7

Long-Term Care Insurance in the Netherlands*

Frederik T. Schut
Department of Health Policy and Management, Erasmus University Rotterdam, the Netherlands

and

Bernard van den Berg
Centre for Health Economics, University of York, United Kingdom

1 Introduction

The Netherlands was the first country to introduce a universal mandatory social health insurance scheme (AWBZ) for covering a broad range of long-term care (LTC) services provided in a variety of care settings. Compared with most other Organization for Economic Cooperation and Development (OECD) countries, coverage of LTC services is relatively comprehensive. This comprehensive coverage might explain why, in comparison with most other OECD countries, both total and public expenditure on LTC in the Netherlands are high, particularly since the percentage of elderly is similar to the OECD average (OECD, 2005). This can at least partly be explained by the relatively generous social health insurance scheme.

Nevertheless, the growth of public spending on health and LTC in the Netherlands was fairly successfully limited until 2000 via the implementation of cost-containment policies. These policies acted essentially through the rationing of supply, wage moderation, price controls and postponement of investment in LTC facilities. However, increasing waiting lists and rising consumer expectations about the quality and variety of LTC services have substantially reduced the scope for containing LTC expenditures along these lines. Hence, the Dutch government is aiming to reform the current LTC financing system to increase incentives for efficiency and consumer direction.

The main aims of this chapter are (1) to describe the background, current deficiencies and proposals to reform the system of LTC financing in the Netherlands; and (2) to discuss whether the proposed reforms can create

J. Costa-Font et al. (eds.), *Financing Long-Term Care in Europe*
© Palgrave Macmillan, a division of Macmillan Publishers Limited 2012

incentives to keep the comprehensive LTC insurance scheme sustainable in view of the ageing of the population and the expected increase in demand for LTC services.

The second section provides a short background of the Dutch public health insurance scheme. In the third section, we discuss the main features of the current public insurance scheme. In the fourth section we analyse the empirical evidence on the growth of public expenditure on LTC over the period 1985–2005. The subsequent section describes the relation between professional and informal care. Then, we specifically focus on the implications of the introduction of the personal care budgets to increase consumer direction and choice, including consequences for informal care. Subsequently we discuss the projections and determinants of future long-term expenditure growth. Next, we discuss the shortcomings of the current system of LTC financing and the proposals for reforming the system. Finally, we discuss the prospects of the reform and the questions that remain to be answered.

Since a uniform definition is lacking, we will first indicate what we mean by LTC. Often, the term LTC is used only in the context of elderly care. In this chapter, however, we use a more comprehensive definition, also including care for the mentally and physically handicapped and care for chronic psychiatric patients. This definition coincides with the types of services covered by the public insurance scheme for LTC in the Netherlands.

2 Background of public LTC insurance

The Netherlands was the first country to introduce a universal mandatory social health insurance scheme (the Exceptional Medical Expenses Act – AWBZ) for covering a broad range of LTC services provided in a variety of care settings. Whereas in the Netherlands public LTC insurance was already introduced in 1968, other countries followed only quite recently, such as Germany in 1995 (Rothgang, 2010) and Japan in 2000 (Ikegami, 2007).

Initially, the AWBZ covered primarily nursing home care, institutionalized care for the mentally handicapped and hospital admissions lasting more than a year. In due course, however, coverage was expanded by including home health care (e.g., for rehabilitation at home after hospital admission and care for the elderly with impairments, in 1980), ambulatory mental health care (in 1982), family care (e.g., home help in the case of frailty, psychosocial problems or after childbirth, in 1989) and residential care for the elderly (1997). In homes for the elderly (residential care), residents receive nursing care less frequently and intensively than residents in nursing homes. Moreover, residents in elderly homes have their own apartments, while residents in nursing homes usually share a room with one or more other residents.

It is worth noting that there is no supplementary LTC insurance market in the Netherlands. This is probably due to the fact that public LTC insurance

is quite comprehensive. In the past, several insurers have attempted to introduce supplementary LTC insurance policies, but failed because of a lack of demand.

3 Main features of public LTC insurance (AWBZ)

The AWBZ constitutes a mandatory insurance scheme for LTC for the entire Dutch population. Every Dutch citizen older than 15 years of age with a taxable income has to pay an income-related contribution (up to a certain maximum amount) that is collected through the income and payroll tax systems, along with the contributions for the other national insurance schemes (e.g., for unemployment and disability). In addition, for most LTC services covered by the AWBZ, income-related co-payments are required. For higher-income groups the maximum co-payment can be so high (about €1800 per month for residential care) that private facilities are often more attractive. Income-related contributions, co-payments as well as an annual State subsidy are collected in a General Fund (AFBZ).

Table 7.1 provides an overview of the different sources of funding of the AWBZ in 2008. Since in the same year the total expenditures from the General Fund were €21.4 billion, there was an overall deficit of €2.1 billion (to be compensated by an extra increase in the 2009 contribution rate). As shown in Table 7.1, more than 75 per cent of the AWBZ is financed directly by households, while the residual amount is paid by the State out of general taxes. Table 7.2 provides an overview of the most important categories of LTC users and their relative share in LTC expenditure.

Formally, the AWBZ is administered by health care insurers that provide coverage for curative health services. In practice, however, health care insurers have delegated various responsibilities – in particular the contracting of health care providers, the collection of patient contributions and the

Table 7.1 Funding of the AWBZ scheme in 2008

Sources of funding	**Payments (€ billion)**	**Share of total payments (%)**
Income-related contributions*	13.1	68
Co-payments	1.7	9
State subsidy (from general taxation)	4.6	24
Total	19.3	100

Note: *In 2008 the income-related contribution was 12.15 per cent of a maximum of €31,589 taxable income (implying a maximum contribution of €3838 per year, exclusive of various possible tax deductions).
Source: SER (2008), p. 31.

Table 7.2 Different groups of AWBZ beneficiaries by numbers and expenditures in 2007*

Type of LTC user	Number	Share of total number (%)	Expenditure (€ billion)	Share of total expenditure (%)
Elderly and chronically ill	360,000	69	11.4	65
Mentally handicapped persons	100,000	19	4.6	26
Physically handicapped persons	15,000	3	0.5	3
Chronic psychiatric patients	50,000	9	1.1	6
Total	525,000	100	17.6	100

Note: *Excluding about 90,000 clients with a personal care budget (expenditure €1.3 billion).
Source: SER (2008), p. 34.

organization of regional consultations – to the largest regional health care insurer. At present the Netherlands is divided into 32 care regions, and in each region a single health insurer (known as 'regional care office') carries out the AWBZ on behalf of all health insurers for all residents living in that region. Regional care offices receive a fixed budget for the administrative tasks. All LTC expenses are directly paid out of the General Fund (AFBZ). Hence, neither regional care offices nor individual health insurers are at risk of long-term expenses covered by the AWBZ scheme.

