Annual National Report 2009

Pensions, Health and Long-term Care

The Netherlands

May 2009

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On behalf of the
European Commission
DG Employment, Social Affairs and
Equal Opportunities

Gesellschaft für
Versicherungswissenschaft
und -gestaltung e.V.

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1 Executive Summary

This report covers the period January 2008–April 2009. 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. As a result the report focuses on the debate after September 2008.

In the Netherlands, the pensionable age of 65 has been under debate for quite some time. Infringement of the state budget because of the first pillar pension scheme was discussed when the current Dutch Government came into power. The recession made it possible to make the decision to raise the pensionable age by two years to 67. The economic crisis and the budgetary constraints resulting from the support provided to the financial sector made this measure inevitable. Only when social partners, within the framework of the Social Economic Council (SER), come up with an alternative plan that saves an equal amount of money can the decision to raise the pensionable age be reconsidered. Besides the first pillar, the second-pillar pension funds are also suffering from the economic crisis. Their coverage rate declined substantially because of losses on the stock markets and the low long-term interest rate. Within five years instead of three as prescribed by law, a coverage rate of a minimum of 105% should be realised. Until now the only measure that has been taken is not to indexate the pension benefits. Increasing contributions or lowering pension benefits is not yet under consideration although it cannot be excluded for the future. The third-pillar pension schemes are also suffering from the recession for the main reason that applies to the pension funds. 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 can 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. It is too soon to conclude if this approach is successful.

The priorities set for the Dutch health-care system are quality, affordability and accessibility. 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. 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. In the light of the recession new measures will be introduced in order to save 0.4% of GDP on health care expenses.

2 Current Status, Political and Scientific Discourse during 2008 and until April 2009

This Annual National Report covers the period 2008 until April 2009. 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. The debate on pensions and health care therefore is dominated by how to survive the economic crises, how to maintain sound public financial sustainability in the longer term and how to maintain the social protection system for the future. As a result the conclusions of the Dutch National Strategy Report, which were based on the developments before the economic and financial crises, need further serious reflection based on the latest developments. This report will therefore cover mostly the developments during the last couple of months.

2.1 Pensions

The Dutch pension system contains of three pillars:

- the first pillar providing a monthly pension for every citizen reaching the pensionable 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 are a 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 is expected to show a shortfall of 5.6% in 2010. Debt has increased from 42% to 62% of GDP over just one year[1]. Both developments: substantial increases in state expenditure and the losses on the stock markets have significant impact on the pension schemes.

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 8800 per year, EUR 12800 per year for a single person. Every year a person living in the Netherlands between the 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.

[1] Figures CPB. Newsletter 2009 March/April.

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 pensionable 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. The second part will reflect on the effects of the current recession, the measures the Dutch Government is proposing and the debate on these measures.

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. This debate intensified with the advice of the Commission Labour Participation in June 2008.

The Commission Labour Participation advised the Government to raise pensionable 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 pensionable age of 65 no longer matches current life expectancy[2]. Raising the pensionable age to 67 would have a positive effect on labour participation of between 0.8 and 2.5%[3]. In its reaction to the advice of the commission the Dutch Government explicitly stated that it would try to prevent the necessity of raising the pensionable age to 67, which could be clearly seen as a political statement as the debate of rising the pensionable 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.

The figures in the NSR show that the participation of the elderly above the age of 50 is steadily increasing, especially for women. The main explanation given by the Dutch Planning Agency (CPB) is that the new law VPL and the accompanying transitional provisions encourage people to work longer. As stated in the NSR the Dutch Government wants to discourage early retirement. The introduction of fiscal arrangements has contributed to this effect. 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[4].

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 the recently published policy plans of the Dutch Government it was announced that working longer than 62 will be rewarded with a financial bonus on wages[5]. 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

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[2] 76.9 years for males and 81.4 for females in 2004 (EU average 75.1 for males and 81.2 for females) in Life Expectancy Increases, CBS Magazine February 2009 http://www.cbs.nl. Also CPB calculations annex 2 report Commission Labour Participation.

[3] Calculations CPB annex 2 Report Commission Labour Participation.

[4] Economic Survey of the Netherlands, OECD 2008.

[5] Official Government Declaration, 16 September 2008.

persons[6]. 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[7]. The Commission Labour participation in addition advises an exemption for contributions regarding unemployment and disability insurance[8].

