POLICY HEALTH IMPACT ASSESSMENT FOR THE EUROPEAN UNION:
Pilot Health Impact Assessment of the European Employment Strategy in the Netherlands

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Introduction

In the framework of the project 'Policy Health Impact Assessment for the European Union' four pilot studies in four different countries were carried out. The studies concerned Health Impact Assessment (HIA) of the European Employment Strategy (EES).
The aim of the pilot studies was to assess what potential health impacts implementation of the EES might cause on a **national** level. This should provide input for the ongoing development of the EES.
The core questions were:

Which intended and unintended **positive health effects** can be expected from the implementation of the EES in the Netherlands?
Which intended and unintended **adverse health effects** can be expected?
How can the expected health gain be maximised, and how can the negative effects be reduced or prevented?

Methods

Role of the steering group
During the HIA a steering group played an important role. This commission consisted of experts and representatives of interest groups. All steps taken in the HIA were discussed with the steering group.

In carrying out the HIA the following steps were taken:

- *Drawing up a community profile*
  As a starting point for the HIA, data that are relevant for predicting the health effects of the employment policy in the Netherlands were collected. A core set of indicators on population, health, work and income, and occupational health, developed by the SANCO Research Group served as a starting point. During the HIA process the profile was adapted.
- *Policy analysis*
  This analysis describes the three core aims of the EES, the ten priorities and the Guidelines for Member States emerging from this, and how they are implemented on national level in the Dutch National Action Plan (NAP). This was then compared with the Annual Budget of the Ministry of Social Affairs and Employment.
- *Data collection, Phase I (interviews)*
  This step was carried out in order to identify focus points for the impact analysis. It consisted of a number of interviews with experts on different work fields related to the EES topics. The experts interviewed were selected, based on their expertise regarding the different groups and the broader fields of interest chosen by the steering group.
- *Data collection, Phase II (literature search)*
  On the basis of the themes that emerged from the interviews, a literature search was undertaken. Besides a systematic search in selected literature databases, snowballing was used. The literature suggested by the respondents interviewed during the qualitative data collection was studied as well.
- *Impact analysis*
  Making use of all the information that had been previously collected (population profile, qualitative data collection, literature search) and the analysis of the implementation of the Employment Strategy, the health effects were analysed. The approach chosen was a life-course perspective.

- *Priorities in health effects*
  A model for prioritisation was developed in co-operation with the steering group and applied to the impacts expected. The criteria concerned the evidence base, the nature of the health effects, the groups affected, and the connection to national and EU health policy priorities.
- *Developing recommendations*

Based on the conclusions from the impact analysis and the prioritisation a number of recommendations were developed.

Results

The comparison of the EES with the National Action Plan and the Annual Budget showed that the main priority in the implementation in the Netherlands is the increase of labour market participation of people who are currently not employed. Cost containment is the most important national policy driver, while the accent is to a lesser extent on aspects of the EES such as increasing the quality of work or creating equal opportunities. Long-term unemployment as well as reliance on disability benefits are to be reduced. The policy analysis further showed that an active policy is being carried out with respect to increasing labour market participation of women and older people. The policy directed towards young people, ethnic minorities and the disabled, the other target groups explicitly mentioned in the Strategy, seems to occupy a somewhat less important position.
Focusing on specific themes, the following results were found:

Theme 1 youth unemployment
Beneficial health effects are expected from the *comprehensive approach* which has its origins in the EES. This approach means that young people are provided with either a job or training, within 6 months after becoming unemployed. Research data show that unemployment under young people increases the number of psychological and somatic symptoms. Unemployed young people smoke more than those employed. Moreover, unemployment at a young age increases the risk of unemployment later in life, with all health impacts related to this. The health effects are not only to be seen at the time of the unemployment, but also in the long run. Programmes for unemployed youth protect them from some of the negative effects of long-term unemployment, especially of the effects on future risk of unemployment. However, undifferentiated target-setting may lead to directing impulses mainly at those that have already better prospects for a job.
The priority for fighting youth unemployment in the implementation of the strategy in the Netherlands is hard to estimate. One of the main measures was the establishment of a taskforce for youth unemployment, but concrete plans of this taskforce were not yet available. Moreover, the implementation of the comprehensive approach is the responsibility of local parties, which may yield different results in different municipalities.

Theme 2 life-course arrangements
Life-course arrangements are introduced to facilitate work-family balance. They are supposed to help women to enter the labour market. Secondly they are meant to provide opportunities for older employees to work less hours instead of retiring altogether. The arrangements are designed as individual savings schemes.
It is doubtful whether the introduction of life-course arrangements will lead to higher rates of *participation* of women in the work force. The combination work-family itself will not change much, rather is it financed and organised differently. Since the facilities are for a larger part financed by the working population itself the influence on participation may differ according to income. *Health* consequences will also differ: facilities will be easier to use for those with higher income. Lone mothers with minimum wage are especially at risk. Someone earning a minimum wage who can only afford to save 1% of this income every month, will have to save for 20 years to be able to take a three-month leave.

The distribution matter comes up again with regard to life-course arrangement as an instrument to postpone retirement. For those who can adequately use the arrangement there may be positive health effects. However, evidence on this matter is not readily available. Opportunities to use the arrangement for part-time retirement are different for women and men. Women will probably be the ones using up their life arrangement savings for care tasks, e.g. for young children, they will therefore not be able to benefit from the part time retirement opportunity to the extent that men will. This will even more be so for women from ethnic minority groups who bear primary responsibility for care.

Theme 3 informal care
If the work participation rates under women are effectively increased by the policy, as intended by the Dutch government and the European Union, problems regarding informal care may be expected. These problems will specifically come up where people are concerned that need intensive care, requiring long hours of supervision by the carer. The problems will intensify when the accessibility of formal forms of care is restricted. A study from the United States showed that full-time employment, as compared with no employment, reduces informal care-giving by more than 20 hours a week. In the UK, the difficulty to combine work and informal care was confirmed by data showing that providing informal care reduced the probability of working by 12.9% for men and by 27% for women.
In the Netherlands, 2 out of 5 informal carers considers her or his situation as (much too) strenuous. One out of 5 feels unhappy because of the care-giving tasks. When more people combine informal care and work this may increase the number of care recipients that will have to be admitted to nursing homes. A study carried out in the United States showed that care recipients whose informal carers experienced negative impact were twice as likely to become institutionalised.
One of the experts interviewed mentioned women from ethnic minority groups as a risk group, because traditionally they do not easily rely on professional care and because formal care is not well accessible for ethnic minorities.

Theme 4 postponing retirement
It is not yet clear to what extent the (financial) policy measures developed to postpone retirement as described in the NAP will be effective to attain increased labour market participation of older people. Early retirement is often used as a way of 'natural downsizing' of companies or organisations. If early retirement becomes impossible it may be substituted by unemployment. This, in combination with a stricter unemployment benefits regime for people over 55, may lead to unemployment-related health problems.
The chance of entering the disability scheme increases with age for both women and men. Postponing retirement may therefore lead to more people on disability benefits.
Health considerations are an important reason to stop working. Work load reduction for older employees (for instance through part time retirement) may therefore be helpful to prevent negative health effects of postponed retirement.

Discussion
The European Employment Strategy allows the member states a lot of freedom regarding the implementation of the formulated policy priorities. Much depends on the degree to which European policies converge with national priorities.
It is therefore difficult to identify which policy measures are really 'European' ones, and which are not. Consequently, it is also hard to make a direct link between the EU policy and the expected health effects on member state levels.
However, the information about health effects related with the implementation (or non-implementation) in member states can be used in the iterative policy development process of the EU, in this case in the field of employment. The discussion of health implications in the Guidelines for Member States annually developed in the framework of the EES may provide an impulse to national governments to also address these issues in their National Action Plans. This, in turn, may help to boost intersectorial policy making on national Levels.

Recommendations

A general recommendation is that health aspects be mainstreamed in all stages of the policy making cycle regarding employment in the European Union.

Regarding specific aspects that are relevant for the Netherlands the following recommendations are made:

- Fighting youth unemployment is, from a health point of view, the most important priority. Specific attention should be paid to this in the annual Joint Employment Report (JER) of the European Commission. The Employment Strategy Guidelines for Member States should explicitly mention youth as a target group. Member States should be asked to describe, in their NAPs, how they plan to address youth unemployment.

- Specific attention in the JER, the Guidelines, and the NAP should be paid to the *composition* of the group unemployed young people. This means that instead of mentioning rough rates of youth unemployment and effective placement in jobs, the plans need to explain how the groups most in need of help are addressed.

- The JER should assess whether policies regarding the facilitation of work-family balance are effective for all socio-economic groups. Moreover, gender and ethnicity based inequity should be a specific point of attention. The Employment Guidelines should address this issue.

- Solutions must be found for consequences of increased labour market participation of women (and men) for the availability of informal care. This should include different types of informal care, which require different input from the caregiver. A second point of attention should be prevention of overload of working informal caregivers. Solutions may lie in changes in working conditions as well as in the organisation of (home) care.

- Facilities to reduce work load such as part time retirement may be supportive to keep older people on the labour market without negative health consequences. This could be one of the EU recommendations for the Member States when drafting their NAPs.

1 Introduction

The document in front of you is a report on a Health Impact Assessment carried out in connection with the project 'Policy Health Impact Assessment for the EU'. This is a two-year development project, financed by the European Commission (Directorate-General for Health and Consumer Protection, otherwise known as DG SANCO).

The aim of this project is to develop and test a methodology for Health Impact Assessment (HIA) in order to identify and describe the health effects, *stemming from spheres other than public health,* that can be expected from EU policy. This is being undertaken in connection with the implementation of Article 152 of the Treaty of Amsterdam that is concerned with guaranteeing health protection in all EU policies.

Health Impact Assessment is a combination of procedures, methods and tools by which a policy, programme or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population. (WHO, Gothenburg Consensus Paper, 2000)

It is commonly agreed that HIA is a *prospective* exercise, i.e. it attempts to predict health impacts of policies which are still to be implemented, in order to prevent negative impacts and to enhance positive impacts. As such HIA is a tool for healthy policy-making.

The organisations taking part in the project are IMPACT, the international Health Impact Assessment Consortium (University of Liverpool, UK), lögd, Landesinstitut für den Öffentlichen Gesundheitsdienst NRW (Bielefeld, Germany), Institute of Public Health in Ireland (Dublin/Belfast, Ireland) and the National Institute for Public Health and the Environment RIVM (the Netherlands). IMPACT is the lead organisation for this project.

The method that has been developed – known as the European Policy Health Impact Assessment (EPHIA) – has been tested by applying it to the **European Employment Strategy**.

Thus, the aim of this HIA is twofold:
To test the EPHIA methodology developed, and to assess what possible health impacts the European Employment Strategy may cause.

In the HIA, the core questions are:

- Which intended and unintended **positive health effects** can be expected from the implementation of the EES in the Netherlands?
- Which intended and unintended **adverse health effects** can be expected?
- How can the expected health gain be maximised, and how can the negative effects be reduced or prevented?

The process and methods are described first, followed by the various sequenced phases in the HIA. Conclusions and recommendations bring the report to a close.

Because the over all aim behind this HIA was to test whether the method that had been developed is applicable in practice, a separate report will be written on this. It will form part of a combined report with the SANCO Research Group. Nevertheless some evaluative remarks regarding the experiences with the method will be made in the concluding section.

2 Process and Method

The draft version of the EPHIA (European Public-Health Impact Assessment) methodology has been used in this HIA. The aim of the methodology is to be able to detect, in a structured way, potential health effects of EU policy, both on the level of the European Union as a whole, and on the national level. A schematic representation of the methodology is shown in Figure 1. The HIA methodology that has been developed consists of two parts, one of which is procedural and the other methodical.
To be able to test the methodology well, the four countries involved have tried to follow the same plan of action.

2.1 Procedure

The phases in the procedure (see Figure 1, left side) may be summarised briefly, as follows:

Identification of policy proposals that are relevant for health

The SANCO Research Group has carried out a screening of the list of policy plans that, according to the European Commission, should be considered for 'extended assessment' in connection with the new integrated-impact assessment procedure of the Commission. A short list has been compiled from this from which, in consultation with DG SANCO, the employment strategy was selected for this pilot.

Setting up the plan for the HIA

The plan for the HIA, or the Terms of Reference (TOR), was established by the steering group. This commission consisted of experts and representatives of interest groups. A list of steering group members' names can be found in Appendix I. There have been 3 meetings with the steering group. Besides this, bilateral consultations with steering group members took place. The Steering Group advised on improvement of the draft report and the recommendations.
The TOR incorporated the role and task of the steering group, the design of the HIA (questionnaire, methods), the extent (in terms of depth, geographical and time limitations, policy context), the products, the necessary means and a time path.

Composition of the assessment team

The assessment team was fixed, because, in this case it was a pilot, for which the RIVM had taken the responsibility beforehand for carrying out the project.

Carrying out the HIA

The methods that were applied for this will be described in the following section. Here it is important to mention that the HIA was set up to be as participative as possible. The steering group had a strong voice in defining specific fields of interest. Moreover, experts were interviewed to support this process of focusing the HIA.

Reporting on health impacts

The first draft version was presented to the Dutch steering group, to the SANCO Research group, and to the SANCO Advisory Group (SAG). The SAG consists of representatives of the respective Ministries of Health of all four countries, and a number of experts in the field of HIA and public health. The SAG critically follows progress and provides advice on the project at large.

Monitoring and evaluation

During the HIA, the progress of the process was continuously monitored. A researchers' diary was kept for this purpose. There were frequent consultations with the other organisations within the SANCO Research Group. After this pilot, there will be a combined evaluation of all four pilots.

2.2 Methods

In carrying out the HIA (see Figure 1, right side) the following phases have been followed:

Drawing up a community profile
As a starting point for the HIA, a profile of the Dutch population was drawn up. The most important data included in the profile were those that are relevant for predicting the health effects of the employment policy. The Sanco Research Group decided to utilise a core set of indicators on the following topics: Population, health, work and income, and occupational health. The data collected for these indicators served as a starting point for the process in which the HIA focuses more and more on specific expected (health) effects of the European Employment Strategy. Later on in the HIA process, the profile had to be adapted and extended, given the focus points selected. This experience led to a change in the methodology model: the policy analysis, orginally the second phase in the HIA process, has now become the first step, instead of the community profile.

Policy analysis
This analysis describes the three core aims of European employment strategy, the ten priorities that emerge from this, and how they are being implemented on the national level in the National Action Plan (NAP). The questions that emerged were what the exact intention is of the EU policy and how it is being, or will be, implemented on a national level. Special attention was given to the target groups featured in the EU policy. As a result of the policy analysis, ideas were exchanged in the steering group about how to proceed further with the HIA process: this led to the establishment of attention points for qualitative data collection and for the collection of evidence that would follow from this.

Data collection, Phase I (interviews)
The EPHIA methodology includes a phase of qualitative data collection. This phase is meant to be helpful in identifying focus points for the impact analysis. The phase consisted of a number of interviews with experts on different work fields related to the EES topics. The experts interviewed were selected, based on their expertise regarding the different groups and the broader fields of interest chosen by the steering group.

Data collection, Phase II (literature search)
On the basis of the five themes that emerged from the interviews, a literature search was undertaken. Besides a systematic search in selected literature databases, snowballing was used. The literature suggested by the respondents interviewed during the qualitative data collection was studied as well.