Before a person can qualify for care under the AWBZ, it is necessary to establish whether care is really required and, if so, what type of care and how much care is needed. Initially, health care providers were responsible for the required needs assessment, but in 1997 this task was assigned to regional independent needs assessment organizations, and since 2005 to a single national organization, the Centre for Needs Assessment (CIZ).[1] The idea behind this was to make needs assessment more objective and uniform and independent from the self-interest of health care providers. Notice that the access to LTC is solely based on a person's health – as in Germany and Japan – and does not depend on his income or wealth – like the Medicaid programme in the USA.[2]

Prior to 2003, the LTC benefits covered by the AWBZ scheme were defined in terms of the type of care or the type of health care provider to which people were entitled. To encourage innovation, consumer choice and an efficient substitution of LTC services, in 2003 the definition of entitlements was radically changed into seven broad functional care categories. In 2007, one of these categories – domiciliary care – was excluded from coverage and

transferred to the responsibility of the municipalities under a new Social Support Act (WMO). The remaining six functional categories of LTC services that were covered under the AWBZ scheme in 2008 are summarized in Box 7.1.[3]

Box 7.1 Functional categories of care covered by AWBZ

1. ***Personal care***: for example, help with taking a shower, bed baths, dressing, shaving, skin care, going to the toilet, eating and drinking.
2. ***Nursing***: for example, dressing wounds, giving injections, advising on how to cope with illness, showing clients how to self-inject.
3. ***Supportive guidance***: for example, helping the client organize his or her day and manage his or her life better, as well as day care or provision of daytime activities.
4. ***Activating guidance***: for example, talking to the client to help him modify his behaviour or learn new forms of behaviour in cases where behavioural or psychological problems exist.
5. ***Treatment***: for example, care in connection with an ailment, such as serious absent-mindedness.
6. ***Accommodation***: for example, some people are not capable of living independent lives, but require, for example, sheltered housing or continuous supervision in connection with serious absent-mindedness. In some cases, a client's care requirements may be too great to address in a home environment, making admission to an institution necessary.

Except for the functional category 'accommodation', clients who are entitled to care have a choice of receiving care 'in kind' or in the form of a *personal care budget* (or a combination of both). The personal care budget is set at about 75 per cent of the average cost of care provided 'in kind', because the personal care budget can be spent on informal care which is expected to be less expensive than professional formal care.

4 Expansion of LTC services and expenditure, 1968–2005

The enactment and gradual expansion of AWBZ paved the way for a strong growth of both LTC facilities and public expenditure on LTC. The percentage of GDP spent on long-term services covered by AWBZ increased from 0.8 per cent in 1968 to 2.0 per cent in 1980, and further to 4.0 per cent in 2005. Part of this increase, however, is due to an expansion of AWBZ coverage.

As shown in Figure 7.1, from 1985 to 2000, the percentage of GDP spent on LTC services that were covered by AWBZ in 2000 was more or less stable, at around 3.5 per cent (in 1985, however, only 2.0 per cent was covered

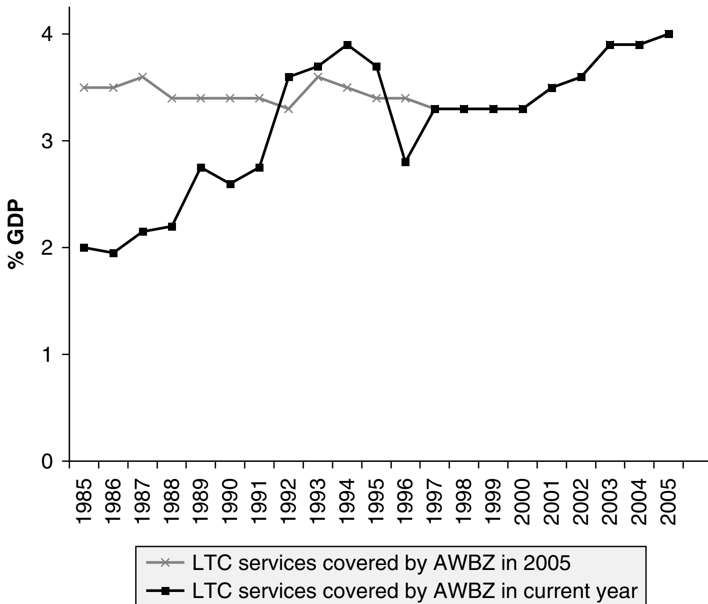

Figure 7.1 Percentage of GDP spent on LTC services covered by AWBZ in the current year and in 2005, 1985–2005*

Note: * From 1997 to 2005 the LTC services covered by AWBZ were the same as in 2005, so both lines overlap. The bubble in the dark plotted line from 1992 to 1995 is caused by a temporary inclusion of outpatient drugs in the AWBZ benefits package.

Source: Ministry of Health (2004) and Eggink et al. (2008).

by AWBZ and 1.5 per cent was financed in other ways). Hence, taking into account the expansion of AWBZ coverage, the expenditure on LTC services as a percentage of GDP has been quite constant over a considerable period of time. This is remarkable given the ageing of the population (albeit fairly moderate during that period) and the susceptibility of LTC to Baumol's cost disease due to the limited scope for productivity gains in the provision of LTC (Oliviera Martins and de la Maisonneuve, 2006). Baumol (1967) distinguished two sectors in the economy. In the first sector relatively straightforward technical innovations result in labour productivity growth, while in the second labour productivity growth seems less straightforward because of the nature of production. Examples of the latter include education and LTC. These are inevitably labour intensive because of the nature of the provided services. Despite the introduction of new technologies in the area of healthy ageing, the quality of many LTC services is likely to remain highly dependent on the input of labour. Therefore the scope of substituting capital for labour is limited.[4]

The main reason for the limited growth of public spending on LTC has been the implementation of cost-containment policies. Since the 1970s the

entry and capacity of new LTC institutions has been strictly regulated. For building and major investments in facilities a licence from the government was required, and only if investments were judged to be of sufficient priority was such a licence granted. Particularly important, however, was the introduction in 1984 of a system of global budgeting for all inpatient long-term health services. In addition, especially during the 1980s, the government successfully mitigated the wages of nursing personnel. In the 1990s, prompted by an economic recession, the budgetary controls were expanded to comprise home health care and other outpatient LTC services.