The effect of the economic recession

This new law and accompanying policies 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, although it is not yet clear which groups of the labour market are paying the highest price because of the rise in unemployment. 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. 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[9]. Despite the response to the Commission Labour Participation not to raise the pensionable age to 67, under the influence of the recession the decision was made that an increase of the pensionable age to 67 instead of 65 is unavoidable. Only for heavy physical professions will exceptions be possible. This measure is expected to have a positive effect on the budget of 0.7% of GDP[10]. 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.

The measure to raise the pensionable age met much resistance, especially from the trade unions. Therefore in good Dutch “polder” tradition it was decided that social partners are invited within the framework of the Social Economic Council to develop an alternative plan with the same positive budgetary consequences. Only then will the Government consider keeping the pensionable age at 65.

Of course the policy of the Government with regard to the pensionable age provoked debate on the effect of the proposed measures. 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[11]. The difference therefore is three years and not eight. As a result, raising the pensionable 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

[6] CPB calculations annex 2 report Commission Labour Participation.
[7] Economic Survey of the Netherlands, OECD 2008.
[8] Commission Labour Participation (Commission Bakker) paragraph 4.4. 2008
[9] Work together, live together, government declaration March 2009.
[10] Ibid.
[11] Gezondheid en zorg in cijfers 2008 CBS. (health and care in figures).

pensionable age has increased as well because of better medical care. 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 pensionable 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[12].

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. In 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 pensionable age[13].

Another theme in the debate is the presumption that people will work longer. This is easier said than done. Research shows that ⅔of the working population stops working earlier than planned[14]. 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%[15] respectively. Only a fraction of the workers reaches the official pensionable age of 65[16]. 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.

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 BNP. Participation in a supplementary pension fund is obligatory and collectively organised (e.g. through collective labour agreements). 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 living standard. 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.

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12 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).

13 Theo van Engelen: from 2 to 16 million people (2009).

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

15 Ibid.

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

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%[17]. 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 the pension funds were already under stricter supervision of the Dutch Central Bank. 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[18]. The law prescribes that a pension fund with a lower coverage rate than 105% gets three years to recover its coverage rate[19]. 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 and extended the recovery period by another two years to a temporary total of five years in order to allow the funds more time. 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 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 pensionable age under the first pillar to 67. This measure is regarded as profitable for the second-pillar pension funds, too, as it saves the funds a substantial amount of money. The savings are estimated at several billion[20]. 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[21]. 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 these 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

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[17] Central Agency of Statistics: Pension funds and Insurers lose on the stock market, 5 April 2009.

[18] Law of 7 December 2006 concerning rules for pensions (Pension law).

[19] It should be noted that the figures used are average figures as the situation can differ from pension fund to pension fund.

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

[21] 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.

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[22].

A fourth element in the debate to be mentioned is on the coverage rate itself initiated by the Fellowship of Actuaries. 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.

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. 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. Currently, there are negotiations between insurers and consumer organisations regarding a deduction of the costs. Furthermore these insurers are threatened with lawsuits. 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. Third-pillar pension products are not adequately supervised and in many cases far from transparent. Measures are being 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. The Dutch Ministry of Finance has requested in-depth research of the financial structure of these products. In total there are 6.5 million products sold on the basis of investments covering EUR 60 billion on contributions[23]. 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

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[22] 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 in Trouw on 9 December 2008.

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

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[24]. 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 of 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 pensionable age. The measure to raise the pensionable 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 a pre-pension increased by 36,000. From 2007 to 2008 the number decreased from 467,000 to 458,000[25]. Fewer men made use of early-retirement schemes, while women showed a slight increase of the use of such schemes.

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 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 [26]. 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. 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

A trend that was not mentioned in the Dutch National Strategy Report concerned the increase in the number of self-employed individuals in the labour market. In the comments to the

[24] Figures CBS, 6 April 2009.

[25] Source: CBS figures early retirement published April 2009.

[26] 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.

Dutch report it was stated that this was a serious omission in the report. Despite the recession the number of self-employed persons is still increasing. According to a report of the Chamber of Commerce more people will start as self-employed in 2009 than in 2008. In March 2009 more persons registered as self-employed than in March 2008. 2008 was already a top year with 107,000 new registrations. The strongest increase is in the service sector covering 54% of all new registrations, 18% starts in the construction sector and 13% in the retail sector. 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 growth of the number of self-employed is stimulated by the recession[27]. Currently there are about 1 million self-employed individuals active in the Netherlands and the growth seems to be structural.

