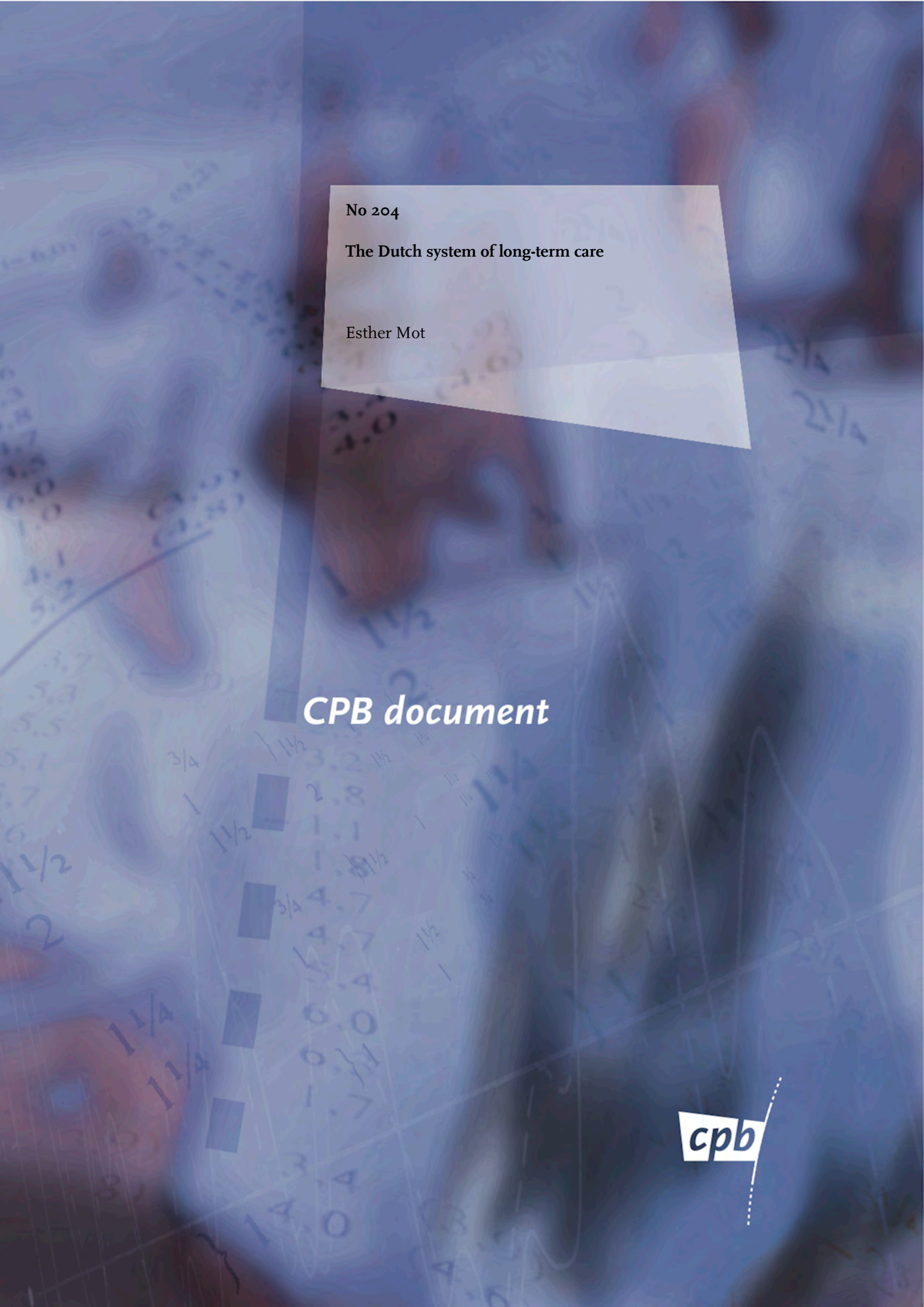

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The Dutch system of long-term care

Esther Mot

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Abstract in English

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

Key words: long-term care, elderly, institutions, healthcare
JEL code: H51, I18

Abstract in Dutch

In dit document wordt een omschrijving gegeven van het Nederlandse systeem van langdurige zorg voor ouderen. Ook het beleid op dit terrein komt aan de orde. Het document is geschreven ten behoeve van een Europees project in opdracht van de Europese Commissie (ANCIEN, Assessing Needs of Care in European Nations), als onderdeel van de eerste fase van het project. De bedoeling is om niet-Nederlanders inzicht te geven in het Nederlandse systeem en om gestructureerde vergelijkingen te kunnen maken tussen de systemen van verschillende Europese landen. Een groot aantal andere Europese landen schrijven namelijk soortgelijke rapporten in het kader van het ANCIEN-project. Deze landenrapporten dienen als basis voor de analyses in de volgende fasen van het ANCIEN-project.

Steekwoorden: langdurige zorg, ouderen, instituties, gezondheidszorg

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Contents

Preface

The ageing of populations has stimulated interest in studying systems of funding and delivering long-term care for the elderly. One way to analyse the optimal design of these systems is to make international comparisons. European countries differ considerably with regard to the way in which long-term care is organised— and therefore also in the expected effects of population ageing. In countries such as the Netherlands, where an extensive system is already in place, the future sustainability of the system is a point to consider. In countries with a much more modest system, or a system that is still being developed, the process of ageing may reveal the need for improvements that have to be made in the system. Furthermore, the current economic crisis has negatively affected the financial situation of governments. Government deficits will also affect the available funding options for long-term care for the elderly.

This report describes the current system of long-term care for the elderly in the Netherlands and the Dutch policy with respect to long-term care. It is part of the output of a project under the Seventh Framework Programme (FP7) of the European Commission, called ANCIEN: Assessing Needs of Care in European Nations. ANCIEN is a far-reaching project with the goal of studying long-term care for the elderly in the European Union. Comparable reports have been written for a large number of other European countries (including new member states). The first stage of the project aims to facilitate structured comparisons of the organisation of LTC for the elderly in different countries and to identify clusters of comparable systems. Future analyses in subsequent work packages within the project will build on the country reports and the cluster analysis. Subsequent analyses will explore not only the need for long-term care but also the demand and supply of informal and formal care for the elderly in selected countries. The quality of long-term care and the impact of technological change will be studied in separate work packages. The final stage of the project will focus on drawing conclusions about the optimal characteristics of systems of long-term care.

The data underpinning this report were collected by Ali Aouragh, Marieke de Groot, Hein Mannaerts and Esther Mot. We are grateful to Evelien Eggink (SCP[1]) for supplying us with data on informal care-receiving. The report was written by Esther Mot, and benefited from comments on the draft report from the following persons: Alice de Boer (SCP), Martin Holling (VWS), Erika Schulz (DIW), Erik Schut (iBMG), Victoria Shestalova (CPB) and Isolde Woittiez (SCP). Our thanks go to all of these persons for their useful comments.

Coen Teulings, Director

[1] SCP: Sociaal en Cultureel Planbureau; VWS: Ministerie van Volksgezondheid, Welzijn en Sport; iBMG: instituut Beleid & Management Gezondheidszorg.

Short overview of the LTC system

Philosophy and objectives

The underlying philosophy of the Dutch system for long-term care is that the state bears the responsibility for the elderly and others who are in need of long-term care. While informal unpaid care given by family members and others does play a role, there is no *obligation* to provide this care— save for the usual care that members of a household give each other.

The general policy goal for LTC was formulated in 2008 as follows: "*To ensure that for persons with a long-term or chronic disorder of a physical, intellectual or psychological nature, care of good quality is available and that the cost level of this care is acceptable to society.*"

Structure of the system

In the Netherlands, a system of public long-term care insurance has been in place since 1968. Everyone who lives in the Netherlands is insured under the AWBZ (Algemene Wet Bijzondere Ziektekosten; Exceptional Medical Expenses Act). The AWBZ covers not only care for the elderly, but in principle all chronic care, especially concerning large expenses where insurance on a private market would not be feasible. At the moment, this act covers at-home care and care in institutions for the elderly, institutions for the mentally and physically handicapped and institutions for chronic psychiatric patients. Some form of income-dependent cost-sharing exists for practically all LTC services. Moreover, elderly in institutions have to contribute to the costs of their board and lodging.

The AWBZ covers a broad package of services: personal care, nursing, assistance, treatment and stay in an institution. Domestic help used to be part of the AWBZ, but in 2007 it was shifted to the Wmo (the Wet Maatschappelijke Ondersteuning; Law on Social Assistance), an act pertaining to social services, which is carried out by the local council.
The AWBZ scheme is open-ended in nature: since it is public insurance, everyone who is eligible for long-term care is— in principle— entitled to receive care. However, every new Dutch government determines budgets for healthcare and long-term care for the subsequent four years. If expenditures exceed budgets, then the ministry of Health, Welfare and Sports (VWS) has to formulate a policy to contain the costs (for example, tariff cuts, higher co-payments or a smaller insured package).

The tax financed Wmo is not an insurance scheme: the entitlement to social services is affected by the available funds. For home help, in particular, local councils receive a (not-earmarked) budget. In this way municipalities have financial incentives to organise home help efficiently. However, to protect the rights of persons with disabilities, municipalities are obliged to compensate for the effects of their limitations in functioning. The local council can do this in the way it sees fit— as long as everyone can participate in society. This obligation that the local

authorities have seems to work reasonably well for persons with limitations in running a household— especially for the elderly.