The persistent rationing of supply, postponement of investments and budgetary controls resulted in growing waiting lists and a general perception of a deterioration of quality, particularly compared with the general increase in the standard of living and the rising expectations about the quality of care people would like to receive in old age. In 1999, the long waiting lists for home health care were successfully challenged in court. The court ruled that public LTC insurance entitled people to timely access to home health care, and that budgetary considerations were not a valid reason for withholding care. In fact, the court decision implied that too stringent a rationing of health services was not compatible with the 'right to care' that was guaranteed by the social insurance legislation (AWBZ).

Urged by the court decision and the mounting public and political pressure to improve access and quality of LTC services, in 2000 the government decided to lift the budgetary controls and to reimburse all extra production necessary to reduce waiting lists. Indeed, from 2000 to 2003, waiting lists were substantially reduced: for home health care by 64 per cent, for nursing homes by 39 per cent and for elderly homes by 23 per cent (Van Gameren, 2005). As a consequence, during that period the expenditure on LTC rapidly increased to more than 10 per cent per year (Figure 7.2), resulting in an increase from 3.5 to 4.0 per cent in the share of GDP spent on LTC (see Figure 7.1).

During the period 1985–2005, the average annual growth of real expenditure on LTC services covered by AWBZ was 3.3 per cent, whereas the average annual increase of GDP was about 2.7 per cent. The average difference of 0.6 per cent, however, was entirely due to the high cost of inflation during the period from 2000 to 2003.

As shown in Figure 7.3, the largest share of expenditure growth can be explained by an increase in relative prices (2.0 per cent), while about 1.3 per cent can be attributed to an increase in production.[5]

From Figure 7.3 it can be concluded that for four of the five major categories of LTC services the annual cost growth was about 4 per cent, which is well above the annual increase of GDP. This relatively high cost increase is largely compensated, however, by a relatively low cost increase of residential elderly care (on average about 1.3 per cent per year). This was caused by a decrease in production (on average −0. 7 per cent per year) due to reductions in the capacity of elderly homes and a substitution towards home health

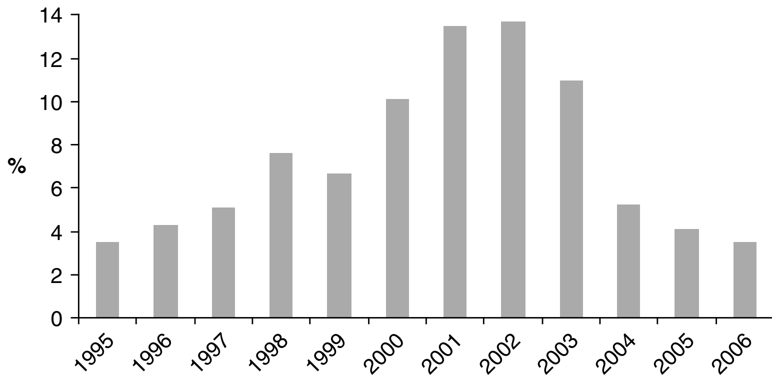

Figure 7.2 Annual growth of LTC expenditures financed by public insurance (AWBZ)
Source: IBO-werkgroep, AWBZ (2006), p. 42.

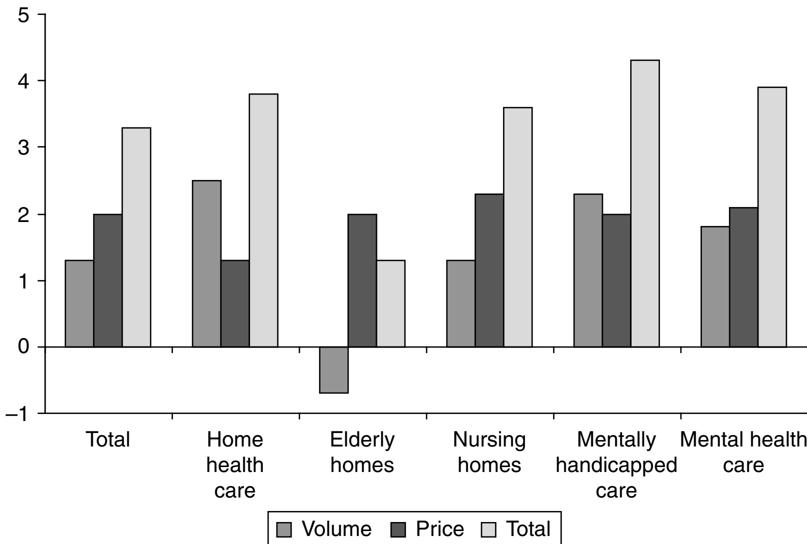

Figure 7.3 Average annual growth (%) of LTC benefits covered by AWBZ, 1985–2005
Source: Eggink et al. (2008).

care. As a result, the annual production growth in home health care is the largest among the five categories of LTC services (on average about 2.5 per cent per year). Clearly, this reflects the trend that elderly people are treated at home for a longer period.

As shown in Figure 7.4, labour productivity for all LTC services decreased by 0.3 per cent over the entire period 1985–2005, contributing slightly to

