2.1 The Daily Challenge of Self-reliance

Maintaining a healthy lifestyle, managing personal finances, finding and holding down a job—these are challenges that everyone faces. This chapter focuses on the following question: what mental capacities must an individual have to be able to meet these challenges?

Health, personal finance and the job market are not the subject of this book, but they do illustrate the importance of having the right mental capacities to be self-reliant in our society. In this chapter we describe situations that apply to a relatively large number of people. While the chapter reports on research conducted in the Netherlands, the situations that it describes also occur in similar forms in other Western countries. We make an analytical distinction between the capacities needed to avoid problems (prevention) and the capacities needed to cope with problems (control). In real life, we see that some of these capacities are important in both situations, and that problems do not always have a clear starting point.

This chapter is based on various sources. In each domain, we conducted a number of interviews with professionals and other stakeholders (more than 60 interviews in total, see Appendix I). We asked our interviewees what people must be able to do to be self-reliant and what typifies those who are good or bad at it. To provide solid underpinnings for the information obtained in our interviews, we draw on research conducted within the various domains. Because we aim to reflect on everyday experience in this chapter, we sometimes use the language of daily life. In addition to capacities, then, we also refer to health literacy, financial literacy, and job market skills.

In the following sections, we review what is required of people in each domain and then discuss the role mental capacities play in each context.
2.2 Health

2.2.1 More Freedom of Choice and More Personal Responsibility

The Dutch systematically rank health as one of the most important life assets.\(^1\) Good health allows them to do what they want. In recent years, Dutch people have been given more scope to take charge of their own health. Freedom of choice and autonomy are paramount; people are increasingly allowed to ‘take control’ of the care they receive. Patient organisations have been fighting for this for years and healthcare providers increasingly share this view. Healthcare professionals believe that they looked after ‘clients’ too much in the past, making them too dependent on care.\(^2\)

In addition to making healthcare more affordable, the Netherlands’ new healthcare system, introduced in 2005, was also meant to give people more control. The point was to allow the public more choice but also greater individual responsibility for ensuring the affordability of care. “The client must become a critical care consumer who is encouraged to make responsible choices”.\(^3\) The Healthcare Insurance Act, introduced on 1 January 2006, turned the funding system for curative care into a regulated market, the assumption being that people would behave in accordance with the rules of that market. As care consumers, they had to be well informed and choose their own insurer and practitioner.\(^4\) Policymakers assumed that the public would force care providers and insurers to deliver good quality at a competitive price.\(^5\) In addition, there were growing references to the ‘active patient’, the primary aim being to let those who wanted to take charge do so, for example by communicating with care providers, engaging in shared decision-making about treatment, and (to some extent) by treating themselves (self-management).\(^6\) In other words, the role of critical care consumer and active patient not only means having more options but also taking more responsibility.

Our attitude towards lifestyle has also changed. Emphases and priorities have varied over the years, but more recently successive Dutch governments have argued
that lifestyle is, first and foremost, the responsibility of the individual. People can make choices that are aimed at staying healthy or improving health. “The government emphasises the personal responsibility and strengths of the individual. This applies equally to matters concerning health. Accordingly, primary responsibility for improving public health rests not with the government but with the people themselves.”

However, people are not always able to determine for themselves the circumstances in which they make lifestyle choices. For example, more and more public environments in the Netherlands encourage people to eat a lot of unhealthy food and not take enough exercise. In an obesogenic environment, the unhealthy choice is often the easiest one.

The reality thus differs from the ideal. Despite valuing good health, many people do not have a healthy lifestyle or have difficulty maintaining one. Only about a quarter of the Dutch population complies with the Dutch Dietary Guidelines issued by the Health Council of the Netherlands. Of the entire Dutch population, 43.1% are overweight and 11.7% are seriously overweight. An unhealthy lifestyle, obesity, smoking and excessive drinking are not limited to a particular subgroup. These problems are also found among those who have attained a higher level of education (see Table 2.1), although to a lesser extent.

| Educational level                                      | Seriously overweight | Satisfy Dutch standards for physical activity | Smokers | % of all drinkers who are heavy drinkers |
|-------------------------------------------------------|----------------------|---------------------------------------------|---------|----------------------------------------|
| Primary                                               | 25.7                 | 53.7                                        | 33.3    | 12.6                                   |
| Pre-vocational secondary, VET1, general secondary, lower secondary | 17.4                 | 57.3                                        | 26.2    | 10.3                                   |
| Senior general secondary, pre-university, VET2        | 14.4                 | 58.5                                        | 27.3    | 10.7                                   |
| Bachelor’s (university or higher professional)         | 10.4                 | 59.2                                        | 20.2    | 9.8                                    |
| Master’s, Ph.D.                                       | 6.1                  | 63.3                                        | 16.5    | 9.1                                    |
| Unknown                                               | 17.2                 | 57.2                                        | 17.1    | –                                      |

Statistics Netherlands, adapted by WRR (figures refer to 2015, percentages of the Dutch population 12 years and older, seriously overweight percentage of Dutch population 4 years and older)

Many people also find it difficult to be a ‘critical care consumer’. Patients do not always appear to choose care providers based on price and quality comparisons but instead let themselves be guided by other factors, such as ‘Is the care close by and is the care provider known to me?’, or ‘Have I had positive or negative experiences in the same hospital?’, even if the specialism concerned was completely different. Almost half of the Dutch population has trouble playing an active role in their own care. The care professionals whom we interviewed confirm this and indicate that they do not always know whether the patient has made a conscious choice. The question is whether every person is willing and able to be an active patient. A passive attitude may also be the result of habit, the patient’s social circumstances or a stressful situation.
Nevertheless, every person has to deal with health problems, whether major or minor, at some point in their lives. Although the Dutch are relatively healthy and there has been an upward trend in recent decades on important indicators such as ‘life expectancy’ and ‘life expectancy in perceived good health’, sooner or later almost everyone faces a chronic or other illness or physical disability (Fig. 2.1).\textsuperscript{15}

![Fig. 2.1 Chronic illnesses and physical disabilities. Source SCP\textsuperscript{16}](image)

Their numbers are also growing. All of the top-10 chronic conditions were more common in both women and men between 2011 and 2013 than between 2005 and 2007.\textsuperscript{16,17} That means that at some point in their lives, more than half of the Dutch population will need the appropriate mental capacities to manage their chronic illness properly.

### 2.2.2 Health Challenges: Live Healthily and Be an Active Patient

A person’s health is affected by various factors, only a few of which are receptive to influence. After all, even people who live very healthy lives can get sick. However, self-reliant individuals are expected to take active steps to remain healthy and, if they do become ill, to know their way around the care process.\textsuperscript{5,18,19}
The challenge that the public faces in this domain is multifaceted and includes both prevention and control. Both call on mental capacities. However, this is an analytical distinction, because prevention applies to everyone and is even more important for patients with certain conditions. After all, lifestyle can have a direct impact on the course of an illness (Table 2.2).