Given this growth in the number of self-employed on the Dutch labour market the questions regarding pensions and other social security arrangements become more and more apparent. Many self-employed are not insured for disability or unemployment and don't 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[28]. 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 economic crisis seems to speed up the debate on the social security position of the self-employed. 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:

- 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. From figures it becomes apparent 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[29]. 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[30]. 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 begs the question of whether legal measures are necessary.

27 Report on starters profile Chamber of Commerce, April 2009.
28 Social Economic Council Bulletin April 2009.
29 The drivers of career success of the job-hopping professional, dr. Arjen van den Born (2009).
30 Ibid.

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 to accomplish these challenges are:

- developments concerning the measurement and awareness of care quality;
- enhancing transparency for patients and enlarging their options in relation to costs and quality of care institutions and insurers;
- increasing freedom of policy-making for care institutions; opening the care market for new players;
- prevention;
- addressing the shortage of skilled personnel within the health sector.

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 one of the highest in Europe. In 2007 this was 78 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. The Central Bureau of Statistics (CBS) expects life expectancy to rise further to 81.5 years of age for men and 84.2 years of age for women in 2050[31].

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.

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) experience their health as significantly better than the Dutch average[32].

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

[31] Figures from RIVM (retrieved on 15 May 2009 from http://www.rivm.nl/vtv/object_document/o2314n18838.html).

[32] 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).

mandatory insurance for all residents. Also, regardless to gender, age, health condition or socio-economic status, access to health care is assured[33].

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.[34]

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 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 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 has been reduced and special chairs used to stand up more easily[35] and allergen-free mattress covers are no longer being compensated. This leads to an expected saving of 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.[36] The individual contribution for psychotherapy has also been ended.

In May 2008 around 171,000 people did not have insurance. Even though this means a decline compared to the years before, this number is still too high. Two thirds of this group are immigrants, of which the share of those from the new EU countries is prominent. Overall the percentage of uninsured first-generation immigrants is much higher than that of the second generation[37]. In order to properly address this problem, a new regulation is in preparation that will allow the tracing, finding and insuring of those currently uninsured.

The no-claim refund[38] 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). 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

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

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

35 The so-called ‘sta-op-stoelen’.

36 Ministry of Health, Beleidsagenda 2009, The Hague, 2009, p.11.

37 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).

38 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.

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[39].

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 this year: 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 Indicating Care (CIZ) will be improved in order to prevent incorrect inflow and relieve the pressure on the AWBZ[40].
- *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 14 April 2009 Parliament approved a legislative change in the WMO in order better guarantee the position of Dutch citizens. If the House of Lords approves, it will be introduced as of 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.

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, its government is continually anticipating the changing needs. Nonetheless, due to its political

[39] Maarsse, Hans, Mandatory deductible in basic health insurance, Health Policy Monitor, April 2008 (retrieved from http://www.hpm.org/en/Surveys/BEOZ_Maastricht_-_Netherlands/11/Mandatory_deductible_in_basic_health_insurance.html).

[40] Ministry of Health, Beleidsagenda kabinet 2009', The Hague, 2009, p.15.

system, proper and timely anticipation is still a work in progress. Transparency, quality and 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[41]. Probably the most important part is that amplifying the development and stimulating further process internally and externally has definitely been successful[42].

  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[43]. 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 a slight increase in nominal prices of 2.1%[44]. The developments in price in 2007–2008 show a decrease of real price of 1.3% for the "old B-segment[45]", and an increase of 1.9% for the "new B-segment". These first figures show a positive impact of DBCs on cost containment[46].

  In 2009 about 34% of all medical activities will have been translated in DBCs, with a final goal of 70% in 2012 when the system will be fully implemented. However, this system is also being opposed as the implementation has turned out to be very complex. For example

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41 For the exact results and figures, see the NIVEL evaluation, p. 46 and further.

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

43 Information retrieved on 17 May 2009 from http://www.dbconderhoud.nl. Also more information can be found there.

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

45 The B-segment is currently being expanded, up to a final 34% of the DBC's. Therefore, there exists a difference between those previously introduced (old B-segment) and currently introduced (new B-segment).