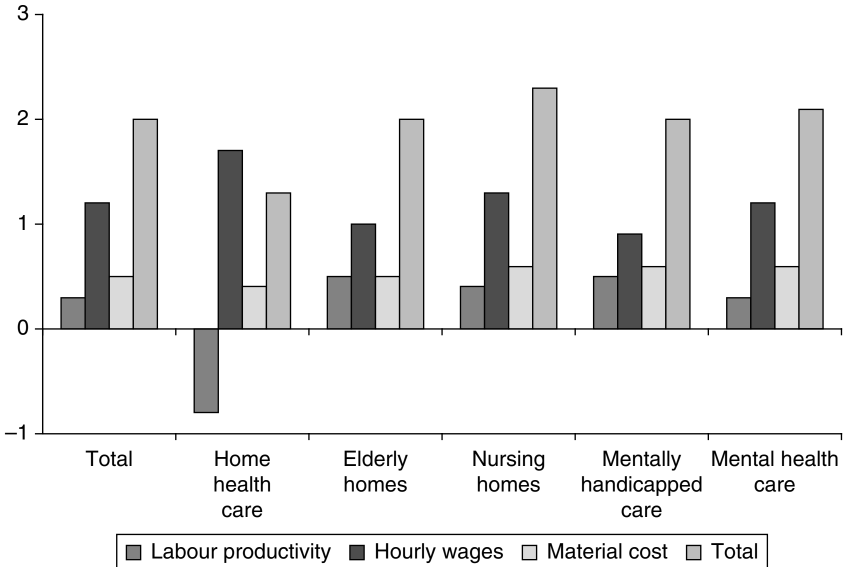

Figure 7.4 Components of the growth (%) of real prices of LTC benefits, 1985–2005
Source: Eggink et al. (2008).

the overall price increase. This corroborates the supposition that Baumol's cost disease is particularly relevant for LTC services (Oliviera Martins and de la Maisonneuve, 2006). Contrary to the general trend, labour productivity in home health care increased by on average 0.7 per cent per year during the same period. The increase in labour productivity in home health care has been particularly pronounced since 1995, and is attributed to a tightening of the budgets for home health care agencies, resulting in a relative decline in administrative and managerial personnel and the introduction of benchmarking and time management to increase the efficiency of production (Eggink et al., 2008).

Looking at the development of LTC expenditure in the period 1985–2000, supply regulation and budgetary restrictions were clearly quite effective in containing cost. The downside of the prolonged rationing policies, however, was increasing waiting lists, resulting in a growing public discontent and incompatibility with the legally established entitlements to LTC services. For this reason, in 2000, a continuation of the prevailing cost containment strategy was no longer politically feasible. On the other hand, the radical change towards an open-ended reimbursement policy proved to be no solution either, since the resulting excessive cost inflation – without accompanying incentives for efficiency – was not sustainable. In 2004 the government tried to regain control over LTC expenditure by concluding agreements with the

interested associations of LTC providers to limit the growth of expenditure and to increase productivity. In addition, particularly for home health services, co-payments were increased. In 2005, the government reinstated budgetary controls by imposing regional budgets for each of the 32 regions, based on the past expenditure on LTC in each region. Regional care offices were made responsible for the allocation of these budgets and had to negotiate with regional providers about prices and maximum output levels. By reintroducing tight budget constraints, the government runs the risk that waiting lists will increase, which could again generate a conflict with the existing legal entitlement to LTC. In contrast with the late 1990s, however, there is an important safety valve: the personal care budget. Since personal care budgets do not fall under the scope of the regional budget constraints, LTC providers can exceed their budgets if they can persuade their clients to apply for a personal budget and to use this to pay the provider. Indeed, this is one of reasons for the vast increasing popularity of personal care budgets.

5 Personal care budgets and informal care

Personal care budgets were introduced in 1995 as a small-scale experiment to provide consumers with the option to buy and organize their own home health services instead of using 'in kind' services contracted by the regional care offices (Van den Berg and Hassink, 2008). Since 1995 the personal care budget scheme has been significantly expanded, both in scope and expenditure. In 2008, personal care budgets comprised about 7 per cent of LTC expenditure covered by AWBZ and were used by more than 10 per cent of LTC users. Table 7.3 provides some key figures about personal budgets in 2005.

There were several reasons put forward for the introduction of personal care budgets (Hessing-Wagner, 1990). First, personal care budgets were considered as a means to empower consumers and to motivate providers to better meet consumer preferences. During the 1990s, LTC providers were increasingly criticized for not being able to deliver the right services at the right time. Moreover, the new generation of LTC users had higher expectations and were supposed to be better able to express their preferences for LTC. By the option to opt for a personal budget rather than contracted LTC services, people would be able to arrange care according to their own preferences.

A second reason for introducing personal care budgets was to encourage the use and provision of informal care as a cheap alternative to professional formal care. Informal care is a crucial part of LTC all over the world. In the Netherlands, however, informal care plays a relatively minor role, which is partly due to the relatively generous coverage of professional formal LTC services.

Using 2004 data from the Survey of Health Ageing and Retirement in Europe (SHARE), Albertini et al. (2007) show that within Europe the annual

Table 7.3 Key data for personal care budgets, 2005

Number of budget holders		**77,883**
Age distribution (years)	< 18	20.4%
	18–55	32.5%
	56–65	12.6%
	66–75	14.3%
	76–80	8.7%
	> 80	11.6%
Type of health problem	Somatic	67%
	Psychogeriatric	1%
	Psychiatric	14%
	Physical handicap	14%
	Mental handicap	11%
	Sensory handicap	1%
	Psychosocial	1%
Net budget amount (in €)*	< 2500	27.7%
	2500–5000	24.9%
	5000–25,000	30.5%
	> 25,000	16.9%
Proportion of budget spent on informal care	Resident providers	21%
	Non-resident providers	17%

Note: * Net of co-payments by budget holder. The average gross personal care budget was about €14,000, of which about €1000 was paid by the budget holder out of pocket.
Source: Ministry of Health (2006).

amount of informal care per caregiver is the lowest in the Netherlands, Denmark, France and Sweden (around 300 hours) and the highest in Italy (almost 1500 hours). Also using SHARE data, Bolin et al. (2008) show that the mean hours of informal care received by single-living elderly per year in the Netherlands are among the lowest within Europe (approximately 50 hours), while in Greece, Italy and Spain the single-living elderly receive the most informal care (over 200 hours). Conditional upon receiving informal care, the amount of care received by the single Dutch elderly is also among the lowest in Europe (about 130 hours per year).

In terms of professional home care use, the opposite pattern seems to hold. Bolin et al. (2008) show that the Netherlands (together with Denmark and France) belongs to the European top level of professional home care use. Of single-living Dutch elderly, approximately 25 per cent use professional home care, while this percentage is the least in Italy (6 per cent).