Assessment

Every request for AWBZ care must be assessed by an independent organisation, the CIZ (Centrum Indicatiestelling Zorg; Centre for Care Assessment). There are no financial incentives for CIZ: its financial position is not affected by its decisions. CIZ's task is to carry out independent, objective and integral assessments. The procedure is the same for care reimbursed in cash and for in-kind care. CIZ adopts certain standards to determine whether an individual is eligible for one or more 'functions' (services) within AWBZ care: assistance, personal care, nursing, treatment and stay in an institution, extended stay for psychiatric reasons. For each of these functions, CIZ determines the amount of care that is necessary. Other persons in the same household are supposed to supply the "usual care" that family members give each other. In other words, this 'usual care' does not fall under AWBZ care. The effect of informal unpaid care that exceeds the usual care is more complicated: this care may diminish an individual's entitlement to AWBZ care— as long as this informal care is voluntarily given and received.

Assessment for home help is carried out by the local council, which has a financial incentive to restrict eligibility. If expenditures on home help are lower than the budget, the local council can spend the money on other goals. The local councils exert democratic control.

Organisation of care

For most of the AWBZ functions, a potential AWBZ user can choose between in-kind care and cash benefits. The cash-reimbursement option is not available for treatment and stay in an institution. The cash is given in the form of personal budgets. Patients who choose the cash-reimbursement scheme receive a personal budget that is 25% lower than the costs of in-kind care. The assumption is that they can buy care more efficiently. They are free to choose who should deliver their care: an official institution, an independent care worker, a family member, friend, neighbour etc. For most of the budget, patients are obliged to be able to show that they did spend the money on care.

Patients who prefer in-kind care have some say with regard to which care organisation delivers their care. The responsibility for organising and purchasing this care remains with the 'zorgkantoren' (regional care offices). These organisations, which are affiliated with health insurers, run no financial risk on buying long-term care. Although the care costs are paid from the AWBZ fund, the care offices are charged with keeping costs within the national and regional budget and with purchasing care as efficiently as possible. If the performance of a care office is poor, the permission to operate a regional care office may be given to another health insurer.

The organisation concept based on a regional care office has been heavily criticised for quite some time, since the care office has few incentives for efficiency and the construction is not transparent. In the future, the role of care offices may well be taken over by other parties (for example, by risk-bearing health insurers).

The Healthcare Inspectorate (IGZ) supervises the quality of care, which is regulated by law. The philosophy of the relevant laws is that the primary responsibility for quality rests with the providers themselves. The Dutch Health Authority (Nederlandse Zorgautoriteit, NZa) has a special role as a supervisor, market maker and regulator in health- and long-term care. Home-based nursing care is partly deregulated. In this area, the NZa monitors competition and determines maximum tariffs. Institutional care is still relatively heavily regulated. The NZa determines tariffs for institutional care, determines the description of the care that should be delivered in order to earn the tariff and monitors whether providers comply with these rules.

Available LTC services

The LTC services consist of informal care, formal care at home and formal institutional care.

Informal care for the elderly is relatively unimportant in the Netherlands compared to that in Southern and Central European Countries. The dominant social norm is that the government is largely responsible for the elderly, while parents (especially mothers) are largely responsible for taking care of their children themselves. Still, informal care plays a considerable role in long-term care. Part of the informal care is considered to be *usual care* that members of a household should give each other. CIZ corrects the entitlement to publicly financed care for this usual care. Cash benefits are regularly used to pay informal carers.

Institutional care plays a relatively heavy role in the Netherlands, compared to many other countries. For quite some time, the policy has been to stimulate the use of formal care at home instead of institutional care. The services available at home under the AWBZ include the following: assistance, personal care, nursing care and treatment. According to the ministry of Health, Welfare and Sports (VWS), 227,000 elderly clients used AWBZ care at home at the end of 2007. This was 9.4% of the 2.4 million elderly in the Netherlands. The numbers of users of domestic help (funded from the Wmo) at that time is unknown. At the end of 2007, 164,000 elderly clients used institutional care (6.8% of the elderly population)— taking place in nursing homes and homes for the elderly, for the most part.

Integration

LTC services are integrated predominately in one system: in other words, the collection of services that is insured under the AWBZ can be seen as a system of LTC. Healthcare and social services are regulated under other schemes: ZVW (the Health Insurance Act) for healthcare, and the Wmo for social services. However, the integration within long-term care is not complete.

Not all long-term care is covered by the AWBZ, and the AWBZ also covers some curative and rehabilitative care.

Some long-term care is covered by the Wmo. When the Wmo was introduced, home help was removed from the AWBZ and shifted to the system of social services. This created more room for integration with social services organised by the local council. At the same time, however, a new partition was created within long-term care— between domestic help and other LTC at home.

An important part of the temporary care covered by the AWBZ is rehabilitation after a health shock (for example, a stroke). At the moment, temporary care at home that is necessary after a hospital admission and temporary care in a nursing home are still covered by the AWBZ, but the intention is to shift this type of care given in a nursing home to the ZVW in 2011 or 2012. In the somewhat longer run, more services might be shifted from one scheme to the other.

Funding

The AWBZ is funded by social security premiums, taxes and co-payments. Since co-payments are income-dependent, care users will not run into severe financial difficulties. But it is quite possible that institutionalised persons have to contribute so much that they just have 'a clothing allowance and pocket money' left to spend according to their own preferences.

Providers of home-based care are paid an hourly wage for almost all types of care, with the exception of day care in groups. The NZa determines maximum tariffs per hour for the different types of care that are covered by the AWBZ. The payment for institutional care is based on so-called ZZPs (severity-of-care packages that are a combination of different care functions in the AWBZ). The NZa determines fixed prices for ZZPs.

Demand and supply of LTC

Our best estimate is that about 700,000 to 800,000 Dutch elderly are in need of care, including persons with IADL (Instrumental Activities of Daily Living) limitations. This is almost one-third of the population aged 65 years and older. In 2006, about 88,000 persons in total used personal budgets (a form of cash benefits). As this also included the handicapped and persons using mental healthcare, the number of elderly users of personal budgets is probably considerably lower. About 157,000 elderly persons received informal care in 2005, a modest share of the elderly in need of care. Formal care was more important: at the end of 2006, over 150,000 elderly used institutional care and 490,000 used care at home in 2006. As the latter number also includes persons who use home care temporarily, the maximum number of older permanent formal care-users is about 650,000.

LTC policy

Dutch LTC policy aims for quality, accessibility and affordability of care. As trade-offs exist among these goals, policy is continually being fine-tuned in order to find the optimal equilibrium.

In 2003, an important reform of Dutch long-term care took place: the 'modernisation' of AWBZ. This reform aimed at increasing the responsiveness of the care system. The distinction between different types of providers and different groups of AWBZ users became less pronounced. The regulation for personal budgets changed, which expanded the role of personal budgets. The modernisation improved the position of care-users, but made it more difficult to stay within the macro budget for AWBZ care. In 2004 and 2005, measures were taken to control costs in the form of higher co-payments and the introduction of regional budgets.

At present, the most important problems recognized in policy discussions are as follows:

1. The long-run sustainability of LTC;
2. The lack of incentives for efficiency in the LTC system;
3. Finding sufficient LTC workers to compensate for the expected increase in LTC demand;
4. The quality of care.

Extensive discussions have taken place in the course of the last few years about further reforms of the Dutch LTC system. The government wants to give health insurers a larger role in LTC, provided that a number of conditions can be met. The idea is that health insurers, instead of the regional care offices, carry out the AWBZ for the persons who are insured with them. Since meeting the conditions for this reform is by no means trivial, some time has been taken to collect information.

The government planned to decide on the organisation of the AWBZ from 2012 on no later than April 1, 2010, but this decision has been delayed by the collapse of the Balkenende IV cabinet.

1 The LTC system in the Netherlands

1.1 Introduction

This report is written as part of the first Work Package (WP1) of the international ANCIEN project. ANCIEN is a research project commissioned by the European Commission (as part of FP7) to explore future long-term care for the elderly in Europe. WP1 aims to provide an overview of LTC systems in the participating European countries.[2] As one of the contributions to this package, this report takes a structured approach to describing the Dutch system and the Dutch policy regarding long-term care. A comparable report is written for all participating countries, so that European countries can be compared with respect to the organisation of long-term care. All participating countries use data for 2006, to the greatest extent possible, in order to maximise comparability. As a consequence of the way ANCIEN is organised, this report is rather descriptive in nature. Our task is to describe the problems that policymakers are trying to solve and to outline the proposed solutions; at this stage we do not make a comprehensive analysis of the effectiveness of the system and of policy. Lessons for policy will be drawn in later stages of the project.

1.2 Overview of the system

In the Netherlands, a system of public long-term care insurance has been in place since 1968. Everyone who lives in the Netherlands is insured under the AWBZ (Algemene Wet Bijzondere Ziektekosten, Exceptional Medical Expenses Act), which concerns not just care for the elderly, but in principle all chronic care— especially concerning large expenses where insurance on a private market would not be feasible. At the moment, this act covers care at home and in institutions for the elderly, care in institutions for the mentally and physically handicapped and care in institutions for chronic psychiatric patients. Some form of income-dependent cost sharing exists for practically all LTC services. Apart from that, elderly people residing in institutions have to contribute to the costs of their board and lodging.