46 Nza, Monitor najaarsrapportage. Prijsontwikkelingen ziekenhuiszorg 2008, Utrecht 2008.

problems occur when one patient has two different DBCs. Also some professionals' argue that this system violates patients' privacy[47].

- *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[48]. 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[49]. 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". The exact details of the programme still need to be worked out by several partners (organisations representing client, care providers and insurers), but 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[50]. 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.
- *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 1735 people needlessly die in Dutch hospitals. The IGZ and hospitals have recently agreed to reduce the number of "preventable deaths" by 50%.[51]

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

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[47] For example, see: http://www.dbcvrij.nl.

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

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

[50] For more information see: Programma "Zeven rechten voor de client in de zorg: investeren in de zorgrelatie", Kamerstuk 23 mei 2008, The Hague, 2008.

[51] Algemeen Dagblad, Taboe af van sterftecijfer, 18 April 2009 (retrieved on 15 April 2009 from http://www.ad.nl/ad/nl/1012/Binnenland/article/detail/402319/2009/04/18/Taboe-af-van-sterftecijfers.dhtml).

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. 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[52].

Much is invested in technological innovation: labour-saving technology, 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. However, the difficulties encountered in designing the EPD demonstrate the complexity of this problem[53]. In 2009 most hospitals, GPs and pharmacies will be connected to the national EPD. If the Senate consents, connection to the system will be mandatory by law as of 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. That this is an item of growing importance is demonstrated by a second edition of eHealth week in May 2009. Several institutions like the University of Twente's Centre for eHealth and the Dutch federation for patients and consumers (Nederlandse Patiënten en Consumenten Federatie: NPCF) inform the public on the opportunities of 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[54] in 2009 is EUR 29 million, increasing to EUR 60 million in 2012[55].

2.2.5 Prevention

As people enjoy better and 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

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[52] Ministry of Health, Kamerbrief innovatie in preventie en zorg, The Hague, February 2008.

[53] Also, many oppose the EPD because of ethical dilemmas, privacy considerations being one of these. In December 2008 around 333,000 civilians objected to the transfer of their personal data to the EPD, including many professionals.

[54] The budget for ICT innovation is an additional EUR 70 million in 2009.

[55] Ministry of Health, Kamerbrief innovatie in preventie en zorg, The Hague, February 2008.

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 are not yet properly arranged.

The programme Better Prevention ran up to the middle of 2008 and aimed at improving collective prevention care. This programme is currently being evaluated by the Research for Policy department of the Royal Dutch Academic Science (KNAW). 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). After the first pilots within the Better Prevention programme, these indicators were amended in 2007. From then on the information on the indicators has been being collected. This year all institutions will be visited for checks from which they will receive individual reports, resulting in an overall report to be published in 2010.

2009 is the year in which the Dutch position on prevention will be further enrolled. Part of this policy is the addition of vaccination for HPV (cervical cancer) to the national vaccination programme. In addition, girls between the ages of 13 and 16 have been given the opportunity to be vaccinated. Currently, a lively social debate is taking place on the effects and dangers of this vaccination. Another element is the connection of collective prevention care and actual care. Programmes to stop smoking, take more exercise or prevent depression by self-management are examples of pilots to reimburse these costs when the need is medically indicated[56].

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 Indication of Care (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. Since 2005 providers of care and care insurers have been obliged to give information to the DBCinformation 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[57]) 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.

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56 Ministry of Health, Beleidsagenda kabinet 2009', The Hague, 2009, p.18.
57 See 'Nationale Atlas Volksgezondheid' on http://www.zorgatlas.nl.

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.

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's response is the current focus on innovation and quality as they aim to reduce costs and enhance the productivity of care. This year over EUR 58 billion has been reserved for care.

Prevention is also one of the new priorities of Dutch policy. Through campaigns the public is being informed on the importance of health and EUR 5.3 million is being reserved for several pilot prevention programmes in 2009. Insurers are stimulated to focus on prevention. Unfortunately, the financial framework to make investments in prevention worthwhile for insurers are not yet properly arranged.

It is expected that these new policies will decrease costs. However, it will remain challenging to balance both objectives of affordable as well as high-quality 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[58]. In the state budgets of 2009 the Ministry of Finance lays down a total care spending of EUR 51.3 billion for 2007[59]. Costs just for health care amount to EUR 26.4 billion.

