The House of Representatives will view the bill in 2010.

- *Making care safer*: This refers to improving the safety of care itself, like decreasing the number of preventable mistakes during treatment and safety management. Much is invested in formulating guidelines to reduce the number of avoidable mistakes in care. For example every year 1,735 people needlessly die in Dutch hospitals. The IGZ and hospitals have recently agreed to reduce the number of "preventable deaths" by 50%.[84] The safety

79 Information retrieved from www.dbconderhoud.nl on 25 April 2010.

80 Advies van de Raad voor de Volksgezondheid en Zorg: 'De patiënt beter aan zet met een Zorgconsumentenwet?' The Hague 2006.

81 Advies van de Inspectie voor de Gezondheidszorg: 'Staat van de Gezondheidszorg. Patient en recht; de rechtspositie van de patient goed verzekerd?' The Hague 2006.

82 For more information see: Programma "Zeven rechten voor de client in de zorg: investeren in de zorgrelatie", Kamerstuk.

23 May 2008, The Hague, 2008.

83 Ministry of Health, 'Positie van de client versterkt met nieuwe wet', persbericht 23 May 2010 (retrieved from www.rijksoverheid.nl/ministeries/vws/documenten-en-publicaties/persberichten/2010/04/23/positie-van-de-client-versterkt-met-nieuwe-wet.nl on 25 April 2010).

84 Algemeen Dagblad, Taboe af van sterftecijfer, 18 April 2009 (retrieved on 15 May 2009 from

programme 'Prevent damage, work safely' aims to improve quality and introduces a safety-managementsystem for which improvement indicators are being developed an applied in hospitals. The IGZ supervises the introduction and will implement these indicators in their reports from 2011. The first results of an interim research on preventable deaths and damages in hospitals are expected in 2010.[85]

The IGZ is responsible for monitoring safety and current safetyprograms.

Several programmes have been set up to ensure a uniform level of quality in health care. Quicker Better has already been mentioned. Care for Better and Better Prevention are programmes set up to improve quality within long-term care and the field of prevention.

Furthermore, care institutions are increasingly practising self-regulation. Accreditations like NIAS (Dutch Institute for Accreditation of Hospitals) for hospitals, HKZ (institution for judging quality within the care sector, varying from hospitals to nursing homes) and ISO are becoming more common and required. The institutions that provide health care insurance demand accreditations from their partners.

The Dutch Government has acknowledged the need to improve the quality systems within the care sector. Many programmes have been introduced to upgrade the care in e.g. hospitals or homes for the elderly. However, the Government relies too much upon the voluntary participation of care institutions. In order to achieve the necessary progress in self-evaluation and transparency, more mandatory regulation is needed.

Despite small differences in the quality of health care due to specialised institutions, there are no significant regional or sectoral disparities in quality.

2.2.4 Innovation

Knowledge and innovation are of great importance to ensure the future accessibility and sustainability of care. The core of the policy on innovation is the facilitation of an innovation platform, policy on experiments, innovative technology and transparent communication. In the innovation platform (Zorginnovatieplatform) partners such as science, industry and Government work together on innovative concepts. Its goal is to contribute to the provision of prerequisites for innovation. Among other things the platform will pay attention to the developments in the labour market, and initiate, stimulate and support experiments by field partners[86]. SenterNovem is commissioned by the Zorginnovatieplatform to supply grants for innovation. Per 2010 calls for some of the platform's instruments for innovation will momentarily not be granted due to the economic crisis[87].

Much is invested in technological innovation: labour-saving technology as well as safety, new medical technology and innovation in the field of sharing and exchanging information.

An example to address quality of care through innovation is the introduction of the Electronic Patient File (EPD). Transfers and alignment within the care cycle still need to be improved. Problems occur as patients are transferred from one care institution to another. The challenge of alignment applies even more with regard to "integral care". Amongst other reasons, this is due to different regulations and financing systems. The Electronic Patient Dossier (EPD) is designed to address this problem, as it enables health professionals to share the medical information of patients. Patients have the right to refuse transfer of their file to the EPD.

www.ad.nl/binnenland/3158049/Taboe_af_van_sterftecijfers.html).

85 Ministry of Health, 'Beleidsagenda 2010', The Hague, September 2009, page 29-31.

86 Ministry of Health, Kamerbrief innovatie in preventie en zorg, The Hague, February 2008.

87 Information retreived on 23 April 2010 from www.senternovem.nl/zorg.

The difficulties encountered in designing and implementing the EPD demonstrate the complexity of this problem[88]. In Octobre 2009 a joint memo on starting points had been drawn up by the most important partners in implementing the EPD. In January 2010 573 of a total of 6.416 care suppliers (GP's, pharmacies and hospitals) were connected to the EPD. Goal is that in 2010 patients will be able to view their file electronically. Expectations are that this will contribute to patient satisfaction and enlarge possibilities for self-reliance and self-management in care[89].

The House of Commons has approved the bill concerning the implementation of the EPD. In December 2009 the House of Lords held an expert meeting concerning this topic, and the process of decision-making continues. The actual implementation of the EPD, envisaged in fall 2009, is delayed with around six months, partially due to the fact that the ICT of care suppliers is not yet equiped for the EPD's. Expectations are that the EPD will be obligatory within 2010. Furthermore, the Government and insurers are introducing multiple networks, as well as ICT innovations to address this challenge of alignment.

Another example of innovation is the current development of eHealth. The Netherlands will host a World Congres on Information Technology in May 2010. The ministry of Health and the Zorginnovatieplatform will contribute on the item eHealth.

The Dutch Government will increase investment in innovation and prevention in the years to come. The planned budget for the platform, policy on experiments and communication[90] in 2009 is EUR 29 million, increasing to EUR 60 million in 2012[91]. In 2009, a total of nearly EUR 99 million was reserved for innovation and ICT developments in care. In 2010, the projected expenditure is EUR 76 million[92].

2.2.5 Prevention

As people enjoy better health, the high demand on care will be relieved and society will profit on both an economic and a social level. This stresses the need for preventative measures. Insurers are stimulated to encourage healthy behaviour, and a prevention programme with a very broad scope has started. It includes addressing socio-economic aspects in order to tackle health issues. Even though insurers are stimulated to focus on prevention, the financial framework to make investments in prevention worthwhile is not yet properly arranged.

The Government wants to stimulate industry, education and local government to create policies on prevention in order to shift from 'after-care' to 'pre-care'. The Sociale Economic Council and a joint Committee (RVZ, Onderwijsraad en Raad Openbaar Bestuur) both have advised the Government on this, looking into issues like work ability, employability and vitality[93]. Their conclusions strengthened the Ministry of Health in her opinion that prevention is an intersectoral issue: health is determined by work, living conditions, education etc.

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88 Also, many oppose the EPD because of ethical dilemmas, privacy considerations being one of these. In March 2009 around 438,000 civilians objected to the transfer of their personal data to the EPD, including many professionals.

89 Ministry of Health, Kamerbrief Voortgangsrapportage electronisch patientendossier, The Hague, February 2010.

90 The budget for ICT innovation is an additional EUR 70 million in 2009.

91 Ministry of Health, Kamerbrief innovatie in preventie en zorg, The Hague, February 2008.

92 Numbers from Beleidsagenda 2009 p. 44 and Beleidsagenda 2010 p. 71.

93 Social Economic Council, 'Een kwestie van gezond verstand. Breed preventiebeleid binnen arbeidsorganisaties', April 2009, and 'Buiten gebaande paden. Advies over intersectoraal gezondsheidsbeleid', May 2009.