The AWBZ covers a broad package of services: personal care, nursing, assistance, treatment and stay in an institution. Assistance includes day care in groups as well as personal (one-on-one) assistance. Currently, the assistance is aimed at being able to live independently (for example, help with organising the household or with administration). In the past, such support was also intended to improve social participation (for example, taking walks, going to the shops or to church, going out). Domestic help used to be part of the AWBZ, but in 2007 it was shifted

[2] The 22 participating European countries: Austria, Belgium, Bulgaria, Czech Republic, Denmark, Estonia, Finland, France, Germany, Hungary, Italy, Latvia, Lithuania, Netherlands, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden and the United Kingdom.

to the Wmo (the Wet Maatschappelijke Ondersteuning; Law on Social Support), which regulates social services and is carried out by the local council.
The AWBZ scheme is open-ended in nature: since it is public insurance, everyone who is eligible for long-term care is— in principle— entitled to receive care. In practice, the central government tries to keep the AWBZ expenditures within a budget. Every time a new government is formed, a projection is made of the necessary AWBZ expenditures in the next four years, based on the expected development of the demand for LTC and on the intended policy of the new government. The ministry of Health, Welfare and Sports (VWS) has to make sure that expenditures stay within this budget. Possible instruments to ensure this are an increase in co-payments, a decrease in coverage and tariff cuts for the providers. The ministry can ask permission in the council of ministers to spend more than the budget, if it maintains that cost-containment measures have too many disadvantages. This request has a relatively good chance of succeeding when other government expenditures are lower than projected (as can happen with social security expenses when the macroeconomic development is favourable).

The Wmo is not an insurance scheme; the Wmo concerns provision of social services. Entitlement to these social services is affected by the available funds. For domestic help, in particular, local councils receive a (non-earmarked) budget. This gives them financial incentives to organise domestic help efficiently. However, to protect the rights to participation in society of persons with disabilities, municipalities are obliged to compensate for the effects of functional limitations. While a local council may do this however it sees fit, it must make provisions so that citizens can engage in the following activities:

- Running a household;
- Moving in and around their home;
- Moving locally by means of transport;
- Meeting other people and engaging in social relations.

The Dutch government bears overall responsibility for the system of LTC: it has to create conditions that enable the system to function. Given this general responsibility, many specific responsibilities are laid down at the micro level of private care providers,[3] which are responsible for providing care of good quality and for good governance of their organisations. Providers that provide care funded by the AWBZ are obliged to have an independent supervisory board. The Dutch Healthcare Inspectorate (IGZ) supervises not only the quality of care but also compliance with most of the governance demands. The Dutch Healthcare Authority (NZa) monitors the functioning of markets in parts of LTC that have become deregulated (LTC outside institutions). Furthermore, the NZa makes rules and supervises compliance with these rules for parts of LTC that are still regulated (institutional LTC). These

[3] There are no government-owned care providers in the Netherlands. All providers are private: either not-for-profit (the large majority) or for-profit.

rules have to do with the description of services offered by providers and a determination of (maximum) tariffs that can be charged for these services. In the regulated part, currently only non-profit providers are allowed to operate.

The original philosophy underlying the AWBZ is that every person in the Netherlands should be insured against very high expenses of necessary care— for example, as a result of becoming severely physically disabled. In some situations, expenses can be so high that practically nobody could afford them out-of-pocket. Experience in other countries has shown that it is difficult to solve this problem with private insurance.[4] In practice, a grey area may exist between extremely high or catastrophic expenses and those that can be seen as a private responsibility. Apart from this grey area, the AWBZ scheme has over time been expanded with the addition of several services that, while not catastrophically expensive (such as domestic help and assistance), are in some way related to the already covered services.[5] The current policy debate centres on limiting the AWBZ entitlements to the most vulnerable persons and the most necessary services. Co-payments are higher for persons with higher incomes. In practice, this can cause some AWBZ services to be mostly used by the less well-to-do— even though all residents of the Netherlands are insured.

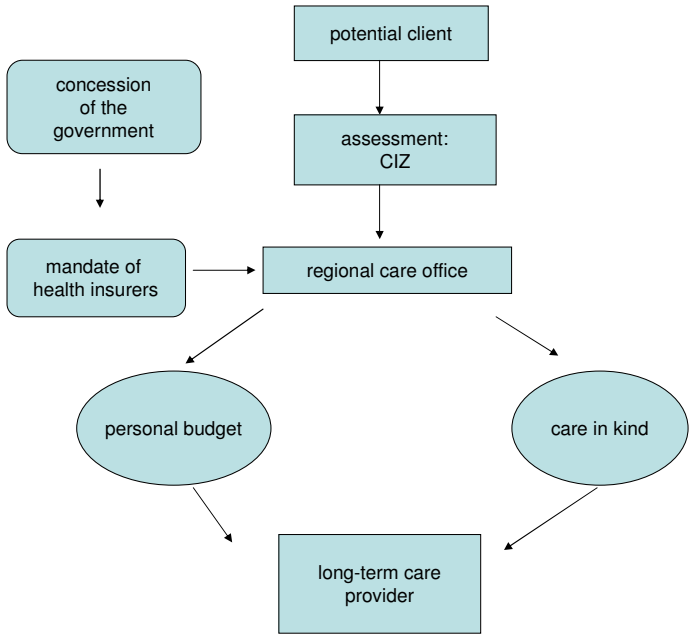
The new Wmo is based on a different philosophy: ideally, citizens should take responsibility themselves in matters of social assistance (for example, by arranging informal care or buying care on the private market). When this is not sufficient, they can apply to the local council, which has a great degree of freedom in making its own policy and responding to local circumstances. Since we do not know to what extent municipalities actually check that claimants have no other option than the Wmo, it is not clear whether the Wmo actually functions in this way, in practice.

Figure 1.1 shows the trajectory that a potential AWBZ beneficiary follows through the system. The steps in this trajectory will be discussed in the following sections.

[4] An important reason is that private companies cannot bear the macroeconomic risk for the future (for example, the increase in the cost of long-term care).

[5] For example, the reasoning might be that coverage of a less expensive service might be more economical, since it would enable clients to use less of more expensive services.

Figure 1.1 Structure of the AWBZ



1.3 Assessment of needs

Every request for AWBZ care has to be assessed by an independent organisation, CIZ (Centrum Indicatiestelling Zorg; Centre for Care Assessment). There are no financial incentives for CIZ, in the sense that its decisions do not affect its own financial position. It should make an independent, objective and integrated assessment. A person may be eligible for AWBZ care only when one or more underlying factors (*grondslagen*) are present:[6]

1. A somatic, psycho-geriatric or mental disorder or limitation;
2. An intellectual, physical or sensory disability.

The assessment procedure is the same for care in cash and care in kind. CIZ uses standards to determine whether a person is eligible for one or more 'functions' (separate LTC services) within AWBZ care: assistance, personal care, nursing, treatment and stay in an institution, extended stay for psychiatric reasons.[7] For each function, the amount of the necessary care is determined. Other persons in the same household are supposed to supply the "usual care" that family members give to each other. People are not eligible for AWBZ care with respect to the usual care. The effect of informal unpaid care that exceeds the usual care is more complicated: this may decrease the entitlement to AWBZ care as long as this informal care is voluntarily given and received.

[6] In the past, persons with psychosocial problems could also be eligible for AWBZ care.
[7] Beleidsregels indicatiestelling AWBZ.

For most of the functions, the potential AWBZ beneficiary can choose between care in kind and cash reimbursement. The cash reimbursement option is not available for treatment and stay in an institution. The cash is given in the form of personal budgets.

There is no classification into levels of dependency. Following the detailed guidelines, the need for publicly financed AWBZ care is determined for each applicant separately, taking into account his or her individual circumstances.

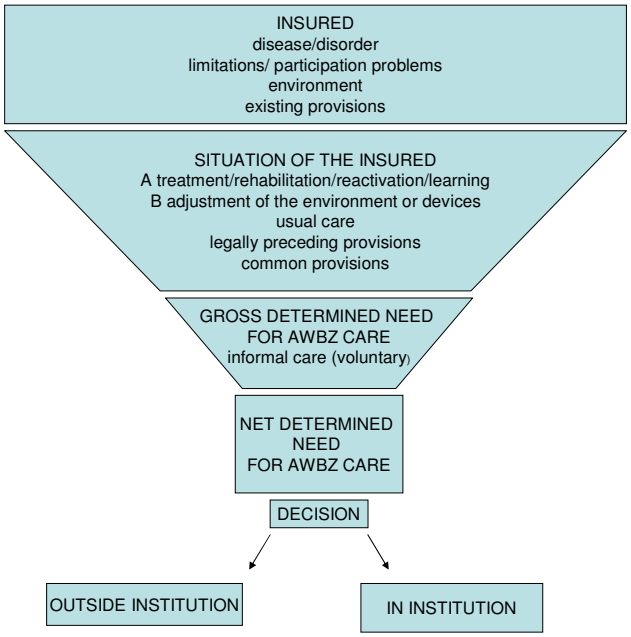
The following discussion examines the assessment process in more detail. CIZ has a model for assessment that consists of several steps, in what is referred to as the funnel model (see Figure 1.2). In the first step, CIZ analyses the situation of a potential AWBZ beneficiary. It looks at not only disorders and functional limitations, but also the circumstances under which the person is functioning. The circumstances concern the availability of usual care and informal care and the existing use of provisions for living, welfare, care, labour and education. The disorders and limitations are both scored on a four-point scale.

In the second step, CIZ determines how the care problems of the potential client may best be solved. The problems could conceivably be solved by other means than care funded by the AWBZ. CIZ starts by checking whether a solution can be found in the form of treatment to alleviate the limitations, adjustment of the environment or the use of medical devices. Secondly, CIZ checks three directions in its search for a solution that precedes the use of AWBZ care:

- Receiving usual care (family members may be supported with respite care, when necessary);
- Using other publicly financed provisions where the regulation states that these provisions precede the use of AWBZ care;
- Using general provisions available to every individual, such as home delivery of shopping, childcare etc.