Although the share of informal care in the Netherlands is lower than in most other European countries, the majority of home care is still provided by informal caregivers. Table 7.4 shows that in the Netherlands the amount of home care used in 2001 was around just 15 per cent of the total amount

Table 7.4 Hours of professional and informal home care provided per year, 2000–2003

Home care	2000		2001		2002		2003	
	Hours (× 1000)	Share (%)	Hours (× 1000)	Share (%)	Hours (× 1000)	Share (%)	Hours (× 1000)	Share (%)
Unskilled housework	13,220	22.4	13,512	21.3	12,545	18.1	12,529	16.6
Skilled housework	16,425	27.9	18,911	29.9	22,653	32.6	26,237	34.7
Total housework	29,645		32,423		35,198		38,766	
Personal care[a]	23,029	39.1	23,877	37.7	25,733	37.0	27,541	36.5
Nursing[b]	6,259	10.6	7,028	11.1	8,536	12.3	9,249	12.2
Total home care	58,933	100	63,328	100	69,467	100	75,556	100
Informal care								
All tasks[c]			375,000					

Notes:
[a]Inclusive specialized personal care.
[b]Inclusive specialized nursing.
[c]Calculated assuming that informal caregivers provide on average five hours care per day, for four days per week for 25 weeks per year.
Source: Van den Berg (2004).

of informal care provided. Nevertheless, Table 7.4 also shows the enormous growth in professional home care use (especially skilled housework) during the relatively short period 2000–2003.

The rapid expansion of personal care budgets was an effective way to encourage the provision of informal care. In 2005, 38 per cent of personal care budgets were spent on informal care, while two-thirds of budget holders use the budget for paying informal caregivers (Ramakers and Van den Wijngaart, 2005). Next to personal care budgets, the role of informal care was also increased by restricting the possibilities of substituting professional for informal care. Initially, using informal care was considered to be people's voluntary choice. Even people having a social network with potential informal caregivers could always apply to get professional care that was covered by the AWBZ. In practice, however, the needs assessment agencies increasingly took into account the amount of informal care a client already received in order to determine the amount of professional care the client could legally claim (Jörg et al., 2002). Since 2003, this practice has been formalized and strict protocols were developed regarding needs assessments taking into account the potential amount of informal care the care recipient's social network could provide.

Another way to encourage the provision of informal care was to support informal caregivers. To prevent informal caregivers getting health problems themselves, needs assessment agencies were permitted to refer caregivers to regional support centres. The support centres developed all kinds of respite care programmes, such as day care, short stays in nursing homes, holidays and informational support (see, e.g., Koopmanschap et al., 2004; Van Exel et al., 2006).

Evaluative studies point out that, as intended, personal care budgets induced a substitution of informal care for professional care, and were valued by many clients as an effective means to purchase and organize care that better met their preferences than regular care contracted by regional care offices (Ramakers et al., 2007).

However, personal care budgets also had several unintended negative effects. First, personal care budgets induced a substitution of paid care for unpaid informal care. Informal care by relatives, neighbours and friends that previously was often provided for free was becoming increasingly paid for. A study among informal caregivers pointed out that 76 per cent of caregivers would be willing to provide the same care without receiving payment, although 78 per cent indicated that getting paid nevertheless was important to them (Ramakers and van den Wijngaart, 2005). In addition, an increasing number of brokers became active, which in return for a fee offered people assistance in applying for a personal care budget. Van den Berg and Schut (2003) calculated that a substitution of paid-for by unpaid informal care from the personal care budget could result in an increase in AWBZ costs of approximately €4 billion per year (about 20 per cent of total AWBZ

expenditure).[6] Counteracting the substitution of paid-for unpaid informal care was another reason for implementing the previously mentioned strict needs assessment protocols that explicitly take into account the amount of informal care the care recipient's social network could provide. According to the protocols, needs were not only based on health status or functional impairments but also on the availability of 'usual care'. For instance, the care partners provide to each other during at least three months is defined as usual care. Hence, the magnitude of the personal care budgets became explicitly dependent on the social network of the beneficiary. Nevertheless, it is unclear to what extent people can still use personal care budgets for replacing unpaid care with paid informal care. In particular, the rapidly increasing number of personal care budgets for the assistance of young people with psychiatric disorders has been attributed to the substitution of paid-for by unpaid informal care provided by their parents.

A second drawback was that personal budgets were increasingly used by home health care agencies to escape the imposed budget constraints. As a consequence, people who did not want to purchase and arrange care by themselves were more or less forced to do so in order to be able to keep the same home care provider.

It is difficult to assess to what extent personal care budgets were successful in accomplishing the aims behind their introduction. The rapidly increasing number of people opting for a personal care budget suggests that, for a substantial proportion of users of outpatient LTC, the budgets offered better opportunities to meet consumer preferences than care in kind. The problem is, however, that there is not much empirical information about the true motives of people to opt for the personal care budget. For instance, the growing demand for personal care budgets can at least partly be explained by the motivation to evade waiting lists for traditionally financed LTC and by consumer preferences to pay formerly unpaid informal caregivers. It is also unclear to what extent personal care budgets induced an efficient substitution of informal for formal care or just an expansion of paid informal care. For instance, the increasing number of parents opting for a personal care budget to provide care for their children seems to point to a substitution of paid for unpaid informal care. Moreover, for this group of clients it is unlikely that empowerment and better consumer-directed care were the main drivers to opt for a personal budget. In contrast, it seems fair to conclude that for people with long-term disabilities, personal care budgets really provide an instrument that helps them to empower themselves and to purchase care that better meets their preferences than care in kind.

6 Deficiencies of current LTC financing

Figure 7.2 showed that a *laissez-faire* policy without supply and demand constraints (as in the period 2000–2003) is likely to jeopardize the sustainability

of the public LTC insurance scheme. On the other hand, a return to the stringent top-down rationing policy of the 1990s has serious drawbacks and does not seem feasible either. Faced with this dilemma, the government has temporarily opted for a mixture of both policies, half-heartedly relying on both supply constraints and arrangements to improve efficiency by increasing consumer direction and choice. For the following reasons, this inconsistent policy compromise can achieve neither cost containment nor an effective increase in efficiency.

First, the currently imposed supply constraints in the form of regional care budgets are not effective in controlling cost because they can be circumvented by opting for a personal care budget. Since personal care budgets are not included under the regional budget, the regional budget constraint is not binding. Although the government introduced a separate macro budget for personal care budgets, particularly since 2005, the demand for personal care budgets is much larger than the available funds. Rather than denying personal care budgets, the government regularly adjusts the macro budget upwards to meet the growing demand. In 2007, for instance, the government decided four times to raise the budget, resulting in a total annual budget increase of 35 per cent (Ministry of Health, 2007).