Local governments are being stimulated to act on prevention with the programme Gezonde Slagkracht (Healthy Strength). From 2009 to 2014 local governments are nationally supported to tackle obesitas, smoking, alcohol and drug use. In total EUR 10 million has been made available[94].

The programme Better Prevention started in 2005 and was prolonged to medio 2009. Its aim was improving quality, transaparancy and efficiency in collective prevention care. Within the Better Prevention programme the IGZ supported the development of indicators and the alignment between care institutions (overall care, transparency and quality: Zorgbrede Transparante Kwaliteit: ZbTK). Despite the complexity of the program, many separate goals of the activities within the programme have been achieved. However, its main goal has not been accomplished yet: implementation and the securing of the developed (benchmark) instruments are still in progress. This needs to be rounded off with utter attention and care[95].

Vaccination is part of the Dutch policy on prevention. In 2009, the vaccination for HPV (cervical cancer) was added to the national vaccination programme. Furthermore, pilots have been run on reimbursement in case of medical indication for programmes to stop smoking, take more exercise or prevent depression by self-management[96]. Per 2011 these costs will be covered in the basic insurance package.

2.2.6 Rehabilitation

Rehabilitation in the Netherlands is organised through different regulations. When ex-patients are in need of supplementary care or rehabilitation, they can claim care from the Exceptional Medical Expenses Act (AWBZ) or the Social Support Act (WMO). For the first an indication of the actual necessary after-care is required from the Centre for Care Assessments (CIZ). Otherwise it is possible that the WMO can provide the needed after-care, which is the responsibility of the local government. A claim for after-care is granted if it meets with the set terms of the regulation.

2.2.7 Access to health care

Waiting lists remain a problem in the Netherlands, for instance to hospitals and nursing homes. Exact numbers of waiting lists in long-term care are not available. Yet it is believed that waiting lists in nursing and care have risen from 2005 up to 2007[97]. Concerning health care hospitals, GP's and medical specialists set target norms for non-ermergency care, provided among others by hospitals (the so-calles Treek norms). The number of times the Treek norm was exceeded for the *average* expected waiting time for non-emergency care in hospitals, decreased by 5% to 22% in the period 2005 to 2007. In December 2009 the excession of the Treek norm summed up to 27,5%.[98] However, a proper national overview of waiting lists for care in hospitals is not available either. Since 2005 providers of care and care

94 For more information see: www.gezondeslagkracht.nl.

95 Research for Policy, 'Evaluation of the programme Better Prevention', Zoetermeer, August 2009, p.56.

96 Ministry of Health, Beleidsagenda kabinet 2009', The Hague, 2009, p.18.

97 RIVM, 'Zorgbalans 2008. De prestaties van de Nederlandse gezondheidszorg', page 113. Residential care has risen from 34,500 in 2005 to 36,800 in 2007. Non-residential care rose from 17,500 in 2005 to 24,900 in 2007. Waiting times for long-term care from 2004 – 2007 differ from 82% of the Treek target norms for nursing and 95% for home care. More information on waiting lists for health care and long-term care and the measuring methods can be found in chapter 3 of 'Zorgbalans 2008'.

98 Zorgbalans 2010, data retrieved from: http://www.gezondheidszorgbalans.nl/onderwerpen/toegankelijkheid/tijdigheid-reguliere-zorg/wachttijden-ziekehuiszorg on 03 June 2010.

insurers have been obliged to give information to the DBC information system (DIS). This independent databank provides insight into waiting lists. Several institutions such as the State Institute for Health and Environment (Rijksinstituut voor Volksgezondheid en Milieu: RIVM[99]) but also hospitals themselves publish this information. Even though it is sometimes incorrect or not up to date, it is increasingly easy to investigate the waiting time for different medical treatments. Due to this trend the lengths of the waiting lists are becoming more transparent per medical treatment. Also most insurers offer mediation to minimise the waiting time, and as patients enjoy more freedom in choosing their own care, the waiting time at any one facility is also considered. This will stimulate care institutions to minimise the time needed for certain treatments through innovation, and thus contributing to reducing waiting lists.

Better cooperation within the care cycle and the introduction of the Social Support Act are two initiatives to ensure that outpatient care is becoming more feasible for as long as possible. These will both contribute to a relief of waiting lists.

Another area in which waiting lists have been an enormous problem is child welfare. However, the alarming situation has been improved as thousands of children have received help during 2008 and 2009. Many provinces managed to tackle the child welfare waiting lists for now. For 2010 and 2011 appointments are made focusing on decreasing the growing need for child welfare. The main target is that all children receive the care they need within an acceptable time frame[100].

Informal care is of great importance in The Netherlands. Currently informal caretakers provide 75% of the home care[101]. The Dutch Government believes in high individual responsibility and community care. This means that only when care from the personal social network is not adequate can it be requested through the formal channels. This approach requires many dedicated informal caretakers, especially as the need for informal caretakers will rise in the near future. The aim is to maintain the current number of informal caretakers of 2.4 million in 2011, and to substantially increase the number of volunteers. For these goals the Government has reserved nearly EUR 16 million in 2010. For the enactment of the Social Support Act an amount of just over EUR 304 million has been reserved for 2010.[102]
Informal care is being stimulated by tax benefits and other (small) reimbursements. Government is supporting municipalities in their challenge of assembling enough informal caretakers by facilitating different projects. The realisation that much can be gained by aiming at an increase of male and immigrant informal caretakers has resulted in several programmes addressing these specific groups. The Ministry of Health finances cooperation between organisations[103] involved in volunteers in care: ‚Better Care with Volunteers. Quality and innovation volunteers in care'. This project runs from December 2008 up to December 2011 and aims at a contribution of volunteers in care, and also better meeting their needs and wishes. Several improvementprojects are being implemented.[104]

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99 See 'Nationale Atlas Volksgezondheid' on www.zorgatlas.nl. This provides an overview of waiting lists for health care and long-term care. For example, one can find the current waiting time for most specialist treatments in hospitals, as well as the number of people waiting for long-term care.

100 Information on http://www.rijksoverheid.nl/onderwerpen 'Wachtlijsten jeugdzorg in 11 provincies nagenoeg weg' nieuwsbericht 23 March 2010.

101 Information from: www.invoeringwmo.nl/WMO/nl-NL/Kernthemas/vrijwilligermantelzorg.nl on 16 April 2010.

102 Respectively EUR 304,071,000- EUR 5,990,885,000. Numbers retrieved from: Ministry of Health, Beleidsagenda kabinet 2010, The Hague, 2010, pp. 65-68.

103 MOVISIE, Sting, Agora, ActiZ and VNG.

104 For more information, see: www.zorgbetermetvrijwilligers.nl.

2.2.8 Sustainability of the health care system

Overall, costs of health care are rising, mostly because of demographic features: more people live longer and thus need more care. This poses a true challenge to the Dutch Government, and it means that efficiency is needed as well as extra investment to ensure the quality and accessibility of care. The government response is the current focus on innovation and quality as it aims to reduce costs and enhance the productivity of care. The Central Bureau of Statistics (CBS) states that the total costs of actual expenditures in care and welfare care have risen by 4–5% in 2007. This means a continuation of the trend of the past few years[105]. In 2008, this has been 6.2%. The rise in costs for hospital and specialst care rose with 7.1% in comparison to the year before[106].