Projected expenditures (x EUR 1,000,000)[60]				
	2008	2009	2010	2012
Care[61]	30,722	31,595	32,784	34,063
Long-term care[62]	20,859	21,780	21,749	22,836
Total[63]	54,228	58,009	61,292	69,378

The Netherlands, too, is struggling with the worldwide economic crisis. In March this year the Government published their plans in response to the crisis. These will be 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.

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

[59] 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 people and people with disabilities) (http://rijksbegroting.minfin.nl/2009/).

[60] State budgets 2009, (figures retrieved on 15 May 2009 from http://rijksbegroting.minfin.nl/2009).

[61] Expenses in care consist of hospitals, specialists, mental care, GP, dentists, etc.

[62] Expenses in long term care consist of (a.o.) care provided in nursing homes and elderly homes.

[63] 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 handicapped people) (http://rijksbegroting.minfin.nl/2009/).

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 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[64].

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. This topic will be further elaborated on below.

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. Also, part of the long-term care has been organised through the WMO.

Through the years the terms for claims on AWBZ have been formulated too broadly. This resulted in too many claims. In the years 1999–2004 the number of new indications for AWBZ rose from 430,000 to 745,000[65]. As of January 2008, 588,000 people are receiving AWBZ-indicated care[66]. This has resulted in a funding problem of the AWBZ. The state budget refers to a projected expenditure for long-term care in 2009 of over EUR 21 billion, around 40% of the total care budget.

To address this funding problem the AWBZ is being reformed, as advised by the Social Economic Council (SER)[67]. This reform includes the introduction of a new financial system; more patient rights, and the transfer of certain care to local government. 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.

2.3.1 Access to long-term care

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, ethnic minority, socio-economic status or geographic location.

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64 Ministry of General Affairs, Werken aan toekomst, een aanvullend beleidsakkoord bij 'samen werken, samen leven', The Hague, 25 March 2009.

65 Figures retrieved on 17 May 2009 from http://www.nationaalkompas.nl: Volksgezondheid Toekomst Verkenning, Nationaal Kompas Volksgezondheid. Bilthoven: RIVM 11 September 2006.

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

67 SER, 'Langdurige zorg verzekerd: Over de toekomst van de AWBZ', The Hague, 18 April 2008.

Long-term care services are coordinated with rehabilitation, health care and other social services, but improvement is needed. Due to different regulations and financing systems, proper alignment between different care institutions within the care cycle remains to be improved.

2.3.2 Quality of long-term care

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.

A first evaluation of Care for Better 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[68].

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[69]. 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.

2.3.3 Financial sustainability of long-term care

As stated before the most important trend in health-care expenditure is the current and increasing lack of manageability of the long-term care budget (AWBZ). One of the reasons is the ageing of the Dutch population. The actual number of citizens over 65 years of age will grow by 63% by 2030. Expectations are that in the same period the need for nursing and care will rise by 34%. The need for residential care in nursing homes will increase by 40%; the need for home care will rise by 32%[70]. These developments will exert pressure on future expenditure on care and long-term care.

Another reason for the pressure on the AWBZ is that over the years the scope of care provided by AWBZ has expanded. The current policy to return to its core business should restore the balance.

Concerning long-term care, the envisioned changes within the AWBZ are expected to save an estimated amount of EUR 800 million by 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 for innovation in 2009 is EUR 98 million[71].

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[68] 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.

[69] IGZ, 'Verpleeghuiszorg op de goede weg. Resultaten van vervolgbezoeken aan de 149 meest risicovolle instellingen voor verpleegzorg in 2006/2007', mei 2008.

[70] Jonker, Jedidah-Jah, Klarita Sadiraj, Isolde Woittiez, Michiel Ras, Meike Morren SCP-publicatie 2007/31, Verklaringsmodel verpleging en verzorging 2007, Den Haag, November 2007.

[71] Ministry of Health, 'Beleidsagenda kabinet 2009', The Hague, 2009.

Besides the content changes within the AWBZ as stated above[72], in January 2009 the new financial system was introduced for care institutions and nursing homes. 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" have been formulated, providing different levels of care needed by patients. Many stakeholders have been 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.

Also, from 2010 onward, the patients' obligation to contribute to the costs of care will be expanded with treatment by means of accompaniment, meaning from then on all AWBZ treatments will require a personal contribution.