Second, the regional budget mechanism punishes providers who do a good job and consequently attract more clients than the target number of clients on which their budget is based. If these presumably efficient providers cannot effectively motivate their clients to apply for a personal care budget, they have to refuse clients or run a deficit.

Third, regional care offices do not have an incentive to allocate the regional budget to the most efficient providers, because they have a regional monopoly and are not at risk for the cost of care. Since LTC users cannot choose another regional care office, these offices have no incentive to allocate budgets to providers that best meet consumer preferences. Again, consumers may opt for a personal care budget (except for inpatient care), but this is not likely to discipline the behaviour of the regional offices because they do not benefit from having more customers. Moreover, since regional offices get a fixed budget for administrative costs, they have a financial incentive to negotiate with a limited number of large providers in order to minimize the cost of contracting. For the same reason, regional care offices have no incentive to take action against overly lenient needs assessment procedures.

Finally, the definition of 'entitlements' in terms of six functional categories (see Box 7.1) has proven to be too imprecise to provide a firm basis for uniform and unambiguous needs assessment. In particular, the number of clients that were assessed as in need of 'supportive guidance' increased dramatically, by 37 per cent, from 2005 to 2007 (Ministry of Health, 2008).

7 Proposals to reform LTC financing

In view of the serious deficiencies of the current system of LTC financing, the government asked a number of advisory and supervisory bodies[7] to draft proposals for reforming the system of LTC financing in order to guarantee a sustainable, efficient and consumer-directed provision of LTC.

This resulted in five different advisory reports, which were not all equivocal. Two reports (by the Health Care Insurance Board (CVZ) and the Council for Public Health and Health Care (RVZ)) recommended complete abolishment of the separate public long-term insurance scheme, to integrate most of the benefits covered by AWBZ into the new national Health Insurance Act for curative health services (ZVW) and to integrate benefits that are related to social support and participation into the new Social Support Act (WMO) in 2007. The main line of reasoning was that the new health insurance scheme for curative services – based on the model of managed competition (Van de Ven and Schut, 2008) – would provide much stronger incentives for efficiency and meet consumer preferences more than the AWBZ. Moreover, integrating curative and LTC into a single scheme would also provide incentives and possibilities for a better coordination of care for people with chronic diseases. Finally, the 2007 Social Support Act (WMO) provided an integrated legal framework for social and community support under the responsibility of municipalities, so the transfer of social care benefits from the AWBZ to the WMO would also enhance a better coordination of social care and welfare assistance.

The radical proposals to abolish the AWBZ scheme, however, also had serious potential shortcomings. Most importantly, it is questionable whether the model of managed competition underlying the new health insurance scheme for curative services is adequate for the provision and financing of LTC (Van de Ven and Schut, 1994). A key element of the managed competition model, which makes it possible to guarantee universal access in a competitive health insurance market, is an adequate system of risk adjustment (Van de Ven and Schut, 2008). At present, there are no appropriate risk adjusters available for LTC and it is even unclear whether adequate risk adjustment is feasible for many of these services (IBO-werkgroep AWBZ, 2006). Given the typically high level of expenditure per LTC user and the intertemporal nature of the risk, imperfect risk adjustment for these types of services may result in unfair competition among insurers and huge incentives for risk selection if insurers are obliged to charge community-rated premiums (as is the case under the 2006 Health Insurance Act). Another reason why the managed competition model may not be appropriate for LTC services is that for many of these services consumers are not able or willing to make an informed choice among health insurers that contract these services. There is substantial empirical evidence that the propensity to switch health plans substantially declines with age and the presence of health problems

(Strombom et al., 2002; Schut et al., 2003; Buchmueller, 2006). For LTC services for which the number of critical buyers is too small, competition may result in a deterioration of quality, since competitive health insurers may have an incentive to reduce quality in order to reduce cost if this does not result in a significant loss of market share (Van de Ven and Schut, 1994). Finally, the experience with both the new Health Insurance Act and the new Social Support Act is limited and it is unclear whether health insurers and municipalities are willing and able to perform as prudent purchasers of health and social services. Therefore, a major expansion of the scope of the responsibilities of health insurers and municipalities would be premature.

In view of these shortcomings, other advisory reports proposed to maintain a separate insurance scheme for several categories of LTC, at least comprising care for the mentally handicapped. Among these reports, the proposal by the Social and Economic Council (SER) is the latest and the most important (SER, 2008). The SER proposed to reform the AWBZ along the following main lines:

1. A much more precise and unambiguous delineation and definition of entitlements.
2. An improvement of the needs assessment by developing uniform protocols, benchmarking and a permanent supervision of the assessment bodies.
3. A reduction of coverage by transferring short-term rehabilitation services to the public insurance scheme for curative health services (Health Insurance Act) and by bringing the provision of social care under the responsibility of the municipalities (Social Support Act).
4. A far-reaching separation of the financing of residing and care, implying that accommodation would no longer be reimbursed by public insurance; a subsidy scheme for lower income groups to pay for the cost of accommodation; the separation of care and residing should lead to innovative combinations of residing, care, welfare and participation.
5. A replacement of provider-based budgeting by client-based budgeting. Rather than clients having to follow the money – as in the current provider-based budgeting system – the money should follow the client. Clients would have the option to choose a personal care budget (as in the current system) and arrange all care by themselves, or to choose among providers contracted by individual health insurers (that would have to replace regional care offices in 2012). Providers can increase revenues if they are able to attract more clients by offering better service (for a fixed budget per client). The client-based budgets should be based on the categorization of clients in 'care-severity packages' (ZZPs) by the needs assessment bodies. A 'care-severity package' describes the type and amount of care needed by the client. For each 'care-severity package' a budget will be calculated.

In June 2008, the government made it clear that it endorsed the main lines of the SER proposal and announced the first steps to implement its recommendations, including a more precise demarcation of entitlements and an exclusion of recovery and social support from coverage by 2009 (Ministry of Health, 2008). In a subsequent policy letter of mid-2009, the reform plans were further elaborated (Ministry of Health, 2009). In this letter the government stated to aim at abolishing the regional care offices in 2012 and instead making individual health insurers responsible for the purchasing and contracting of LTC services on behalf of their insured (next to maintaining the option for clients to choose for a personal care budget or voucher and to purchase care by themselves). However, this decision is made contingent on the possibility of making health insurers financially accountable for LTC expenses of their insured and on the feasibility of an adequate system of client-based budgeting.