In the state budgets of 2010 the Ministry of Finance lays down the following projected expenditures:

Projected expenditures (x EUR 1,000,000)[107]				
	2009	2010	2011	2014
Care[108]	32 567.8	33 346.8	34 421.6	34 480.5
Long-term care[109]	22 532,4	22 484,6	23 062,0	23 454,3
Total[110]	57 967,0	60 054,4	62 736 8	73 506,2

The Netherlands is struggling with the worldwide economic crisis, too. In March 2009, the Government published their plans in response to the crisis. These have been worked out in more detail in the Government's spring financial report (Voorjaarsnota) and in the concept budget for 2010. The priority is to maintain and recover certainty and perspective for all. The availability and affordability of care is one of those certainties that must to be guaranteed.

Measures taken by the Dutch Government in response to the crisis have been costly and press on its budget. Among other things, money originally reserved to finance future care has been spent. Without proper action, the Dutch high standards of quality and accessibility of care will no longer be self-evident. One of the multiple short- and long-term measures taken by the Dutch Government is the acceleration of its spending on maintenance and on infrastructure and construction for the care sector (a short-term stimulus of EUR 80 million in 2009 and EUR 240 million in 2010). Furthermore, to guarantee care for the long term, structural measures will be implemented in a so-called sustainability package. The package requires that in the years to come the care sector should save 0.4% of the GDP. This will be partly

105 CBS, press release 08-037 Uitgaven aan zorg stijgen met 5.1%, 16 May 2008 (retrieved on 15 May 2009 from www.cbs.nl/nl-NL/menu/themas/gezondheid-welzijn/publicaties/artikelen/archief/2008/2008-037-pb.htm).

106 CBS, press release Uitgaven aan zorg stijgen met 6,2 %, 14 May 2009 (retrieved on 25 April 2010 from http://www.cbs.nl/nl-NL/menu/themas/gezondheid-welzijn/publicaties/artikelen/archief/2009/2009-037-pb.htm).

107 State budgets 2010, (figures retrieved on 24 April 2010 from www.rijksbegroting.nl/2010/voorbereiding/begroting,kst132834b_14.html, Table 3).

108 Expenses in care consist of hospitals, specialists, mental care, GP, dentists, etc.

109 Expenses in long-term care consist of (a.o.) care provided in nursing homes and elderly homes.

110 The total refers to all costs within the care sector as a whole as regarded by the Ministry of Finance, and a.o. includes costs for welfare, unsuspected costs, fund for education, and expenses for Wtcg (legislation on allowance for chronically ill and disabled people) (www.rijksbegroting.minfin.nl/2010).

generated by reducing spending on care benefits the actual cut being dependant on income. Furthermore, The Ministry of Health will present additional measures in the near future[111].

As the economic crisis continues it calls for budget cuts and reviewing policies. Several work groups of (former) civil servants and experts have been installed to advise the Government. One for these work groups has taken up care ('cure'), looking into ways to achieve a reduction of 20% in costs. Three elements have been reviewed: improvement efficiency; making people more responsible for their own care; and narrowing the insurance package. Two variants have been worked out in which these three elements have been taken into consideration. The Government will study this advice[112].
It is challenging to balance both objectives of affordable as well as high-quality care. Care ('cure') has the largest and fastest growing expenditures. If policy remains unchanged, this will claim all available health budgets and will also challenge other budgets in the period 2011- 2015[113].

The facts of too few qualified staff in health care and long-term care are alarming, especially bearing in mind the growing need for care. The Dutch policy to deal with this problem is to raise the inflow of new personnel (policy on labour market), to maintain the current staff, and increase productivity of staff through innovation.

2.3 Long-term care

Long-term care is created for people with a disability or illness who aren't able to look after themselves, either for a long period of time or permanently. In the Netherlands the social insurance for long-term care has been laid down in the Exceptional Medical Expenses Act (AWBZ) and covers the expenses of those medical risks that are not covered by insurance. This includes care at home and care in institutions for the elderly, care in institutions for the mentally and physically handicapped and institutions for chronic psychiatrist patients. Since 2007 domestic help is organised through the Social Support Act (WMO). Local governments are responsible for its enactment and receive budget to do so.

There are four main policy debates on long-term care in The Netherlands[114]:

1. the quality of care;

2. the long-run sustainability of long-term care;

3. the lack of incentives for efficiency in the system of long-term care;

4. finding sufficient workers in long-term care to compensate for the expected increase in demand for long-term care.

The first is discussed in 2.3.2, the others in 2.3.3.

2.3.1 Access to long-term care

The access to long-term care in the Netherlands is similar to the access to health care in general. Due to the Insurer Act of 2006 there is no inequity due to gender, age, health status,

111 Ministry of General Affairs, Werken aan toekomst, een aanvullend beleidsakkoord bij 'samen werken, samen leven', The Hague, 25 March 2009.
112 Inspectie der Rijksfinanciën, 'Curatieve Zorg 2.0, Rapport brede heroverwegingen', April 2010, p 8.
113 Inspectie der Rijksfinanciën, 'Curatieve Zorg 2.0, Rapport brede heroverwegingen', April 2010, p 7.
114 Mot, Esther, SCP publicatie 204, ,The Dutch system of long-term care', The Hague, March 2010, p.13.

ethnic minority, socio-economic status or geographic location. Also, access to the AWBZ is open for all those who are eligible for long-term care as it is an open-ended scheme.

In order to receive long-term care an indication from the Centre for Care Assessment (Centrum Indicatiestelling Zorg, CIZ) is necessary. The CIZ is responsible for independent and objective assessment; in order to guarantee its objectiveness its financial position is not dependent on the assessments it performs.

Long-term care services are coordinated with rehabilitation, health care and other social services, but improvement is needed. The main problems are non-transparency, high transition costs, inefficient decision-making, coordination problems, external effects and free-riding. The solution must be found in better alignment of these systems[115].

2.3.2 Quality of long-term care

The health sector (including client organisations, professionals, health insurers, the IGZ and the Ministry of Health) has set indicators for the quality of care institutions. These are in use and constantly in further development. Since January 2010 care offices (instituted by the care insurers in order to carry out the AWBZ) are responsible for the direct link between quality and defrayment in the purchase of care[116].

The previous years much has been invested to maintain and improve quality. Care for Better, National Elderly Programme and the Transition Programme for Long-term Care to name a few. In order to stimulate the institutions to use en share this newly gained knowledge, the programme In for Care! (‚In voor Zorg!') has been set up[117].

As stated before, the Dutch Government is investing in a uniform level of quality in health-care services by improving the transparency of quality. One of the multi-annual action programmes that targets long-term care is Care for Better, and focuses on quality and labour reduction. The programme has been prolonged to 2011.

A first evaluation of Care for Better in 2008 from the Institute of Health Policy and Management (iBMG) shows progress in several areas, such as less falling incidents, better ambiance in nurture and a big reduction in decubitus. However, as more improvement is needed the evaluation points out that higher involvement of management is required, as well as better connections between different developments within the sector as a whole[118].

Similar to health care, long-term care is under the scrutiny of the IGZ. Among other things it investigates the development of nursing homes. In a recent report it found that the quality of care in these institutions is improving. However, there is still much to be done. The pressing need for enough qualitative and quantitative personnel to provide adequate care is one of the concerns, as well as the conclusion that the orientation to clients is still insufficient[119]. Furthermore, self-regulation among long-term care institutions is growing. This results in a growing need for HKZ accreditations for nursing homes and other care institutions offering long-term care. This accreditation ensures a.o. the central position of clients and a decent internal organisation. Accredited institutions are able to present decent results and are continuously improving their services.