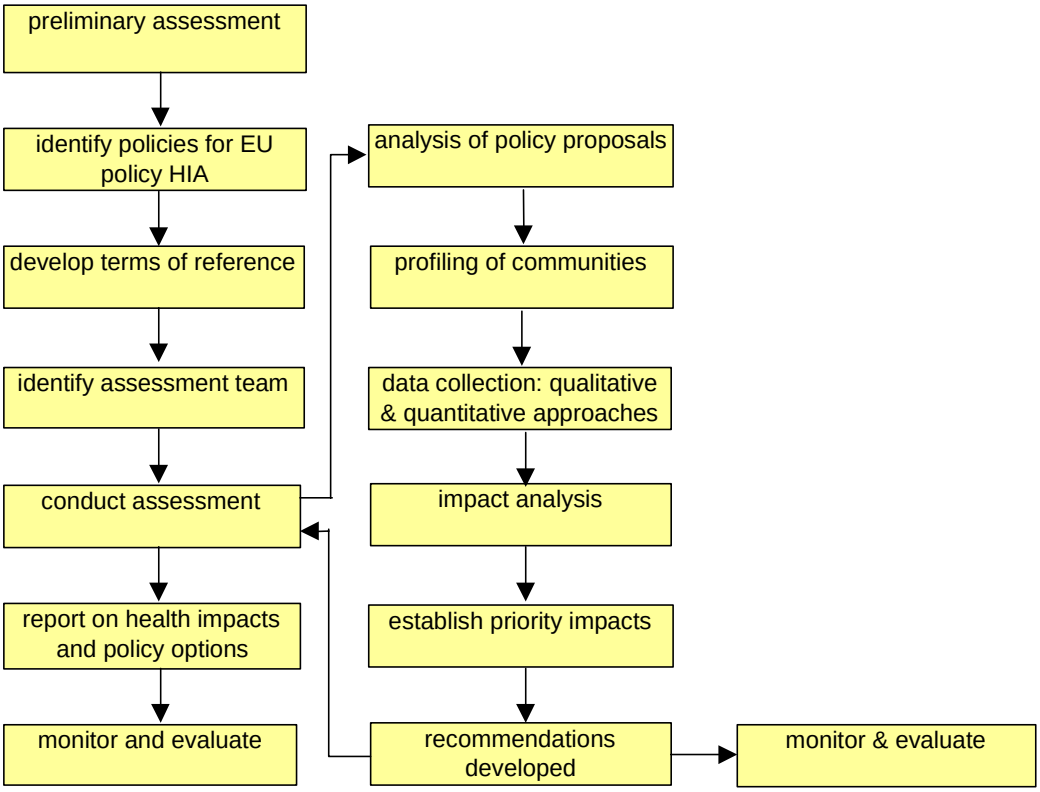
Making use of all the information that had been previously collected (population profile, qualitative data collection, literature search) and the analysis of the implementation of the Employment Strategy, the health effects were analysed. This was done from a life-course perspective. This perspective was chosen because the policy implementation regarding employment has clear consequences for the population's life-courses. Indeed, part of the measures are explicitly referring to changing life-courses.

Priorities and health effects
A model for prioritisation was developed in co-operation with the steering group.

Developing recommendations
Based on the conclusions from the impact analysis and the prioritisation a number of recommendations were developed.

Evaluation
Evaluation was carried out as a joint exercise with the Sanco Research Group. The aim of the evaluation was to refine the EPHIA methodology.

Figure 1: EPHIA Methodology



3 Policy Analysis

3.1 Introduction

This chapter focuses on the implementation of the EU Employment Strategy (EES) in the Netherlands. The analysis of this strategy is an independent step in the HIA process, as developed in the project 'Policy Health Impact Assessment for the European Union'. It is a necessary step to be taken, because the broadly defined EU priorities will be implemented differently in each member state. Therefore the (health) consequences may differ per member state, even more so since differences between member states already exist regarding health situation and circumstances in the policy field concerned, in this case the employment field.

The main question is:
How are the EU employment guidelines translated into policy on the national level in the Netherlands?

We will focus first on the European Employment Strategy. Secondly, we will discuss the National Action Plan in which the Netherlands explain how implementation of the EU guidelines will be carried out. Finally, we will analyse how this relates to the National Budget of the Ministry of Social Affairs and Employment, which supposedly reflects the national priorities regarding employment.

3.2 The European Employment Strategy

The background of European Employment Strategy (EES)[1] is the strategic aim that the European Council established in Lisbon, in March 2000 (Commission of the European Community, 2000, European Council, 2002). The aim is: *to make the European economy the most competitive and dynamic economy in the world in order to achieve full employment over a period of time.*
The European Union has chosen to implement a so-called open method of co-ordination for the EES. It is an iterative process with room for adjustments based on learning processes and changing circumstances. Moreover, member states are given space to implement policy guidelines as is deemed appropriate in their specific national settings. This differs from other EU policies where guidelines are implemented in a strict way and where there are penalties for non-compliance (Goetschy, 2000).
Every year, the European Council devises guidelines for carrying out the European Employment Strategy, on the basis of which, National Action Plans (NAPs) are established. The European Commission studies the NAPs and prepares a Joint Employment Report for the European Council, which contains not only information about each country, but also includes a synthesised description of the developments at EU level. This report is an important input for the further development of EU employment policy, both for the EU and for the member states. Comments on the National Action Plans are given in the Joint Employment Report (Commission of the European Communities, 2004), for instance about the effectiveness of implementation of the guidelines.

[1] information about the EES can be found at URL:http://www.europa.eu.int/comm/employment social/employment strategy.

3.3 Core aims and priorities

The three core aims of European employment strategy are:

Full employment
By means of an overall policy that includes measures on both the demand and supply sides, the Member States try to achieve full employment, and thus to raise employment levels to meet the quantitative aims set in Lisbon. These are:

— a total level of work participation of 67% in 2005 and 70% in 2010;
— a work participation level for women of 57% in 2005 and 60% in 2010;
— a work participation level for older employees (55-64) of 50% in 2010.

Quality and productivity at work
This includes the intrinsic quality of work, skills, lifelong learning and career development, gender equality, health and safety in the workplace, flexibility and security, integration and access to the labour market, the organisation of work and the balance between work and private life, social dialogue and employees' participation, diversity and non discrimination, and overall labour productivity.

Cohesion and an inclusive labour market
The policy on employment must make it easier to participate in the labour process by stimulating access to high-quality employment for all women and men who are able to work; discrimination within the labour market must be combated, and the exclusion of people from working life must be prevented.
An economic and social balance must be encouraged by reducing regional differences in employment opportunities and unemployment, tackling the employment problems in disadvantaged areas of the European Union, and by supporting economic and social reorganisations.

These general policy aims have been translated into a number of policy priorities. The Council of the European Union has established specific guidelines for each of these priorities, to be implemented in all Member States. In addition, there are special recommendations for each individual member state that are considered important for that specific country .

The priorities are:

- Active and preventive measures for the unemployed and the inactive[2]
- Making work pay
- Fostering entrepreneurship to create more and better jobs
- Transforming undeclared work into regular employment
- Promoting active ageing
- Promoting adaptability in the labour market
- Investment in human capital and strategies for lifelong learning
- Gender equality
- Supporting integration and combating discrimination in the labour market for people at a disadvantage
- Addressing regional employment disparities

[2] Policies regarding the unemployed can be either active or passive. A passive policy is aimed at handling the consequences of unemployment, e.g. by paying unemployment scheme benefits. An active policy is aimed at helping the unemployed to become employed.

The implementation of European Employment Policy is the task of the individual member states. In this analysis, the central question is therefore how it will be carried out in the Netherlands.

Converting the EU Employment Strategy into Dutch national policy
The Netherlands has set up a National Action Plan (NAP) in which it is stated, for each priority, what action will be taken in response to the EU guidelines (Ministerie van Sociale Zaken en Werkgelegenheid, 2003). In the following sections, the measures for each priority will be discussed, linked to the policy instruments set up by the Dutch government. For a detailed overview of the policy measures included in the NAP, see Appendix II.

3.4 Policy instruments and priorities

A range of policy instruments are available to the Dutch government. These are:

Communicative instruments (giving and distributing information, but also interactive policy development and intersectorial co-operation)
Financial instruments (e.g., fiscal regulations)
Legal instruments (e.g., the introduction of legal obligations and priorities in the policy for tracking down offenders)

The *priorities* of the EES are addressed as follows :

Active and preventive measures for the unemployed and the inactive
This has to do with **communicative** instruments (assistance, client counselling, performance agreements with municipalities and the UWV, and covenants with employers), supported by **financial** instruments (funding to municipalities to facilitate carrying out these projects, and funding for subsidised jobs and apprenticeships. A key term is the so-called 'comprehensive approach': every unemployed or inactive person should be offered work or guidance/training within a certain period of time. It is interesting that the responsibility for designing these measures has been delegated to the municipalities. This enables an rapid and decisive application of these measures to the specific situations within a municipality; at the same time, however, there are differences in the approach and service provision available to jobseekers.

Making work pay
Fiscal measures will be introduced to make working **financially** more attractive; not working will be discouraged by cutting back on the arrangements for the unemployed. The so-called poverty trap must be reduced[3]. However, the policy is not only directed towards citizens, but also towards municipalities. Where municipalities are successful in reintegrating inactive citizens, then they will be free to use any remaining funds to help meet their own priorities. Municipalities will implement the **communicative** set of instruments in the form of supervision. In doing this, attempts will again be made to achieve a comprehensive approach. Finally, there are **legal** measures (legal instruments) being created to sharpen the rights and obligations of job-seekers. The Law on Work and Welfare, which has been drafted, will be an important law in this respect.

Fostering entrepreneurship to create more and better jobs
How this will be implemented is still unknown.

[3] The poverty trap exists when people receiving welfare benefits are financially worse off when they start working, due to loss of different kinds of additional benefits such as rent support.

Transforming undeclared work into regular employment
For this, legal measures, especially of a repressive nature, are applied. The core of the measures is to deter illegal working. To support this policy, communication between institutions will be improved.

Promoting active ageing
In particular, the government will look for financial incentives to stimulate older people to carry on working. They will make it more difficult financially to stop working early, while, at the same time, there will be a fiscal life-course arrangement that will give people the option of taking a part-time pension. Changes will also be made to **the issuing of laws and regulations**, whereby older people, who become unemployed, will be more forcefully obliged to reintegrate. Further recommendations are expected from the taskforce on older people and employment.

Promoting adaptability in the labour market
The key word here is flexibility. What is important here is **how regulations are issued** with respect to combining care and work. The aim here is to make this combination of tasks easier. Fiscal (**financial**) measures will be introduced (a life-course arrangement) and the implementation of 'good practices' will be extended. How the latter will be achieved has still to be determined. Flexibilising labour in the sense of making more flexible contracts by adapting the ways in which laws and regulations are issued can also be expected on the basis of the National Action Plan.
Adaptability by looking for labour power abroad is not considered. The immigration policy will not be made more flexible in terms of regulations and grounds for admission. Communicative measures will be used to improve information for EU citizens about the possibilities to work in the Netherlands.

Investment in human capital and strategies for lifelong learning
Lifelong learning is less in the foreground here than investing in preparing for occupational life. The youth is an important target group here. Investments are being made in stimulating measures, both **communicative** and in giving **financial** support. Not only vocational education but also higher education are interesting fields from the point of view of policy. In the case of the latter, the female/male ratio is also a focus of attention, even though no budget will be reserved for it: initially, a 'delta plan' will be made (in time, this could lead to financial support or to amendments in the issuing of laws and regulations).

Gender equality
To achieve equality for men and women, initially, measures will be sought that mainly appear to affect women, such as the legal protection of pregnant and young mothers, covenants with respect to women returning to work and stimulating women in higher positions. New **laws and regulations** are expected to be issued around child care. The government is also working in a **communicative** fashion to increase equality, by, for example, information campaigns.

Supporting integration and combating discrimination in the labour market for people at a disadvantage
Making **arrangements** with all kinds of parties in the labour market field plays an important role here. A **law** is being designed to protect the disabled against discrimination.
As far as discrimination of another group, namely ethnic minorities, is concerned, the government is less active. Indeed the government is reconsidering the question of interculturalisation in work places and the necessity of carrying out/stimulating an active policy in this area.

Financial means will be made available, especially by offering financial incentives to employers, to help people, such as the long-term unemployed, who are difficult to place. In

this action plan, people who are ill are also considered as people with a disadvantage on the labour market. An explicitly stated aim here is to reduce absence from work due to illness and entry into the Disablement Insurance Act (WAO) system. The aim is to try and find regular jobs for these people, if necessary under supervision, rather than special work arrangements such as subsidised (ID and WIW) jobs.

Addressing regional employment disparities
This topic is being partially tackled. Communication between and within regions is being furthered by means of the regional platforms. It is the government's intention that the main role should be played by local and regional bodies. The intersectorial approach, using the major cities policy, in which other ministries are also active, is an interesting aspect here. However, what remains unclear is what the specific input will be from the perspective of employment policy.

3.5 Consideration of the National Action Plan and the target groups

That a number of specific groups should participate more in employment is a core issue in the EES. The following can be said about this:
Women: policy is actively focused on increasing the participation of women on the labour market, and particularly that of mothers. Measures are mainly being sought in the sphere of facilitating task combiners (life-course arrangement, child-care, care leave). A specific issue of governmental interest is horizontal and vertical segregation on the labour market.
Young people: the government is taking measures to offer young people more possibilities and opportunities, combined with a more disciplined approach to the unemployed in general. The so-called comprehensive approach will be more strongly applied with respect to the youth: the length of time during which the young unemployed get an offer of work, or have to take another line of action, will be much shorter than for other unemployed people. Despite that, according to the NAP, youth unemployment will be allowed to increase to twice the employment level of the overall working population. Finally, the NAP mentions the establisment of a national task force for youth unemployment. However at this stage it is not yet clear how the task force will contribute to pushing back youth unemployment rates.
Older people: a clear goal of the policy is increasing the participation of older people on the labour market. The most important incentives in this respect are financial; the possibility of taking a part-time pension, paid with the help of a life-course arrangement, must be put into effect and must also be attainable for individual citizens.
The chronically ill and the disabled: the effort here seems to be mainly to realise changes with respect to the work environment, i.e. to move people into less protective work places. Attracting this target group to the labour market is not a marked priority. Discrimination will be fought against in the future; the aim of this is to make access to the labour market a bit easier, but not more than for women and ethnic minorities.
Ethnic minorities: on the one hand, there are performance agreements about the participation of ethnic minorities on the labour market, but, on the other, the government is considering reducing the use of interculturalisation in personnel policy or even of bringing it to a halt.

All in all, the measures such as those described in the NAP appear to be most strongly aiming at raising the participation of women and older people on the labour market.

3.6 From European strategy to National Action Plan

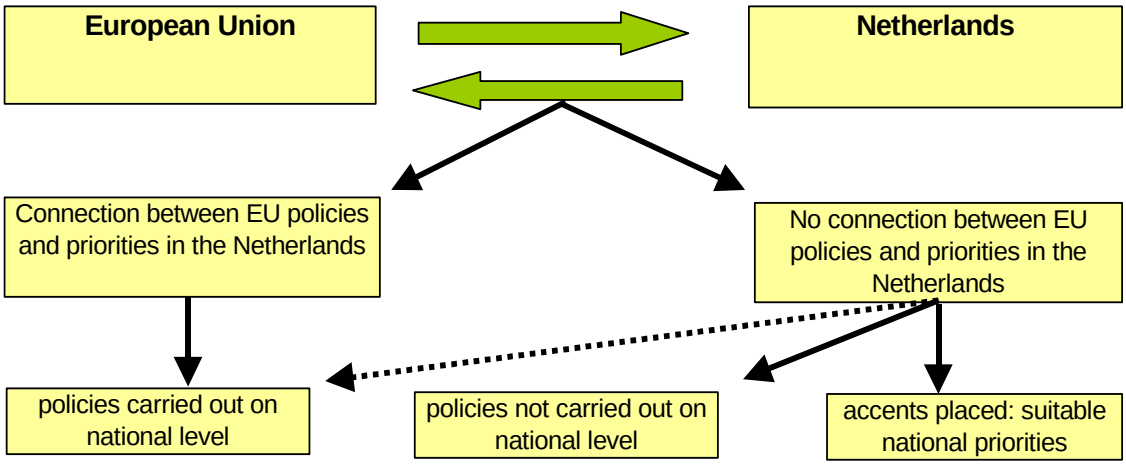
The route from European policy priorities to national implementation is sketched above as a three-pronged approach. However, a number of nuances can be added. Two mechanisms seem to play a role (see Figure 2). We can identify these as 'congruence' and 'change of accent'. We see the first mechanism at work when we realise that the National Action Plan (NAP) is made up, for the most part, out of measures that do not entirely arise from EU strategy. Gender equality, for example, has long been a topic of attention for the Dutch

government, and the problems around the Disability Scheme have been on the political and managerial agenda for some time. In addition, many of the measures included in the Action Plan are already current policy. An exception is the comprehensive approach. Without doubt, the congruence mechanism is inherent in national action plans in which European policy is being implemented. After all, European policy has been developed with contributions from all the Member States. Consequently, a similar congruence will already exist between European and national policy priorities.