8 Towards sustainable LTC financing?

Whether the proposed reform will lead to a sustainable financing and more consumer-directed provision of LTC services crucially depends on the ability to develop a clear-cut definition of entitlements, to improve the accuracy of needs assessment[8] and to develop appropriate ZZPs as a solid basis for client-based budgeting. The feasibility of these three requirements is highly uncertain. In particular, client-based budgeting may turn out to be complicated. In 2008, ZZPs had been developed for inpatient care, which from 2009 to 2011 will be phased in to determine the budgets for inpatient care LTC facilities (i.e., nursing homes, elderly homes, institutions for mentally and physically handicapped and mental care institutions). The experience with these ZZPs for financing inpatient care may make clear whether these packages can provide a firm basis for client-based financing. A key question will be whether the predictable cost variation per care package will be small enough to avoid problems of cream-skimming and misallocation of funds.[9] The first experiences with the introduction of client-based budgeting for inpatient LTC were evaluated by the Dutch Healthcare Authority (NZa, 2009). The NZa reported that it received signals from both health care providers and regional care offices of strategic upcoding (classifying clients in higher ZZPs than indicated) and risk selection (avoiding patients that are unprofitable given the ZZP, capitation payment). The main reason put forward for such behaviour was that for several ZZPs or for several patients classified within a certain ZZP capitation payments were insufficient to cover the costs. Based on the limited available data, the NZa could not determine whether upcoding and risk selection indeed occurred, but it announced it would monitor this type of behaviour and examine the accuracy of ZZP payments.

An important, yet unanswered question is how future client-based budgets should be determined: should they be based on the average cost of all providers that offer the care package? Given the increasing pressure to contain public expenditure on LTC services, the most likely outcome may be that the client-based budgets will be derived from the regional budgets (or a national budget) set by the government, using the ZZPs as relative weights for the determination of the (regional) level of the client-based budget for each care package.[10] The way of determining the budget will be closely related to another still unanswered question, namely, for which party the client-based budget should be binding. In other words, if the actual cost of providing a care package differs from the client-based budget, then who should bear the additional costs or may keep the residual: the client, the provider or the insurer contracting the provider? At present, providers receive the full ZZP capitation payments for each client they serve and neither clients nor regional care offices bear financial risk (except for the income-related co-payments clients have to pay). However, if risk-bearing health insurers replace regional care offices by 2012, it is conceivable that ZZP capitation payments will be given to the insurers, which subsequently have to negotiate prices per ZZP with various LTC providers.

In theory, the Dutch proposed reforms involve appropriate incentives to improve the sustainability of the comprehensive LTC insurance scheme. As argued, in practice the success of the reforms will depend heavily on the way entitlements are defined, an improvement of the accuracy of needs assessment and the feasibility of determining appropriate client-based budgets. For adequate client-based budgeting it is crucial that the ZZPs that are currently being developed are relatively homogeneous in terms of predicted costs, as substantial variation involves clear incentives for upcoding and risk selection.

Although the proposed reform offers a promising perspective on combining a sustainable and universally accessible LTC financing with a consumer-directed provision of care, a number of complicated issues have to be resolved. The Dutch experiences in implementing the reform may therefore provide important lessons for countries with a public insurance scheme for LTC – for example, Japan and Germany – that also struggle with the question of how to guarantee a sustainable, universally accessible and high-quality system of LTC (Ikegami, 2007; Rothgang, 2010). In addition, it may also provide important lessons for countries considering the introduction of a system of social insurance for LTC (Barr, 2010).

Acknowledgement

A previous draft of this chapter was presented at the 7th World Congress of the international Health Economics Association (iHEA) in Beijing and at the International Conference on the Policies and Regulations of Health and

Long-term Care Costs of the Elderly in Tokyo. Part of this research has been supported by a research grant to Hitotsubashi University from the Ministry of Education of Japan (grant number 18002001).

Notes

*This chapter is largely based on Schut and Van den Berg (2010).

1. In 2008, CIZ had one main office, six district offices and 30 local offices.
2. Following the recently proposed typology by Ariizumi (2008), the Dutch public insurance system can be characterized as health-based rather than a means-tested programme.
3. In 2009, two functional categories – supportive and activating guidance – were combined into a single category ‘guidance’. At the same time, guidance that is aimed at social participation is excluded from coverage and brought under the scope of the Social Support Act (WMO).
4. When productivity growth in the LTC sector lags behind that in other sectors while wages grow at the same rate, relative prices of LTC *vis-à-vis* other goods and services in the economy will rise. In the case of a low price-elasticity of demand for LTC – which is likely in the presence of public insurance – the share of LTC expenditure in GDP will also increase over time.
5. Production of LTC services is measured by the Netherlands Institute for Social Research (Eggink et al., 2008) using indicators of production (e.g., admissions, day treatments, length of stay, number of patients and so on) weighted by the type and intensity of treatment.
6. This number was based on the assumption that a substantial proportion of informal caregivers already get paid from the personal care budget; see also Van den Berg and Hassink (2008). Their average payment is around €10 per hour. Multiplication of this average payment by the informal care hours presented in Table 7.4 makes approximately €4 billion.
7. Specifically, the Social and Economic Council (SER), the Council for Public Health and Health Care (RVZ), the Health Care Insurance Board (CVZ), the Dutch Healthcare Authority (NZa) and a governmental working group (IBO).
8. In the Japanese LTC insurance scheme, for instance, nationally uniform standardized eligibility criteria are used to determine to which services the elderly are entitled (Ikegami, 2007).
9. The determination of adequate ZZP capitation payments for outpatient LTC may be more complicated, because the need for outpatient care crucially depends on the availability of a social network of informal caregivers, which typically varies substantially across individuals.
10. Using a national rather than regional budgets may be politically attractive, because then government may avoid a socially controversial regional variation in the level of client-based budgets.

References

Albertini, M., Kohli M. and Vogel, C. (2007) ‘Intergenerational transfers of time and money in European families: common patterns – different regimes?’, *Journal of European Social Policy,* 17, pp. 319–334.

Ariizumi, H. (2008) 'Effects of public long-term care insurance on consumption, medical care demand, and welfare', *Journal of Health Economics,* 27, pp. 1423–1435.

Barr, N. (2010) 'Long term care: a suitable case for social insurance', *Social Policy and Administration*, 44 (4), pp. 359–374.