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115 Mot, Esther, SCP publicatie 204, ‚The Dutch system of long-term care', The Hague, March 2010, p.27.
116 Ministry of Health, Beleidsagenda kabinet 2010, The Hague, 2010, p.19.
117 For more information see: www.invoorzorg.nl.
118 Minkman, M.M.N. en J. Zomerplaag 'Kwaliteitsimpuls in de langdurige zorg: Blik op drie jaar Zorg voor Beter', Kwaliteit in Zorg nr 2, 2008.
119 IGZ, 'Verpleeghuiszorg op de goede weg. Resultaten van vervolgbezoeken aan de 149 meest risicovolle instellingen voor verpleegzorg in 2006/2007', May 2008.

In order to enhace quality, the Government aims to improve the clients' position. Clients are becoming better equiped to get customised care. Also experiences of clients have to become public, using a Consumer Quality index. With interviews and questionnaires clients' experiences are collected. The national results are availlable at the site www.kiesbeter.nl. In July 2009 the cabinet approved the bill Client Rights Care (Wet Clientenrechten Zorg). This will strengthen the position and rights of clients and an enactment is expected in 2011.

2.3.3 Financial sustainability of long-term care

At the start of each new cabinet the Dutch Government determines budgets for health care and long-term care. In case the actual expenditures exceed those projections, the ministry of Health is responsible to formulate policy to contain the costs. One can think of tariff cuts, higher co-payments or a smaller insured package[120].

The most important trend in health-care expenditure is the current and increasing lack of manageability of the long-term care budget (AWBZ). In the years 1999–2004 the number of new indications for AWBZ rose from 430,000 to 745,000[121]. As of January 2008, 588,000 people are receiving AWBZ-indicated care[122]. In 2009, this number rose to 680,000. One of the reasons of this rising number is the ageing of the Dutch population. The ‚grey pressure'[123] rises from 24,7% in 2010 to 43,8% in 2040. These developments will exert pressure on future expenditure on care and long-term care. Also the fact that the AWBZ is eligible to all in need of care (a.o. the elderly, handicapped and the mentally ill) has proved that containing en controling costs is difficult. The fact that the Dutch standards of care have risen, making the quality improvements available for everybody, also contributes to the rising costs[124].

In 2009, the number of new requests for AWBZ care was reduced by 18% with reference to 2008[125], as a result of the new policy of the Ministry of Health.

To address the tight funding problem the AWBZ is being reformed, as advised by the Social Economic Council (SER)[126]. This reform includes the introduction of a new financial system, more patient rights, and the transfer of certain care to local government. Also it concerns returning to its core objectives guarantees the future care for those who really need it, like for example elderly people with dementia, those with mental disabilities and psychiatric patients. Another measure in order to maintain the affordability of the AWBZ, the Ministry of Health is preparing to transfer the rehabilitation to the Insurer Act.

Concerning long-term care, the envisioned changes (a.o. the restriction of entitlements to assistance and of the use of AWBZ care by youths with a mild intellectual handicap and psychiatric problems) within the AWBZ are expected to save an estimated amount of EUR 800 million in 2010. At the same time a financial injection of EUR 2.5 billion addresses the challenges of AWBZ's core business in the next few years. The estimated total expenditure

120 Mot, Esther, ‚the dutch system of long-term care' CPB, Den Haag March 2010, p.9.

121 Figures retrieved on 17 May 2009 from www.nationaalkompas.nl: Volksgezondheid Toekomst Verkenning, Nationaal Kompas Volksgezondheid. Bilthoven: RIVM 11 september 2006.

122 Figures retrieved on 17 May 2009 from www.minvws.nl/dossiers/awbz/feiten-en-cijfers.

123 The grey pressure equals the number of people of 65 years of age and older divided by the number of people between the age of 20 and 64. Information from Social Economic Council (2005-02): Of all ages. A future-oriented elderly policy concerning work, income, pensions and care, January 2005.

124 Mot, Esther, ‚the dutch system of long-term care' CPB, Den Haag March 2010, p.66.

125 Stam, Caroline, 'CIZ: 'Kabinet geslaagd in beperking AWBZ-zorg'', 18 May 2010, retrieved from: http://www.zorgwelzijn.nl/web/Actueel/Nieuws/CIZ-Kabinet-geslaagd-in-beperking-AWBZ-zorg.htm on 28 May 2010.

126 Social Economic Council, 'Langdurige zorg verzekerd: Over de toekomst van de AWBZ', The Hague, 18 May 2008.

for innovation in 2009 is EUR 98 million[127]. The total projected expenditure for long-term care in 2010 is EUR 5.9 billion[128].

The changes in the financial system for care institutions and nursing homes were introduced in January 2009. From then on defrayment from the insurer is based on actually needed care and accomplishments, instead of on available capacity of institutions. In 2009, 52 "packages of care" (zorgzwaartepakket: ZZP) have been formulated, providing different levels of care needed by patients. In 2010, this process will be further enrolled. Possibilities to also introduce this system outside the care institutions are being explored, and efforts are made to relate the defrayments even more to the care-seeker[129]. Many stakeholders are involved in the process, and even though the system is still in development, care suppliers are positive about this system as it is based on the need of care of the client. The money now "follows" the patient in his/her care, putting the patient in the central position. In June 2009 the Nza evaluated the first 6 months of the ZZP introduction. The most important conclusion was that the offer of ZZP is insufficiently transparant for (future) clients[130].

Also, patients' obligation to contribute to the costs of care is being expanded per 2010 with treatment by means of accompaniment, meaning from then on all AWBZ treatments will require a personal contribution. Also some minor amendments have been made in the AWBZ concerning mandatory deductible. A mandatory deductible of 27% of the (gross) total budget has been introduced for care-seekers with a PGB[131]. Also for support not financed with a PGB a mandatory deductible will be introduced per June 21st 2010, the exact amount is related to the patients' income. Finally, the mandatory deductible for care in long-term care institutions has been raised to EUR 2.018 per month[132].

The decision on the organisation of the AWBZ from 2012 onwards was envisaged in April 2010. The fall of the Dutch cabinet in February 2010 has delayed this decision.

Staff shortages in long-term care are concerning. The recent report of the Zorginnovatieplatform predicts with an unchanged policy a need for 470,000 extra employees in care in 2025. This is due to several trends: the need for care rises and becomes more complex; the offer of labour forces decreases; and the variety within the offer of labour forces increases[133]. The Dutch Government aims to address this problem by investing in increasing the inflow of new personnel, maintaining current personnel, and innovation. In 2010, EUR 98 million is invested in an internship fund that increases the quality and quantity of internships. Also attention is paid to youths, immigrants and lower qualified people to recruit them for jobs in care (around EUR 7.7 million). Around EUR 10 million is projected for regional labor policy[134].

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127 Ministry of Health, 'Beleidsagenda kabinet 2009', The Hague, 2009.

128 Respectively EUR 304,071,000- EUR 5.990,885,000 Numbers retrieved from: Ministry of Health, Beleidsagenda kabinet 2010, The Hague, 2010, p.65-68.

129 Ministry of Health, Beleidsagenda kabinet 2010, The Hague, 2010, p.18.

130 Nederlandse Zorgautoriteit, ,Voortgangsrapportage Invoering ZZP. Rapportage over de periode januari 2009 – 30 juni 2009', June 2009.