The second mechanism can also be clearly observed. The NAP follows the priorities set by the EU, but places its own accents upon them. The most important aspect in the Netherlands is the expansion of participation in employment, by guiding the unemployed and disadvantaged job-seekers back into the labour market. To a somewhat lesser extent, another policy thrust is to attract more women into the labour market and to keep older employees active in the labour process. Cost containment is the dominant national policy driver, while the accent is to a lesser extent on aspects of the EES such as increasing the quality of work or creating equal opportunities. Full employment is – in the Netherlands – the most important core aim of the EES. The two other core aims – to increase the quality and productivity of labour and social integration – remain more in the background, although they can play a role in increasing participation.

Finally, however, it must be stated that the NAP is not a stand-alone governmental policy. In a broader sense, it is either embedded in, or coupled with, the policy of the Ministry of Social Affairs and Employment. In addition, there are links with policy in other fields, such as education, large-city policy and health care. On the European level, there are also links with adjacent policy. However, in the context of this pilot HIA, we have looked specifically at the implementation of the EES.

Figure 2: Policy development: EU – NL and vice versa



3.7 The National Budget

The Dutch policy on employment is also described within a wider national framework — the National Budget (Ministerie van Sociale Zaken en Werkgelegenheid, 2003). What is the relation of the policy, as expressed in the National Budget, to the NAP?

In the Preface to the policy paper, in which the most important frameworks for the policy are itemised, there are two topics of particular importance: too high a call on social insurances (especially the disability scheme) and the need to increase participation in employment, especially among those groups that are currently under-active on the labour market.

Both the Dutch National Budget and EES mention policy priorities. The five most important core aims of the National Budget are:

- Reducing the entry of workers into the provisions of the Disablement Insurance Act (WAO)
- Increasing the departure of beneficiaries from the disability and the unemployment schemes and the social welfare scheme
- Increasing the net participation of older workers (55-64 yrs) in the employment process
- Work and care: reducing the gap between the desired and actual extent to which tasks are combined
- Reducing administrative burdens on the labour market

These aims partly overlap the priorities set by Europe, but not entirely. When we place them next to each other, we see that the following priorities recur in those set by the Dutch government:

- Active and preventive measures for the unemployed and the inactive (including people on the disability scheme)
- Fostering entrepreneurship to create more and better jobs
- Promoting active ageing
- Gender equality (including reduction of gender pay gap)
- Promoting adaptability in the labour market

These appear to be the themes on which there is general congruence between the priorities set by the EU and those of the Dutch government.
The remaining EU priorities are not addressed:

- Addressing regional employment disparities
- Making work pay
- Transforming undeclared work into regular employment
- Investment in human capital and strategies for lifelong learning
- Supporting integration and combating discrimination in the labour market for people at a disadvantage

As we have seen, when discussing the NAP, this does not mean that nothing is being done in these fields. What can be observed is that these are not considered to be the most important issues for the Dutch national policy.

Moreover, the policy priorities in the Dutch National Budget are not worked out 'one for one', but are interwoven in the policy clauses associated with 17 policy *themes*. In the light of the priorities set by the EU, the following of these *themes* are relevant:

- The basic provision of services for work and income
- Stimulating and raising the quality of participation in the labour process
- Adaptive and supervised working
- Societal participation of the disabled
- Increasing the possibilities for combining work and care
- Co-ordinating the emancipation policy

Many of the activities and measures stated in these policy themes are the same as those included in the NAP. More detail as to concrete implementation can however be found in the Dutch National Budget.

The basic provision of services for work and income
An activating service provision is offered to registered job-seekers by the local centres for Work and Income (CWIs). The comprehensive approach is central in this. Prevention and departure quotas are also measured (by 'prevention' we mean that the job-seeker finds work before his or her file is handed over to the benefit authority; 'departure' means that people are no longer registered with the CWI). Other measures are geared towards achieving more efficient administrative processing.

Stimulating and raising the quality of participation in the labour process
The aim is to decrease the number of long-term unemployed, so that fewer people become permanent unemployment scheme beneficiaries.
For this, in addition to the already mentioned comprehensive approach for the newly unemployed, special activating paths for those who receive welfare benefits have been devised and are being applied (by the end of 2004, 300,000 of these action paths have to be carried out by municipalities; how they go about this, is up to them). Single parents (lone mothers especially) are also being stimulated to go out to work by offering them child care (however, how this is done has been left to the municipalities).
According to the Ministry of Social Affairs and Employment, the special target groups that currently participate too little in the labour market are ethnic minorities, young people, older people and women who could return to work. As far as ethnic groups are concerned, we see, as was also indicated when discussing the NAP, that a number of arrangements and projects will stop shortly. What will remain are plans directed towards integration and (Dutch) language acquisition in relation to guidance towards work. The measures for young people are the same as those stated in the National Action Plan, and that also applies to the policy with respect to older people (keeping them on the labour market for longer).

Women returning to work and women from ethnic minorities should be stimulated to search for jobs. For this, the government is making financial means available for communication activities aimed at women and employers. Until 2005, the 30 large municipalities will be supported by the Committee for the Participation of Women from Ethnic Minorities (the PAVEM Committee). The specific activities of this Committee have yet to be made known.

Adaptive working
No special measures can be listed here apart from those that already appear in the NAP.

Social participation of the disabled
This policy clause has been moved to the Ministry of Health, Welfare and Sports.

Increasing the possibilities for combining work and care
The measures given here are those that are included in the NAP. The life-course arrangement is discussed in detail. Important is that the intention is for this to replace other measures, namely paid parental leave and measures allowing long-term unpaid leave. Of importance is also that, alongside this, the Dutch government wants to assess to what extent people are actually able to make use of their rights to take leave.

Co-ordinating emancipation policy
As far as labour is concerned, this policy clause contains no other measures than those already mentioned.

From reading the Dutch National Budget it again transpires that an active policy is being carried out with respect to women and older people, and that the policy directed towards ethnic minorities, the disabled, and perhaps young people, is occupying a somewhat less important position.
Those who are in the disability scheme and the unemployed (both newly as well as long-term unemployed), are viewed in totality as the most important target group. Reintegration of these people and providing them with guidance towards work are core concepts in the Dutch National Budget.

3.8 A final remark

This analysis of the implementation of European employment strategy shows where the Dutch priorities lie. Based on this, the steering group started focusing, concerning the direction that should be taken in compiling qualitative data (the interview phase). This can be found in the chapter on qualitative data collection.

4 Community profile

4.1 Introduction

The SANCO Research Group chose to use a number of basic indicators as starting point for the community profile. Initially, in each pilot carried out in connection with this project, the same indicators were used. The reason for this is that, to test the methodology well, the pilots need to be comparable. The intention is that this method should be suitable for showing how the same EU policy can lead to other health effects in different countries or regions. Similarly, because of the comparability, the choice was made to use information that can be found in the European database, Eurostat.
Below the initial core indicator set is shown. Considerations to choose especially these indicators were that

- a basic picture of the population size and composition as well as health needed to be given
- additional basic information was needed about aspects of the population related to work and health.

Table 1: Initial core indicator set

INDICATOR GROUP	INDICATOR	OPERATIONAL DEFINITION
Population status	Total population Population composition	Total population, stratified by gender % of children (0-14) % population of working age (by 10 year age bands) % population over 65
Population by ethnicity	Proportion by ethnic origin	% of population registered as members of ethnic minority group
Population by socio-economic status	Proportion by income level or distribution	% population with income below 60% national median
Population by household composition	Proportion by categories of household composition	% of households in each of 5 classes: 1-person, lone parent, couples with / without children, other
Population by disability	Proportion of population who are disabled	% population registered disabled
Health status	Life expectancy	Life expectancy at birth, stratified by gender Healthy life expectancy, stratified by gender
Health status	Self reported health	% of population reporting good health, gender stratified
Health status - morbidity	Occupational morbidity	Occupational injuries Occupational diseases (by occupational sector?)
Health determinants - employment	Population by occupational class Total employment Proportion of ethnic minority groups who are employed	% of working age population employed, stratified by gender and age groups. Working population by occupational class % of working population registered as ethnic minority group members
Health determinants - unemployment	Proportion unemployed Proportion of ethnic minority groups who are unemployed	% labour force registered unemployed < 1 year by gender, age % labour force registered unemployed > 1 year by gender, age % of unemployed registered as ethnic minority group members

Where Eurostat failed to provide the information sought, national data sources were used as an alternative. Initially, these were:

Statistics Netherlands (CBS) and the **Public Health Forecast** (via the **National Compass for Public Health**)

Wherever these provided insufficient facts, the search for information was extended to the most important institutions that collect and make available data in the fields of demography, specific population groups, and work and health:

Netherlands Bureau for Economic Policy Analysis (CPB)
Netherlands Center for Occupational Diseases
The Netherlands Interdisciplinary Demographic Institute (NIDI)
The Consumer and Safety Foundation
Social and Cultural Planning Office of the Netherlands
The Employee Insurance Scheme's Implementing Body (UWV)

Only data sources that are available on-line were consulted. The data reported in this community profile were the most recent data available at the time of the search.

4.2 Adapting the community profile

The Health Impact Assessment has been a continuing process. In the course of this process, further choices were made regarding the content of the health profile. A number of indicators proved irrelevant in the framework of the focus chosen later on; others were included. Therefore, the profile presented in this report is not corresponding completely to the initial core indicator set as depicted above.

4.3 The population

Composition of the population
In 2001, the Netherlands had a total population of over 16 million people. Compared with 10 years earlier, the population has grown by about half a million. Older employees and young people are target groups in the European employment strategy. Therefore, an important factor in assessing employment policy is the change in age composition of the population. The number of people above 45 years is relatively growing. The ageing of the Dutch population, that began a few decades ago, will continue for the time being (Van Imhoff, 2003).

Table 2: The population aged between 15-64 years as a percentage of the total population

	1991	1996	2001
Total	68.82	68.28	67.75
males			
Total % of males	34.95	34.67	34.35
15-24 yrs	7.75	6.48	6.03
25-34 yrs	8.66	8.61	7.62
35-44 yrs	7.99	7.87	8.16
45-54 yrs	5.99	6.99	7.31
55-64 yrs	4.56	4.72	5.23
females			
Total % of females	33.87	33.6	33.41
15-24 yrs	7.43	6.26	5.82
25-34 yrs	8.27	8.23	7.41
35-44 yrs	7.66	7.63	7.89
45-54 yrs	5.73	6.71	7.11
55-64 yrs	4.78	4.78	5.17

Source: Eurostat, August 2003

Table 3: Population >64 years as a percentage of the total population

	1991	1996	2001
Total	12.92	13.34	13.63
males	5.15	5.37	5.62
females	7.77	7.97	8.01

Source: Eurostat, August 2003

The *fertility rate* (number of live births during a year per 1000 women 15-50 years) has been around 50 the last years. Roughly speaking, the *total fertility rate* gives an idea of the number of children women have on average. In the Netherlands the total fertility rate has been slightly increasing since the mid-nineties and is now 1.7.
The average age of women giving birth to their first child is 29.1 years; one of the highest in Europe (CBS [Statistics Netherlands], 2003/2004).

Household composition
In 2002, there were 6.9 million households in the Netherlands. The average size per household was 2.3 persons. In 1995, there were only 6.5 million households. The composition of these households is also changing.
What is noticeable is the growing number of single-occupant households. A third of all households consists of one person. Thirty-six percent of the households are occupied by parents and resident children, a sixth of which are single-parent families. In later life, most of the people living alone are women. The most frequent reason for this is the death of their partners (Van Imhoff, 2003, NIDI, 1997).
Ethnic minorities
Ethnic minorities and immigrants are target groups of EU employment policy. Statistics Netherlands (CBS) maintains statistics on the sizes of the different ethnic minority groups. The CBS defines this as follows: ‘For the CBS, a person is a member of an ethnic minority group if at least one parent was born abroad. In this, a distinction is made between people who themselves were born abroad (first generation) and those who were born in the Netherlands (second generation)’.

In connection with the higher unemployment among these groups, the percentage of registered *non-Western ethnic minorities* in the population is important for this HIA. These are people from Turkey, Africa, Latin America and Asia, with the exception of Indonesia and Japan. Together, they comprise 9% of the population. Ethnic minorities are concentrated in the large cities. Of the youth under 18 years, 14% come from ethnic minorities (Latten, 2003).
The expectation is that the number of people of non-Western ethnic minority origin will continue to rise in the coming decades. According to the estimates of Statistics Netherlands, this increase will amount to 1.6 million in 2003 and to almost 2.0 million in 2010 (CBS [Statistics Netherlands], 2003).

4.4 Health

Two basic health indicators that we collected data for are life expectancy and healthy life expectancy. In 2000, the life expectancy at birth was 75.5 years for men and 80.6 years for women. Women, therefore, live longer than men. However, if we look at life expectancy in good health, there is less difference: 61.3 years for men and 60.8 years for women, respectively.
There are important differences between different sections of the population. Level of education appears to have a strong influence on life expectancy. Poorly educated men live five years and women approximately two and a half years shorter lives, than well-educated men and women. The poorly educated also have a much shorter healthy life expectancy. The differences are 15.8 years for men and 14 years for women (Perenboom, 2003).

In addition to life expectancy, we can also look at self-reported health as an indicator of health in the Netherlands.
In 2000, 82% of the men and 78% of the women reported that they felt healthy or very healthy. The percentages are lower for older people (Tijhuis, 2003). Socio-economic differences are also evident here. People with a lower level of education feel less healthy than their peers in the same age group, who have a higher education: the chance of them having a less good experienced health is about 2.5 times times higher among those with a lower education than among those with a higher vocational training or university education. Ethnic minorities, especially Turks and Moroccans, have a lower self-evaluation of their health than native Dutch people appear to have. However, there are no exact figures on this. Income also plays an important role, especially for women. In the 80's, the chance for women from the lowest income groups to report less good health was about twice as large as for those from the highest income groups. In the 90's, this difference increased to almost three times (Tijhuis, 2003).

4.5 Income

Income — general
Income is an important statistic for this HIA, firstly, because, in the Netherlands, employment policy is carried out in order to improve the incomes of the population. Secondly, it is important because the policy itself is partly dependent upon applying income incentives. An example of the latter is the attempt to reduce the so-called *poverty trap*: the situation in which an unemployed person does not experience financial improvement -or is even worse off- when accepting a (low wage) job, because of related loss of other benefits such as rent support.

In 2000, the standardised average annual income per household was € 17,400. Approximately 3.8 million households have an annual income of between € 10,000 and € 20,000; 1.6 million households have between € 20,000 and € 30,000; 500,000 households have a disposable income of more than € 30,000; and 1 million households have to make ends meet with less than € 10,000 a year (CBS [Statistics Netherlands], 2003/2004).

Income — developments in spending power
During recent years, households in the Netherlands have witnessed improvements in their spending power. This applied to all income groups and to different household compositions. The change in spending power varied between 4 and 11% (CBS [Statistics Netherlands], 2003/2004).
The two most important factors that played a role in this are the increasing participation of women in the labour process and the decrease in reliance on benefits.

On the individual life-course level, the so-called '*family dip*' is visible in the income situation. It appears to be caused by the arrival of children and the fewer number of worked hours associated with it. During the 90's, this dip became less deep: from –11% in 1990 to –2% in 2000 (Pommer, 2003). In any case, the dip can still be linked to the reduced participation of mothers in the labour process. Although fewer and fewer women stop working completely after the birth of their first child, when they return after maternity leave they often work fewer hours than before (Dagevos, 2003).
Because of the economic recession, spending power will decrease in the coming years. For 2003, the Central Planning Office predicts a decrease in spending power for working people and for 2004 also for those receiving social benefits (CPB [Netherlands Bureau for Economic Policy Analysis], 2003).