Table 2.2  Health challenges

| Prevention                                      | Control                                           |
|-----------------------------------------------|---------------------------------------------------|
| Choosing to live healthily and maintaining a healthy lifestyle | In the event of illness, finding one’s way around the care process and playing an active role in that process as a patient |

Choosing to Live Healthily and Maintaining a Healthy Lifestyle

On paper, it’s easy enough to live a healthy lifestyle: maintain a healthy dietary pattern, don’t smoke, consume little or no alcohol or drugs, and get enough exercise but also enough rest and relaxation. Individuals themselves choose what to eat, drink and how much exercise to take. We might therefore conclude that a person who lives unhealthily has chosen to do so and that it is his or her own responsibility. In reality, it’s not that straightforward. Eating, drinking and exercising are complex aggregates of what are at times very diverse behaviours. The determinants of an unhealthy diet can also differ considerably from those of not exercising enough or of lighting up a cigarette.

Choosing to live healthily and to maintain a healthy lifestyle requires a variety of different capacities of people. First of all, they must gather and process the relevant information. It is widely known that certain food products are unhealthy, but there is now so much information available on healthy nutrition—some of it contradictory—that it can be hard to identify the most sensible choice. Sometimes the problem is how best to apply that information. For example, do squeezed oranges count towards the two pieces of fruit that we’re supposed to eat every day? Nowadays we no longer refer to an unhealthy diet but to an unhealthy dietary pattern. People are not only expected to know about nutrition, but also to have an overview of their own situation. What are healthy or unhealthy choices for them? That requires them to plan and set personal goals. A healthy lifestyle is not contingent on choices made at specific moments but is an aggregate of many choices that are made every day and that influence each other: if you eat too much or exercise too little one day, you can compensate the next day. But it is up to the individual to actually do so.
The next step, then, is to take action: get off the couch and actually do the sensible thing. Even more important is to persevere with these sensible choices. Many people are capable of losing weight, but keeping the weight off is another story altogether, especially in an obesogenic environment with its many tempting but unwise choices. Perseverance is particularly important when people are facing setbacks or experiencing life events. The ability to cope with stress and sorrow is therefore also crucial to a healthy lifestyle.

**Box 2.1: Obesity Clinic CGG**

It can be very hard for people to develop a healthy lifestyle for themselves. That was one of the main reasons for setting up the Obesity Clinic CGG in Rotterdam. Whereas the usual interventions are geared to averages and mainly focus on nutrition and exercise, the Obesity Clinic looks at the individual patient from a ‘holistic and multidisciplinary perspective’. Our rapidly growing knowledge about obesity makes it increasingly clear that a multitude of different factors are at work. These factors are partly socio-psychological and cultural, but to a significant degree they are also biological or related to medicine use, for example. That is why the Obesity Clinic first examines the root cause of each individual’s overweight and adjusts his or her treatment accordingly.

Individual treatment of this kind is important because it would otherwise not only be ineffective but even counterproductive. The well-known ‘yo-yo effect’ occurs not just because people revert to old habits; it also has a biological basis. For example, a low-calorie diet can interfere so much with a person’s appetite and feelings of satiety that a healthy dietary pattern becomes an even greater challenge. Ineffective treatment also induces frustration, stress and sometimes even depression, putting pressure on people’s mental capacities.

Once the biological and medical factors have been examined and treated, people who are clearly capable of losing weight from a medical perspective qualify for an 18-month group training programme. Mental capacities play an important role in this group. The programme focuses on learning healthy lifestyle habits, with weight loss as a side effect. The participants are usually highly motivated and lead active lives, but have difficulty taking action in this specific domain. They often find it hard to actually carry out their plans. That is because they are very focused on the short term, have trouble controlling their impulses, and find it unfair that they have to cut down on portion size and deny themselves certain foods (‘Why am I not allowed to eat that?’).

Participants often have enough general knowledge about healthy dietary patterns but lack the insight to apply that knowledge in their own situation. Sometimes the devil is in the detail, for example not knowing that 250 g of uncooked rice will weigh 600–700 g once cooked, resulting in unintentional excess calories.
Many of the patients have trouble dealing with emotions, such as anger or sorrow. Life events—often several at a time—play a major role. They need not always be events as significant as the death of a partner or a job loss; they can also be more minor events that disrupt their routine, such as changing jobs or going to live on their own. The participants are very concerned about others, but often have low self-esteem. After every failed diet, they feel more stress and lose self-confidence. If they lose weight, their self-image often improves.

The Role of an Active Patient
When people develop health problems, the role of the active patient comes into play. What that role requires of the individual differs from one condition to the next, but there are many disorders that call on the same capacities. The healthcare professionals we interviewed stress that the perception of what patients want and what they must be able to do has changed dramatically in recent years.

First of all, an active role requires patients to be able to articulate their problem clearly and to understand and carry out the doctor’s orders properly. It is especially important that they communicate clearly and honestly with their GP, the first point of contact for complaints. Once diagnosed, patients need to learn about the disease and be able to act accordingly, for example when and how to contact a health care professional about their chronic disorder. When should they go to their GP and when should they contact their specialist? This type of question requires more than knowledge alone; patients must have an overview of the situation, take action when necessary, and be able to cope with the emotions and limitations that their illness entails.

The next step is to engage in shared decision-making about treatment. Most patients find this important, but not all of them want to talk about treatment options and share in decision-making. It requires people to be able to communicate properly with their healthcare professional, but also to understand themselves and what they need as patients. That is not always easy, certainly in situations in which the diagnosis is (as yet) unclear. After all, in order to engage in shared decision-making about treatment, they need to understand and assess the various treatment options. That is why so much effort has gone into making information available to patients in recent years.

However, the ideal image of the patient who takes decisions with his or her practitioner is often contradicted by reality when someone receives a diagnosis or suffers physical complaints. Most people are not very assertive once they enter a hospital as a patient. “An unexpected illness makes people anxious and they do not always know how to behave as patients and what they can ask or say”. After receiving the diagnosis, they first have to process the news and learn to deal with the accompanying uncertainty and fear. Studies show that people forget more than half of what doctors tell them in the consulting room.

Some conditions require only a brief period of treatment, after which patients can resume their lives, where necessary under orders to live a very healthy lifestyle.
Increasingly, however, people are being diagnosed with chronic disorders. With all the treatment options now available for many chronic conditions, patients may remain under treatment for a lengthy period of time—in many cases, for the rest of their lives. The more serious the illness, the older the patients or the more disorders they have, the more self-management tasks they are obliged to shoulder.\textsuperscript{30, 31}

In response, the healthcare sector increasingly offers chronic patients specialist support, such as specialist nurses and nurse practitioners assigned to general practices. However, the success factors for self-management lie largely with the patient. Their motivation, opinions and intentions are very important.\textsuperscript{32} When patients enter the consulting room, it is difficult for the care provider to assess the capacities that they may or may not have.\textsuperscript{31} Objective parameters such as age, educational level or migration background do not necessarily provide an accurate basis for predicting someone’s ability to cope with their illness.\textsuperscript{33} Some interviewees indicate that they lack the necessary knowledge to make such assessments.

In recent years, the healthcare sector has devoted more attention to helping patients take an active role. For example, patients are now involved in drafting guidelines for doctors and the national government supports the development of protocols for patient-care provider dialogues.\textsuperscript{34} But existing interventions in support of patients will only go so far in meeting expectations. Heijmans et al.\textsuperscript{31} conclude that interventions should be more ‘personalised’ and make allowance for patient characteristics such as motivation, preferences and what an individual chronic patient is capable of doing.