131 A PGB is a personal budget, that is related to the client and no longer to the care-supplier. The use of PGB's has risen from 51,000 in 2003 to 119,000 in 2009. That is 19% of all AWBZ-users (information from:Letter from the State Secretary of Health to the House of Representatives ,Concerning the definition of vision on long –term care for defrayment AWBZ, 1 February 2010).

132 See www.rijksoverheid.nl/onderwerpen/algemene-wet-bijzondere-ziektekosten-awbz/vraag-en-antwoord/wat-is-er-sinds-1-januari-2010-veranderd-in-de-eigen-bijdrage-van-de-awbz.html, information retrieved on 16 April 2010.

133 Zorginnovatieplatform, ,Zorg voor mensen, mensen voor zorg. Arbeidsmarktbeleid voor de zorgsector richting 2025', November 2009, p. 5-10.

134 Ministry of Health, 'Beleidsagenda kabinet 2010, The Hague, 2009, p.46.

Recent figures show a more relaxed labour market in 2009: in June the number of vacancies declined with 25% compared to a year before, and the number of new students in care educations (ROC –vocational- and highschools) rose to 7,000. Even though this relieves the short-term stress, employing new and qualified personnel is still a great concern to the care institutions. Taking the aforementioned trends into consideration, the care sector will call heavily upon the labour market in the future[135].

It is promising that the Dutch Government and its partners have dedicated themselves to tackling the problem of the lack of qualified personnel, but it will be solved neither easily nor quickly.

The Social Support Act has been evaluated in 2009. The most important conclusions are[136]:

1. most local governments are implementing the Act in pursuit of an integrated policy;

2. most local governments have set up a board, respresenting most groups of clients;

3. local governments that pursue a demand-led approach have a wider range of services. Also the average social and life skills of residents are greater;

4. small target groups are not well represented and their care needs are not always supplied;

5. local governments do little to help those impaired to make social contact;

6. attention for the informal carers of those applying for support offers opportunities which local authorities are not exploiting sufficiently;

7. local authorities appear not always to offer clients a choice between support in kind or a personal budget.

2.3.4 Conclusions

From the previous chapters we can conclude that the following major challenges in the sustainability of the health care system lie ahead:

- The rising cost of health care. Will we be able to afford the current system?
- The tension between affordable health and high quality care
- The lack of inflow of qualified staff
- The high dependance on informal care workers now and even more in the future
- The lack of alignment of the various care systems
- The lack of manageability of the long-term care budget (AWBZ)

135 State Secretary of Health, Arbeidsmarktbrief 2009.

136 De Klerk, Mirjam, Op weg met de WMO in: De Klerk, Mirjam, Rob Gilsing and Joost Timmermans, Op weg met de WMO. Evaluatie van de Wet Maatschappelijke Ondersteuning 2007-2009, March 2010, Den Haag, p.313.

3 Impact of the Financial and Economic Crisis on Social Protection

The worldwide economic crisis has also hit the Netherlands hard. Being a very open economy, the Dutch economy is vulnerable to economic decline in other countries such as the EU Member States, the USA and Asia. An aspect of the crisis that is of special interest for the Netherlands concerns the large internationally operating financial sector. This sector needed substantial support of the Dutch Government, which explains the spectacular increase in the national debt. For recapitalisation the Dutch Government invested EUR 20 billion, and furthermore a guarantee was given of EUR 200 billion to banks. Figures show that the operational results of the Dutch banks have decreased since the beginning of 2007[137]. The cause of this loss can be explained by the losses with regard to financial transactions, which illustrates the financial crisis in a nutshell[138].

Caused by the recession, Dutch unemployment increased from 304,000 in 2008 to 379,000 in 2009, being 4.9% of the working population[139]. For 2010 unemployement is expected to increase to 6.5%. Economic decline was 4% for 2009 and a moderate recovery of econmic growth of 1.5% is expected in 2010[140]. Dutch budget deficit is expected to be 6.9% in 2010.

In its analyses the Dutch Government describes the crisis as a conjunctural downturn sharpened by new shortages (energy, raw materials) and new constraints (climate, water). Furthermore irresponsible risk-taking and behaviour resulted in an abrupt decline of confidence in the financial system, which created an unprecedented decline in worldwide demand[141]. In its response to the crisis the Dutch Government launched four challenges:

- to keep and recover the labour market with special attention for young unemployed
- to contribute to a sustainable and innovative economy
- to recover to a balanced budget in order to avoid budget problems shifting to the next generations. This way an infringement of the Dutch social protection system in the future will be avoided
- to avoid protectionism and promote European solidarity

From these challenges it becomes apparent that a fundamental threat to the social protection system comes from unsustainable public finances, which will make the social protection system unaffordable. Within the election campaigns much attention is paid to the reduction of the budget deficit. The former cabinet installed 20 working groups in order to prepare measures for reducing the budget deficit. 4 working groups were dealing with social protection. The results of the working groups are now part of the discussion between all political parties and for sure the results will play an important role for the composition of a new government.

To keep the social protection system financially sound a plea was made to the social partners for solidarity: solidarity between the working population and the unemployed and pensioners; solidarity between the market and the collective public sectors; and solidarity between generations. Social partners agreed to contribute to a very modest wage development and

137 Quarterly report Dutch National Bank, December 2008.
138 Ibid.
139 Figures CPB.
140 Figures CPB http://www.cpb.nl/nl/news/2010_13.html.
141 Work together, live together, government declaration March 2009.

even no wage growth in the coming year. This also saves the Government EUR 3.2 billion on wages in the public sector. A modest wage policy will make benefits and pensions affordable and reduces inflation. In return the Government together with local authorities (municipalities and provinces) will invest in e.g. training, infrastructure and other public works.

The so-called automatic budget stabilisers are an important feature with regard to combating the crisis. The additional number of unemployment benefits will keep domestic demand at sufficient levels even if they contribute to budget deficits. These deficits will also be limited because of the adequate level of demand on the domestic market, which generates tax benefits[142]. The Government is committing itself to improve the budget deficit by 0.5% per year when economic recovery appears. The purpose is to return to the criteria of the Stability-Growth Pact. An exact time path has not been provided to achieve this ambition. It is completely dependent on the state of the economy in the years to come. With regard to pensions, this policy is translated into the measure to raise the retirement age to 67, stopping indexation and the obligatory return of the pension funds to a coverage rate of 105% within five years.

The health care sector is, together with the pensions, regarded as the most expensive part of the social protection system. Financial incentives should contribute to more efficiency and less budgetary constraints. For the health care sector it can be noted that discussions on the financing of the sector had already started long before the current crisis, resulting in a major change of the health care sector by means of the introduction of the new Insurers Act in 2006. After the introduction of this act new measures were introduced to limit spending in the sector, such as the reform of the Exceptional Medical Expenses Act (AWBZ) in 2009. In addition, a focus on prevention is one of the key priorities of Dutch Government policy aimed at keeping the health care system sustainable. In its government declaration concerning the recession the Government has not yet been very explicit on its measures regarding health care[143]. Availability and affordability of care has to be guaranteed. To achieve this, spending on health care has to be reduced, and savings of 0.4% of GDP are necessary. The new financial system for the AWBZ introduced in January 2009 should especially contribute to this objective. As a result patients will have to contribute when making use of medical treatments under the AWBZ.

As the economic crisis continues it calls for budget cuts and reviewing policies. Several work groups of (former) civil servants and experts have been installed to advise the Government. One for these work groups has taken up care (‘cure’), looking into ways to achieve a reduction of 20% in costs. Three elements have been reviewed: improvement efficiency; making people more responsible for their own care; and narrowing the insurance package. Two variants have been worked out in which these three elements have been taken into consideration. The Government will study this advice[144].