The outcome of the second step is the determination of the gross need for AWBZ care (including usual care of household members) in terms of the kind of care that is necessary, the volume, the period of validity of the assessment and the delivery conditions. The latter refers to the manner in which the care has to be available: is care by appointment sufficient, should it also be possible that care is requested at unexpected moments, should care be continuously available in the vicinity or should the caregiver be present in the direct vicinity 24 hours a day?

Figure 1.2 Funnel model for assessment



Source: CIZ Indicatiewijzer, versie 1.0.

The third step concerns the possible role of voluntary care. Family members are supposed to supply the usual care, but anything more than usual care is voluntary. This means that for informal care exceeding the usual care, an entitlement to AWBZ care in principle exists. The insured might, for example, request a personal budget and use that to pay for the services of the formerly informal caregiver. Only if the informal caregivers want to go on giving the informal care and the care receiver wants to go on receiving it, will the need for AWBZ care be corrected downwards for the availability of informal unpaid care. To support the informal caregiver, some form of respite care may be included in the assessment decision.

In the fourth step, CIZ makes the decision about institutional care or care at home. When the client needs a protective environment in which to live, a therapeutic living climate or permanent supervision, CIZ will decide on institutional care. The client might prefer to stay at home, despite possible cost-inefficiency. In certain circumstances some inefficiency is acceptable: for care at the end of life and for care for children. Apart from that, the client can try to make use of the scheme "Full package at home". This means that insured persons could get the care that they would get in an institution at home, if this can be arranged at the same cost. The latter might be difficult, and providers are not obliged to deliver this kind of care.[8]

In the end, this elaborate process leads to a formal decision on the entitlement to AWBZ care that may be appealed by the potential client, based on the Algemene Wet Bestuursrecht (General Administrative Law Act).

[8] Table 3.9 shows that expenditure on the full package at home was very limited in 2007.

Assessment for home help is carried out by the local council, which has a financial incentive to contain the cost of care. If expenditures on home help are lower than the municipal budget for home help, then the local council can spend the remaining money on other goals. Local authorities can choose to contract out the actual assessment process: 52% of municipalities share this task with CIZ or another assessment organisation, 28% do it alone and 21% leave the assessment entirely to CIZ or another assessment organisation.[9] The local council has a great deal of freedom in developing rules for assessment. For example, it might decide that persons with higher incomes are not eligible for publicly financed domestic help, since they can fund it privately. The local council exerts democratic control. Being too strict with the elderly and chronically ill might make a bad impression on the voters.

1.4 Available LTC services

LTC services consist of informal care, formal care at home and formal institutional care.

Although informal care for the elderly is relatively unimportant in the Netherlands, compared to Southern and Central European Countries, it still plays a considerable role. The total number of informal caregivers for all persons in need of care was 3.5 million in 2007—but not all of these persons were giving help during a longer period (De Boer et al., 2009). About 1.7 million persons helped others during relatively long and intensive periods.

There are no benefits for informal caregivers, but informal caregivers can receive payment out of personal budgets. These budgets can be used to purchase professional care as well as informal care. The Wmo has formally given the local council the task of supporting informal caregivers. The local council can organise support (e.g. information and advice) for informal caregivers directly, or it can fund organisations that support them. Furthermore, respite care to relieve the burden of informal caregivers can be funded from the AWBZ (e.g. day care and night care).

There are arrangements for care leave: this can be unpaid or paid, but the paid care leave has a maximum per year of twice the number of work hours per week.

Formal care at home is covered by the AWBZ, except for domestic help and social services, which fall under the Wmo since 2007. The services available at home under the AWBZ include the following: assistance, personal care, nursing care and treatment.[10] The Wmo covers home help, meals on wheels, home adjustments and transport. According to the ministry of VWS, at the end of 2007, some 227,000 elderly clients were using AWBZ care at home. This number concerns clients of 65 years or older at a specific point in time.[11] The numbers of users of home help at that time is unknown. In 2007 as a whole, 187,000 elderly persons used home help as

[9] Van Houten et al. (2008).

[10] Although *treatment* is normally covered by the Health Insurance Act (ZVW), some forms of treatment for the elderly or handicapped are covered by the AWBZ (e.g. diagnosis by a nursing home physician for persons still living at home).

[11] The number of persons who used care during the year is larger, of course, since care can be used temporarily.

the only form of LTC. Since people are allowed to use home help on a temporary basis, the number of users at the end of the year is expected to be lower.

In the Netherlands, institutional care plays a relatively heavy role compared to other countries. For quite some time, the policy has been to stimulate the use of formal care at home instead of institutional care. Prior to 2009, there were two main categories of institutional care: nursing home care and residential care. From 2009, ten separate products are distinguished within institutional care for the elderly and chronically ill, in what are referred to as severity-of-care packages (ZZPs; *zorgzwaartepakketten*). Each of these packages represents a combination of different care functions in the AWBZ. For long-term care for the elderly, these ZZPs range from "sheltered living with some assistance" (ZZP1) to "sheltered living with very intensive care, because of specific disorders, with the emphasis on care and nursing"(ZZP8).[12] For institutional care, certain hotel services (accommodation, food, cleaning, etc.) are included in the AWBZ coverage. Residents, however, have to pay an income-dependent contribution (see 2.3). This co-payment can be seen as a way for the elderly with sufficient income to pay for their board and lodging themselves, after all.

At the end of 2007, 164,000 elderly clients used institutional care— in nursing homes and homes for the elderly, for the most part.

1.5 Management and organisation of care

The responsibility for the LTC system as a whole rests with the central government, where the legislation is made. The government strives to ensure that the conditions are fulfilled under which the goals of LTC policy (accessible and affordable care of good quality) can be achieved.

The purchasing of care within the AWBZ can be done in two ways: patients choose a personal budget to buy care themselves or the regional care offices (*zorgkantoren*) buy care in kind on behalf of the patient. Patients who choose the cash-reimbursement scheme receive a personal budget that is 25% lower than the costs of in-kind care. The assumption is that they can buy care more efficiently. They are free to choose who should deliver their care: an official institution, an independent care worker, a family member, friend, neighbour etc. For most of the budget, patients have to be able to show that they did spend the money on care.

Patients who prefer in-kind care may specify which care organisation delivers their care. In other words, they can state which provider they prefer. The responsibility for organising and buying this type of care, however, rests with the regional care offices. These organisations, which are affiliated with health insurers, run no financial risk on buying long-term care. Formally, the health insurer is responsible for the execution of the AWBZ for its population of insured. In practice, the management of the AWBZ is organised as follows. The health insurers that are active in a region voluntarily give a mandate to one health insurer to carry out the

[12] ZZPs 9 and 10 concern rehabilitative care and palliative care, respectively.

AWBZ for their insured. This health insurer runs a separate legal entity (the care office) that has to 'earn' a concession of the government to perform this task. That is to say, the regional care offices have to fulfil a number of conditions of the government, or the concession may be withdrawn.[13] The costs for LTC are paid from the AWBZ fund. In order to make sure that national AWBZ expenditures stay within the budget, the NZa calculates regional budgets for the care offices at the request of the ministry of VWS. The regional care offices are supposed to keep costs within the regional budget and to purchase care as efficiently as possible. If they run out of money, they can try to redistribute money between providers within their region, or between regions. If this does not solve the problem, they can discuss their financial constraints with the NZa. If the performance of a care office is poor, then permission to operate a regional care office might be given to another health insurer. The organisational form with a regional care office has been heavily criticised for quite some time, since the care office has few incentives for efficiency and the mandate construction is not transparent. New concessions have been given for the period 2009-2011. But by 2012, the ministry of VWS wants the health insurers to take over the role of the care offices for the persons who are insured with them— if a number of conditions can be met (see 4.3).

Since 2007, home help is regulated by the Wmo. Local governments have to give users of home help the choice between a personal budget and care in kind. In-kind home help is purchased by municipalities, who organise tenders to buy these services. For contracts above the threshold, the European rules for tenders apply. In a survey, local council representatives stated that quality of care was the most important criterion for them: according to 78% of municipalities, this was the most important aspect. The price was also an important criterion: 23% of the municipalities considered price to be the most important aspect; 31% used a maximum price and 21% used a system with fixed prices. In the latter case, the providers are supposed to compete on quality. In principle, the maximum term for contracts was four years. Many municipalities followed the advice to choose a shorter period for the first round of tenders. The average period of the contracts was just over two years.[14]

Monitoring and quality assurance

The quality of care is regulated by law. The central idea underlying the relevant laws is that the primary responsibility for quality lies with the providers. The Healthcare Inspectorate (IGZ) has a role as supervisor. Two laws directly concern the quality of care:

1. Law on quality in care organisations (Kwaliteitswet zorginstellingen*;* KWZ);
2. Law on professions in personal healthcare (Wet op de Beroepen in de Individuele Gezondheidszorg; Wet BIG).

[13] The risk of losing the concession does not seem to be very large. But in 2005, the assistant secretary of VWS made the prolongation of the concession for one health insurer for the period 2006-2008 dependent on meeting a specific condition.
[14] Van Houten et al. (2008).

The KWZ concerns organisations or group practices that deliver care. Examples include not only nursing homes and hospitals, but also a group practice with cooperating physiotherapists. Although organisations are obliged to deliver care of good quality (effective, efficient, patient-centred and attuned to the realistic needs of the patient), they are afforded a degree of discretion in how to realise this. They have to have a deliberate policy aimed at delivering good quality care. In 2008, the parties involved in the LTC sector published a set of performance indicators for good care (see 4.3 for further details).[15] Speaking in general, good care means that care has to be well organised, with a good internal communication and sufficient and capable personnel. Organisations have to have a quality system in order to safeguard the quality of care, and they have to make an annual quality report that is sent to the IGZ. However, a recent IGZ report (IGZ 2009) states that not all new providers of home-based care have to make an annual quality report.[16] The KWZ is relevant for these providers, but as there is no obligation to register, the IGZ does not know about all of the new providers and cannot monitor them. The IGZ research showed that there were serious quality problems with many of the 30 inspected organisations. The IGZ seriously doubts that the way personal budgets are organised at the moment— where the budget holder is responsible for purchasing good quality care— is satisfactory with respect to the protection of vulnerable elderly persons.