**Box 2.2: Using e-health applications to capitalise on the capacity to act**

Recent years have seen a surge in e-health applications that are said to make patients more self-reliant.\textsuperscript{24} In many cases, however, websites and apps are mainly designed to transmit information. What is truly interesting is an app that capitalises on an individual’s capacity to act. One example in the United Kingdom is the ‘Baby buddy’,\textsuperscript{35} an app that tracks an expectant mother’s pregnancy, offers relevant information at each stage, and allows her to ask questions. Women can also use the app to set goals for themselves, for example to get at least 20 min of exercise a day, and are encouraged by the app to meet those goals. The app keeps track of doctor’s appointments and check-ups and issues timely reminders. Women can also personalise their avatar, for example by changing its outfit. That makes the app more fun and motivates women to continue using it for a 15-month period.

\textit{Not Everyone Is Health Literate}

Until recently, researchers focused mainly on what people need to know and must be able to do to process information properly. The voluminous literature on health literacy was limited to reading, writing and maths skills. Later, researchers added
the ability to deal with oral and digital information, and more recently that has been extended to include motivation and other factors. Today, researchers are also looking at non-cognitive attributes under the ‘health literacy’ heading, albeit sporadically. Health literacy is not a goal in and of itself but rather influences health in different ways. It is a determining factor in: (1) the individual’s level of knowledge; (2) lifestyle; (3) healthcare use and access to care; (4) communication with healthcare professionals; (5) self-management and medicine use.

Various tools have been developed both in the Netherlands and abroad to create patient profiles that chart patients’ (self-management) skills. Hibbard et al. developed the Patient Activation Measure (PAM), a scale that analyses why some patients work actively on their health and others do not. The scale consists of four levels of patient activation, running from low (1) to high (4): (1) believing that one’s own (patient) role is important; (2) having the confidence and knowledge necessary to take action; (3) actually taking action to maintain and improve one’s health; (4) staying on course even under stress. People with a low score are more likely to feel overwhelmed with the task of managing their health; they have little confidence in their ability to have a positive impact on their health; they misunderstand their role in the care process and have limited problem-solving skills. Negative experiences have led them to become passive, and that means that they would rather not think about their health.

Rademakers tested the PAM tool in the Netherlands. Her studies show that, as elsewhere, not everyone in the Netherlands is equally health literate and that the differences between people cannot all be reduced to educational level (see Table 2.3). High-educated persons do have higher scores, but even there, only 29.1% attain level 4 and 16.1% never go beyond level 1.

| Patient activation level | Educational level |
|-------------------------|------------------|
|                         | Low | Medium | High |
| 1. Believe one’s role is important | 31.4 | 21.2 | 16.1 |
| 2. Have confidence and knowledge to take action | 23.3 | 27.7 | 23.3 |
| 3. Take action | 31.8 | 29.2 | 31.5 |
| 4. Stay on course | 13.5 | 21.9 | 29.1 |

Being knowledgeable is therefore not enough to meet the challenges of self-reliance in health matters. Based on our interviewees’ experiences and the literature, we have produced an outline of the necessary capacities (Table 2.4).
2.3 Personal Finance

2.3.1 More People with Problem Debt

The temptations and the level of complexity have also increased in the domain of personal finance. Instead of an obesogenic environment, Jones et al.\textsuperscript{45} refer to ‘debto-genic urban landscapes’. In the UK, it is precisely in poorer neighbourhoods that main streets are lined with casinos, ATMs and pawnbrokers. This is less extreme in the Netherlands, but the Dutch can still spend money 24 h a day at web shops or online casinos, and there are ads for mortgages that can be taken out in the space of a week.\textsuperscript{46}

It is not always clear to the public what lies behind these temptations. Financial products, such as mortgages, investment products or insurance, are by their very nature difficult to fathom.\textsuperscript{47} They are complicated and often involve hidden risks. These are products that people often purchase only a few times in their lives, lim-
iting their ability to fall back on prior knowledge and experience. Nevertheless, in recent years Dutch households have increasingly purchased a wide range of financial products, such as investments, supplementary pensions and savings and investment insurance, including many risk-bearing capital insurance policies and other complex investment products.

At the same time, the public has assumed or acquired greater responsibility for covering financial risks. Examples include the rise in the number of self-employed persons who are not covered by the pension system and the transition from student grants to a student loan system. Governments also add to the complexity of financial planning in other ways. In 2013, the National Ombudsman of the Netherlands concluded that government schemes are so complex and their effects often so unclear and unpredictable that they lead to more problem debt. There are so many government schemes that many people no longer know what they are entitled to, making financial planning almost impossible. In the spring of 2014, Deloitte counted a total of 27 different income-support schemes that households could potentially claim to supplement their own income. The calculations that determine what an individual is entitled to under these schemes apply a total of seven different definitions of income and assets. For example, people must be able to distinguish between such concepts as aggregate income, means-test income, disposable income and net income. And in order to request a waiver of municipal taxes, for example, applicants sometimes have to submit up to 15 supporting documents. In addition, the rules change regularly.

A substantial number of Dutch people face or are at risk of getting into financial difficulties. One in three households does not have a big enough buffer to absorb a normal setback, such as a broken washing machine. Only 37% of households have more than 3,500 euros in reserve. Approximately 650,000 households have problem debt, while another 735,000 households are at risk. These are not hard figures but estimates based on large-scale surveys. There is no Dutch database of people who have (or are at risk of) problem debt, and not everyone in debt reports to official bodies.

The debt problem has grown since the 2008 financial crisis. More people found themselves facing a drop in income, unemployment and falling house prices. Household purchasing power declined sharply for a number of years. The increase in the number of debtors is now levelling off. BKR Financial Registration Office observed that in the second half of 2015, the number of consumers with payment arrears on
loans had not increased but remained stable for the first time since 2008 at three
quarters of a million. In the past ten years, more and more people have applied for
debt assistance. Figure 2.2 shows the number of requests for assistance submitted to
members of the NVVK, the sector organisation for debt assistance services.\textsuperscript{55} The
average debt of those who register currently stands at to €42,900.

Fig. 2.2 Applications for debt assistance submitted to NVVK. Source NVVK annual reports

In recent years we have seen that problem debt occurs at all levels of the population,
not only among the traditional underclass, but also among those with a good education
and a decent income. It is relatively common among people with little education,
low income and rented accommodation, but certainly not limited to these groups
(see Fig. 2.3). Other factors apparently also play a role.

| Level of education                                      |
|--------------------------------------------------------|
| Up to and including prevocational secondary education (VMBO) | 55% |
| Senior general secondary education (HAVO), Pre-university education (VWO), Senior secondary vocational education (MBO) | 29% |
| Higher professional education (HBO), University education (WO) | 16% |
| Total                                                  | 100% |

| Net monthly income                      |
|-----------------------------------------|
| ≤ 1,000                                 | 11% |
| 1,000 - 2,000                           | 49% |
| 2,000 - 3,000                           | 32% |
| ≥ 3,000                                 | 8% |
| Total                                   | 100% |

| Type of home                        |
|------------------------------------|
| Owner-occupied home                | 42% |
| Rented home                        | 58% |
| Total                              | 100% |

Fig. 2.3 Personal characteristics problematic debts. Source Panteia\textsuperscript{51}
2.3.2 Financial Challenges: Display Healthy Financial Behaviour and Get Out of Debt

What you must be able to do to be financially self-reliant depends on your personal situation. It is easy to manage your finances when a fixed salary is deposited into your account every month that automatically covers your regular expenses, with money left over to save. But it is precisely when problem debt arises that people’s mental capacities are put to the test. In this section, we look at what we must be able to do to avoid financial problems, and what happens if we do end up with problem debt or a debt restructuring arrangement (Table 2.5).