The overall effect of the financial crises on social security will depend mainly on the possibility of the Dutch Government to control the budget deficit and national debt when the crisis is over. The part time use of the unemployment benefit scheme, the prevention of early retirement and the forseen recoverage of the pension funds even will make strong measures in the social protection system inevitable. As the Committee Goudzwaard stated the pension system needs to be reformed in the sense of lower expectations or accepting greater risks. Problematic is the rise of expenses in health care. This was however already problematic before the crisis. The crisis only created more urgency to the problem. Rising expenses in the

142 Work together, live together, government declaration March 2009.
143 Ibid.
144 Inspectie der Rijksfinanciën, ‘Curatieve Zorg 2.0, Rapport brede heroverwegingen’, April 2010, p 8.

health care is not only special for the Netherlands. The greying population will require more health care services and as a result more expenses. Therefore it is to be expected that in the future citizens will have to pay more for health care services. The crisis will only accelerate this tendency. As noted in this report a personal contribution was already introduced this year.

4 Abstracts of Relevant Publications on Social Protection

[[R] Pensions

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

[H] Health

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

[L] Long-term care

[R1] VAN ENGELEN Theo, «Van 2 to 16 miljoen mensen», 01 April 2009
"From 2 to 16 million people"

In this book the demographic development of the Netherlands is described from a historical perspective from 1800 till 2000. From the population figures it becomes obvious that the Netherlands already had a greying-population problem from 1900 when life expectancy increased by 56% and fertilisation rates dropped by 64%. According to the author, because of lower birth rates the greying population presents no problemas such . In society there are two groups who are dependent and need support: youngsters and pensioners. The decline in the size of the first group will make it possible to meets the costs for the pensioners. The book illustrates that, despite the greying population, in total the demographic pressure has declined.

[R1] NEDRLANDSE REGERING, «Werken aan de toekomst, een aanvullend beleidsakkoord bij samen werken, samen leven», 25 March 2009.
"Government declaration work together, live together"

This governmental declaration unveils the policies of the Dutch Government with regard to the economic and financial recession. It contains all kinds of measures in the fields of economics and social protection. The declaration is seen as an annex to the policy agreement made when the Dutch Government was founded.

[R1] SOCIAAL ECONOMISCHE RAAD, «Bulletin» April 2009
"Bulletin"

In this bulletin the SER reflects on the position of self-employed in relation to the Dutch social protection system. Many self-employed people are not insured for disability and unemployment and don't built up pension provisions. Politics will be challenged to find answers regarding the social protection position of the self-employed.

[R1] CENTRAAL PLANBUREAU, «Rethinking retirement» April 2009

This study argues that Dutch policy regarding the labour market for elderly is at a crossroads. Indeed, the Dutch labour market for elderly is characterised by long unemployment duration, long job tenures, low mobility and little investment in human capital. The inefficiencies were previously hidden by massive early retirement, but will become more pressing as the workforce ages and participation rates increase. This imposes a new challenge for Dutch policy, a challenge that has become more urgent due to the current financial crisis that is expected to cause a substantial rise in unemployment.

[R1] CHAMBER OF COMMERCE, «Rapport: starters profiel» April 2009

"Report: starters profile"

In this report a profile is made of the persons who start their own businesses. From the report it becomes apparent that the number of self-employed people will increase further and that there is a structural trend. The strongest increase is in the services sector. The reasons for starting up as a self-employed person are mostly freedom and independence. Furthermore it becomes clear that most of the self-employed are older professionals with quite considerable working experience.

[R2] BLOM, Laurens, «De verplichtstelling pensioenfondsen ter discussie», 2006.

"Discussing the obligatory participation in pension funds"

This book introduces another method of calculating the profitability of pension funds taking into account the societal function of pension funds, which differs e.g. from insurance companies. The new calculation method, the Money Weighted Return (MWR), is a better way for pension fund participants to calculate their pension opportunities than the most frequently used Time Weighted Return (TWR). On the basis of MWR the author recalculates the profitability of 20 pension funds and reaches the conclusion that the profitability of these pension funds are lower, on average by 1%, than expected. For the author, these results provide reasons to question the obligatory participation in pension funds. His calculations show that obligatory participation does not contribute to the profitability of the pension funds.

[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.

[R2] CENTRAAL PLANBUREAU, «Memorandum verhoging AOW-leeftijd en dekkingsgraad pensioenen», 13 February 2009

"Raising the retirement age for the first pillar and coverage rate of pensions"

This memorandum reflects on the government proposals for raising the retirement age to 67 and the financial consequences for the pension funds and the public financial situation. Effects are calculated for the labour market in the longer term, the coverage rate of pension funds and the state budget. Furthermore the effects of the long-term interest rate is taken into account.

[R3] VAN SOLINGEN, Hanna; HENSKENS, Kene, & VAN DALEN Harry, «De vervagende grens tussen werk en pensioen; over doorwerkers, doorstarters en herintreders. NIDI rapport», 2009
"The diminishing line between pension and work"

This report reflects on the greying population and the labour market position of elderly workers. The report proves that ⅔ of workers stop working before reaching the retirement age. Furthermore it elaborates on the reasons for early retirement. The research predicts that the possibilities of early retirement will be finalised in the near future.

[R3] VAN PRAAG, Retirement age of 67 will not solve the crisis, March 2009

Article questioning the relation between the raise of the retirement age and the financial crtisis of the first pension scheme. In this article the relation of retirement age in the first and second pillar is stressed. When the retirment age is not obligatory for the second pillar as well this pillarwill be used as an early retirement scheme. Van Praag pleas for a flexible approach.

[R4] VAN DEN BORN, Arjen «The drivers of career success of the job-hopping professional», 2009

Extensive research regarding the position of the self-employed including the omissions of the social protection system. The research shows that the real problem lies with self-employed people with a low income. It also becomes apparent that self-employed people are mostly of an older age and that there is a connection with the difficult labour market position of elderly persons. For them social protection has to be developed in which collective arrangements can play an important role.

[H] Health

[H1] MINISTRY OF FINANCE, «Nota over de toestand van 's Rijks financiën», tekstgedeelte Miljoenennota 2009, 16 September 2008.
"Note on the situation of the state's finances"

This states the budget of The Netherlands for 2009. See also Rijskbegroting 2009 (State Budget 2009) from the Ministry of Finance.

[H1] RIJKSINSTITUUT VOOR VOLKSGEZONDHEID EN MILIEU, «Zorgbalans 2008. De prestaties van de Nederlandse Gezondheidszorg», 2008.
"Care Balance 2008. Accomplishments of Dutch Health Care"

This document is the second edition of the monitor of the achievements of the Dutch care system. It informs the reader on curative care, long-term care and preventive care. It shows the results in quality, accessibility and affordability. This past period the effects of all the changes within the Dutch system have become visible. Even though the results are mostly adequate and quality has been upgraded, further improvement is still necessary. For example quality still is insufficiently transparent.
The information from this document has been used in preparation of the policy and budget for 2009.

[H2] INSPECTIE VOOR DE GEZONDHEIDSZORG, «Indicatoren openbare gezondheidszorg Basisset 2007», April 2007.
"Indicators public health care basic set"

The IGZ has developed a set of indicators in order to check, monitor and evaluate health care. This report presents this set of basic indicators, and describes how the set was developed and also how it will be used. In developing the indicators many different stakeholders were consulted. Furthermore, two pilot projects have demonstrated their practical use. This has enabled the further development of the set.