Baumol, W.J. (1967) 'Macroeconomics of unbalanced growth: the anatomy of urban crisis', *American Economic Review,* 57 (3), pp. 415–426.

Bolin, K., Lindgren, B. and Lundborg, P. (2008) 'Informal and formal care among single-living elderly in Europe', *Health Economics,* 17, pp. 393–409.

Buchmueller, T.C. (2006) 'Price and the health plan choice of retirees', *Journal of Health Economics,* 25 (1), pp. 81–101.

Eggink, E., Pommer, E. and Woittiez, I. (2008) *De ontwikkeling van de AWBZ-uitgaven. Een analyse van de AWBZ-uitgaven 1985–2005 en een raming van de uitgaven voor verpleging en verzorging 2005–2030* (Den Haag: Sociaal en Cultureel Planbureau (SCP)).

Hessing-Wagner, J.C. (1990) *Cliëntgebonden budget en zorg. De individualisering van geldstromen nader beschouwd* (Den Haag: Sociaal en Cultureel Planbureau (SCP)).

IBO-werkgroep, AWBZ (2006) *Toekomst AWBZ. Eindrapportage van de werkgroep Organisatie romp AWBZ*, Interdepartementaal Beleidsonderzoek 2004–2005, no. 4, Den Haag.

Ikegami, N. (2007) 'Rationale, design and sustainability of long-term care insurance in Japan – in retrospect', *Social Policy and Society,* 6 (3), pp. 423–434.

Jörg, F., Boeije, H.R., Huijsman, R., De Weert, G.H. and Schrijvers, A.J.P. (2002) 'Objectivity in needs assessment practice: admission to a residential home', *Health and Social Care in the Community*, 10 (6), pp. 445–456.

Koopmanschap, M.A., Van Exel, N.J.A., Van den Bos, G.A.M., Van den Berg, B. and Brouwer, W.B.F. (2004) 'The desire for support and respite care: preferences of Dutch informal caregivers', *Health Policy,* 68, pp. 309–320.

Ministry of Health (2004) *Op weg naar een bestendig stelsel voor langdurige zorg en maatschappelijke ondersteuning*, Letter to Parliament, DVVO-U-2475093, Den Haag.

Ministry of Health (2006) *Fact sheet personal budget AWBZ*, http://www.minvws.nl/en/folders/zzoude_directies/dvvo/2005/fact-sheet-personal-budget-awbz.asp, date accessed 3 November 2010.

Ministry of Health (2007) *Pgb in perspectief*, Letter to Parliament, DLZ/ZI-U-2811809, 9 November, Den Haag.

Ministry of Health (2008) *Zeker van zorg, nu en straks*, Letter to Parliament, DLZ/KZ-2856771, 13 June, Den Haag.

Ministry of Health (2009) *Nadere uitwerking toekomst van de AWBZ*, Letter to Parliament, DLZ/CB-U-2912189, 12 June, Den Haag.

NZa (2009) *Voortgangsrapportage Invoering ZZP's. Rapportage over de periode 1 januari 2009 – 30 juni 2009* (Utrecht: Dutch Healthcare Authority (NZa)).

OECD (2005) *Long-term Care for Older People* (Paris: OECD).

Oliviera Martins, J. and de la Maisonneuve, C. (2006) 'The drivers of public expenditure on health and long-term care: An integrated approach', *OECD Economic Studies,* 43 (2), pp. 115–154.

Ramakers, C. and van den Wijngaart, M. (2005) *Persoonsgebonden budget en mantelzorg, onderzoek naar de aard en de omvang van betaalde en onbetaalde mantelzorg* (Nijmegen: ITS/Radboud University).

Ramakers, C., de Graauw, K., Sombekke, E., Vierke, H., Doesborgh, J. and Wolderingh, C. (2007) *Evaluatie persoongebonden budget nieuwe stijl 2005–2006* (Nijmegen: ITS/Radboud University).

Rothgang, H. (2010) 'Long term care insurance in Germany: A system of permanent reform?', *Social Policy and Administration*, 44 (4), pp. 436–460.

Schut, F.T. and Van den Berg, B. (2010) 'Sustainability of long-term care financing in the Netherlands', *Social Policy and Administration*, 44 (4), pp. 411–435.

Schut, F.T., Gress, S. and Wasem, J. (2003) 'Consumer price sensitivity and social health insurer choice in Germany and the Netherlands', *International Journal of Health Care Finance and Economics,* 3, pp. 117–138.

SER (2008) *Langdurige zorg verzekerd: Over de toekomst van de AWBZ*, Publicatienummer 3 (Den Haag: Social and Economic Council (SER)).

Strombom, B.A., Buchmueller, T.C. and Feldstein, P.J. (2002) 'Switching costs, price sensitivity and health plan choice', *Journal of Health Economics,* 21, pp. 89–116.

Van den Berg, B. (2004) 'Dragen de sterkste schouders de zwaarste lasten? Een discussie over de positie van mantelzorgers ten opzichte van de AWBZ-zorg', *Tijdschrift voor Politieke Ekonomie,* 26, pp. 24–37.

Van den Berg, B. and Hassink, W.H.J. (2008) 'Cash benefits in long-term home care', *Health Policy,* 88, pp. 209–221.

Van den Berg, B. and Schut, F.T. (2003) 'Het einde van gratis mantelzorg?', *Economisch Statistische Berichten,* 88 (4413), pp. 420–422.

Van de Ven, W.P.M.M. and Schut, F.T. (1994) 'Should catastrophic risks be included in a regulated competitive health insurance market?', *Social Science and Medicine,* 39 (10), pp. 1459–1472.

Van de Ven, W.P.M.M. and Schut, F.T. (2008) 'Universal mandatory health insurance in the Netherlands: a model for the United States?', *Health Affairs,* 27 (3), pp. 771–781.

Van Exel, N.J.A., Morée, M., Koopmanschap, M.A., Schreuder Goedheijt, T. and Brouwer, W.B.F. (2006) 'Respite care – An explorative study of demand and use in Dutch informal caregivers', *Health Policy,* 78, pp. 194–208.

Van Gameren, E. (2005) *Regionale verschillen in de wachtlijsten verpleging en verzorging. Een emprisch onderzoek naar verklarende factoren,* Werkdocument 119 (Den Haag: Sociaal en Cultureel Planbureau (SCP)).