Table 2.5 Challenges for personal finance

| Prevention                      | Display healthy financial behaviour |
|---------------------------------|-------------------------------------|
| Control                         | Get out of problem debt              |

Display Healthy Financial Behaviour
Avoiding payment arrears is what healthy financial behaviour is all about. This means that spending does not exceed income, that people plan ahead for the longer term, are aware of financial risks and take appropriate steps, such as accumulating a financial buffer. More specifically, it means being able not only to purchase a complex financial product such as a mortgage, but also to perform basic tasks such as opening the post and paying bills on time.

Financially healthy behaviour does not always prevent payment arrears. Bad luck can still plunge people into a precarious financial situation. On the other hand, individuals with a positive bank balance do not always exhibit financially healthy behaviour. They manage to stay out of trouble as long as their income exceeds their spending. In other words, simply having the right mental capacities is not enough to be financially self-reliant.

The Netherlands’ Institute for Budgetary Information (NIBUD) describes what someone must be able to do to be financially self-reliant, based on five areas of competence (see Box 2.3). Some of these competences are required every day, others only occasionally.

Box 2.3: Competences needed for financial self-reliance
NIBUD has identified five competences associated with financial self-reliance. These competences describe the knowledge and skills that consumers need to ensure that their spending does not exceed their income in the short and long term.

- Having an overview. Consumers have an overview that helps them to understand how best to manage their personal finances.
- Sensible spending. Consumers spend their income in such a way that they can manage their household finances properly in the short term.
- Looking ahead. Consumers realise that their desires and certain events over the medium and longer term will have consequences, and they adjust their current spending accordingly.
- Making informed choices. Consumers choose financial products in line with their budget and appropriate to their personality and personal household circumstances.
- Having enough knowledge. Consumers have all the relevant knowledge they need to manage their household finances in the short, medium and long term.

Source: Nibud

Nibud’s list describes very precisely which tasks and actions an individual should be able to undertake. Knowledge is a factor, but it is clear that knowledge alone is not enough. Nevertheless, until now financial literacy has been the main focus of international literature, which emphasises people’s ability to process economic information and the extent to which they make informed decisions. Although broader definitions now apply, which also include behavioural aspects, the focus is still on knowledge. The prevailing hypothesis in this field of research is that people get into financial difficulties because they lack financial knowledge and that increasing that knowledge is the key to improvement. Recent research has raised growing doubts about this. When personal characteristics such as risk attitude, preference for planned behaviour, confidence in one’s own abilities and numeracy are taken into account, the correlation between knowledge and behaviour almost completely disappears.

The debt relief workers we spoke to confirm this picture. For example, it is not the case that higher educated people always make a better job of managing their finances than lower educated people. Problem debt is not limited to certain groups. Only some of those affected belong to the traditional underclass, the group of people who have trouble managing their personal finances themselves, under any circumstance, because they do not have the necessary cognitive capacities. Debt relief workers note the rise of two new groups with problem debt. The first are the ‘nouveau poor’, people who, until recently, had a job and a reasonably well-regulated lifestyle, but who suddenly find themselves in serious trouble owing to setbacks. Many of these people do not have large and immediately available financial buffers, making them relatively vulnerable to changing circumstances. The second group consists of the well-off, people who have a good income but who get into financial difficulties due to divorce, illness or another life event. High recurring costs, often combined with an inability or unwillingness to alter their familiar lifestyle, cause this group to run up considerable debt in a short space of time, despite their comfortable income. Debt relief workers note that both groups are unable or unwilling to adapt to the changed circumstances.
The foregoing shows that financial problems seldom occur in isolation. Various studies and interviews make clear that life events play a major role in whether or not someone falls into debt. Such events, such as having a child, being dismissed or losing a partner, can happen to anyone. Whether they lead to financial problems has to do with the impact of the event and whether the individual has a financial buffer. Not everyone sees the event and associated loss of income coming, or has even given thought to the possibility that such an event might occur. Unforeseen circumstances combined with a tendency to underestimate risks and optimism about the future mean that people do not spend enough time reflecting on future events that could have major financial consequences. How people react to a life event is also a factor. They must be capable of assessing their personal situation, accepting changes and adjusting their goals. That requires adaptability and confidence in their ability to quickly turn a situation around.

Dealing with Problem Debt and Debt Restructuring

Once people have problem debt, they find themselves in a complex situation, one that requires vigilance. They will most likely be dealing with several creditors and claims, each with its own rules and payment arrangements. The debtor needs to know what information to pass on when and to whom, must be able to deal with the many forms and requisite documentation, procedures and waiting times, be aware of any opportunities for objection, know where to turn for assistance, and understand the bureaucratic rules and logic involved. In addition, debtors must be assertive and persistent in the face of a bureaucracy that is not always set up to support the individual. They must be able to defend themselves against creditors that may intimidate them and abuse their ignorance. Debt collection agencies are not always subtle in their actions, often exacerbating the problems of debtors. The Netherlands Authority for Consumers and Markets (ACM) concludes that debt collection agencies ‘regularly exert undue pressure’ to get bills paid. For example, they threaten to take steps for which they have no legal authority, such as summons, forced sale, eviction or seizure. This kind of pressure often produces results, since most debtors are not sure what a debt collection agency is and is not authorised to do.

The creditors often include various government entities, such as the Tax and Customs Administration, the Central Judicial Collection Agency (CJIB) and the Health Insurance Board (CVZ). Although they are all part of government, they do not apply the same rules and procedures. Each government entity has its own regime, and there is virtually no coordination between them. As a result, they sometimes get in each other’s way. It is conceivable, for example, that a bank will unexpectedly refuse to execute payment of a CJIB fine because another government agency has just emptied the debtor’s bank account the day before to cover a debt. This is particularly frustrating because the CJIB then immediately charges a hefty penalty if required to send a reminder for late payment.
All the experts agree that it is important to take action without delay. At the same time, however, they also note that it often takes quite a while before people acknowledge their problem. People are ashamed of their own failure, blame themselves and therefore believe that it is up to them to fix the problem. Sometimes their problems are so severe that debt relief or restructuring is necessary. This is yet another situation that calls on the debtor’s mental capacities.