[H2] MINISTRY OF HEALTH, «Kamerbrief innovatie in preventie en zorg», February 2008.
"Letter to Parliament on innovation and care"

In this letter to Parliament the Ministry of Health describes its policy on prevention and innovation. It states that innovation is important in order to be able to handle the growing and changing need for care, to provide an answer to the problem of too few skilled staff in the care sector, and to make better use of technology in the care sector. Among other items it describes the establishment of the platform (Zorginnovatieplatform) and its goal of stimulating innovation in care. Furthermore, developments in technology can contribute to relieving the pressure on the care labour market. It also allows care suppliers to make better diagnoses and to make their treatment more effective.

[H2] MINISTRY OF HEALTH, 'Programma «Zeven rechten voor de client in de zorg: Investeren in de zorgrelatie» ', Kamerstuk MC-U-2852129, 23 May 2008.
"Programme 'Seven rights for clients in care: investing in care relations'"

The Ministry of Health wants to further strengthen the rights of patients. To achieve this, it has formulated seven rights for patients. Several stakeholders have been involved during the process, such as organisations representing clients, care providers and insurers. Also in the follow-up they will be involved in further developing these rights. The formulated rights are: the right to quality and safety; the right to available and accessible care; the right to choose care and be well informed; the right to information, consent, file development and privacy; the right to effective and easily accessible treatment of complaints and disagreement; and the right to good governance and participation.

[H2] NEDERLANDSE ZORGAUTORITEIT, «Visiedocument (In) het belang van de client. Het consumentenprogramma van de NZa», 01 November 2007.
"Vision document, (in) the interest of clients. The consumer programme of the NZa"

This document elaborates on the term "public consumer interests" and presents the consumer programme of the NZa. The programme consists of multiple measures to strengthen the market position of consumers in the time to come. These measures concern: transparency in care insurance; better information on waiting lists; more insight into quality (differences) among care providers; guaranteeing the quality of and accessibility to information; preventing lack of choice; allowing choice and switching; quicker provision of service; and improving the rights position of clients.

[H2] VAN DER KEMP, S., Noordhuizen en Poortvliet (RESEARCH VOOR BELEID) «Evaluatie van het programma Beter Voorkomen», August 2009.
"Evaluation of the programme Better Prevention"

In 2005 the programme Better Prevention started at the initiative of the Ministry of Health. It ended in 2009. Its aim was improving quality, transaparancy and efficiency in collective prevention care. This report evaluates the programme Better Prevention, researching wether its goals have been accomplished and viewing the succes- and fail factors. It also advises on future programs. Despite the complexity of the program, many separate goals of the activities within the program have been achieved. However, its main goal has not been accomplished yet: implementation and the securing of the developed (benchmark)instruments are still in progress.

[H2] RAAD VOOR DE VOLKSGEZONDHEID EN ZORG, «Advies van de Raad voor de Volksgezondheid en Zorg: De patient beter aan zet met een Zorgconsumentenwet?», 2006.
"Advice from the Board for Health and Care: patients better off with a Consumer protection act for care?"

This advisory report is focused on the way that rights of patients, which are of importance in fulfilling their role as care-consumer, are anchored in the Dutch legal system. One must think of the right to choose, the right to information, the right to responsible care, and the right to complain. Even though the legal position of patients is well organised, the report discusses some shortcomings. One of these is the lack of comparative information on care. An innovative aspect of this report is its advice for a central information point on patient rights for patients, care consumers and other stakeholders.

[H4] COMMISSIE ARBEIDSPARTICIPATIE, «Naar een toekomst die werkt», 16 June 2008.
"Towards a future that works"

The Ministry of Social Affairs requested the Commission Bakker to investigate and formulate proposals and opportunities that will result in a healthier working of the Dutch labour market. This resulted in an advisory report with three main conclusions: as many people as possible need to be working; work should be guaranteed for all; and labour participation must be sustainable. The first "track" addresses the short-term problem, the latter two provide long-term solutions.

[H4] MINISTRY OF HEALTH, «Arbeidsmarktbrief 2008», 23 December 2008.
"Letter to the Parliament concerning labour market 2008"

In this letter the Ministry of Health informs Parliament on the progress that has been made in the action plan Work on Care (stimulating the labour market in the health sector) and on recent developments in the care labour market. As it discusses the measures taken to enough skilled personnel in the care sector, special attention has been paid to education, participation of immigrants in care labour, the outflow of older personnel, and the circumstances in the workplace.

[H4; L] MINISTRY OF HEALTH, «Beleidsagenda kabinet 2009», September 2008.
"Policy agenda cabinet 2009"

In this policy agenda the Ministry of Health presents its policy for 2009. It gives priority to quality, transparency, innovation and prevention. In order to meet these priorities a care system is needed that provides structural terms. One of these terms is to allow care suppliers to investigate in high quality and affordable costs of care, so that care itself will be improved. That way, patients can actually decide on where to

get their care, and care remains affordable. Standards for safety and accessibility, as well as patient rights, guarantee a basic level of quality.

[H4; L] MINISTRY OF HEALTH, «Beleidsagenda 2010», September 2009
"Policy agenda cabinet 2010"

In this policy agenda the Ministry of Health presents its policy for 2010. It does so by following the next themes: cure; long-term care; prevention; quality and safety in care; participation; innovation; working in care; governance; ethics and health care; war caualties; sports; and finance.

[H4; L] RAAD VOOR WERK EN INKOMEN, «Diversiteit in de zorg vraagt om doorpakken», October 2008.
"Diversity calls for action"

Taking into account that the Dutch population is growing older, as well as the fact that the care sector has to deal with a shortage of skilled personnel, it is necessary to invest in a multicultural staff policy. The current participation of immigrant women in the care sector is low, especially among Turkish and Moroccan women. The RWI stresses the need to specifically target these women in the near future. They can play an important role in relieving the shortage in care personnel. This can also improve the care given to immigrant patients.

[H4] SOCIAAL ECONOMISCHE RAAD, «Een kwestie van gezond verstand. Breed preventiebeleid binnen arbeidsorganisaties', April 2009
"A matter of a sound mind"

In this report the SER subscribes the importance of health management and improvement of employees. A sound health increases the chances to a longer life, a life of good quality, sustainable labour and social participation. Employeras and eployees alike have a responsibility in prevention policy in organisations.

[H4] WERKGROEP HEROVERWEGING CURATIEVE ZORG, «Curatieve zorg 2.0. Rapport brede heroverwegingen», April 2010
"Curative care 2.0. Report on broad re-evaluation"

On request of the Dutch cabinet a workgroup of (former) civil servants and experts have thorougly reviewed the current system of care ('cure'), exploring ways to structurally cut costs of care with 20%. In this report the workgroup presents three elements, which have taken into consideration drawing up two possible varations. It's up to the Government and politics to weigh these reflections and decide upon its follow up.

[L] Long-term care

[L] INSPECTIE VOOR DE GEZONDHEIDSZORG, «Verpleeghuiszorg op de goede weg. Resultaten van vervolgbezoeken aan de 149 meest risicovolle instellingen voor verpleegzorg in 2006/2007», May 2008.
"Nursing homes on the right path. Results of visiting nursing homes in 2006–2007"

In 2005, some alarming signals led to heightened scrutiny of nursing homes . Over 600 nursing homes were visited, and almost all of them (600 out of 640) needed a plan of action to improve. This report discusses the results of the second round of visits and the improvements made by the nursing homes. Most of these nursing homes have progressed since the first visit. For 21 nursing homes the visits resulted in increased supervision.