4.6 Labour

The working population (15-64 yrs) is considered to be made up of:
people who already work for at least 12 hours a week, or
people who have accepted a job that will keep them employed for at least 12 hours a week, or
people who state that they would like to work for at least 12 hours a week, who are available for this, and who develop activities to find work for at least 12 hours a week. People who deliberately remain unemployed, such as housewives or housemen, are not included in these statistics.

In 2002, the Dutch working population consisted of 4,366,000 men and 3,077,000 women. That is an increase compared with 1996, when it was made up of 4,098,000 men and 2,588,000 women (CBS [Statistics Netherlands], 2003/2004).

The percentage of the total population between 15 and 64 years that works is referred to as the net labour participation. Between 1992 and 2002, this increased from 57 to 66%. The biggest increase – from 41 to 54% – was for women (CBS [Statistics Netherlands], 2003/2004).

It is not only the number of working people that is important in the light of the employment policy, but also the number of hours worked per person. The table below shows that, in general, men work more hours than women. Even though they go to work more than they used to do, women continue to be substantially more active in care and housekeeping than men. In addition, it is noticeable that the amount of time per day spent on looking after others is somewhat less than it was, both for women and men, while the time spent on home-based tasks has increased for both sexes.

Table 4: Use of time per day: care tasks, home-based tasks and paid work

Sex	Age (in years)	Periods	Caring for others	Paid work	Home-based obligations
Men	18-24	1997	0:10	3:21	0:49
		1999	0:03	4:09	0:59
		2001	0:02	3:25	1:04
	25-44	1997	0:35	4:55	1:25
		1999	0:37	5:02	1:42
		2001	0:30	5:35	1:30
	45-64	1997	0:15	3:20	1:55
		1999	0:16	3:30	2:21
		2001	0:17	3:39	2:12
Women	18-24	1997	0:10	2:59	1:22
		1999	0:12	2:44	1:52
		2001	0:10	3:05	1:29
	25-44	1997	1:28	2:19	2:28
		1999	1:16	2:54	3:19
		2001	1:16	3:02	3:16
	45-64	1997	0:38	1:09	2:49
		1999	0:28	1:18	4:12
		2001	0:26	1:33	4:02

Source: CBS statline

If we look at part-time work, we see that for women, parenthood is positively associated with part-time work, especially if there are two or more children, whereas the already low incidence of part-time working among men becomes even lower for fathers. In the Netherlands almost all mothers (over 80%) with two or more children work part-time.

Table 5: Percentage of part-time working women/men of 25-54 years, in relation to parenthood

Women				Men		
childless	1 child	2 children	Total	childless	children	Total
38.3	72.6	82.7	55.9	6.2	4.6	5.5

Source: OECD

Sixteen percent of the working women in the Netherlands have a part-time job of less than 12 hours a week (Portegijs, 2002).

Members of ethnic minority groups have also worked more in recent years: their participation in labour has risen from 40% in 1992 to 50% in 2002. However, this participation is still less than that of the population as a whole (CBS [Statistics Netherlands], 2003/2004).

Trends in labour participation can be largely attributed to demographic developments. It is unclear whether we should expect a higher or lower participation in labour in the coming years: although the burden of labour is stabilising, the population is ageing (Witte, 2003). Economic change plays an even more important role. Because of variations in the economy, changes also occur with respect to employment, and consequently to the participation in labour.

That older people should go on working for longer is one of the focus points of EU policy. At the end of December 2000, there were 512,000 employed people of 55 years and older. Of these, 492,000 were younger than 65. That is 30% of the population between 55 and 65 years. Seven out of ten of those over 55 years was male and six out of ten had a full-time job (Van der Zwan, 2002). In 2001, the average age at which people retired was 61 years.

4.7 Unemployment

The *unemployed working population* is defined as people between 15-64 years, who are looking for a job of 12 hours or more a week, who are available for work, but have either no work at all or a job of less than 12 hours a week.

Unemployment rates decreased from 7% to 4% of the working population in the period 1996-2002. During that period, more women than men were unemployed (in 2002: 5% of the women compared with 3% of the men), but the percentages decreased in both groups (CBS [Statistics Netherlands], 2003/2004). However, in the mean time, this trend has stopped. The CBS's latest figures show that, in 2003, unemployment for both men and women has increased strongly. In 2003, 6.1% of the women in the working population was unemployed. For men, this was 4.7% (CBS [Statistics Netherlands], 2004).
At the end of 2001, 51% of those receiving unemployment (WW) benefits were long-term unemployed. This occurs more with men than with women. Of the men receiving unemployment benefits, 54% are long-term unemployed, compared with 46% of the women. The proportion of people who have been receiving unemployment benefits for more than a year increases rapidly with age. In the age group up to 25 years, 6% have been receiving unemployment benefits for a year or longer. In the group 55 years and older, the percentage is 79% (UWV, 2002).

In 1996, 22% of the working population of the ethnic minorities was unemployed, but in 2002 only 10%. Unemployment among young people up to 24 years increased from 1992 (to 7.6% for men and 6.1% for women) to 1994-1995 (12.1% for men in 1994; 10.3% for women in 1995) and from then onwards gradually decreased. Currently the unemployment rates under the young are again on the increase. In 2003 the unemployment rate under both young men and young women was 10.6% (CBS [Statistics Netherlands], 2003/2004).

An increase in unemployment is expected in the coming years. The SCP predicts an increase in unemployment to 7% of the working population in 2004. The expectation is that women will be affected less than men, because they are so strongly represented in the care sector, where there will be less of a decrease in job supply. Young people and the working population of ethnic minority groups will be more strongly affected.

4.8 Work and Health

Disability to work, as defined by the Disablement Act (WAO) applies to those who are, either totally or partially, unable to work in general. Under the Disablement Act, a person is unable to work if she/he is unable to carry out her/his normal duties due to illness or accident.

In recent years, the number of disability scheme beneficiaries has increased continuously. In 1999, there were 750,000 people receiving disability benefits. In 2002, this had risen to more than 800,000 (UWV, 2003).

The increase in the number of current disability benefits since 1980 is almost entirely due to increases in the number of women receiving benefits. In 1980, 487,000 male employees including civil servants received benefits. By the end of 2000 this number had risen to 550,000, an increase of 13%. During the same period, the number of benefits given to female employees had risen by not less than 137% — from 170,000 to 403,000. During that

time, therefore, almost four times as many women as men (233,000 compared with 63,000) had entered the disability scheme (Besseling, 2003).

The disability percentage, in other words, the percentage of the working population that is work-disabled, has oscillated around 10% since 1993 (figures since 1993). The **entry percentage** shows what percentage of the working population of the previous year is made up of new entries into the disability scheme this year. It thus gives an estimate of the likelihood of having to claim from the WAO system. The entry of women into the disability scheme is higher than for men. The *difference* in the chance of having to claim from the system is particularly high in the group aged between 25 and 35 years. The chance of having to claim from the disability scheme increases with age for both for women and men.

Table 6: Percentage, by age and sex, of working people entering the disability scheme in 2000

Age Group (in years)	Percentage of Men	Percentage of Women
<25	1.1	1.5
25-35	0.7	1.7
35-45	1.1	2.1
45-55	1.8	2.9
>55	3.2	4.3

Source: National Compass of Public Health

4.9 Unpaid labour: informal care

Alongside paid work, a lot of unpaid work is undertaken in the Netherlands. Within the framework of this HIA, of particular importance is the work that is linked to health care – informal care. In the Netherlands, there are an estimated 3.7 million people who work as informal carers. If the definition of an informal carer is restricted to those who offer care for a minimum of three consecutive months and/or more than 8 hours a week then one can talk of 2.4 million people.

The relative proportion of informal carers who also have a paid job is the same as that of the total population. The average age of informal carers is 49 years. More informal care is given by women than by men (De Boer, 2003).

5 Data collection phase I: interviews[4]

5.1 Introduction

This section of the report focuses on the third step in the HIA – qualitative data collection. The aim was to find an answer to the following question:

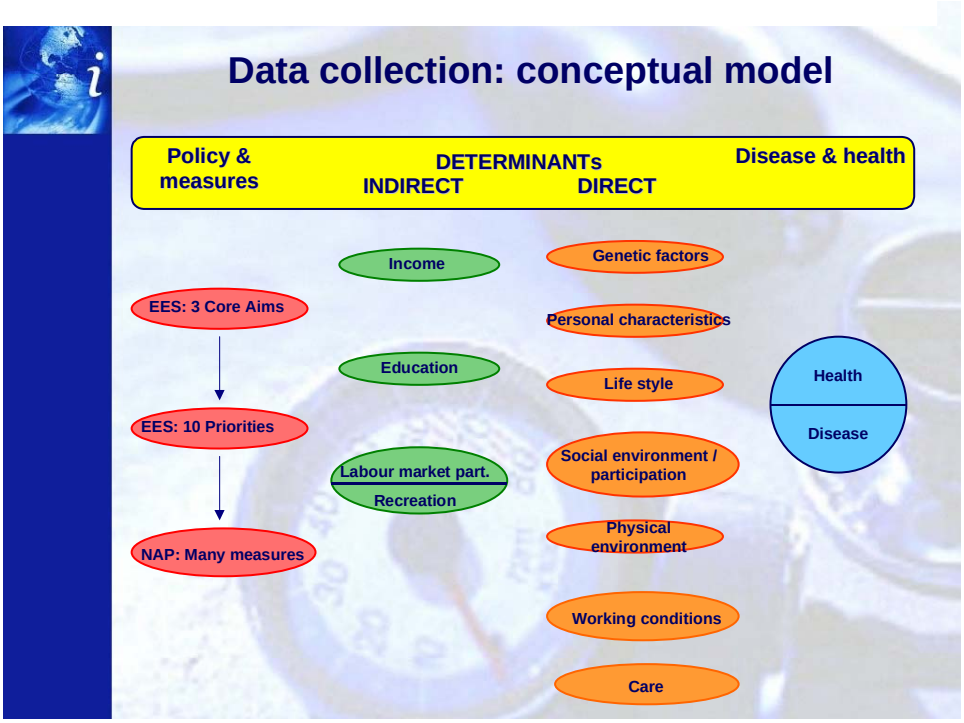
What potential positive and negative effects on (public) health in the Netherlands do experts and representatives of target groups foresee, should the EES and the policy measures on which the NAP 2003 is based be implemented?

This general question was specified by focusing on identified health determinants and target groups. Furthermore the focus was on tangible policy measures. This process of focusing down is described in this chapter. The method of data collection is discussed. Finally the main themes identified through this process are described.

5.2 Operationalising the question

The steering group for the Dutch pilot HIA of the European Employment Strategy decided to conduct a restricted enquiry. In support of the discussion, and to facilitate making a choice, the possible area of research was visualised by constructing a conceptual model for collecting data, as follows:

Figure 3 Conceptual model used for data collection, phase I



[4] This section is based on the report on qualitative data collection prepared by F.van Zoest, iResearch.

There are innumerable relations between the many parts of the model, which, because of their number, are not shown. Bearing in mind the impossibility to represent reality in simple models, nevertheless, for the purposes of this discussion, the assumption was made that the influence of employment policy on health takes place through effects on more indirect socioeconomic determinants of health[5], which, in turn, influence health through more direct determinants. The assumption is that, for the indirect determinants, it is easier to identify connections to employment policy, and, for the direct determinants, it is easier to establish the impact on health.

It was agreed that the collection of data must be focused on tangible measures, on target groups and on the determinants of labour participation, life style, social environment, and on care. The considerations connected with this are discussed below.

Focus on tangible measures
The primary assumption is that the more tangible a policy measure is, the easier it will be to study its effect on health. For this reason, it was decided not to start with the three broad core aims, but to begin with the 10 priorities in the EES and the (almost 70) tangible measures in the NAP (see the section on Policy Analysis).

Focus on target groups
After that, data collection could be contained by selecting a number of target groups for the purposes of collecting data, groups for which the effects could be supposed to be either different and/or more serious than for the general population, or groups which are known to have poorer than average health. Attention was also given to which target groups in the EES are considered to be direct or indirect. Therefore, the target groups on which the collection of data are directed are *young people, older people, women (gender issues), ethnic minorities and people with a restriction or a disablement (including the chronically ill).* These target groups can overlap each other, which means that attention also has to be given to combinations of these groups.

Focus on labour participation, life style, social environment, and on care
As far as indirect determinants were concerned, the decision was made to exclude income effects. The main reason for this was that income effects are very complex. Education is an important determinant of health, but the influence of employment strategy on health *through education* in the Netherlands is probably rather limited. Therefore the decision was made not to specifically include the topic 'education' when collecting data. Because of the 'life-long learning' priority in the EES, it was agreed to include educational factors in the analysis through this determinant, should it emerge from the interviews as being important. *Of the indirect determinants, data collection is thus focused, in particular, on the effects of the EES/NAP2003 on labour participation.*

Of the direct determinants in the conceptual model, 'genetic factors' and 'personal characteristics' are not likely to be influenced by employment policy. The effects on the 'physical environment' are linked, in particular, to income (e.g. income determines people's living environment), and were thus excluded since the decision had been made to exclude income effects. Although quality of work is one of the core aims of the EES, there is hardly anything to be found in the implementation of the guidelines and measures of the NAP. Regarding occupational health, it seems improbable that the HIA would be able to add anything new to the EES, as there is already an enormous institutional infrastructure in place in this area. Moreover, considering the that operates in this area. Therefore, effects on health due to 'working conditions' were also omitted from the data collection. *Of the direct*

[5] Direct effects on working conditions are possible, but influences on working conditions are hardly dealt with in the EES and the NAP2003. For this, other policy paths are used.

determinants of health, collecting data was directed, in particular, to effects on life style, social environment, social participation, and to the effects of (giving and receiving) care.

5.3 Methodology: interviews

The data were collected by conducting semi-structured telephone interviews. On the basis of suggestions from the Steering Group and internet research on keywords from the questionnaire, a list of people who were likely to be able to supply relevant information, knowledge and/or points of view was made. In making that selection, attention was given to the mission of the organisation where they worked, their position within that organisation and, as far as it is possible to come by that information, their personal (work or other) experience in relation to the topic. In the course of time, as more information was gathered, and considering time limits, the list was further specified, leading to 5 key respondents being interviewed.
The aim of the interviews was to identify health impacts that needed to be looked into more specifically.
An interview protocol was developed for conducting the interviews. This protocol (which was developed in Dutch) can be found in Appendix III.

5.4 Outcome of the interviews: five themes

Processing the interviews revealed five important themes on which the literature search and the impact analysis should be concentrated. These were:

Theme 1
Selection on the basis of health on entering the labour market
This theme is related to the socio-economic differences in health. From the interviews, it became clear that the policy could strengthen the negative spiral through not only life style but also income: *bad health/restrictions → limited chances on the labour market→ even worse health.* Although there is a circular relation, it seemed useful, nevertheless, to begin by looking at the magnitude and character of the disadvantage on the labour market of people with poor health or with restrictions.

Theme 2
Youth unemployment
This theme has to do with the influence of the policy on labour participation among young people. The interviews confirmed the picture that emerged from the policy analysis with respect to young people and work: the measures to fight against unemployment among young people do not appear to be very forceful. The respondents acknowledged that it is particularly important at the beginning of one's working life to have a job, as a starting point for further employment. Concern was also expressed about the more limited movement on the labour market due to the measures being taken to keep older people at work for longer.

Theme 3
Life-course arrangements
The fiscal life-course savings scheme is the focus of this theme. The respondents acknowledged that the people excluded by this measure are those with low incomes, who thus will have fewer possibilities of adequately combining work and care tasks. Differences between ethnic groups were also mentioned.The underlying assumption is that there are links between combining work and care on one hand and health on the other hand.

Theme 4
Informal care
This theme has to do with the health of people who give informal care, but also with the possibilities for those in need of care to receive it. This theme is of specific importance because it is applicable to groups that were targeted for data collection: older people, the

disabled, and the chronically ill. In addition, there appears to be a strong gender component attached to this. There is a concern that increasing (female) labour market participation will lead to lack of capacity for informal care. The people interviewed indicated that combining informal care and work is particularly problematic for women from ethnic minorities.