To begin with, the debtor must be able to ask for help. For many people, requesting debt assistance is a major step. On average, it takes about five years from the first arrears in payment before people register for municipal debt assistance. This is not only because they are ashamed, but also because access to the scheme is subject to strict requirements and precisely these people find it most difficult to satisfy them. Many local authorities, for example, will refuse assistance if the debtor’s divorce has not yet been finalised, and those who own a home or a car not required for commuting will have to sell them first. In addition, the municipal authorities examine the debtor’s behaviour. The latter must abide by agreements, have their accounts in order and not incur any new debts. The issue here is that people struggling with problem debt have often lost their grip on things. They spend all their time addressing urgent problems, can no longer plan ahead and are constantly under pressure from creditors. It is not easy for them to have a clear grasp of their financial situation in such circumstances, and their loss of control is precisely why the problem arose in the first place.

The debt restructuring process is difficult and requires considerable perseverance and discipline. Of those who are accepted, around 30% do not complete the process, despite the strict selection criteria. Not everyone is sufficiently motivated. Sometimes people do not seem willing to abandon the lifestyle to which they are accustomed or to give up what they see as necessities. Professionals point out that people need time to recognise and accept their situation and to make real choices. This is partly because of the stress of the situation itself.

What you must be able to do involves much more than knowledge, in other words. Research shows that having a positive attitude—thinking beyond the short term, being able to resist temptation and being willing to save—has a greater impact than possessing practical skills, for example having a clear overview, actively keeping up with paperwork, or having a savings account. Based on our interviewees’ experiences and the literature, we have produced an outline of the capacities that are required to be financially self-reliant. Getting out of debt requires other actions than preventing debt in the first place, but the necessary capacities are very similar (see Table 2.6).
### Table 2.6 Personal finances

| Financial challenges | Prevention |
|----------------------|------------|
|                      | *Take an active role in the care process* |
|                      | Control |
|                      | *Get out of debt* |

|                      | Gather and process information |
|----------------------|-------------------------------|
|                      | Choose financial products consciously and understand what they entail for your personal financial situation |
|                      | Know and understand the rights and obligations associated with allowances and schemes |

|                      | Have an overview of the situation, set a goal, make a plan |
|----------------------|---------------------------------------------------------------|
|                      | Keep financial records up to date, balance incomings and outgoings, build up financial buffers that allow you to absorb life events (savings) |
|                      | Get financial records in order, adjust spending and income to personal situation, choose strict debt restructuring programme to get out of debt |

|                      | Take action, implement plan |
|----------------------|------------------------------|
|                      | Open post, pay bills, increase income, believe that it is possible to rein in spending so that it does not exceed income |
|                      | Get in touch with creditors, ask for assistance, believe that you yourself can have a positive impact on your debt problem |

|                      | Persevere |
|----------------------|----------|
|                      | Resist advertisements and sales/discounts |
|                      | Resist the temptation to buy things that people without debt buy |

|                      | Cope with emotions |
|----------------------|--------------------|
|                      | Don’t make any impulse purchases |
|                      | Overcome shame and ask for assistance |

### 2.4 Labour Market

#### 2.4.1 Flexible Work and Individual Responsibility

In the Dutch participation society, everyone is expected to participate, preferably through gainful employment. That means being employable and finding and keeping a job. Many people support this basic premise, but an individual’s job opportunities are influenced by various factors.

The first is the economy. For example, after the 2008 crisis began, the unemployment rate in the Netherlands rose. Job losses increased from 80,000 a year in 2008 to between 105,000 and 125,000 in subsequent years. Unemployment rose from 3.7% in 2008 to 6.6% in 2015, declining to 5.7% in the third quarter of 2016. The group of unemployed persons is not homogeneous. Older people are more likely to be long-term unemployed than young people, and the low- and medium-skilled are somewhat more likely to be unemployed than high-skilled workers. But the differences are relatively small and although some groups are more at risk, unemployment can happen to anyone.
Second, flexible labour market practices mean that people have to compete more often for jobs during their careers. The Netherlands is at the forefront of Europe in this regard: one in five Dutch workers has a flexible job and one in ten is self-employed. In 2005, 72% of the active labour force had a permanent employment contract; by 2015 this had fallen to 62%. Over the same period, the number of flexible contracts rose from 15 to 21%. The number of self-employed is also growing. Whereas in 2005 they represented only 13% of the working population, in 2015 they accounted for 17%. The vast majority of these, about 70%, are self-employed. We also see more hybrid forms of work, where people have a permanent job and are self-employed at the same time. So far, the economic climate seems to have had little impact on the upsurge in flexibility. That upsurge is not an organic phenomenon, however, but is influenced by various factors that are susceptible to change, such as employer behaviour and labour market tightness (Fig. 2.4).

Flexible contracts do not always lead to a permanent contract. At the end of the 1990s, 43% of employees on temporary contracts received a permanent contract within a year, but between 2008 and 2011 this had dropped to 28%. Employees on a flexible employment contract change jobs up to twice as often as employees on a permanent contract, and are more likely to be offered a flexible contract again.
Flexible employment practices affect job security. For example, the likelihood of people on temporary contracts still having a job two years later is 10% points lower than for people on permanent contracts.\textsuperscript{77} And because the self-employed have to bring in their own commissions, they are less certain of work. The implications are all too palpable; in 2013, about half of the Dutch population were worried about their jobs, 45% were thinking about other employment, and 23% actually took steps to find another job.\textsuperscript{78}

Third, technological advances mean that the nature of work is increasingly subject to change.\textsuperscript{77} Routine work will be ever more automated. As a result, creativity, social skills, adaptability and other meta-skills appear to be gaining importance in the job market.\textsuperscript{79} Over the past 25 years, the demand for labour in the middle segment has fallen, while the demand at the high and low ends of the labour market has grown.\textsuperscript{80, 81} This job polarisation means that many medium-skilled workers have been pushed to the lower end of the labour market or are obliged to make their way to the upper end of the labour market, for example by retraining.

As the nature of work changes, so does the type of organisation. More knowledge-intensive production can lead to less division of labour and more demand for broadly employable workers who can handle complex tasks and a large measure of individual responsibility. A broadly employable workforce can help a company to remain flexible and competitive.\textsuperscript{82, 83} Employees feel this too: between 45 and 59% of workers say that they need training.\textsuperscript{84} The need is strongest among those who are worried about their jobs and weakest among those who are not worried.

A fourth factor is that government has shifted more of the responsibility for maintaining an income and finding work to the individual. Income security had already started to decline in the 1990s, with the introduction of the Participation Act (see Box 2.4) representing the most recent step.\textsuperscript{85} Eligibility criteria have been tightened and the amount and duration of benefits restricted.\textsuperscript{86} People are therefore under greater financial pressure to look for work. Workers accrue entitlement to unemployment benefit more slowly nowadays, and the period of entitlement has been curtailed to a maximum of 24 months. In addition, government expenditure on coaching and job mediation for the unemployed has fallen in recent years.\textsuperscript{87} The budget for active labour market policies was halved between 2002 and 2013, even as the unemployment rate rose.
In exchange for the benefits that it does pay out, the government has imposed more obligations on recipients. Van Echteld and Josten⁸⁶ have noted a shift from ‘caring’ to ‘disciplining’. There is stricter monitoring of compliance with the obligation to apply for a job, the definition of appropriate work has been extended, and people are more likely to be obliged to accept work below their level of competence. Moreover, government now plays a less active role in the reintegration process. Unemployed persons only have their first personal appointment at the Employee Insurance Agency (UWV) three months after registering. In other words, they are obliged to do more and more by themselves.