[L; H4] MINISTRY OF HEALTH, »Beleidsagenda kabinet 2009», September 2008.
"Policy agenda cabinet 2009"

In this policy agenda the Ministry of Health presents its policy for 2009. It gives priority to quality, transparency, innovation and prevention. In order to meet these priorities a care system is needed that provides structural terms. One of these terms is to allow care suppliers to investigate in high quality and affordable costs of care, so that care itself will be improved. That way, patients can actually decide on where to get their care, and care remains affordable. Standards for safety and accessibility, as well as patient rights, guarantee a basic level of quality.

[L] DE KLERK, M., Op weg met de WMO in: De Klerk, Mirjam, Rob Gilsing and Joost Timmermans, «Op weg met de WMO. Evaluatie van de Wet Maatschappelijke Ondersteuning 2007-2009», March 2010, Den Haag
"On the road with the Social Support Act"

This report the Netherlands Institute for Social Research/scp evaluates the first period (2007-2009) of the Act. It focuses on two questions: first the question of whether the system of the Social Support Act contributes to its effective and efficient implementation by local authorities. The second question is whether the objectives of the Social Support Act, such as increasing the social and life skills and participation of people with disabilities, have been achieved.

The Social Support Act is working, in the sense that most local authorities are implementing the Act as the legislator intended and with the instruments provided by the Act. Many local authorities are pursuing a more integrated policy, involving linkage with other policy domains, are working together with numerous organisations and have set up a Social Support Act board which adequately represents the interests of (the biggest) client groups. Local authorities have taken a step forwards in the development of better local social policy. Despite this, there are a number of areas where things have not quite gone to plan.

[L] MOT, E., «The Dutch system for long-term care» (publication CPB nr 204), March 2010
"The Dutch system for long-term care"

This document describes the Dutch system of long-term care (LTC) for the elderly. An overview of LTC policy is also given. This document is part of the first stage of the European project ANCIEN (Assessing Needs of Care in European Nations), commissioned by the European Commission under the Seventh Framework Programme (FP7). Since the first stage of the project aims to facilitate structured comparisons of the organisation of LTC for the elderly in different countries, comparable reports have been written for most other European countries (including new member states). Future analyses in subsequent work packages within the project will build on these country reports.

[L] NEDERLANDSE ZORGAUTORITEIT, «Voortgangsrapportage invoering ZZP's. Rapportage over de periode 1 januari 2009 - 30 juni 2009», June 2009
"Evaluation on the implementation of ZZPs. Report over January 1rst – June 30st 2009"

This first evaluation shows the current situation concerning the implementation of ZZPs. It debates the actual implementation, the purchase in March, the reallocation and changes in defrayment. It calls attention to the bottlenecks and transitional problems of implementation. Also, it shows whether the care offices and care providers have prepared sufficiently. The conclusions of this evaluation will contribute to the further implementation of ZZPs.

[L; H4] RAAD VOOR WERK EN INKOMEN, «Diversiteit in de zorg vraagt om doorpakken», October 2008.
"Diversity calls for action"

> *Taking into account that the Dutch population is growing older, as well as the fact that the care sector has to deal with a shortage of skilled personnel, it is necessary to invest in a multicultural staff policy. The current participation of immigrant women in the care sector is low, especially among Turkish and Moroccan women. The RWI stresses the need to specifically target these women in the near future. They can play an important role in relieving the shortage in care personnel. This can also improve the care given to immigrant patients.*

[L] SOCIAAL ECONOMISCHE RAAD, «Van alle leeftijden. Een toekomstgericht ouderenbeleid op het terrein van werk, inkomen, pensioenen en zorg», January 2005
"Of alle ages. A future-oriented elderly policy concerning work, income, pensions and care"

> *This report considers the future policy on elderly, and pays special attention to: participation of elderly in labour and voluntary work; the income position of elderly; the future sustainability of pensions and the AOW; and on the sustainability of care and welfare resources. The SER has answered these questions, looking also into policies concerning all generations.*

[L] STAATSSECRETARIS VAN VOLKSGEZONDHEID, WELZIJN EN SPORT, «Arbeidsmarktbrief 2009», January 2010, Den Haag
"Letter on labour market"

> *In this letter the State Secretary of Health informs the House of Representatives, paying attention to the recent developments on the labour market within the care sector, on future trends, on the experience of labour of care personnel, HRM policy, strenghtening regional labour market policy, and on the extra investments in education.*

[L] STAATSSECRETARIS VAN VOLKSGEZONDHEID, WELZIJN EN SPORT, «Brief aan de Tweede Kamer, betreft de betekenis van visie langdurige zorg voor bekostiging AWBZ», February 2010, Den Haag
"Letter to the House of Representatives: Concerning the definition of vision on long-term care for defrayment AWBZ"

> *In this letter the State Secretary of Health informs the House of Representatives on her vision for long-term care and its defrayment.She also explains her views on as much care at home as long as possible, the developments in ZZPs and PGBs.*

[L] STAATSECRETARIS VAN VOLKSGEZONDHEID< WELZIJN EN SPORT, «Brief aan de Tweede Kamer, betreft voortgang electronisch patientendossier», February 2010, Den Haag
"Letter to the House of Representatives: progress of electronis patient file"

> *In this letter the State Secretary informs the House of Representatives on the progress made with the implementationa of the electronis patient file.*

[L] WERKGROEP HEROVERWEGING LANGDURIGE ZORG, «Langdurige zorg. Rapport brede heroverwegingen», April 2010
"Long-term care. Report on broad re-evaluation"

> *On request of the Dutch cabinet a workgroup of (former) civil servants and experts have thorougly reviewed the current system of long-term care, exploring ways to structurally cut costs of long-term care with 20%. In this report the workgroup*

presents four varations. It's up to the Government and politics to weigh these reflections and decide upon its follow up.

[L] ZORGINNOVATIEPLATFORM, «Zorg voor mensen, mensen voor zorg. Arbeidsmarktbeleid voor de zorgsector richting 2025», November 2009
"Care for people, people for care. Labour market policy for the care sector towards 2025"

This report signals three trends which calls for answers on the issues of a growing need for care personnel, a declining offer in the labour market because of a decline in working force in eneral, and a more and more varied offer of labour. In its conclusions the Zorginnovatieplatform advises the Government and care partners on possible solutions in order to sustain the solid care in The Netherlands and to maintian this in the future.

[L] SOCIAAL ECONOMISCHE RAAD, «Langdurige zorg verzekerd: over de toekomst van de AWBZ», 18 April 2008.
"Long-term care guaranteed: on the future of the AWBZ"

In this report the SER argues in favour of significantly improving the Exceptional Medical Expenses Act (AWBZ) in the next four years. This will be necessary in order to improve the quality of care, ensure that costs are manageable, and guarantee its financial basis. Claims filed under the AWBZ must be clearly delineated. Essentially, the focus should be on the client and not on the care provider. A "core AWBZ" should remain for persons who are disabled at a young age and for comparable groups.
The report sets an agenda for amending the AWBZ in the short and medium term. The agenda essentially covers all the various elements or parts of the AWBZ and also involves its relationship to adjoining policy domains, for example the Health Care Insurance Act and the Social Support Act.

5 List of Important Institutions

Centraal Bureau voor de Statistiek - Statistics Netherlands

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

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

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 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 for Social Research

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
Postal address:	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