Theme 5
Postponing retirement
Stimulating older people work for a few more years is an aim of both the European and national policies. The respondents indicated that this could have negative effects on health. In addition, they said that self-experienced poor health is a reason in itself to retire earlier. Another point put forward was that older people are important for the role they play in all sorts of socially relevant activities, such as voluntary care and voluntary work. Finally the concern was expressed that increased labour market participation of older people would reduce young people's opportunities for work.

5.5 Discussing the five themes in the steering group

The five themes were put before the Steering Group. The Steering Group decided to drop the first theme. In the group's opinion, the relation with the policy was difficult to determine. Explicit selection based on health is not a policy measure: it does not feature in the plans laid down in the NAP. In addition, a medical check-up prior to being accepted for a job is not allowed in the Netherlands (except for specific cases).

As far as the other four themes are concerned, the Steering Groups's advice was to study these in relation to each other. For this, a life-course perspective was recommended.

6 Data collection phase II: literature search

6.1 Introduction

This chapter presents the results of a literature search on the four main themes identified by the Steering Group for the Dutch HIA pilot. This phase of the HIA aimed at:
Determining what scientific and other evidence is available on four themes: *promoting youth employment, life course arrangements, informal care, and postponing retirement.*
Determining, more specifically, the evidence on effects predicted by the respondents interviewed.
Providing input for the impact analysis.

The procedure followed these steps:

- Operationalising the themes in the questions asked.
- Determining the search terms and strategy.
- Performing the literature search.
- Reporting.

6.2 Operationalising the themes

The formulation of the questions was based on the issues brought forward by the respondents. The basic question was: what evidence exists that supports (or contradicts) the effects of the policy measures as predicted by the respondents? This general question can be specified for each theme:

Theme 1
Promoting youth employment
Questions relating to the impacts identified by the respondents:
What are the health implications of youth unemployment?

What is the relation between employment and opportunities for work in later life?
How do employment policies aimed at young people impact on youth employment?

Theme 2
Life-course arrangements
Question relating to this theme:
What are the health consequences of combining work with a family?
Will parttime retirement improve health?

Theme 3
Informal care
Questions relating to this theme:
Is there a relation between labour market participation and the time spent on informal care?
Does combining informal care with paid work have consequences for the health of the person giving the care?

Theme 4
Postponing retirement
Questions relating to this theme:
What is the relation between health and the age of retirement?
Will earlier retirement lead to more job opportunities for young people?

6.3 Search terms and search strategy

The strategy consisted of searching the following databases:

- RIVM library database
- Dutch Central Catalogue NCC
- PUBMED

Search terms for the RIVM database were in Dutch, while those for the other two databases were in English. The titles found were selected for relevance to the themes and questions. Initial search terms were:

Work & participation
Employment & health
Elderly & employment
Youth & employment
Well-being & employment
Informal & care

Titles were screened for relevance. Additional titles were provided by the persons interviewed and through snowballing. The next section will report on the evidence found.

6.4 Overview of evidence

6.4.1 General remarks

There is a vast body of knowledge on the effects of employment policies and other policies on employment, and the related health effects. These studies usually compare the unemployed with the employed. The general trend revealed in the findings is that higher employment leads to better health of the population. For example, a study on the impact of unemployment rates on mortality in EU countries showed a clear decline in mortality rates (Brenner, 2002). Although the impact of (un)employment on health (causation) is a point of focus for research, it is plausible that poor health will lead to fewer opportunities for employment (selection) (Stronks,1997). Moreover, this association may differ along the lines of occupational class. For manual workers limitations caused by disease are a stronger barrier to the labour market that for those with non-manual work (Bartley,1996).

Jin et al. (Jin,1995) in their review of literature on the relation between unemployment and health found suggestions of a strong, positive association between unemployment and many adverse health outcomes. However, they pointed out that caution must be taken not to simply state that poor health is directly caused by unemployment, since many confounding factors have to be taken into account.
However, the European employment strategy aims not only at reducing unemployment, but also at including people in the labour market who are not registered as unemployed or do not perceive themselves as unemployed, such as women who do not work outside the home and the elderly (pensioners). It is not certain whether these groups would benefit as much from becoming employees as those officially unemployed. People without a job are not necessarily as bad off as the unemployed. De Beer suggests, referring to the comparison between housewives and unemployed, that the detrimental effects of unemployment are perhaps not mainly caused by income aspects, but more by the societal norms about work (De Beer, 2001). Even those who are employed are not always better off than the unemployed. Dooley (Dooley, 2003) uses the term 'economically inadequate employment' for those who have involuntary part-time or low-wage jobs. His review of literature on this topic suggests that the inadequately employed resemble the unemployed when it comes to mental health problems. Precarious (e.g. fixed-term) employment is associated with demonstrable adverse health outcomes as well (Quinlan, 2001).

6.4.2 Promoting youth employment

Youth unemployment is usually higher than unemployment under the general population. Also, youth unemployment fluctuates more strongly with changes in the economic tide than unemployment under the general population. The most important explanation for these facts is that in times of recession, it is cheaper for companies/organisations to lay off younger employees than older ones. Also, if the demand for workers shrinks, newcomers on the job market -young people- are affected more strongly. Less important, but still influential are the lack of work experience that young people have and –to some degree- 'shopping around' behaviour under youth on the labour market (O'Higgins,1997).
Although *direct* health effects of unemployment under young people are less prominent than under older adults (O'Higgins,1997, Breslin, 2003) it is very clear that unemployment under young people has serious health consequences. A study in an industrial town in Sweden showed that youth unemployment[6] can contribute to health problems later in life. The study concerned a 14-year follow-up of a cohort of over 100 school leavers, starting in their last year of compulsory education at age 16. Early unemployment (defined as > 0.5 years unemployment between 16 and 21 years) significantly correlated with daily smoking, psychological symptoms and (for men) somatic symptoms at age 30, which was still significant when controlling for initial smoking, working-class background and unemployment (Hammarström, 2002). Novo et al found similar results confirming that there is an association between unemployment and smoking in young people (Novo, 2000). A combined qualitative/quantitative study in Sweden comparing 1083 young people five years after finishing their compulsory education at age 16 showed a greater increase in physical and psychological symptoms, and in smoking habits and cannabis-use, among long-term unemployed youth (>24 weeks unemployed) than in youth who were not long-term unemployed. An association between long-term unemployment and increase in systolic blood pressure, alcohol consumption and crime rate was found among boys. Somatic and psychological symptoms were stronger in long-term unemployed girls than in long-term unemployed boys (Hammarström,1994).
An important factor determining the magnitude and severity of the health effects is educational level. A Dutch study showed differences between unemployed youth with low and high levels of education. Those with low education had more mental health problems

[6] In general, programmes are excluded when referring to unemployed youth who are studying or involved in youth work programmes.

than the highly educated ones. This difference seems caused by differences in coping styles and over-all opportunities on the labour market (Schaufeli,1997).

Youth unemployment also has permanent effects on opportunities in the labour market (O'Higgins,1997). Hammarström found that young people who were unemployed within the first two years of leaving school had a higher risk of being unemployed after five years' follow-up (2.39 RR for males and 1.76 for females) (Hammarström, 2000).
Even precarious employment has negative impacts for young people's prospects. Job insecurity is a risk factor for later unemployment among both women and men; for women, having few opportunities for development at work also predicts later unemployment. These occupational conditions are more important than ill health in explaining future unemployment among women and men (Bildt, 2003).

Unemployment policies aimed at youth are important but need to be carried out carefully. Policy measures to reduce youth unemployment were evaluated in a case study in the UK and Germany by O'Higgins (O'Higgins,1997) The findings showed that training programmes could easily lead to a substitution effect, where some young people attain a better labour market position at the cost of other young people. Moreover, such schemes tend to increase inequality in this respect, being most beneficial to those who already have a better position. Thirdly, programmes for unemployed youth are most helpful in times of economic prosperity. However, even when only fairly beneficial in terms of moving young people into jobs, programmes protect them from some of the negative effects of long-term unemployment, in particular of the effects on future risk of unemployment (Jensen, 2003).

6.4.3 Life-course arrangements

The combination of work and family tasks has been mostly studied in women, as women are most often the 'task combiners', both in childcare and in their care of other people (e.g. informal care). Two hypotheses are common: 1) the spill-over hypothesis, which states that working women with family responsibilities have a double burden under which their health suffers, and 2) the hypothesis that combining work and family protects women from over-engaging in either field. The literature on the health consequences of fulfilling multiple roles was reviewed by Bekker et al., who conclude that women's work participation is essentially beneficial for health. However, work overload, role conflicts and responsibility for unpaid work may have adverse health effects, such as mental health problems and a higher incidence of occupational diseases. The period after giving birth and the time spent mothering young children is a specifically vulnerable phase of life (Bekker, 1999).
Multiple roles may change into what is called *double exposure*: a high level of job strain combined with high responsibility in the home. Double exposure in women is associated with having more health complaints than average, as was shown in a study under working women in Sweden. The relative importance of the job strain is higher than that of the home responsibility (Krantz, 2001).
Research in the Netherlands on women becoming unfit for work however showed that the high rates of women applying for disability benefits are not due to the combination of work and family life. Single women are over-represented in the disability benefits scheme and entering this provision is 2.5 times more probable for women without children than for mothers (Van der Giezen, 2000).
A protective factor for mothers may be the strong custom and high acceptance of part time work in the Netherlands. The Netherlands has the highest rates of part-time workers under women of all EU countries. Research carried out by Statistics Netherlands (CBS) shows that, for women, the situation at home determines to a certain degree whether and how much they work, whereas this has no influence at all for men. This evidence corresponds with the

[7] In general, programmes are excluded when referring to unemployed youth who are studying or involved in youth work programmes.

finding that 25% of all women and 50% of all men tend to think that women are better fit to look after young children than men (Bekker, 1999).
Men are also facing other norms regarding work participation. More than for women, part time work for men is generally perceived as a lack of commitment to the work place and lack of ambition. This makes it difficult for men to work part time, even if they wish to do so. It is much easier, and, given gender pay differences, cheaper, for women to cut down working hours or stop working altogether when they have children (Van Doorne-Huyskes, 2001). However, the fact that mothers tend to work part time also *causes* part of the gender pay gap (OECD, 2002). This pay gap will cause differences in opportunities to use the life-course arrangement, predicts Fatos Ipek-Demir. She calculated that a lone mother with minimum wage, saving 1% per month, will have to save 20 years to be able to take up a three months leave. Similarly, people with less paid jobs, such as women and ethnic minorities, as well as those who have been temporarily out of the work process such as mothers, will have more trouble in accessing 'parttime retirement' paid out of their life-course arrangement savings money, (Ipek-Demir, 2004). We have not found evidence on the contribution of part time retirement on health in older employees.

6.4.4 Informal care

The relation between work and informal care giving is complex. On one hand the time available may be reduced by being employed. A study from the US shows that full-time employment, compared with no employment, reduces informal care-giving by more than 20 hours a week. Moreover, full-time employees are more likely to carry out care tasks that do not require constant presence of the care-giver: bathing and dressing (Boaz,1996). On the other hand working women still provide vast amounts of care, while also utilising other sources of help (Doty,1998).
The Netherlands Scientific Council for Government Policy has calculated the effects of future increased labour-market participation, especially of women, for the availability of informal care. The question was what the combined effect of increased labour market participation of women, demographic trends, and the need for care among people over 75 would be in terms of sufficient or insufficient informal care supply. In these projections those providing care were supposed to be women between 50 and 64 years. The Council expects problems with informal care provision once the 'baby boom' generation (people born shortly after the Second World War) reach old age. The Council predicts that then new forms of paid care will develop. Furthermore, the Council argues that the average number of working hours per week will probably decrease, and that men will increasingly contribute to informal care (WRR, 2000). However, data about informal carers show that the group female carers between 55 and 64 years comes third (9 % of all carers) after those between 45 and 54 years (20%) and those between 35 and 44 years (15%). Moreover, men already constitute 42% of all carers – although it is not clear what type and how much care they provide (De Boer, 2003).
The Dutch Social and Cultural Plan Bureau (SCP) is even more optimistic: it sees no problem for the future availability of care whatsoever. The argument is that informal care is strongly demand-driven, and that, when relatives cannot help out, other people within the social network of those needing care, such as friends and neighbours, will contribute (Van den Berg Jeths, 2004). This prediction is partly supported by a study which shows that the main reasons for informal carers to provide care are 'love and affection' and 'self-evidence' (De Boer, 2003).
However, data from research in other countries present a different image.
Carmichael *et al*. performed a study in the UK aimed at finding out how providing informal care influenced the care-givers participation in the labour market as well as the wages they earn. A comparison between men and women was made. The findings showed that for men providing at least 10 hours care per week, the probability of working was reduced by 12.9%; for women in the same situation this probability was larger, namely 27%. Both groups earn less than equally qualified non-care-givers, but the wage reduction is greater for male

caregivers. The authors suggest that this may be due to the fact that male care-givers, are restricted to flexible or part-time work types, which are typically female labour markets; therefore, they suffer from the gender pay gap. Both for men and women, the effect that indirect earnings had on work participation was negative (i.e. quitting work depended on the magnitude of income loss they would suffer). An additional direct effect of care on participation was found for women. The authors stated that these results suggest that men do not give up paid work as willingly as women, even when providing demanding care (Carmichael, 2003).
Data about the health consequences of providing informal care for the carers are scarce. In the Netherlands, 2 out of 5 informal carers considers her or his situation as (much too) strenuous. One out of 5 feels unhappy (Van Exel, 2002). This may be of importance for the care provided. A study carried out in the United States showed that care recipients whose informal carers experienced negative impact, particularly on family life and employment, were twice as likely to become institutionalised (McKinlay,1995).

6.4.5 Postponing retirement

Employment policies are aimed at increasing the employment rates in the population; however, they can have various other impacts as well:
Dead-weight: the observed effect is caused by another circumstance;
Substitution: policies may increase employment in one group while decreasing employment in another group;
Displacement: the net effect is smaller than the gross effect, e.g. extra jobs in one sector lead to higher loss of jobs in another sector (Brenner, 2002).
No evidence was found on whether early retirement of older workers would induce substitution in favour of young people. The evidence, on the contrary, seems to point to early retirement as a way of downsizing organisations (Henkens, 2002).
A review of policies regarding (early) retirement showed that the rates of early retirement, unemployment rates under older workers and the rates of older people with disability benefits are interrelated. Unemployment and long-term sickness leave or disability benefits are often *de facto* forms of early retirement (Henkens, 2002)
Health considerations contribute strongly to decisions about (early) retirement. Mutchler *et al*. analysed the data on the 1884 and 1885 panels of the Survey of Income and Program Participation in the United States. They showed that for their cohort of men aged 55-69 in the mid-eighties, health was a major consideration for labour force exit or re-entry. However, the extent to which health determined this was shaped by other characteristics. Health was a stronger factor for those with working wives and those who had limited financial resources: the healthier they were, the stronger the probability that they would remain in the workforce or re-enter after unemployment (Mutchler, 1999).
A study under men older than 70 showed that work beyond retirement age was positively related to good health, strong work commitment, higher educational level and being married to a working wife. A negative correlation existed with age and – again – the level of income in absence of work (Parnes,1994)
In the Netherlands health is a very important reason for Dutch older employees to retire. The perception is that retirement will improve health; in fact, this is often the reason they give for their decision to stop working. After retirement, 40% of the 798 people interviewed are of the opinion that retirement has benefited their health. Medical consumption decreased after retirement: i.e. those under supervision of a medical specialist decreased from 52% to 32% and medication use decreased from 52% to 47%. This, together with the better evaluation of their own health, indicates a slight improvement in these people's health (Van Solinge, 2003).
A study comparing four groups of people 55-65 years however, consisting of older employees, those on pre-retirement, those unemployed and those unfit for work showed that people who were employed or unemployed, and those who had retired, did not differ much in self-reported health, their utilisation of GP services or in ADL activities. Those unfit for work

were doing worse. This last group was also worse off with respect to social participation (measured as participation in organisations, and contacts with family and friends). The results suggest that leaving the workforce either voluntarily or involuntarily does not affect health and well-being adversely, but that those unfit for work are indeed in worse health than the other groups (Henkens, 2000).
Van Dalen *et al*. carried out a survey on the 'hidden value' of older employees and the forces hindering their labour market participation. The survey, which concentrated on perceptions under the Dutch population, showed that raising the age of retirement found little support under the population, while reducing the number of people who retire before 65 was supported. The hidden value - as perceived by the population - differs along the lines of social class: people with a higher level of education find that retirement often comes too early, while those with a lower level of education expect to work longer than is good for them; 75% of the population think that people over 65 can still adequately perform at working activities. The attitude on older people seems to fluctuate with developments in the economy. In times of economic depression more people tend to think that older people should retire to provide job opportunities for the younger generations (Van Dalen, 2003).