**Box 2.4: Stricter rules and more obligations**

The Unemployment Act (WW) was cut back even further as from 1 January 2016. Former employees receive unemployment benefit, giving them income security during their search for work. The benefit covers 70% of their last-earned wage and is paid out for between three and 24 months, depending on their employment history. The UWV’s services include an online environment through which the unemployed can contact their client manager, find tips, take self-tests, gather information and take online training courses. Only after three months do they sit down with an advisor, followed if necessary by another appointment in the seventh or tenth month of their unemployment benefit. Additional services are available, but only for specific target groups, such as people over 50.⁸⁷

Since 2015 a new law has been in place. The Participation Act that focuses on people who are able to work but who need support from the local authority to find and hold down a job. That support consists primarily of coaching and mediation by a client manager, if necessary supplemented by education, training or a wage cost subsidy for the employer.⁸⁷ In addition, people on social assistance receive income support of up to 70% of the minimum wage.

The introduction of these laws has imposed more obligations on people. For example, recipients of a social assistance benefit have a duty to work and reintegrate into the labour market and to reciprocate to the best of their ability. The recipients of unemployment benefit are obliged to undertake job-search activities four times in a four-week period.⁸⁸ For the first six months, they need only apply for work commensurate with their level of competence; thereafter, all work is deemed ‘appropriate’. Regardless of whether they are receiving social assistance or unemployment benefits, recipients must be prepared to travel up to 3 h a day or to relocate for appropriate work. In addition, they must report any changes, from days off sick to volunteer work and odd jobs they do for friends. If the recipients do not comply with these obligations, their benefits may be cut.
2.4 Labour Market

2.4.2 Labour Market Challenges: Be Employable and Find and Keep Work

Finding and keeping appropriate work are the most important challenges in the job market. What must you do or be able to do to find and hold down an appropriate job? Workers must maintain their employability, not only in their current job, but above all with a view to their future careers. An unemployed person focuses primarily on finding a job and must be employable for that to happen. Both situations require the right training and work experience. But these attributes do not fully explain why one person can find and keep a job much more easily than another. Other capacities also play an important role (see Table 2.7).

Table 2.7 Challenges in the job market

| Prevention                                      | Employability and continuous professional development |
|-------------------------------------------------|-------------------------------------------------------|
| Control                                         | Finding and holding on to appropriate work             |

From Job to Job

Flexible labour market practices mean that working people are less certain that they can hang on to their current job for the rest of their careers. Workers therefore face two main tasks: to hold onto their current job by performing well while simultaneously preparing for their next job. A new position often involves a different set of tasks, requiring additional knowledge and skills. Employees must adapt and continue to work on their professional development.

The focus on professional development has intensified in recent decades, and is often referred to as ‘employability’. The term is also used to indicate that employees have more freedom to pursue their own careers. It is the ideal image of an emancipated worker who stands up for himself, without being hemmed in by oppressive, entrenched structures. In that ideal world, the responsibility for employability lies increasingly with the individual and less with the organisation.

The emphasis on employability blurs the boundary between training and work. Employees must invest continuously in their knowledge and skills, even if certain training is only relevant in the longer term. Career coaches note that people have very different ways of dealing with this. Some people resist taking action while those who are highly motivated and believe in their own abilities find it easier to do so.

To change jobs, people need to know where they want to go. That requires them to have a self-image, a subject that coaches often raise by having their trainees ask themselves ‘who am I?’, ‘what am I capable of?’ and ‘what do I want?’ But people also need to know what is happening in the labour market and what this means for their capabilities. The employee must be willing to discuss this with his employer or ask people in his network to brainstorm with him. He can then use the information this generates to identify a goal and draw up a plan to achieve it.

All these activities take time, attention and energy. People may find it confrontational to realise that their current job is not their dream job after all, and then to plunge into the uncertainty of seeking other work. They may easily feel inclined
to postpone all that ‘for now’. Our interviewees also say that people need a certain amount of calm in other areas of their lives before they can work on their employability without feeling constrained. In other words, our ability to focus on employability is undermined not only by the distractions of more interesting activities but also by problems we are experiencing in other areas of life.

Even under favourable conditions, employees still have to deal with the uncertainty and disappointment inherent to the process of a career realignment and professional development. Maybe a training course doesn’t go as planned, or a job application ends in rejection. Despite such setbacks, they will have to persevere.

*From Unemployment to Work*

People who lose their jobs for whatever reason are also obliged to work on their employability, but then under greater pressure. The pressure comes from outside, for example due to stricter enforcement of the requirement to apply for work, but it can also be self-imposed; after all, work can be an important part of someone’s identity.

Losing one’s job can be a major setback, both financially and personally. Our interviewees say that the unemployed first have to come to terms with this setback before they feel ready to move on to a new job. They refer to the ‘period of mourning’ that follows dismissal. How long that period lasts varies from person to person. Being overly protective of people can hamper the mourning process and discourage them from taking action. Someone has a better chance of finding work if they start applying for new jobs as soon as possible. Experience also shows that interventions are less effective for the long-term unemployed than for those who have only recently lost their jobs.91, 92

In addition, the longer the period of unemployment, the unhappier many unemployed persons become. Their psychological well-being deteriorates, and they are more likely to suffer symptoms of depression, stress and low self-confidence93, making it more difficult for them to get back to work. These mental factors help to explain the self-reinforcing effect of unemployment.94

Unemployed persons who have not applied for work for a long time often have weaker job search skills.91 It also appears that not everyone has a clear understanding of which jobs are available or can assess the extent to which they have the necessary skills.95 If they do not have the requisite knowledge and skills to work or apply for a job, they can ask for assistance from Social Services or the Employment Insurance Agency (UWV), for example. The problem is that these agencies have mandatory training courses and job application rules, with participants experiencing very little autonomy.96 Both professionals in the field and researchers indicate that job seekers tend to be more successful when they are intrinsically motivated to seek work.97 Without autonomy, however, their intrinsic motivation tends to decline.98

Job seekers are likely to encounter setbacks throughout the entire process: their dream job requires them to speak a certain foreign language, employers do not respond to their job applications, or they make an enormous effort and are still not chosen for a position. Our interviewees emphasise that it helps to see the job search as a learning process and to continue believing in one’s own abilities. People with a
greater self-esteem who are more optimistic and have fewer financial worries are less susceptible to negative feelings. In addition, people who feel that they are in control of their situation or who have a less negative view of their unemployment are less likely to be unhappy in this period.93

To recap, then, the labour market demands more of people than cognitive abilities alone. Based on our study of the literature and our interviewees’ experiences, we have produced an outline of the capacities that people need to possess to be self-reliant in the job market (see Table 2.8).