Personal care professionals who work alone have to meet the criteria of the *wet BIG*, which can be more or less strict, depending on their profession and the sort of activities they undertake. A patient has a great deal of freedom in choosing the care provider he or she wants. However, a number of guarantees and requirements have been developed to protect patients. The law *BIG* determines that it is a criminal offence for a professional to damage a client's health. The law distinguishes a number of specific activities (e.g. catheterising and anaesthesia) that may be carried out only by professionals qualified to do so according to this law. The law stipulates educational requirements for eight professions: physicians, dentists, pharmacists, clinical psychologists, psychotherapists, physiotherapists, midwives and nurses. Practitioners of these professions have to be registered in the "BIG-register". The patient can look up the provider in this register to see whether the provider is a qualified professional. This register does not apply to home-helpers, aides etc. The regulation for "*verzorgende individuele gezondheidszorg* (nurse aides)" is less strict. Their training is regulated in a particular government decision (the "*Algemene Maatregel van Bestuur*"). There is no register for nurse aides. The law *BIG* determines that most of the quality requirements of the KWZ apply also to individual care professionals. But they do not have to submit an annual quality report.

Care outside of institutions is less strictly regulated than institutional care. Home-based care may also be delivered by for-profit organisations. For many years now, providers have been

[15] Prior to that time, no common agreements had been made with regard to the nature of good care.

[16] The quality report is an obligation for organisations that are admitted under the Law on the admission of care-providing organisations (WTZi) and have a contract with a regional care office. Thus, organisations with no WTZi admission, or no contract with the care office, or those that work as subcontractors or provide private care and care financed from personal budgets, do not have to make an annual quality report.

free to decide on capacity and are able to compete on tariffs. But this does not mean that the market for home-based care is completely deregulated. For example, there is still regulation to maximise tariffs. Merger control in care markets is carried out by the Dutch Competition Authority (Nederlandse Mededingingsautoriteit; NMa). Moreover, the NZa has a special role as a supervisor, market maker and regulator in healthcare. The NZa monitors competition in the home-based nursing care sector and determines maximum tariffs. Institutional care is still relatively heavily regulated, but is in the process of being made more competitive by the introduction of a new funding system. Furthermore, at the start of 2009, the government abandoned capacity planning. The NZa determines tariffs for institutional care[17], determines the description of the care that should be delivered in order to earn the tariff and monitors whether providers comply with these rules.

1.6 Integration

The collection of services that is covered by the AWBZ can be seen as a system of LTC. Healthcare and social services are regulated under other schemes (respectively, the Health Insurance Act ZVW, and the Wmo). The Wmo is a wide-ranging scheme covering e.g. home adjustment, transport, meals on wheels, support for young people with problems, support for informal caregivers, help for the homeless, shelters for mistreated women and ambulatory care for drug addicts. However, not all long-term care is covered by the AWBZ, and the AWBZ also covers some curative and rehabilitative care (see Table 1.1).

Some long-term care is covered by the Wmo. Recently, home help was removed from the AWBZ and shifted to the system of social services under the new Wmo. This created more room for integration among social services. Then again, a new partition was created within long-term care, between domestic help and other LTC at home.

Rehabilitation after a health shock (for example, a stroke) is covered by the AWBZ.[18] At the moment, temporary care for rehabilitation that is necessary after a hospital admission is still covered by the AWBZ, but the intention is to shift this type of care partly to the ZVW in 2011 or 2012. Only the part provided by nursing homes will be shifted in 2011 or 2012— not the care at home. In the somewhat longer run, more services might be shifted from one scheme to the other.[19]

[17] These are flat rate tariffs, not maximum tariffs.

[18] An exception is rehabilitation in a specialised clinic.

[19] VWS, Overheveling zorg AWBZ naar Zvw, February 10, 2009.

Table 1.1	Integration of LTC		
	AWBZ	Wmo	ZVW
LTC	Assistance, personal care, nursing care, treatment, stay in an institution	Home help	Some medical devices
Social services in LTC context		Meals on wheels Home adjustment transport	
Non-LTC	Maternity care, rehabilitation in a nursing home or at home, temporary care	Many social services	Healthcare

Problems may arise in the coordination between the different systems. Elderly persons who need help may well have to deal with several systems, each with their own rules. It is likely they will want to use services covered by the Wmo and by the ZVW. If they need more than domestic help in their daily life, AWBZ services will also play a role. As they start looking for help, they will first have to solve the problem of where to apply for which services. The website regelhulp.nl was designed to help people with this. Secondly, their request may have to be assessed by several organisations— each with different rules— each needing information about the potential client. Whether this actually happens depends on the way the local council has organised the assessment process. The local council can ask the CIZ to do this. Thirdly, once the elderly have found help, they may be confronted with several organisations and several professionals. It is quite possible that providers are not cooperating in an optimal way. Potential clients may be supported and led through this process by a case manager. However, the availability of case management is certainly not standard in the Netherlands. There have been a number of projects with case management for persons with dementia and their family. Ligthart (2006) showed that case management for dementia was funded differently in different regions in the Netherlands. Sources of funding were for example AWBZ mental healthcare, AWBZ long-term care, project subsidies and/or the Wmo, and funding was a problem in many regions in the country. This case management is also part of the plans for integrated dementia care. The regional care offices are to purchase integrated care for dementia, including case management. The ministry has made some budget available to fund integrated care including case management (see further 4.3).[20]

At the level of all systems together (health, LTC and social services), suboptimal decisions may be taken. The systems affect each other's performance, but this is not sufficiently taken into account, since costs and benefits occur in different systems and for different parties. For example, it is not in the financial interest of the local council to invest heavily in independent living for the elderly, as the council will bear the costs of this policy, while the benefits will appear in the form of lower AWBZ expenditures. But for all three systems together, such investment might well be the optimal course. Where the healthcare system and the LTC system

[20] *Casemanagement is geen kop erbovenop*, Interview with Iris van Bennekom, Nieuwsbrief van het Landelijk Dementie Programma, October 2008.

meet, comparable problems may occur. For example, the discharge of elderly persons from the hospital may have to be delayed because the necessary LTC services are not available on time (the bed blocker problem). At the start of this century, a number of hospitals set up transfer units or transmural units to solve this problem.[21] The patients at the transfer unit are formally discharged from the hospital. They receive the necessary non-medical specialist care (for example, physiotherapy, additional nursing care, occupational therapy) at the transfer unit.

In 2006, about 40% of Dutch hospitals had transfer units. 80% of the transfer units were formally a part of the nursing home organisation in 2006. The nursing home physician was medically responsible for the care in all cases. 80% of the transfer units had structural funding out of the AWBZ. There were differences in funding, and several sources of funding played a role (including own funds of the hospital or the nursing home, temporary funds from the AWBZ, funds from the ZVW, etc.). The problem of blocked beds has become less important in recent years because of the transfer units. Looking at the effect of the health system on the care system, the performance of the healthcare system will affect how much LTC is needed— for example, with stroke patients. But the healthcare system, in its decision-making, will not take into account savings on LTC expenditures.

In short, the coordination within and especially between systems can suffer from the following problems:

- Non-transparency
- High transaction costs
- Inefficient decision-making
- Coordination problems
- External effects
- Free-riding

In principle, these problems could partly disappear by merging all systems in one big system for social services, LTC and healthcare. However, this would probably make the system too large to manage and insufficiently attuned to the very different functions it has to fulfil. A solution will likely (partly) have to be sought in improving the interaction between different systems. As an example of this, the local council might have to pay a fine for the elderly who have to be admitted to an institution because of insufficient provisions in the municipality. Incidentally, this is a purely theoretical example; the Dutch government is not considering implementing such a measure. Finding solutions for the coordination problems has been difficult up to now. There is no clear insight as to what would be the best way to improve coordination.

[21] Borghans and Van Hartingsveldt (2007).

2 Funding

2.1 AWBZ

This section first discusses AWBZ expenditures and their funding. As explained before, the AWBZ handles more than merely care for the aged, which is the object of our study in ANCIEN. Total AWBZ expenditures were approximately 22 billion euros in 2007 (or 4% of GDP; see Table 2.1). With inclusion of expenditures for home help under the Wmo, just over 4% of GDP was spent. This is not just on long-term care, as also some temporary care is included. Within the AWBZ expenditures, 4 billion euros was spent on mental healthcare in 2007, and over 5 billion euros on care for the handicapped (mentally and physically). Over 11 billion euros was spent on nursing and care for the non-handicapped, of which about 3 billion euros concerned care outside of institutions. Nursing and care for the non-handicapped is mostly care for the elderly. AWBZ expenditures are not much lower than healthcare expenditures: the expenses on healthcare of 28,150 million euros in 2007 form 5% of GDP.[22] Thus, for healthcare and non-curative care (mostly long-term care) together, about 9% of GDP was spent in 2007.

Expenditure on LTC for the elderly is not exactly known, as expenditure on nursing and care not only includes temporary care but also concerns non-elderly people in need of this type of care. Related to GDP, expenditure on LTC for the elderly is less than 2.5%.