7 Impact analysis

7.1 Introduction

The information collected during earlier stages of the HIA has been put together in this chapter to identify and describe possible positive and negative health impacts of the EU Employment Strategy implementation in the Netherlands.

A qualitative approach, employing a life-course perspective, has been used as starting point. There are two reasons for doing so. Firstly, work (paid and unpaid) is an important constituent of people's life-courses. People's relationship to and attitude towards work change during their lives; inversely, work also influences change in people in the period from growing up to growing old. Secondly, government policies, and especially social policies such as those for employment and education, shape a person's life-course (Leisering, 2003). The definition of old age, for instance, is directly linked to the age at which people can receive retirement benefits. *How* people get through certain stages of their life and the influence of this in later life is also strongly determined by social policies. Unemployment benefits help people in times of crisis caused by loss of work, thus restoring the continuity of their life-course. The help in finding a new job that people meanwhile receive from municipal agencies impacts on their future prospects. Another example of the importance of social policies is the school curriculum, for which the government has set quality criteria as well as final terms. School leaving age (or the age where mandatory schooling ends) is an important social marker produced by educational policy.
Not only is the employment policy significant for the life-course, indeed, the policy explicitly aims at influencing it. The Dutch Ministry of Social Affairs and Employment wants to create 'life-course sensitive' policies, the exponent of which is the proposed fiscal life-course arrangement. Two important aims of this arrangement are to facilitate, and thus increase, women's participation in the labour market, which will obviously change the 'working-age' phase in women's lives, and to help older people postpone retirement by giving them the opportunity to take up part-time retirement, thus postponing what is seen as retirement age, or 'old age'.

There are quite a number of ways to conceptualise the life-course. In the past, a three phase model was used, based on a standard (male) life-course. The Dutch Ministry of Social Affairs and Employment currently uses a model consisting of 5 phases:

Table 7: life-course models

Phase 1 Early childhood 0 - 15 years	Phase 2 Early adulthood and 'rush hour' 15 – 30 years	Phase 3 Consolidation and ageing 30-60 years	Phase 4 Active care 60 - 80 years	Phase 5 Intensive care 80+
Phase 1 Youth 0 - 20 years	Phase 2 Adulthood 20 - 65 years	Phase 3 Old age 65 - approx. 75 years		

Source: Council for Social Development

This model gives an adequate description of the life-course of a majority of the Dutch population. However, the Council for Social Development (Raad voor de Maatschappelijke Ontwikkeling, 2002) rightly points out that there are large groups who do not fit into this framework, such as teenage mothers, single people and certain ethnic groups. Although we use this model to analyse the health consequences of the implementation of the EU Employment Strategy, this has to be taken into account.

7.2 The four themes in a life-course perspective

7.2.1 Promoting youth employment

Employment is important for young people, since it shapes their opportunities for both health and future employment. We have seen that when comparing young people with people over 35, the older age group seems to suffer more from unemployment. However, the consequences of youth unemployment will be felt during young people's whole further life. The relationship between poor health and work can be described as both causative (unemployment leads to health problems) and selective (people with health problems have fewer opportunities on the labour market). Therefore it may be expected that the group of young unemployed contains a relatively high proportion of people with health problems. The experience of unemployment will increase the health gap between these young people and others. Investing in reduction of youth unemployment will promote the their health both now and in the future if attention is paid to this specific group.
Opportunities for work start with the basic level of education reached before entering the labour market, referred to by the Ministry as 'start qualifications' brings the educational system into the picture. The discussion about the start qualifications therefore will be meaningful for people not yet active in the work force, i.e. children.

Impacts of the EU Employment Strategy.
In the EU Employment Strategy young people are a specific target group. However, the implementation of the strategy in the Netherlands *does not correspondingly focus on this group*. The Dutch government allows the youth unemployment rate to rise to twice the general unemployment rate, and to a maximum of 15%. In this light it is also important whether the government views young people from ethnic minority groups as youth per se, or as 'ethnic minority youth'. Since the unemployment rates under ethnic minorities are higher than under the general population, we might expect extremely high unemployment rates for these young people -who constitute 14 percent of the young under 18- in the second case. In this sense the impact of the EU Employment Strategy seems limited.
On the other hand the *comprehensive approach* will be applied for young unemployed people, providing them with either a job, training or other path of action to increase their opportunities on the labour market, within 6 months after becoming unemployed. The comprehensive approach has its origins in the EU Employment Strategy. The approach will certainly have beneficial health effects, even if not directly leading to work. The evidence found on programmes for unemployed youth showed beneficial effects for those who participated in contrast to those who did not participate, at least during the project. Regarding

the distribution of these effects, much depends on whom the programs are targeted at; those with better or poorer opportunities.
It is important to remember here that the actual implementation of the policy regarding unemployed will for a major part be a task and responsibility of municipalities. It cannot be predicted how municipalities will prioritise their input, especially since agreements with the government are made regarding the success rates for programmes for the unemployed. To be able to report high rates it may be necessary for municipalities to concentrate on those with better prospects in the first place. This will lead to a vicious circle for those with poor start position.

7.2.2 Life-course arrangements

The facilitation of combining work, care and learning by means of the proposed life-course arrangement is relevant, the government claims, for people in the 'rush hour' of life and for the ageing population. However, it also has implications for those to whom care is given, i.e. children, the ill and disabled, and the old aged. Furthermore, this facilitated combination shapes how people relate to one another within families and between generations; care becomes something that needs to be organised (and paid for) instead of something that you just undertake when necessary. As more women work, and as they work longer hours, role patterns between partners may change; these are changes that may continue into old age as well.
The life-course in the Netherlands is strongly gendered; women's life-courses differ from men's. Even when women work there is always a double perspective; a life as a housewife is an acceptable alternative for a working life. The life-course arrangement is *explicitly meant to change* life-courses. The government claims to facilitate more flexibility in life-courses, instead of the three stage model which was the blueprint for all social policies up to currently. People would be offered more freedom of choice regarding the timing of work, care, and learning. However, the arrangement may well lead to a new stereotype. Although formulated in gender-neutral terms it is very clear that this arrangement, if successful, will change women's lives to become more similar to men's, as far as work-centeredness is concerned. Although it is known that finding a job benefits the health of the unemployed, this may not be equally the case for women who, as described, have different role perspectives.
As we have shown in the community profile, women, even though they have entered the work forces, still keep on carrying out most of the household and care tasks. This increases the risk of role overload, especially for women in young families.
Will the arrangement help prevent this risk? It may, for those in well-paid occupations. People in low wage jobs may not be able to save as much money as is needed for, for instance, a long term leave to care for a sick child or relative. In the mean time other arrangements will be cut down or will disappear completely. Extra opportunities for combining work and care for the affluent will thus be balanced out by poorer arrangements for the low-pay workers.
The same will then be true for people in later phases of their lives. Those who wish to work less hours when ageing can use the money saved through the life-course arrangement to finance this. Here again it is to be expected that those who earn less have fewer possibilities to actually do so. Socio-economic health differences at age 50+ will thus increase. Moreover, a gender inequality may come up here. As women will probably be the ones using up their life arrangement savings for care tasks, e.g. for young children, they will not be able to benefit from the part time retirement opportunity to the extent that men will. This will even more the case for women from ethnic minority groups.

Impacts of the EU Employment Strategy.
The wish of the Dutch government *coincides* with the EU priority to include more women in the labour force. It is however doubtful whether the introduction of life-course arrangements will lead to higher rates of *participation* of women in the work force. The combination

work-family itself will not change much, rather is it financed and organised differently. Since the facilities are for a larger part financed by the working population itself the influence on participation may differ according to income. *Health* consequences will also differ: facilities will be easier to use for those with higher income. Combined with an increasing pressure on lone parents (mostly lone mothers) on welfare benefits, this may mean that this group of people will enter the labour market with very few opportunities to benefit from the new arrangement – they have not been saving for the arrangement and will probably be in low income jobs which makes it harder to effectively save.
The life-course arrangement is also presented as an instrument to postpone retirement, another important priority in the EU Employment Strategy. However, even if effective, the distribution matter comes up again here. The less well-off will be limited in their possibilities to use the arrangement. For those who can adequately use the arrangement there may be positive health effects. This may be expected because studies have shown that retired people feel that retiring benefits their health – the same may be true for 'part time retirement'. However, in the framework of this HIA we found no evidence on this matter.

7.2.3 Informal care

The theme 'informal care' is relevant in phases 3, 4, and 5 of the life cycle, as the mean carer age is now 49 and those who are cared for are mostly elderly people. As more women work – which is a target in the NAP – the tasks of caring may be shared more equally between men and women, and across generations, involving younger people as well. The evidence suggests that when relatives cannot provide care, other people tend to take over, such as neighbours and friends.
Although projections into the future of the availability of informal care state that this will not be endangered by higher work force participation of women, some things must be taken into account.
First of all, these projections look at macro figures. It may well be possible that certain groups, such as young informal carers, may experience problems getting the care organised.
Secondly, a distinction needs to be made regarding the *kind* of care required. Higher rates of work participation under women (and men) may produce problems for those forms of informal care that require continuous presence of a carer.
Thirdly, part of the carers are retired people. If the retirement age goes up, as is one of the priorities of the National action Plan, this may have an impact on the availability of care which was not yet studied.
Finally, there may be effects regarding the well-being of the carers. Providing informal care is rewarding for the carers, but also hard. The evidence suggests that the provision of informal care is to a great degree demand-driven. Or in other words, people 'just do it' when it is necessary. We have seen that women are more willing to work less hours or even to completely give up work in order to provide informal care. The need for care in the informal setting, which will be growing due to demographic developments and the pressure on women –and men- to work and to work more hours are therefore contradictory to one another. Much depends on the facilitation of providing informal care for those that work. It is doubtful whether a life-course arrangement can contribute much here. Informal care can be very lengthy – in terms of years rather than in terms of weeks or months. The money saved in the framework of a life-course arrangement will not be sufficient for this. The pressure on the (working) carers may not only lead to role overload and reduced well-being, but might also increase the number of care recipients that will have to be admitted to nursing homes. One of our respondents mentioned the stronger reliance on informal care by people from ethnic minority groups, due to cultural aspects and inability to organise professional help. Although no publications were found on this topic, that were relevant for the Netherlands, it is a point of attention.

Impacts of the EU Employment Strategy.
The aim to increase female work participation *corresponds* with the EU priorities regarding this target group. It is however not yet clear how succesful the Dutch government will be in increasing the work participation rates under women. But if we suppose it will be, problems regarding informal care may be expected. These problems will specifically come up where people are concerned that need intensive care, requiring long hours of supervision by the carer. The problems will intensify when the accessibility of formal forms of care is restricted, e.g. due to increased costs for the care recipients or due to shortage of capacity, both in home care and institutional care.

7.2.4 Postponing retirement

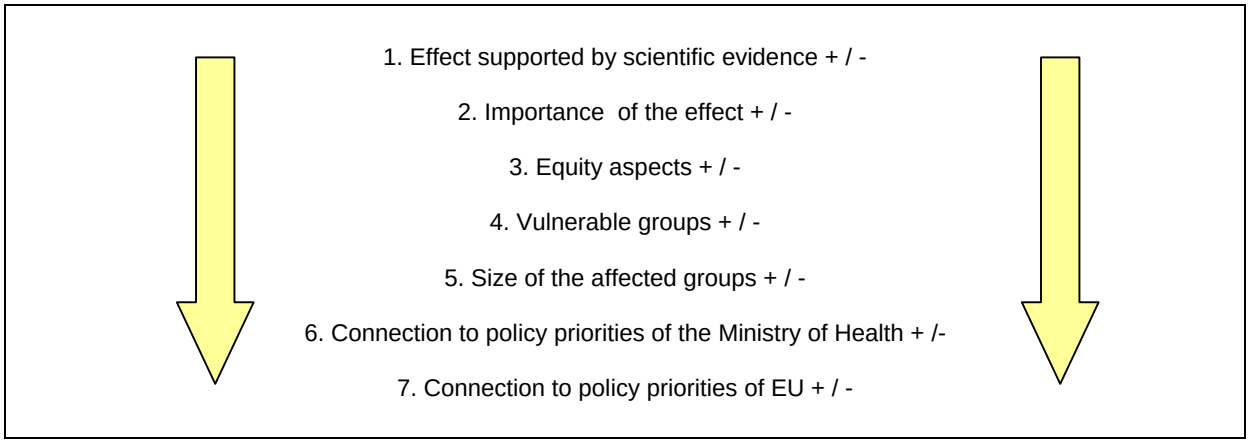
Postponing retirement, although seemingly relevant for those in the third and fourth life phase will have implications for other generations as well, such as reducing informal care for the elderly. It will also affect the dynamics of the labour market. Volunteer work done by retired people (including looking after -grand- children) will be affected. Moreover, the measures will have implications for how the retirement benefits system is shaped; this has implications for all the employable members of the population.
The measures taken to postpone retirement are mostly financial ones. Facilitation of 'part time retirement' through life-course arrangements are presented as one of the measures to complement this. The evidence suggests that the presence of sufficient retirement benefits is a strong factor determining whether people will retire or not. It can therefore be expected that the financial disincentives will have a certain effect on reduction of early retirement. The magnitude of this effect depends on the income loss associated with retirement, but also with health considerations that people have. As long as people perceive retirement as beneficial to health strong financial disincentives will be needed. It is not certain whether related policy decisions will be socially defendable.
Moreover, involuntarily postponed retirement might give rise to an increase in (work related) health problems. The community profile showed that people over 55 have a substantially higher risk of becoming unfit for work than younger people – the risk for women being higher than that for men. Since the 'baby boom generation', born shortly after the Second World War, is now in their fifties, it concerns a large group of people possibly affected.
Of course, the policy proposals may be beneficial for those who wish to work past 65 years, but they might have done so anyway.
Postponement of retirement will probably not lead to a substantial decrease in job opportunities for younger age groups. Although the rationale behind early retirement schemes in the 80s of the last century was to create vacancies for the young, the pensioners were not succeeded by others on a one-to-one basis. Retirement is often used as a 'natural release' of unnecessary staff. If this way of 'natural' downsizing becomes harder to apply, people may instead be laid off, which will make them dependent on unemployment schemes. Meanwhile, people over 55 will be subjected to a stricter regime under the unemployment schemes, such as obligatory applications for jobs. The combination of this pressure with poor job opportunities (ageism) may negatively influence the health of this population group.
Some effect may however be expected on career development opportunities for younger generations, when older people are facilitated to both cut down on work hours and step back in the hierarchy of the work place (which is facilitated by implementation of a new system of retirement benefits calculation, that takes the mean salary over the whole working life as a starting point and not the end salary). What the *health* effects of this may be cannot be predicted.

Impacts of the EU Employment Strategy.
The Dutch Government's wishes regarding later retirement *coincide* with the EU priorities in this field. We have argued that it is not yet clear to what extent the policy measures developed will be effective to attain the goals set.