Table 2.8  Job market

| Labour market challenges       | Prevention From job to job                                                                 | Control From unemployment to work                                                                 |
|-------------------------------|-------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| Gather and process information| Know what is required in the job market, compare this with your own situation, knowledge and skills | Knowledge of job application processes and their (unwritten) rules of conduct                      |
| Have an overview of the situation, set a goal, make a plan | Make career choices, work to achieve them                                                 | Select appropriate occupations and identify the steps in the job application process                |
| Take action, implement plan   | Continue working on personal development, network and apply for jobs                      | Apply for jobs, network, take training courses, build and maintain trust in your own capacities     |
| Persevere                     | Make time for additional training as an investment in your future                         | Continue looking for a job, and believe in your own capacities even when rejected                  |
| Cope with emotions            | Dare to ask for feedback and take it on board, dare to take a new step in your career     | Cope with dismissal, and with rejection                                                            |

2.5 Conclusion: The Bar Is Set High

People want to be self-reliant, but not everyone seems capable of self-reliance at all times. That is partly due to changes in the everyday environment in which they operate. People have assumed and are being given more responsibility. Having less job security, being expected to live healthily in an obesogenic environment, and coping with a shrinking income because of the economic crisis all require considerable flexibility. The demands being made are huge. A self-reliance paradox may arise, whereby the enormous emphasis on personal responsibility in fact diminishes people’s ability to be self-reliant. Freedom of choice is an ideal that almost everyone endorses, but it can also cause mental burden and choice anxiety. That is even more so when individuals suffer health problems or debt, or lose their job, whether or not through their own actions. These situations demand even more of a person’s mental capacities, but that is precisely when people are less able to call on them.
In this chapter, we have seen that not everyone is self-reliant at all times. We know that some people do not have the necessary intellectual capacity or literacy and numeracy skills. According to the Court of Audit\textsuperscript{99}, the Netherlands has approximately 2.5 million low-literate people aged 16 and older (that is 18% of the total population). These people may have problems reading safety instructions, filling in forms (for example to apply for a care allowance or rent subsidy), writing a letter of complaint, or reading and understanding health tips, patient leaflets and medicine package leaflets. In addition, 18% of the Dutch aged between 12 and 74 have limited and 9% have very limited computer skills.\textsuperscript{100} This is an important factor in their lack of self-reliance and requires close attention from professionals and policymakers.

This is not the whole story however. Self-reliance also requires the capacity to act. We have seen in this chapter that even people with a high level of education are not always financially or health literate or possess the necessary job market skills. Researchers and our interviewees confirm that knowledge alone is not enough to get people off the couch, to be able to assess their own situation and to persevere with their sensible choice even if things do not go their way (Fig. 2.5).

![Mental capacities](image)

**Fig. 2.5** Mental capacities

The second conclusion is that self-reliance issues are not limited to the ‘traditional underclass’. Even highly educated people have trouble taking action, persevering and coping with setbacks. Professionals point out that it can be difficult for them to determine who possesses or lacks certain capacities. They must first understand the role that mental capacities play and then know how to deal with them. We have come across professionals, services or programmes in every domain that make allowance for this. However, attention for non-cognitive mental capacities is still limited.

A brief glimpse into everyday life shows that the capacity to act is critical to the self-reliance that is so vital in present-day society. What does research tell us about the capacity to act? That is the topic of the next three chapters.
Endnotes

1. Kooiker, S. (2011).
2. Mast, J., Wijenberg, E., & Minkman, M. (2014).
3. Tweede Kamer. (2004–2005, see p. 10).
4. Nijman, J., Hendriks, M., Brabers, A., de Jong, J., & Rademakers, J. (2014).
5. Reitsma, M., Brabers, A., Masman, W., & de Jong, J. (2012).
6. Rademakers, J. (2014).
7. de Boer, A., & Kooiker, S. (2012).
8. Ministerie van VWS. (2011, see also p. 6 of english translation).
9. Dagevos, H., & Munnichs, G. (Eds.) (2007).
10. Addiction may play a role here. Heredity is estimated to account for about 50% of the risk of alcohol, nicotine or drug addiction (Ministerie van Financiën 2016a). Genetic factors also play a role in overweight.
11. Health Survey/Lifestyle Monitor, Statistics Netherlands in cooperation with the National Institute for Public Health and the Environment (RIVM), 2014 figures.
12. People who are seriously overweight have a BMI of 30 and higher. BMI is a person’s weight in kilograms divided by the square of their height in metres (kg/m²). Other standards apply for persons under the age of 18. A much smaller share, 2%, are underweight. People who are underweight have a BMI of less than 18.5. Other standards apply for persons under the age of 18 (source: Statistics Netherlands).
13. Victoor, A. (2015).
14. Nijman, J., Hendriks, M., Brabers, A., de Jong, J., & Rademakers, J. (2014).
15. In 2014, life expectancy in the Netherlands at birth was 79.9 for men and 83.3 for women, an increase of 4.1 years for men and 2.6 years for women over 2001. Life expectancy ‘in perceived good health’ also increased in the same period from 61.8 to 64.9 (men) and from 61.6 to 64.0 (women) (Statistics Netherlands, adapted by WRR).
16. SCP . (2013).
17. The increase is associated with the ageing of the population but also with improved diagnostics and a higher percentage of overweight people in the population (diabetes).
18. van der Heide, I. (2015).
19. This study considers various aspects of a healthy lifestyle, for example healthy nutrition, exercise and sport, and not smoking. We follow the suggestion of the Dutch National Prevention Programme, which identifies four risk factors as priorities: smoking, consumption of alcohol, overweight and exercise and sport (and two disorders: depression and diabetes) (Ministerie van VWS 2013).
20. We confine ourselves here to the risk factors identified by the Dutch National Prevention Programme (Ministerie van VWS 2013), but there are others that can be taken into account, such as stress or playing high-risk sports.
Researchers are studying the group therapy approach at the Obesity Clinic CGG. The study is still under way, but initial results agree with other research findings regarding long-term, close guidance of obese patients.

Under Dutch law (Medical Treatment Contract Act, WGBO), patients must to the best of their knowledge give care providers the information and cooperation that the latter reasonably requires to deliver proper care (see Article 7: 452 of the Dutch Civil Code).

The Dutch health minister has therefore advised patients to record their conversations with doctors and replay the recording at home. This can help them gather their thoughts and take decisions (Minister van VWS 2016).

That is why many experts are in favour of a ‘universal precautions approach’: “basically, straightforward communication with everyone but using special techniques to check that patients understand and to clarify the need for additional information” (Heijmans et al. 2016: 56).

The Dutch Association of Medical Specialists and the Federation of Patients and Consumer Organisations in the Netherlands (NPCF) are collaborating on a broad programme in support of the Shared Decision Making (SDM) agenda (Ministerie van VWS 2015). The relevant activities focus on raising awareness among doctors and patients, providing patient information, and developing support tools.

The app was developed by the charitable organisation Best Beginnings (https://www.bestbeginnings.org.uk/baby-buddy). It has been downloaded more than 90,000 times and won the 2016 BIMA Award for Well-Being and Health.

Nutbeam (2000) introduced a now widely used classification of literacy into three levels and emphasised that health literacy should involve more than being able to read and write. Nutbeam’s three levels are: (a) functional literacy: sufficient basic skills in reading and writing to be able to function effectively in everyday situations, broadly compatible with the narrow definition of ‘health literacy’; (b) interactive literacy: more advanced cognitive and literacy skills which, together with social skills, can be used to actively participate in everyday activities, to extract information and derive meaning from different forms of communication, and to apply new information to changing circumstances; (c) critical literacy: more advanced cognitive skills which, together with social skills, can be applied to critically analyse information, and to use this information to exert greater control over life events and situations. The third level (c) is comparable to the WHO’s broader definition of health literacy.
37. Vilans (National Centre of Expertise for Long-term Care in the Netherlands) published a list of 17 tools in October 2013. The authors note that the list is not exhaustive and that most of these tools only measure some aspects (Vilans 2014). In her Kennissynthese gezondheidsvaardigheden, Rademakers (2014) included a list of eight tools for measuring health literacy that are available in the Netherlands.