Staff shortages in long-term care are alarming. The Commission Bakker report, "To a Future that Works", predicts a shortage of care personnel in 2020 of half a million. The Dutch Government aims to address this problem by investing in increasing the inflow of new personnel, maintaining current personnel, and innovation. Recent figures show a growth of care personnel for level 3-4-5 (qualified nurses and caretakers in e.g. nursing homes or homes for the elderly) that easily compensates the annual rise of positions within the sector. Even though education courses in the care sector are still popular, it remains uncertain weather this will be enough to address the future staff shortage. Projections inform us that the difference between supply and demand of staff in these levels can rise up to 6%, not even taking into account the rising need for care[73]. The University of Maastricht's Research Centre for Education and the Labour Market (Researchcentrum voor Onderwijs en Arbeidsmarkt: ROA) predominately concurs with these expectations[74]. Therefore, in addition, immigrant professionals need to be considered in future. The Board for Work and Income (Raad voor Werk en Inkomen RWI) calls for diversity policy in its report "Diversity in care calls for action". Focusing on involving immigrant students in care is a means of addressing the problem of staff shortages.

In order to maintain the current personnel several programmes have been set up to deal with the problems concerning the serious physical work, aggression and violence at the workplace, and the heavy workload experienced by staff. In 2007 the action plan "Work at Care" was presented – aiming at innovation of care processes, keeping personnel and raising the inflow of new personnel – to support the labour-market policy of care institutions and social partners.

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.

Informal care is of great importance in The Netherlands. Better still, the 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. 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

[72] i.e. the expansion of patients' opportunities to decide on their treatment and care, the transfer from some of the AWBZ care to local government, and the improvement of indications of the CIZ, thus preventing incorrect inflow and relieving the pressure on the AWBZ.

[73] Ministry of Health, Arbeidsmarktbrief 2008, The Hague, 23 December 2008.

[74] Researchcentrum voor Onderwijs en Arbeidsmarkt (ROA) – Universiteit Maastricht, Rapport 'De arbeidsmarkt van opleiding naar beroep 2012', Maastricht, November 2007.

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.

2.3.4 Conclusion

The Dutch objectives of social protection within the open coordination method (OCM), regarding care and long term care is to provide accessible, high quality care and long term care and sustainability. 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 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.

3 Impact of the financial and economic crises 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 the substantial support of the Dutch Government in the past months, which explains the spectacular increase in the national debt. For recapitalisation the Dutch Government invested 20 billion Euro, and furthermore a guarantee was given of 200 billion Euro for banks. Figures show that the operational results of the Dutch banks have decreased since the beginning of 2007[75]. The cause of this loss can be explained by the losses with regard to financial transactions, which illustrates the financial crisis in a nutshell[76].

Caused by the recession, Dutch unemployment is expected to increase from 304,000 in 2008 to 675,000 in 2010, being nearly 9% of the working population[77]. An economic decline is expected of -3.5% for 2009 with moderate recovery (-0.25%) predicted in 2010[78]. In addition, the public finance situation has swiftly worsened.

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[79]. 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;

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75 Quarterly report Dutch National Bank, December 2008.
76 Ibid.
77 Figures CPB.
78 CPB short term economic predictions, March 2009.
79 Work together, live together, government declaration March 2009.

- 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. In 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.

To keep the social protection system financially sound an 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 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 payable and reduces inflation. In return the Government together with local authorities (municipalities and provinces) will invest in e.g. schooling, infrastructure and other public works.

The so-called automatic budget stabilisers are an important feature with regard to combating the crisis is. 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[80]. 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 measures of raising the pensionable 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[81]. Availability and affordability of care has to be guaranteed. To achieve this, spending on health care has to reduced, and savings made of 0.4% of GDP. 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.

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[80] Work together, live together, government declaration March 2009.

[81] Ibid.

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.

[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.

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

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.

[R2] CENTRAAL PLANBUREAU, «Memorandum verhoging AOW-leeftijd en dekkingsgraad pensioenen», 13 February 2009
"Raising the pensionable age for the first pillar and coverage rate of pensions"

This memorandum reflects on the government proposals for raising the pensionable 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.

[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.

[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.

[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 pensionable 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.

[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

[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.

[H2] INSPECTIE VOOR DE GEZONDHEIDSZORG, «Indicatoren openbare gezondheidszorg Basisset 2007», 04-2007.
"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.

[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.

[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», 09-2008.
"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.

[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] 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; 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.