7.3 Prioritisation of the effects

The effects predicted can be prioritised according to a funnel model that takes into account a number of aspects:

Figure 4: Prioritisation model



Evidence base
The effects predicted related to *youth unemployment* and the effects of programs for unemployed youth are supported by abundant and high quality evidence.
There is also adequate evidence regarding the combination of work and family, especially for women. However, there is no information available as to the effects of introducing *life-course arrangements* as an intervention to promote work participation, since this a new approach and it has never been evaluated.
The evidence regarding the effects of work participation of men and women on *informal caregiving* is convincing. Although the trends as described for the Netherlands seem to be different from those elsewhere this may be due to different ways of looking at this field, i.e. from a macro- or individual point of view.
The relationship between (decisions about) early or postponed retirement and health is well documented, although the number of publications seems slightly less abundant. Evidence is also available about the relation between retirement benefits policies and de facto decisions to retire.

Importance of the effect
Youth unemployment has far reaching health consequences for those affected. The consequences are also meaningful for the longer term in shaping health and employment later in people's life-courses. It concerns mental health problems and a related loss of quality of life, but also a higher risk of smoking-related diseases which in turn will influence morbidity and mortality under the population. The implementation of the EES reducing youth unemployment has potentially important positive health effects preventing loss of health. However, these potential preventive effects will probably not be realised as such.
Role overload caused by difficulties combining work and family can lead to mental health problems, including stress which reduce quality of life and can lead to other health complaints. It can also lead to sickness leave and inflow in the disability scheme. The *life-course arrangement* will, if at all, be helpful only for those who are in a position to save. This is a missed prevention opportunity.
Reduction of available *informal care* is a serious effect since it will reduce the quality of life of the care recipients. It is the question whether formal (paid) care can provide as much personalised care such as keeping someone company.

The proposed measures aimed at *Postponing retirement* may not have very important health effects. However, some extra inflow in benefits schemes may be caused by the barriers put up for early retirement.

Equity aspects
The effects of unemployment under the young are especially strong for those with few opportunities due to low educational level. Implementation of the policy measures on a local level may lead to selecting the 'top dogs of the underdogs', i.e. those who are already in a better position.
The life-course arrangement may not be as helpful for people with low income as compared to those with better paid jobs.
Informal care leads to loss of income, under men and under women. If problems in care provision develop, women (especially with low paid jobs) have a stronger inclination to give up work.
The policy discouraging early retirement will affect those with manual work more than those with nonmanual work. Since older members of ethnic minority groups are over-represented in manual work, this group will be disproportionally affected.

Vulnerable groups
People depending on informal care are obviously vulnerable. Children and other dependants may be affected by the lack of facilities to combine work and family for those who cannot afford to utilise the life-course arrangement. Older people with poor health are a vulnerable group. Some of them may be affected by retirement discouragement policies, although it is to be expected that they are already out of the work force.

Size of groups affected
One out of every ten people in the workforce under 25 is currently unemployed.
Unemployment under ethnic minority *youth* is even higher.
The life-course arrangement is specifically relevant to working women, which are more than half the women between 16 and 54. It is also relevant to older people. As reported in the community profile the population is ageing, which will increase the relative size of the group of older people as compared to the over-all population.
Ageing is also relevant when the availability of informal care is concerned. The group needing informal care will increase correspondingly.
Postponing the retirement age also potentially affects a large group. In fact, the ageing of the population is the very reason for the priority given to policy measures in this field.

Policy priorities
The health effects expected from youth unemployment and life-course arrangements, link up to prevention policy priorities as laid down in the Memorandum on Prevention, recently published in the Netherlands (Ministry of Health, Welfare and Sports, 2003). These are smoking and mental health. Specifically they link up to policy priorities regarding youth mental health and work-related mental health problems. Older people are a specific target group for the Ministry of Health, Welfare and Sports. Finally, reducing socio-economic health inequalities is an important policy priority and a cross-cutting theme for the Dutch government.
Smoking and mental health are two important priority fields for the European Union. Both are specifically mentioned in the new EU Public Health Action programme (Commission of the European Community, 2003).

A consideration of these aspects leads to the following schematic picture:

Table 8: themes and priorities

	Scientific evidence	importance of effect	Equity aspects	Vulnerable groups	Size of groups affected	Policy priorities MOH	Public health priorities EU
Promoting youth employ-ment	+++ abundant evidence of high quality	+++ both short term and long term effects	+++ young people with low educational level	-	+ high numbers of young people from ethnic minorities affected	+++ smoking under young people youth mental health	+++ smoking mental health
Life-course arrange-ments	++ evidence on combining work and family	++ role overload	+++ increases socio-economic health inequalities	+ children and other dependants	++ working women	+++ work related mental health problems socio-economic health inequalities	+ mental health (stress) socio-economic health inequalities
Informal care	++ evidence on relation work / informal care	+ effects on care provision	+ M/F differences under caregivers	+++ people depending on informal care	+++ growing group of older people (ageing trend)	+ attention for older people's health	-
Post-poning retirement	++ evidence on income, health & retirement	+ possible inflow in other benefits schemes	+ differences manual - nonmanual workers	+ older people	+++ growing group of older people (ageing trend)	+ attention for older people's health	-

Based on this scheme the effects with highest priority are those related to youth unemployment, and more specifically unemployment under young people from ethnic minority groups. The effects will not only be seen during the phase that young people are unemployed, but will also have consequences for health and later employment (which will then affect health again). There are clear links to policy priorities both of the Ministry of Health, Welfare and Sports of the Netherlands, and of the EU.
The life-course arrangement as a way of promoting women's participation in the labour market is also important when judged with this set of criteria. The effects will be unequally distributed within the population, thus potentially enlarging socio-economic, as well as gender-based and ethnicity-based health inequalities. The effects will be relevant during all working life. Links with policy priorities are identifiable. Moreover, this topic relates to the third theme discussed: availability of informal care. If the life-course arrangement is successful in increasing women's labour market participation, problems regarding this availability may arise.

The last theme seems least important. It is yet unclear how successful the government policy regarding postponing retirement will be. Even if successful, the policy might lead to extra inflow of older employees into other benefits schemes.

8 Discussion and recommendations

8.1 Discussion

This report focused on the assessment of potential health impacts of the EES. The core questions were:

Which intended and unintended **positive health effects** can be expected from the implementation of the EES in the Netherlands?
Which intended and unintended **adverse health effects** can be expected?
How can the expected health gain be maximised, and how can the negative effects be reduced or prevented?

The health consequences of the implementation of the European Employment Strategy in the Netherlands can be very diverse. In this report the focus was on four main themes: youth unemployment, life-course arrangements, availability of informal care, and postponing retirement. We may summarise the results as follows:

There is a potential preventive effect of the EES regarding youth. The effects concern mental health, smoking behaviour, and opportunities for employment later in life. However, the implementation of measures to fight youth unemployment needs more input to be effective - an exception being the comprehensive approach. If the priority for youth unemployment reduction will be raised by way of the Task Force for Youth Unemployment this would provide an opportunity for intersectorial co-operation for health of young people. This intersectorial co-operation could not only include the policy fields employment and health, but also education.

Life-course arrangements are a specific way of implementation of the EU policy priority regarding both increased labour market participation of women and postponement of retirement. The health effect for older people may be limited. Differing opportunities to adequately use the arrangement may be caused by income differences.
For women such socio-economic inequalities are expected as well. Women with low income will have problems saving for the arrangement, and will thus face a higher risk of role overload. Particularly lone mothers on welfare who will be pressurised to work are the ones who will profit least from the arrangement due to low income and short labour market participation.
It is uncertain if the arrangement will be helpful in facilitating women's labour market participation at all, since it merely changes the financing of the facilities and not their magnitude or organisation. It is also uncertain whether increased female participation on the labour market will benefit women's health as much as employment would benefit the health of the unemployed. However, the policy priority given to preventing role overload for women (and men) is a positive factor.

Informal care and women's (and men's) labour market participation seem to be two contradictory priorities. The availability of informal care may be endangered if more women work, and if they have larger jobs. The most important bottleneck will be those forms of informal care that require the constant physical presence of the carer.

The difficulty to reconcile two priorities (informal care and work) may lead to negative health effects, especially for women, and even more so for those from ethnic minority groups. Moreover, the number of requests for admission into nursing homes may increase.

Finally, policies to discourage early retirement are being designed. Much depends on the strength of the financial disincentives, since many people tend to think that retirement benefits their health. Important contributions that retired people have to offer to society, such as volunteer work, informal care and child care, may be reduced should the policy measures be effective.

The European Employment Strategy allows the member states a lot of freedom regarding the implementation of the formulated policy priorities. This is clearly to be seen in the Netherlands. Comparing the Nation action Plan with the EES, and the National Budget with the National Action Plan makes clear that much depends on the degree to which European policies converge with national priorities.
It is almost impossible to identify which policy measures are really 'European' ones, and which are not.
This however does not mean that it is not useful to carry out an HIA on EU policies. The information about health effects related with the implementation (or non-implementation) can be used in the iterative policy development process of the EU, in this case in the field of employment. The discussion of health implications in the Guidelines annually developed may provide an impulse to national governments to also address these issues in their National Action Plans. This, in turn, may help to boost intersectorial policy making on national levels.

8.2 Recommendations

The European Employment Strategy is certainly relevant to public health in the EU member states. It provides opportunities to promote health and prevent disease.

A general recommendation is therefore that health aspects be mainstreamed in all stages of the policy making cycle regarding employment in the European Union.

Regarding specific aspects that are relevant for the Netherlands the following recommendations are made:

- Fighting youth unemployment is, from a health point of view, the most important priority. Specific attention should be paid to this in the annual Joint Employment Report (JER) of the European Commission. The Employment Strategy Guidelines for Member States should explicitly mention youth as a target group. Member States should be asked to describe, in their NAPs, how they plan to address youth unemployment.

- Specific attention in the JER, the Guidelines, and the NAP should be paid to the *composition* of the group unemployed young people. This means that instead of mentioning rough rates of youth unemployment and effective placement in jobs, the plans need to explain how the groups most in need of help are addressed.

- The JER should assess whether policies regarding the facilitation of work-family balance are effective for all socio-economic groups. Moreover, gender and ethnicity based inequity should be a specific point of attention. The Employment Guidelines should address this issue.

- Solutions must be found for consequences of increased labour market participation of women (and men) for the availability of informal care. This should include different types of informal care, which require different input from the caregiver. A second point

of attention should be prevention of overload of working informal caregivers. Solutions may lie in changes in working conditions as well as in the organisation of (home) care.

- Facilities to reduce work load such as part time retirement may be supportive to keep older people on the labour market without negative health consequences. This could be one of the EU recommendations for the Member States when drafting their NAPs.

8.3 Final remarks: the methodology

The aim of this Health Impact Assessment was twofold: first of all, to test the European Public Health Impact Assessment (EPHIA) methodology in a pilot study.
Secondly, to assess, within that pilot HIA what the potential health effects of the European Employment Strategy are. This report focused on the second aim. The results of the methodology testing are discussed in the over-all report of the project 'Policy health impact Assessment for the European Union'. However, some preliminary remarks can be made regarding the experiences during the Dutch pilot HIA:

- The method is systematic enough to provide a basis for rigorous HIA. Meanwhile it is flexible enough to be applied in different national contexts. Different member states emphasize different aspects in the employment strategy implementation. However, all pilots were fruitful and informative.
- It seems also fit to be used for application on different policy fields. The field of employment is rather broad and contains many aspects. The methodology was suitable to address various kinds of topics.
- The explicit accent in the methodology on distribution of health impacts helps to focus on underprivileged or vulnerable groups as well as on gender matters.
- Community profiling should best be carried out after policy analysis. Also, the subsequent steps need to be revisited during the HIA process, as more information is being gathered.
- It is difficult to involve representatives of different national stakeholder groups, either in the steering group or as respondents for interviews. EU policies seem to be perceived as taking place at great distance from daily life in the Netherlands. Moreover, policies from the EU are perceived as too complex to be able to say sensible things about them. Ways to tackle this problem need to be considered.

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Appendix I

Steering group HIA of the EES

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Mr G. Varela Put MA
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Mr H.C.M. Middelplaats
Ministry of Social Affairs and Employment

Mr F.C.L. Goosmann
National Patient and Consumer Federation,
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Ms A.M. Jongerius
FNV Federation of Trade Unions

Ms L.C. Nicolaï MSc
Royal Dutch Medical Association

Prof. C.Vos
National Liaison Center European Foundation for the Improvement of Working and Living Circumstances

Appendix II

EU framework and National Action Plan

Priorities	Guidelines	Specific guidelines for the Netherlands	National Action Plan
Active and preventive measures for the unemployed and the inactive	(a) Establish the needs of all job-seekers at an early stage of their unemployment and supply services such as giving advice and supervision, help in looking for work, and providing individualised staged plans; (b) Offer job-seekers access to effective and efficient measures to increase their utility and chances of integration, paying special attention to people who have the biggest problems on the labour market. In particular, the Member States should take care that: – all unemployed people are offered a new start before they have been out of work for 6 months (for young people) or 12 months (for adults) in the form of training, retraining courses, practical working experience, a job or another measure to increase their usability, where necessary combined with permanent supervision in looking for work; – before 2010, 25% of the long-term unemployed should be taking part in an active measure in the form of training, retraining courses, practical working experience or another measure to increase their usability, with		Comprehensive Approach enhanced by additional financial means to enable municipalities to supervise clients (within the framework of the 'Agenda for the Future') on the basis of performance agreements about action paths and departures from the system. Aims of the co-ordinating body for unemployment and disability benefits (UWV): 85% of the unemployed who are greatly distanced from the labour market must be in contact with a reintegration organisation within 4 weeks of the qualifying intake undertaken by the Centres for Work and Income; at least 95% of the clients who are receiving unemployment benefit must be put on a reintegrative course of action within 12 months of starting to receive benefit, or, if no course of action is implemented, have departed from the system. Half of the reintegrative courses of action must lead to employment of 6 months or more. The pilot second-chance reintegration scheme is being extended by 2 years to include an experimental preventive application of reintegrative courses of action for threatened employees (current policy)

	the aim of reaching the average of the three best performing Member States; (c) Modernise and strengthen labour-market institutions, especially the labour facility services. (d) Regularly evaluate and adjust accordingly the effectiveness and efficiency of labour-market programmes.		Fighting youth unemployment: Comprehensive Approach for all young people (also those who are not receiving benefit) that must be realised by municipalities and funded from the budget for subsidised jobs for unemployed (WIW budget). Aims: in the cabinet period 2003-2007, youth unemployment must not be higher than twice the overall unemployment; every young unemployed person must be back in work (again) within 6 months and/or at school, thereby preventing long-term unemployment. Intersectorial co-operation by, among other things: 40,000 additional apprenticeships via covenant agreements with employers, the Centres for Work and Income and educational organisations the existing fiscal facility for employers who train (former unemployed) employees of 23 years and older to starting-qualification level is being extended to young people of under 23 years; the design will be such that the budgetary burden will remain the same; € 35 million will be reserved for 'threshold removal'; for the group of young people at risk, for whom mediation on its own is insufficient; using these funds, short activities, such as individual guidance, application training and a short position-oriented course can be financed. Taskforce on youth unemployment
Making work pay	The unemployment, poverty and inactivity traps must be eliminated and the labour contribution of women, poorly qualified workers, older employees, the disabled and those furthest	To make the management of benefit payments more transparent by	Restructure the disability scheme: increase the responsibilities of both employers and employees. Reintegration; performance agreements with the

	away from the labour market must be stimulated. By simultaneously maintaining an adequate level of social protection, Member States must review, in particular, the replacement ratios and the length of benefit receipts; they must ensure that benefits are managed effectively, especially in relation to actually looking for work, including the access to activating measures to support the applicant's usability, taking in account individual situations; considering paying benefits to working people, where necessary; and strive to eliminate inactivity traps.	making more use of fiscal measures instead of issuing subsidies, and, in addition, by co-ordinating national and local income policies better. To ensure that entry into the disability scheme will be restricted, and that the current beneficiaries will be activated to look for work.	UWV: at least 90% of the clients who are receiving a work-disablement benefit must be given a reintegrative course of action within 12 months of receiving their first benefit payment, or, must have left the disability scheme before a course of action is organised; 40% of the courses of action must lead to an employment contract of 6 months or more. Sharpen the admission requirements for the unemployment benefit (WW); cut short-term WW benefits and follow-up benefits. Introduce the Law on Work and Welfare: municipalities will be given responsibility for the reintegration policy, together with a budget that they can use at their own discretion. Municipalities have also been given the task of paying benefits; remaining funds may be used at their discretion. Sharpen the rights and duties of job-seekers. Help prevent the poverty trap by increasing the combination tax reduction to € 190 for working parents with young children. Extend the supplementary tax reduction for single parents by raising the age limit of their children from 12 to 16 years. Increase the tax reduction for working people to € 204 by 2007.
Fostering	– simplifying and reducing the administrative		A policy letter was sent to the Lower House listing

entrepreneur-ship to create more and better jobs	burdens and regulations attached to starting a company and for small and medium-sized businesses, and also for attracting personnel; simplifying access to capital for starting businesses, new and existing small and medium-sized businesses, and those with a large growth potential. – encouraging education and training in entrepreneurial and managerial skills and giving support, also via training, to bring entrepreneurship within everyone's reach.		the most important actions that have been taken in the area of entrepreneurship in the Netherlands, and specifically the measures that have been taken to make it easier to start a company (Autumn 2003)
Transforming undeclared work into regular employment	Member States must develop and carry out broad actions and measures comprised of a combination of simplifying the entrepreneurial climate, eliminating the hindrances and introducing the necessary incentives in the taxation and benefit systems, up-holding the laws more closely and applying sanctions.		Introduce an identification obligation for all citizens. Introduce managerial fines in the Labour Law for Foreign Nationals, the Obligatory Identification Law, and, where these laws have been encroached, the rapid and obligatory submission of a report to Social Security. Clear the files of the most important bodies (Centre for Work and Income, UWV, Municipal basic administration) Optimalise the exchange of information between monitoring and registering bodies. Introduce identity cards with biometric data. Sharpen fraud alertness among reception-desk personnel at the Centres for Work and Income.
Promoting active ageing	– increasing participation in the labour market by applying a overall approach, to utilise the possibilities offered by every group in the population, especially with respect to the availability and attractiveness of work, making labour remunerative, increasing skills and		Introduce fiscal measures to make early retirement and pre-pension arrangements less attractive. Make applying for jobs compulsory for people of 57 years and older with recent work experience.