Table 2.1 AWBZ costs, millions of euros

	2002	2003	2004	2005	2006	2007
Mental healthcare	3164.5	3455.0	3743.6	4006.6	3791.9	4071.4
Care for the disabled	3974.6	4386.2	4594.4	4887.6	5058.2	5169.5
Nursing and care for the elderly and others	9847.5	10855.8	11164.5	11394.4	11914.3	11178.3
Other care	291.7	128.0	133.7	125.7	339.2	255.9
Other non-care AWBZ expenditures	1137.3	1459.6	1636.2	1740.2	1713.4	1811.0
Total	18415.6	20284.6	21272.4	22154.5	22817.0	22486.1

Source: www.cvz.nl (May 13, 2009).

In principle, the AWBZ is funded by social security premiums and co-payments. However, the AWBZ premiums do not have to be set at a level sufficient to cover the costs. In that case, part of the AWBZ expenditure is funded from taxes. In 2005, 70% of AWBZ expenditures were financed from social security contributions, 22% from taxes and 8% from user charges.

The AWBZ premium is at the moment 12.15% of income in the first two tax brackets (maximum income of about 32,000 euros; see Table 2.2). Income solidarity is thus maximised within social security, but the other sources of funding also contribute to income solidarity:

[22] Expenditures on AWBZ and ZVW from CVZ website and publications.

taxes are progressive and co-payments are income-dependent. The degree of risk solidarity is very high: only the co-payments are affected by risk— and even then, this is mostly the case for people with higher incomes. For persons with low incomes, the maximum co-payments are low (see below).

Table 2.2 Taxes and social security premiums in 2009

Length of bracket (in euros)	Taxes %	AWBZ % (long-term care)	AOW % (public pension)	ANW % (benefits for widows and orphans)	ZVW %[23] (healthcare)	ZVW flat rate, euro
First : 17,878	2.35	12.15	17.9[24]	1.1	6.9	1064
Second: 14,249	10.85	12.15	17.9[25]	1.1	6.9	
Third : 22,649	42					
Fourth, open	52					

Source: *Centraal Economisch Plan 2009*.

Table 2.2 provides an overview of taxes and premiums for national insurance. These premiums are levied only on the first two tax brackets. Insurance for employees (for example, against unemployment and disability) is not included. The table does not show the numerous tax credits.[26] There is an allowance for health insurance to help households with lower incomes to afford the flat rate of about 1000 euros.[27]

2.2 Wmo

Local councils receive a (non-earmarked) budget for home help. In 2007, this budget was 1,218 million euros for all municipalities together.[28] Is it estimated that municipalities had a surplus of about 150 million euros on this budget in 2007. They were free to use this surplus for other goals. Op top of the budget, they levied out-of-pocket payments of about 214 million euros— so that they had a total of 1432 million euros available to fund home help.

The macro budget for the local councils is determined by the central government each year on the basis of a binding advice by the Social and Cultural Planning Bureau (SCP). The SCP uses a formula for determining the macro budget that was agreed with the parties before the SCP's advisory role started. The realisation of year t-1 is adjusted for volume and price. The volume index is determined by the change in the number of persons of 75 years and older who

[23] The maximum premium income for the ZVW is 32,369 in 2009.

[24] Not for the elderly.

[25] Not for the elderly.

[26] There are the following tax credits in 2009: general for the non-elderly, general for the elderly, labour, elderly with a not-too-high income, single elderly, single parent, income-dependent combination (for working persons with a child and no partner or being the least-earning partner).

[27] Health insurers compete on premiums. The 1064 euros reported in the table is an average flat-rate premium.

[28] SCP (2009), *Definitief advies over het WMO-budget huishoudelijke hulp voor 2009*.

still live independently (outside an institution). The price index is a weighted average of the government contribution for changes in the terms of employment in the health sector [29](90%) and an index of consumption prices for households (10%). For 2009, the volume change is almost 2% and the price change about 3.5%. Corrections may be made for specific developments (e.g. a change in the product mix towards the cheaper type of home help).[30] The local council has an obligation to find some solution for citizens who need home help.

This means that municipalities would have to find additional funding if the sum of the budget and the co-payments would not be sufficient. Given the fact that local governments together have a sizable surplus (12% of the budget) in 2007, this does not appear to be a problem at the macro level.[31] A separate model has been designed to distribute the macro budget over municipalities.[32] On the micro level there are also municipalities with a deficit, compared to the budget. In 2007, 11% of the municipalities spent more than 105% of the budget, while 16% spent less than 75%. More than half spent from 75 to 95% of the budget.[33] Insofar as local councils spend more than the budget for home help, they have to find another source of funding. They can use other means they receive from the central government or revenues raised from local taxes.

2.3 Cost sharing in AWBZ and Wmo

Cost-sharing differs between institutional care and non-institutional care. Outside of institutions, AWBZ beneficiaries have to pay 12.60 euros for each hour of care that they receive, with an income-dependent maximum. The maximum depends not just on income, but also on the number of persons in the household and whether the client is 65 or older. For single elderly persons with an income of 14,812 euros or less, the maximum amount of cost-sharing per four weeks is 17.20 euro, which is less than the price of one hour of care. For the same person with a total income of 40,000 euros, the maximum would be 307.83 euros for four weeks.[34] Cost sharing for domestic help under the Wmo is structured in the same way, but the local council can change some of the parameters— as long as maximum cost sharing does not exceed the AWBZ maximum, and cost sharing does not exceed the cost price of domestic help.[35] For example, the local council can lower the maximum cost-sharing for households with

[29] This so-called OVA (overheidsbijdrage in de arbeidskostenontwikkeling) is money that the government allows the care sector to spend on the change in wages, etc. The intention is that the care sector does not lag behind the market sector in development of the terms of employment, so that it can compete on the labour market. The employers in the care sector are in principle free to contract higher wages with the unions, but in that case they might have a financial problem.

[30] The two types are called HH1 and HH2. HH1 is pure help with household chores. HH2 is also help with organising the household.

[31] However, changes in policy are expected to lead to higher expenditures on home help (see 3.4).

[32] In 2007, the budget was still distributed on an historical basis. From 2008 on, a model with characteristics of the different municipalities was used to divide the money. At the time of this transition, redistribution effects were maximised.

[33] Pommer et al. (2009); table 2.7.

[34] The maximum in this case is 15% of (total income minus 14,812 euros) plus 223.60 euros divided by 13.

[35] Invoering WMO, *Handreiking Hulp bij het Huishouden*, July 2006, versie 2.

a low income, or change the threshold income from which the cost-sharing starts to increase, or decrease the share of income with which cost-sharing increases to less than 15%. The local council can also decide on the contribution per hour of home help. This may be as high as the total price for an hour of home help, so that, for example, elderly persons with a high income have to pay for all of their domestic help until the point that they exceed the maximum.[36] The maximum is calculated in the same way as for the AWBZ. The maximum per period can never be more than the AWBZ maximum for AWBZ- and Wmo care together. Cost-sharing for the Wmo has to be paid first.

With regard to institutional care, there are two levels of cost-sharing: low and high.[37] Low cost-sharing is relevant for the first six months in an institution and for a number of special situations— for example, when the client has a spouse who is still living independently. In the situation of low cost-sharing, the client has to pay 12.5% of the relevant income with a minimum of 141.20 euros and a maximum of 741.20 euros per month. In the situation of high cost-sharing, the maximum amount of cost-sharing is 1838.60 euros per month. If this is too high compared to the relevant income, the client has to pay 8.5% of the relevant income, with a reduction of 8% or 16% in 2009.[38] This reduction was introduced in 2009 as part of new regulation (replacing an older scheme) to financially support chronically ill and handicapped persons.[39]

A single person should at least have 276.41 euros left per month to spend freely on clothes and incidentals (clothes allowance and pocket money). For a couple, this amount is 430 euros per month. For example, a single person over the age of 65, living in an institution with an after-tax income of 30,000 euros, has to contribute about 1500 euros a month. This includes an 8% reduction. A couple in the same situation (both admitted to an institution) would have to pay about 1350 euros.

The total co-payments for AWBZ care for the elderly amounted to some 1.4 billion euros in 2005.[40] This was about 12% of AWBZ expenditures for the elderly. In 2005, the AWBZ expenditures still included home help. About half of the co-payments were paid by users of residential care. Of the 4 billion euro expenditures on home-based services, only 270 million euros was funded from user charges. This is because users of institutional care also, in principle, have to pay for board and lodging (depending on their income), and not just for the care they receive— and so their co-payments are higher.

[36] For example, cost-sharing per hour of simple domestic help in 2009 is 12.40 euros in The Hague and 19.43 euros in Heerlen.

[37] Bijdragebesluit Zorg.

[38] The relevant income is the total after-tax income, corrected for a number of factors.

[39] The new regulation is the Wet Tegemoetkoming Chronisch Zieken en Gehandicapten, Wtcg, Act on compensation for the chronically ill and disabled. This law aims at compensating chronically ill persons for the extra costs they incur because of their illness.

[40] More recent data for total co-payments in the AWBZ are available, but for 2005 we tried to calculate co-payments just for the elderly.

The co-payments for home help under the Wmo were about 200 million euros in 2007. This is for all home help, not just home help for the elderly.

2.4 Payment systems

Home-based care

The providers of home-based care are paid by the hour for almost all types of care. Day care in groups is an exception. The NZa determines maximum tariffs per hour for the different types of care that are covered by the AWBZ. For example, for personal care, the maximum tariff in standard situations is 42.96 euros, and the maximum tariff in special situations is 64.94 euros per hour.[41] The regional care office can try to negotiate a tariff below the maximum.