[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.*

[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», 05-2008.
"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] JONKER Jedid-Jah, SADIRAY KLARITA, WOITTIEZ Isolde, RAS Michiel, & MORREN Meike, «Verklaringsmodel verpleging en verzorging 2007», SCP 2007/13, 11-2007.
"Explanation model nursing and care 2007"

> *This report presents the researcher's analysis of the demand for care and nursing from 2006 up to 2030. This explanation model has been developed at the request of the Ministry of Health.*

[H4; L] MINISTRY OF HEALTH, »Beleidsagenda kabinet 2009», 09-2008.
"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] RESEARCH CENTRUM VOOR WERK EN INKOMEN (ROA), «De arbeidsmarkt van opleiding naar beroep tot 2012», Universiteit van Maastricht, November 2007.
"The labour market from education to profession up to 2012"

> *Every two years the ROA publishes a report on the future situation on the labour market as recards profession and education. This report focuses on the developments in the medium-long term, i.e. five years. The report concludes that the position in the labour market for technical professions has improved. In contrast, projections for those in social and cultural professions are less positive. Nevertheless, the ROA*

foresees problems in technology, transport, and education. For now, the labour market in the care sector is more or less balanced. Possibilities and projections are very much dependent on the level of education.

[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.

[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: http://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: http://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.

Ministerie van Sociale Zaken en Werkgelegenheid – Ministry of Social Affairs and Employment

Postal address: Postbus 90801, 2509 LV Den Haag
Visiting address: Anna van Hannoverstraat 4, 2595 BJ Den Haag
Phone: 0031 (0) 800 – 8051
Webpage: http://english.szw.nl

The tasks of the Ministry of Social Affairs and Employment (SZW) are to create employment opportunities and to foster modern industrial relations and an activating social security system, and to do so by developing feasible policies that can be monitored. The Ministry's tasks lie in following areas: Employment and the labour market, Social security, Income, Industrial relations, Working conditions.

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Ministerie van Volksgezondheid, Welzijn en Sport – Ministry of Health, Welfare and Sport

Postal address: Postbus 20350, 2500 EJ Den Haag
Visiting address: Parnassusplein 5, 2511 VX Den Haag
Phone: 0031 (0) 70-3407911
Webpage: http://www.minvws.nl

The Ministry encourages people to live healthily. People with health problems should be able to consult their GP, a hospital, or other care providers as whenever needed. They have the right to health care. Together with health insurers, care providers, and patients' organisations, the Ministry ensures that enough services are available and people have enough choice. Although the Netherlands is a wealthy country, some of its inhabitants see little of that wealth. Lacking economic independence, they cannot fully participate in society. To improve their position, the Ministry is working with the Ministries of economics, education and housing to strengthen social infrastructure. The Ministry strives to enable everyone to engage in sport. It also finances top-level sport, enabling the Netherlands to compete at an international level.

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: http://www.nivel.nl

NIVEL contributes to the body of scientific knowledge about the provision and use of health-care services. For this purpose NIVEL carries out research activities on a national and international level on the entanglement between: the need for health care (health status, lifestyle, social environment, norms and attitudes); the supply of health care (volume, capacity, organisational structure, quality and efficacy; and health-care policy (legislation, regulations, financing and insurance).

NIVEL's research capacity and expertise are used by many organisations, such as: governmental bodies (Dutch and foreign ministries, European Commission), scientific research organisations and organisations representing health-care professionals, health-care consumers, health-care insurance companies.

NIVEL's activities include the collation and publication of existing knowledge and evidence in articles in scientific, professional and policy journals, in reports, bibliographies, reviews, summaries and fact sheets. NIVEL has a statutory obligation to publish the results of all its activities. NIVEL's research covers the entire "somatic" health care.

Nederlandse 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: http://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: http://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: http://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: http://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: http://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: http://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

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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.

This publication is financed by the European Community Programme for Employment and Social Solidarity (2007-2013). This programme was established to support the implementation of the objectives of the European Union in the employment and social affairs area, as set out in the Social Agenda, and thereby contribute to the achievement of the Lisbon Strategy goals in these fields. The seven-year Programme targets all stakeholders who can help shape the development of appropriate and effective employment and social legislation and policies, across the EU-27, EFTA and EU candidate and pre-candidate countries. The Programme has six general objectives. These are:

(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/employment_social/progress/index_en.html