	adequate supportive measures; – encouraging older workers to remain active in the labour market, especially by improving working conditions, to persuade employees to carry on working, such as giving them access to supplementary and refresher courses, recognising the special importance of health and safety at work and of flexible ways of organising work. – removing incentives to leave the labour market early, especially by restructuring the Early Retirement Scheme (VUT) regulations, and in its place ensuring that it pays to remain active in the labour market; and to persuade employers to take on older workers. By 2010, on EU level, the policy must lead in particular to an increase of 5 years in the average age at which people actually stop working (estimated at 59.9 years in 2001).		Make working compulsory for older beneficiaries of social assistance. Issue recommendations to the taskforce on older people and labour Fiscal life-course scheme.
Immigration			
Promoting adaptability in the labour market	Evaluating and restructuring sections of the labour laws that have a negative influence on the dynamics of the labour market and on the employment opportunities of groups whose access to the labour market is difficult, extend the social dialogue, promote the social responsibility of companies and devise suitable measures to promote: – a diversity of contractual and labour regulations, also concerning working hours, that furthers career development, a better balance between work and private life, and between		Simplify the social affairs and employment regulations (was brought into Parliament in the autumn of 2003). Develop a viewpoint concerning the Flexibility and Security Act following advice given by the Labour Society. Deregulate and simplify the laws and regulations surrounding work and rest periods and harmonise these with international requirements, including the implementation of the new EU guideline.

	flexibility and security; – employees' access to training, especially for the poorly qualified; – better working conditions, including health and safety; The policy must be especially directed towards: a considerable decrease in the incidence of accidents at the workplace and in occupational illnesses; – the development and diffusion of innovative and long-lasting forms of work organisation that can support productivity and the quality of the working environment; – anticipating and the positive management of economic changes and reorganisations.		Propose a legalised clause in the law giving the right to long-term care leave to look after a seriously or terminally ill child, partner or parent. Fiscal life-course scheme Implement, on a local level, the results of experiments on working schedules. Introduce measures concerning the transfer of pension values of self-employed professionals, such as doctors, dentists, etc. Stimulate geographical mobility within the EU by putting information on web sites. Stimulate the social partners to make agreements about measures to prevent accidents and to help rapid reintegration. A restrictive, demand-led immigration policy
Investment in human capital and strategies for lifelong learning	Carrying out strategies for lifelong learning, by, among other things, improving the quality and efficiency of the education and training systems, with the aim of providing all individuals with the skills required by a modern working population in a knowledge society, to facilitate their career development, and to reduce the qualification gaps and bottlenecks on the labour market. According to the national priorities, the policy must have achieved the following results before 2010: – at least 85% of the 22 year olds must have	The policy in the area of lifelong learning, in close co-operation with the social partners, must be tuned in with labour-market demands to combat unemployment and to prevent poorly qualified workers from gradually falling out of the labour	Plan a platform for lifelong learning. Give an impulse to vocational education (structurally, € 136 million). Stimulate innovative vocational education (an impulse of € 10 million was given in 2003). Knowledge-centre recognition of competencies attained. Use European Social Fund means to improve dual course-of-action paths.

	completed a higher secondary training; – the average level of participation with regard to lifelong learning in the European Union must be at least 12.5% of the adult working population (25 to 64 yrs).	market.	Evaluate experiments on the costs of individual schooling (current project). Aim at 15% more graduates from higher hard science and technical science courses and a better balance between men and women within them: set up a 'deltaplan' for the hard and technical sciences.
Gender equality	By using an integrated approach, combine gender mainstreaming and specific policy measures before 2010, increase the number of women on the labour market and reduce the gender gap in the participation of labour, significantly reduce unemployment and remuneration differences, using a multiple approach to the underlying factors of the payment differences between men and women, including horizontal segregation, education and training, function classification and reward systems, awareness and transparency. Special attention must be given to combining work and family, in particular by providing child-care facilities and other members of the family who are dependent on care, encouraging a shared responsibility for the family and for occupational activities; and to facilitate returning to work after a period of leave. The Member States must eliminate restrictions that detract women from taking part in the labour market, bearing in mind the demand for child-care facilities and taking into consideration their national regulations in this area, to try, before 2010, to provide child care for at least 90% of the children between 3 years and the obligatory school age, and for at least 33% of the children under 3 years old.	To work further, together with the social partners, on developing a strategy to tackle the factors that underlie the remuneration inequalities between men and women.	A test instrument has been developed to assess the sex neutrality of function-reward systems (current policy) Give information to both employers and employees (current policy) Benchmark and decide on target figures for women's share in higher job positions (current policy) Investigate ways of breaking horizontal male/female segregation. Extend child-care facilities (the aim of providing 10,000 places has already been achieved under current policy). The Provision of Basic Child Care Act, January 2005 Protection from dismissal for pregnant women and for those who have recently given birth (current policy). Covenants with regional parties in relation to the numbers of women returning to work (current policy).

Supporting integration and combating discrimination in the labour market for people at a disadvantage	The Member States further the integration of people with special problems on the labour market, such as early school-leavers, the poorly qualified, the disabled, immigrants and ethnic minorities, by developing their usability to increase their chances of getting a job and to prevent all forms of discrimination. The policy must achieve the following results before 2010: – an average EU percentage of not more than 10% of early school-leavers: — a significant decrease in each Member State of the differences in unemployment for people in a disadvantaged position, according to the national target figures and definitions; – a significant decrease in each Member State in the differences in unemployment between non-EU and EU subjects, according to the national target figures.		Reduce the number of young people without a starting qualification: draw on the responsibility of the employer, apply for ESF funds. Tax reduction for businesses who take on long-term unemployed and low-paid personnel (current policy – the regulation will extend until 2007) Undifferentiated budget for municipalities from which subsidised jobs can be paid. A measure to stimulate the normalisation of subsidised jobs (current policy; the employer receives € 17,000 per job) Existing supportive facilities for work-disabled people (current policy) Move more people from social workplaces to ‘supervised work’ outside. Modernise Law on Social Workplaces: Step 1, set an independent indication. Occupational health (ARBO) covenants: aim to reduce absence from work due to illness or entry into the disability scheme by 20% (current policy) Make agreements with the Centres for Work and Income, UWV and the 30 large municipalities about the labour market participation of minorities(current policy) Covenants with 110 large companies (current policy)

			Evaluate the Act on multiculturalisation of work places: should action still be undertaken to further the policy concerning multicultural personnel? Inform both employers and employees about equal treatment (current policy) Carry out a national action programme to combat racism and discrimination (the cabinet's current policy) Equal Treatment for the Disabled or Chronically Ill Act
Addressing regional employment disparities	The Member States: – promote favourable conditions for activities in the private sector and investments in disadvantaged regions; – take care that the government's support in disadvantaged regions is directed towards investing in human and knowledge capital, as well as in suitable infrastructure		Regional platforms for labour-market policy (current policy) The major cities policy: prevent a split occurring along socio-economic, ethnic and societal lines. One of the aims is to reduce unemployment (current policy, intersectorial)

Appendix III

Interview protocol

Introductie *[introduction*]:
Bedank geïnterviewde voor deelname aan het interview
Geef aan dat je handsfree telefoneert en het geluid daarom iets hol kan klinken. Als de één praat en de ander stil is, lijkt het alsof je tegen een muur aanpraat.
Check of geïnterviewde alle informatie heeft ontvangen: brief, achtergrond informatie over het project, de beleidsanalyse, de lijst met maatregelen en het informed consent.
Wijs geïnterviewde erop dat het gesprek wordt opgenomen, dat er geen letterlijke verslagen worden gemaakt en dat de tapes na het project vernietigd zullen worden.
Informeer de geïnterviewde dat van het gesprek een korte samenvatting op hoofdlijnen zal worden geschreven. Dit verslag zal per e-mail worden toegezonden.
Check of de geïnterviewde het informed consent heeft getekend en geretourneerd.
Leg kort uit wat het EU Policy HIA project, de EU Employment Strategy, de interview procedure, tijdsplanning en de thema's van het interview zijn. Geef daarbij duidelijk aan wat de doelgroepen zijn waarover data worden verzameld en dat het om zowel positieve als negatieve effecten gaat.
Check of er nog vragen zijn.

Doelgroepen *[target groups]*
De dataverzameling spitst zich toe op de volgende doelgroepen:
Ouderen
Jongeren
Allochtonen
Vrouwen
Mensen met een handicap of beperking, inclusief chronisch zieken

Thema 1: Uw achtergrond, expertiseveld(en) en relevante functie(s*) [theme 1: your background, fields of expertise and relevant positions]*
Kunt u mij kort uitleggen wat uw achtergrond is, wat uw expertise velden zijn en welke functie(s) u bekleed die mogelijk relevant zijn voor dit onderwerp?
Tijd: max. 5 minuten

Thema 2: De huidige arbeidsparticipatie van de doelgroepen *[theme 2: current labour market participation of the target groups]*
? Hoe participeren genoemde groepen op dit moment in het arbeidsproces? Cijfers m.b.t. participatie, kwalitatieve beschrijving
Participatie in betaalde arbeid
Participatie in onbetaalde arbeid

? In hoeverre lukt het deze doelgroepen om passend werk te vinden?
Passend bij opleiding
Passend bij werkervaring
Passend bij hun levensomstandigheden en sociale omgeving

? Wat zijn daarbij de knelpunten?
Aanpassingsvermogen, mobiliteit, flexibiliteit?
Mogelijkheden voor scholing en training?
Gender issues?
Mogelijkheden een eigen bedrijf te starten?

? Welke trends zijn daarbij te waar te nemen?
Positieve trends?
Negatieve trends?
Waardoor worden die trends veroorzaakt?

Tijd: max. 10 minuten

Thema 3: Wat zou er moeten gebeuren om de arbeidsparticipatie van de doelgroepen te verbeteren? *[theme 3: what should be done to improve the labour market position of these target groups?]*

? Wat zijn effectieve maatregelen om de arbeidsparticipatie van de doelgroepen te verbeteren in kwantitatieve zin?
B.v.: Levenslang leren, levensloop regeling, meer en betaalbare kinderopvang

? Wat zijn effectieve maatregelen om de arbeidsparticipatie van de doelgroepen te verbeteren in kwalitatieve zin?
B.v.: Levenslang leren, gezonde en veilige werkplekken, mogelijkheden voor evenwicht tussen werk en privé-leven

Tijd: max. 5 minuten

Thema 4: Gevolgen van de huidige arbeidsparticipatie en trends daarin voor belangrijke determinanten van gezondheid (leefstijl, sociale omgeving en participatie, zorg). *[theme 4: consequences of the current labour market participation and trends for important health determinants (life style, social environment and participation, care)]*

? In hoeverre beïnvloed de huidige participatie in het arbeidsproces en de trends daarin de leefstijlen van deze doelgroepen?
dagindeling
roken
alcohol
voeding
lichamelijke activiteit
verkeersgedrag

? In hoeverre beïnvloed de huidige participatie in het arbeidsproces en de trends daarin de sociale omgeving en sociale participatie van deze doelgroepen?
gezinsleven
sociale relaties
werkomgeving
vrijetijdsomgeving

? In hoeverre beïnvloed de huidige participatie in het arbeidsproces en de trends daarin de zorg voor en door deze doelgroepen?
mantelzorg
curatieve zorg
verpleging en verzorging
gehandicapten zorg
geestelijke gezondheidszorg
openbare gezondheidszorg

Tijd: max. 10 minuten

Thema 5: Aansluiting Europese Werkgelegenheid Strategie en het Nationaal Actie Plan Werkgelegenheid 2003 bij de positieve en negatieve ontwikkelingen in arbeidsparticipatie

van de doelgroepen. *[theme 5: connection of the EES and the NAP to positive and negative developments in the labour market partiipation of the target groups]*

Neem de guidelines en de 10 richtsnoeren van het EES door met korte verwijzing naar de bijbehorende maatregelen uit het NAP Werkgelegenheid 2003.

? Sluiten de maatregelen in het NAP 2003 naar uw perceptie aan bij de doelen uit het EES?

? In hoeverre steunen volgens u de doelen en maatregelen uit het EES en NAP2003 de positieve ontwikkelingen in de arbeidsparticipatie van de doelgroepen.

? In hoeverre geven de doelen en maatregelen uit het EES en NAP2003 volgens u een antwoord op de door u genoemde knelpunten m.b.t. arbeidsparticipatie van de doelgroepen?

Tijd: max. 15 minuten

Thema 6: Mogelijke effecten van de Europese Werkgelegenheid Strategie en het Nationaal Actie Plan Werkgelegenheid 2003 op belangrijke determinanten van gezondheid (leefstijl, sociale omgeving en participatie, zorg) van de doelgroepen. *[theme 6: possible effects of the EES and the NAP on important health determinants (life style, social environment and participation, care) of the target groups*]

Gezien de besproken effecten van het EES/NAP op arbeidsparticipatie en,
gezien de besproken relatie tussen arbeidsparticipatie en gezondheidsdeterminanten:

? In hoeverre zou het beleid van de EES/NAP kunnen leiden tot veranderingen in de leefstijlen van de doelgroepen?
dagindeling
roken
alcohol
voeding
lichamelijke activiteit
verkeersgedrag

? In hoeverre zou het beleid van de EES/NAP kunnen leiden tot veranderingen in de sociale omgeving en sociale participatie van deze doelgroepen?
gezinsleven
sociale relaties
werkomgeving
vrijetijdsomgeving

? In hoeverre zou het beleid van de EES/NAP kunnen leiden tot veranderingen in de zorg voor en door deze doelgroepen?
mantelzorg
curatieve zorg
verpleging en verzorging
gehandicapten zorg
geestelijke gezondheidszorg
openbare gezondheidszorg

Tijd: max. 10 minuten
Afsluiting *[closing remarks]*
Bedankt voor uw medewerking aan dit interview!
Een kort verslag op hoofdlijnen zal u voor commentaar worden toegezonden.
Vragen en/of opmerkingen?