Institutional care

The payment for institutional care is based on the aforementioned ZZPs (severity-of-care packages that combine different care functions in the AWBZ). Before the introduction of the ZZPs in 2009, institutional care was financed in the Netherlands by budgets given to the relevant organisations (nursing homes, homes for the elderly, institutions for the handicapped). Although the budget extended to institutions was influenced somewhat by the occupancy rate and by the presence of specific categories of patients with special needs (e.g. stroke patients), the budget was still more or less fixed. Institutions had few incentives to compete for clients—an undesirable state exacerbated by the prevalence of waiting lists, in particular. At the moment, the way in which institutions are funded is being changed fundamentally. Every potential user of institutional care receives, during the assessment process, a determination of which package of care he or she is entitled to, given the user's specific needs. For each package, the NZa has determined a fixed tariff.[42] There are thus no negotiations on the tariff due. Tariffs are on a per-day basis, and tariffs for nursing and care range from 56.44 euros for ZZP1 excluding treatment to 216.92 euros for ZZP8 including treatment. In principle, the institution receives this sum of money per day when the user selects that institution, and loses it when the user moves to another.[43] Compared to the old situation, this provides an incentive to pay more attention to the preferences of clients. Institutions thus run more financial risk in the new situation than they did in the old.

[41] NZa, Beleidsregel CA-353, Extramurale zorg.

[42] For now, capital costs are not part of the price of the package.

[43] The years 2009 and 2010 are transition years in which the negative effects for individual institutions are maximised (ZN, 2009).

3 Demand and supply of LTC

3.1 The need for LTC

In 2006, the population of the Netherlands consisted of about 16 million persons. About 14% of these persons were 65 years of age or older and 3.6% were 80 or older. The almost 600,000 persons aged 80 or older have a rather large probability of needing some form of long-term care. The number of elderly is expected to increase. According to the most recent population projection of CBS, in 2050 the number of persons over the age of 65 will be 4.25 million (or 24.5 % of the population) and the number of persons over 80 will be 1.7 million (or almost 10% of the population).[44] In 2050, the number of persons aged 80 or older will be almost three times as high as in 2006.

The need for LTC is based on limitations in functioning. In the Ancien project, the number of persons in need of care is defined as the number of persons with limitations. So persons who do not actually ask for care at a certain moment, but still have limitations, are also included. This section first examines the physical and psychological disabilities of the Dutch elderly and then tries to find out how many persons actually need LTC. The Dutch Social and Cultural Planning Bureau (SCP) carries out extensive research on limitations and the use of care of the elderly.

According to SCP (2004), in 2003 356,000 persons over the age of 65 suffered from moderate physical limitations and 265,000 persons from severe physical limitations. Of the elderly, 209,000 had problems with continence and 162,000 had psychological problems (such as anxiety and depression).[45] Since one person can suffer from several disabilities, we cannot merely total these numbers. SCP (2004) tries to estimate how many elderly are in a vulnerable position and might need help. Using a broad definition, almost 700,000 elderly (aged 65 and older) suffered from severe self-care impairments in 2003; using a narrow definition, the total is only 60,000. Based on a more intermediate definition (that is, persons with severe physical disabilities or with moderate physical disabilities combined with psychological problems and/or continence problems), 340,000 elderly suffered from severe self-care impairments.

Another measure of the need for LTC is having one or more limitations in Activities of Daily Living (ADL). In 2006, about 425,000 elderly suffered from ADL limitations, according to the data of the Dutch statistical office (CBS). The results from the Share survey are somewhat lower for the Netherlands: over 320,000 elderly persons suffer from one or more ADL limitations. This may have to do with the fact that Share does not include persons using residential care. If the some 160,000 elderly who use institutional care would be added to this figure, the total for Share would be about 480,000 persons. The Ageing Working Group (2009)

[44] http://statline.cbs.nl/StatWeb/publication/?DM=SLNL&PA=71866NED&D1=0&D2=0,121-133&D3=a&HDR=T,G1&STB=G2&VW=T; population projection for January 1 of the years 2009-2050.

[45] The database SCP used for this analysis did not contain information on cognitive disabilities (such as dementia).

estimated that there were 387,000 dependent older persons in the Netherlands in 2007. Although this number appears to be based on information from Share, it differs somewhat from the numbers mentioned before, which were based on Share. The Dutch statistical office does not give data on IADL limitations (in Instrumental Activities of Daily Living). Based on Share, 545,000 elderly Dutch (65 years and older) suffered from at least one IADL limitation. Combining ADL- and IADL limitations, we see that 636,000 Dutch elderly suffer from one or more limitations, according to Share. This number is in the same range as the SCP number using the broad definition. We can thus conclude that (taking into account users of residential care) about 700,000 to 800,000 Dutch elderly are in need of care. With a stricter definition (e.g. only looking at ADL limitations), about 425,000 to 480,000 elderly would be in need of care.

For the whole population, we do not have data for the number of persons in need of care based on (I)ADL limitations. Share and CBS data only concern persons middle-aged or older. For the total number of Dutch in need of long-term care of all ages, we can only make an estimate. We base our estimate on SCP calculations of the number of people aged 20 and older, living independently, who have chronic moderate or severe *physical* limitations. So, other types of limitations are neglected for people living independently. According to Schellingerhout (2007), this concerns about 1.1 million persons in 2005.[46] Over 250,000 persons who used institutional care at the end of 2007 are added (see table 3.6). Our best estimate is that about 1.35 million persons aged 20 and older are in need of long-term care— about 11% of the relevant population.[47]

3.2 The role of informal- and formal care in the LTC system (including the role of cash benefits)

The SCP analysed the roles of formal and informal care in ten European countries, based on the Share database.[48] The use of Share means that information on formal care is incomplete, as Share does not include information on institutional care for most countries. Figure 3.1, which SCP uses to summarise their results, reveals that there are large differences in the relative importance of informal and formal care among the countries considered. The Netherlands, together with Denmark and Sweden, considers formal care to be relatively important and informal care relatively unimportant. In the so-called Scandinavian model, the public sector has the primary responsibility for persons in need of care. Greece can be found at the other extreme, where practically all care reported in Share was informal. Greece is an example of the Mediterranean model, where the extended family is responsible for care. In France and Belgium, both informal care and formal care play a considerable role.

[46] Some of these people state that they do not need help. Since they do have limitations, we include them in the total number of persons in need of care.

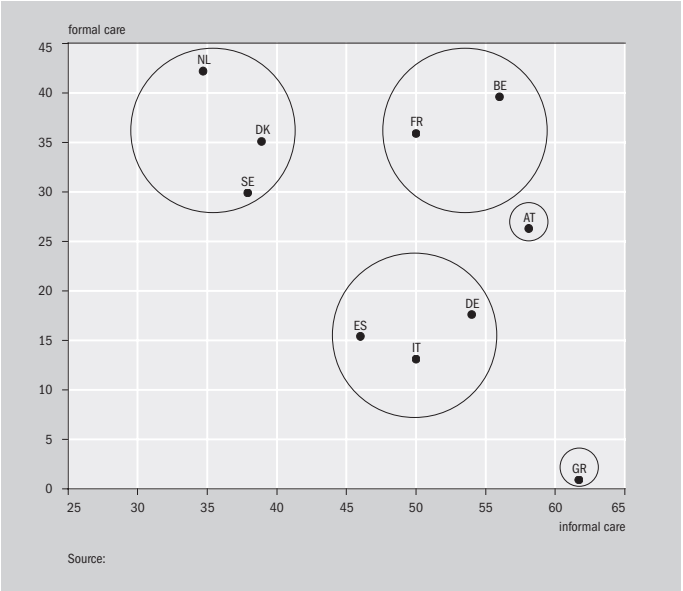
[47] For the institutional care-users, this includes persons with mental disabilities. This figure is not really comparable to the figures we described above for elderly persons, as those use another definition.

[48] Pommer et al. (2007).

In the Netherlands, a relatively large share of women works part-time. Informal care could thus potentially play a relatively large role. The availability of informal care is largest in the Netherlands among the ten countries analysed, according to SCP.[49] The take-up, however, is lowest. In practice, the available time is used by many parents (especially mothers) to take care of their children themselves instead of choosing for more formal childcare. Bettio and Plantenga (2004) state: "In the Netherlands, in fact, the family is considered to be the "natural" provider for children, while the state is thought to be the steward for the elderly"(p. 101). While many Dutch people partly take care of their parents, partners and others, formal care is very much accepted, and the elderly might prefer to be independent and not trouble their children.[50]

Figure 3.1 Relationship between formal and informal care in ten European countries

Figure 10
Title



Source: Pommer et al. (2007).

According to SCP, about 250,000 persons in the Netherlands receive informal care outside institutions (see Table 3.4). The number of formal care-users is much higher, as we can see from other sources (VWS and CBS): more than 600,000 persons received home-based formal care in 2006, and about 253,000 received institutional care at the end of 2007— of whom 164,000 were elderly (see Tables 3.6 and 3.7). [51]

[49] The large availability of informal care in the Netherlands has to do with the high proportion of part-time workers and the fact that elderly partners tend to reach a relatively high age together.

[50] According to De Boer and Timmermans (2007), the willingness to *give* informal care is larger than the willingness to *receive* it. However, the answers about willingness to give may be affected by social desirability.

[51] The number of persons who received institutional care in 2007 was higher, because that includes also persons with one or more temporary stays in an institution.

Cash benefits

For most types of long-term care, the users can choose between in-kind care and cash benefits in the form of personal budgets (PGBs).[52] Patients who choose the cash-reimbursement scheme receive a personal budget that is 25% lower than the costs of in-kind care. The assumption is that they can buy care more efficiently. They are free to choose who should deliver their care: an official institution, an independent care worker, a family member, friend, neighbour, etc. For most of the budget, patients must be able to demonstrate that they did spend the money on care.