38. Hibbard, J. H., Stockard, J., Mahoney, E. R., & Tusler, M. (2004).

39. PAM was developed by asking a panel of experts “What are the knowledge, beliefs, and skills that a consumer needs to successfully manage when living with a chronic disease?” (Hibbard et al. 2004). PAM scores are only moderately correlated with socio-economic status (Hibbard and Gilburt 2014).

40. Rademakers, J., & Heijmans, M. (2018).

41. Between 25 and 40% of the population of the United Kingdom have low levels of activation (Hibbard and Gilburt 2014: 7).

42. Hibbard, J., & Gilburt, H. (2014).

43. Rademakers, J., Nijman, J., Van der Hoek, L., Heijmans, M., & Rijken, M. (2012).

44. Rademakers, J., Nijman, J., Brabers, A., de Jong, J., & Hendriks, M. (2014).

45. Jones, R., Pykett, J., & Whitehead, M. (2013).

46. February 2018, the Dutch Authority for the Financial Markets (AFM) warned banks that the law does not allow them to advertise for ‘quick mortgages’.

47. WRR. (2016).

48. Actal. (2014).

49. Jungmann, N., & Madern, T. (2016).

50. Wijzer in geldzaken. (2014).

51. Panteia. (2015).

52. We refer in this book to ‘problem debt’ and not simply to ‘debt’ because debt is not necessarily bad or wrong. Many people face major expenses in the first half of their lives—for example, their education or the purchase of a car or house—that they pay for by borrowing against their future earnings. There is also no reason not to borrow money to cover expenses that are perhaps not strictly necessary but that add to the quality of life, such as certain hobbies or nice home furnishings. As long as people can make their payments, there is nothing wrong. In the literature, the term ‘problem debt’ is often operationalised as an arrears that a person cannot reasonably pay within three years, given their debt repayment capacity (Tiemeijer 2016).

53. The most recent survey, which involved a sample of more than 10,000 households, qualifies as extensive.

54. Nibud. (2014).

55. In reality, the increase was not quite as sharp as this graph indicates because a certain amount can be attributed to a gradual rise in NVVK membership.

56. Jungmann, N., Moerman, A., Schruer, E., & van den Berg, I. (2012).

57. Nibud. (2012).

58. Fernandes, D., Lynch, J. G., Jr., & Netemeyer, R. G. (2014).
Creditors in the Netherlands have been given much greater authority to collect debts in recent years. In particular, the wide-ranging powers of public authorities make it very difficult for debtors to retain control over their finances and comply with any payment arrangements. In 2013, the National Ombudsman of the Netherlands observed that many branches of government chart their own course when it comes to debt collection, settlement and reclamation. They each apply their own rules. As a result, a debtor’s income may fall below the attachment threshold (or protected earnings rate), leading inevitably to new debts (e.g. Jungmann et al. 2012).

In the Netherlands, government entities such as the Tax and Customs Administration, the Central Judicial Collection Agency (CJIB), the Employment Insurance Agency (UWV) and the organization that implements the Dutch national insurance schemes such as pensions, and child benefit (SVB) are often the main creditors because of their special status. Public authorities do not need a court-issued attachment of earnings order; a writ of execution is all that they require. In certain situations, they may collect a claim of up to €1,000 directly from the debtor’s bank account and are not obliged to take the attachment threshold (or protected earnings rate) into account. The attachment threshold is the portion of a debtor’s wages that other creditors are not permitted to attach. As a rule, this is 90% of the social security norm. The Tax and Customs Administration may also offset benefits received in excess against benefits still to be paid (see also Tiemeijer 2016).

A flexible labour market or flexible employment practices refer to a situation in which workers and employers do not have a permanent contractual relationship. In this study, we also include temporary contracts (including temping and payrolling) and freelance work. We do not include permanent part-time jobs. We use the term ‘flexible workers’ to refer to self-employed persons and people working on a flexible contract. It should be noted that self-employed persons do not always remain so. Someone can work freelance temporarily, or be self-employed in addition to having a permanent job (hybridisation).
2.5 Conclusion: The Bar Is Set High

74. Keune, M. (Ed.) (2016).
75. A flexible contract is an employment contract for a limited term or for an unspecified number of hours. This includes temping, payrolling and being on call. These workers are sometimes referred to as flex workers (‘flexwerker’ is the term used by Statistics Netherlands). The term also includes the relationship between an employer and an employee whereby the employment contract is for a limited term (Statistics Netherlands’ definition).
76. CBS and TNO. (2015b).
77. van Echteld, P., Croezen, S., Vlasblom, J., de Voogd-Hamelink, M., & Mattijssen, L. (2016).
78. http://www.monitorarbeid.tno.nl/dynamics/modules/SFIL0100/view.php?fil_Id=129.
79. Went, R., Kremer, M., & Knottnerus, A. (Eds.) (2015).
80. van der Berge, W., & ter Weel, B. (2015).
81. The labour market is divided into segments based on educational level. Completion of secondary school or a VET1 programme is low-skill, a VET2 to VET4 programme is middle-skill, and a higher professional or university programme is high-skill.
82. Guilbert, L., Bernaud, J. L., Gouvernet, B., & Rossier, J. (2015).
83. The extent to which such adaptability is an advantage differs from one company or sector to the next.
84. http://www.monitorarbeid.tno.nl/dynamics/modules/SFIL0100/view.php?fil_Id=150.
85. Vrooman, C. (2016).
86. van Echteldt, P., & Josten, E. (2012).
87. CPB. (2016).
88. Job-search activities can include networking, training, or actually submitting a job application.
89. While the term has been in use for quite a while, since the 1990s the growing emphasis on personal responsibility and self-reliance means that it has increasingly come to refer to individuals (Thijssen 2000).
90. Thijssen, J. (2000).
91. Liu, S., Huang, J. L., & Wang, M. (2014).
92. A comment is in order here. This effect is not necessarily attributable to the length of unemployment. It can also be the case that the ‘remaining’ long-term unemployed are precisely those who had the most trouble finding a job because they do not have the right work experience, for example. In that case, any intervention focusing on job search skills will be of little use to them.
93. Paul, K. I., & Moser, K. (2009).
94. McKee-Ryan, F., Song, Z., Wanberg, C. R., & Kinicki, A. J. (2005).
95. de Ruig, L., Frouws, B., & Stroeker, N. (2011).
96. Raad voor werk en inkomen. (2010).
97. Gelderblom, A., De Koning, J., & Lachhab, K. (2007).
98. Vansteenkiste, M., Simons, J., Lens, W., Sheldon, K. M., & Deci, E. L. (2004).
99. Algemene Rekenkamer. (2016).
100. Baay, P., Buisman, M., & Houtkoop, W. (2015).