The main goal of personal budgets is to give more autonomy to persons who need care. A personal budget allows them to organise their own care in the way they like. This could also provide an incentive for the traditional suppliers to be more responsive to the needs of clients. With the modernisation of the AWBZ that took place in 2003, the possibilities for using personal budgets were standardised over client groups, and the regulation for personal budgets became clearer, making the role of personal budgets larger. Both the number of persons using a PGB and the expenditures on PGBs increased rapidly.

Table 3.1 Expenditures on personal budgets AWBZ (in millions of euros)

	2002	2003	2004	2005	2006	2007
PGB old - care and nursing	243.9	290.9	108.6	34.7		
PGB old - handicapped	156.3	191.8	152.8	102.4		
PGB old - mental healthcare	13.3	40.6	9.8	1.3		
PGB new		130.0	450.5	783.4	1136.0	1309.0
Total	413.5	653.2	721.7	921.8	1136.0	1309.0

Source: CVZ (2008), table 13.1.

Table 3.1 shows that expenditures on PGBs in 2007 have doubled compared to 2003 (and have tripled since 2002), despite the fact that home help was shifted to the Wmo in 2007. The tables concern personal budgets for all ages and all underlying reasons (somatic, psycho-geriatric, physical, sensory or intellectual handicap, psycho-social problems). CVZ does not publish PGB data on separate age categories. Ramakers et al. (2008) analysed the budget holders of a large Dutch health insurer with four regional care offices (VGZ). Only 18% of the budget holders were older than 70 in 2007. For budgets on a somatic and psycho-geriatric basis, respectively, 40% and 73% of the budget holders were older than 70.[53] Ramakers et al. also show (using CIZ data) that older AWBZ clients are less likely to prefer a personal budget than younger persons are.[54]

Table 3.2 shows that while the total number of AWBZ personal budget holders in the Netherlands decreased in 2007 because of the shift of home help, the expenditures on PGBs in

[52] Exceptions are treatment and stay in an institution.

[53] For the budgets with a somatic basis of VGZ, 31% of the budget holders were 50 years or younger in 2007.

[54] For example, in the group aged 75-84 years, 8.6% prefer a personal budget. In the group of 18-49 year-olds, this is 31.8%.

the AWBZ still increased in 2007 compared to 2006. Including home help, the number of budget holders increased by 26% in 2007.[55] In 2007, without the relatively inexpensive home help, the expenditure per PGB holder was about 17,000 euros. For older VGZ budget holders (over the age of 70), the average budget was 12,681 euros in 2007. This was lower than the budgets for the younger age groups. So, long-term care for the elderly plays a relatively small role in the use of personal budgets. But the growth of total expenditures on personal budgets is a threat for the financial sustainability of the long-term care system.

Table 3.2 Average number of users personal budget AWBZ

	2002	2003	2004	2005	2006	2007
PGB old - care and nursing	30649	32796	15329	4968		
PGB old - handicapped	10181	11703	8750	5093		
PGB old - mental healthcare	1406	3014	895	109		
PGB new		14467	39844	66456	87642	76561
Total	42235	61979	64818	76627	87642	76561

Source: CVZ (2008), table 13.2

In 2007, expenditures on personal budgets (excluding home help) amounted to 1.3 billion euros. The continuing growth of personal budgets can be seen from the maximum amount the government has allocated for spending on personal budgets in 2009: 2.3 billion euros.[56]

One of the effects of the wide availability of personal budgets was almost certainly that some people started paying their caregivers who otherwise would have given informal care without payment. This is doubtless one of the causes of the increase in expenditures. Not everybody wanted to receive formal care, and some people were discouraged at the start of the 1990s by the waiting lists for formal care. For these persons, the personal budgets opened up new possibilities. In a survey, 33% of the budget holders indicated that one of the reasons they preferred a budget is that they wanted to use it to pay for informal care.[57] That some informal care became paid care was not necessarily an unintended policy effect. The idea was that where informal caregivers were supplying a lot of care, they were entitled to be paid. In any case, cash benefits are only available after the same assessment procedure that is used for in-kind benefits. Ramakers et al. (2008) analysed the growth in personal budgets between 2004 and 2007 for VGZ budget holders. They show that the number of persons in all categories of budget holders increased, but the increase was largest for young budget holders (under the age of 18) with a psychiatric basis for their entitlement to AWBZ care. The share of this group (in numbers of persons) increased from about 24% in 2004 to about 29% in 2007. The group ‘adults with a

[55] www.rivm.nl

[56] www.minvws.nl, pgb, consulted on June 22, 2009.

[57] Ramakers et al. (2008); table 5.2.

somatic basis' does, however, continue to be the largest group (35% in 2007).[58] The growth in the number of budget holders is thus at least partially influenced by factors that have nothing to do with ageing or care for the elderly. More young persons with disorders related to autism are applying for personal budgets. According to Ramakers et al. (2008), not only has knowledge and diagnosis of autism improved, but also the increasing complexity of society poses a challenge for children with autistic disorders to function within it.

The ministry of VWS is worried about the rapid growth in expenditures on personal budgets— all the more so as this growth does not appear to be accompanied by a lower growth of expenditures on in-kind home care. When the PGB scheme was evaluated in 2007, the Assistant Secretary wrote the following:

"At the moment, it seems that the far-too-generous definition of the entitlements in general, in combination with 'the convenience of money,' is the cause of an unprecedented growth— without there being apparent substitution of care in kind. In itself, growth does not have to be negative. But an extreme growth that cannot be explained easily, combined with indications for an unintended use of means, demands a very critical look at the instrument— precisely to keep the good elements for the future." [59]

This quotation shows that the Assistant Secretary envisions at least three problems:

- Entitlements to AWBZ care are not clear enough;
- Cash is so attractive that it may elicit new demand;
- There might be unintended use of public means.[60]

The following is a recent example of unintended use of cash benefits. Residential elderly homes that lost the bid for home help in their municipality (because they were too expensive) found a loophole to nevertheless keep their clients. They did this by requesting a collective personal budget for all clients, while their clients were incapable of managing a personal budget themselves.[61] However, this kind of unintended use appears to be rare. Another possible risk of cash benefits might involve family members pressuring a patient to apply for a personal budget in order to pay those family members— in cases where the patient would have been better off with professional care.

According to the ministry of VWS, the option of personal budgets has so many advantages for users that it should not be abolished. Having said that, there has been a growing perception of the need for improving the regulation. Following the evaluation, several measures were taken

[58] The somatic group consists of budget holders with as basis for their entitlement somatic problems or a physical handicap or a sensory handicap, or those with psycho-geriatric problems who do not have as basis intellectual handicap, psychiatric or psychosocial problems.

[59] VWS (2007), pgb in perspectief, brief aan de Voorzitter van de Tweede Kamer der Staten-Generaal, November 9, 2007. Quotation translated from Dutch.

[60] This refers to rumours that, for example, providers use the personal budgets to increase their turnover, or that grandchildren use them to take their grandmother to a jazz festival.

[61] *Volkskrant*, Tehuizen Zaanstad innen collectief pgb, April 21, 2009.

to improve the scheme for personal budgets. One of the measures was that the amount of expenditures out of the personal budget that did not have to be justified, which was increased to 2500 euros at the start of 2007, was decreased again. The Assistant Secretary is considering changing the rules in such a way that cash benefits can only be paid out to the budget holder him- or herself. In addition, more general measures were taken to improve the sustainability of long-term care that also can be expected to affect PGB expenditures. For example, the entitlements to assistance were decreased at the start of this year (2009) (see 4.3). This is relevant for the expenditures on personal budgets, as 76% of the VGZ budget holders were entitled to supportive assistance. This was the function that was most often purchased with the personal budget. For entitlements on the basis of psycho-geriatric problems, a mental handicap or psychiatric problems, the frequency of supportive assistance was, respectively, 96%, 95% and 92%.

3.3 Demand and supply of informal care

Supply of informal care

The number of informal caregivers, which is determined on the basis of surveys, heavily depends on the exact definition. The most recent survey in the Netherlands was carried out in 2007 (see De Boer et al., 2009). The total number of informal caregivers for all persons in need of care was 3.5 million in 2008— but not all of these persons were giving help during a longer period. Of these 3.5 million caregivers, a selection of persons who helped others in relatively serious care situations was approached with a survey. For the Netherlands as whole, this concerned 1.7 million persons. Data were collected and published for these persons, although we must bear in mind that the definition of informal care is not completely in accordance with long-term care in the Ancien project: the survey was held under persons who helped in relatively serious care situations, and the respondents could give help for a longer or shorter period, of an intensive or non-intensive nature.[62] The average period of informal care-giving was more than five years in the survey.

Of the persons who received informal care in 2007[63], more than half (57%) were 65 years and older— and 31% were 80 years and older.[64] Two-thirds of the care-receivers were women (65%). About half of the group was educated at a low level and had a low household income (less than 1400 euros (after tax) per month for the household).

[62] Earlier results can be used as a comparison. In 2001, 3.7 million persons in the Netherlands gave informal care (De Boer et al., 2003). When only the persons are counted who gave informal care more than eight hours per week *and/or* more than three months, the number is 2.4 million. This was 19% of the population of those aged 18 and older. With a stricter definition, informal care given more than eight hours per week *and* more than three months, the number of informal caregivers decreased to 750,000 persons.

[63] This information is based on the answers in the survey of persons who gave informal care.

[64] Den Draak (2009).

The majority of informal caregivers helped someone outside their own household.[65] More than 40% helped a parent or parent in-law, and 11% helped a friend. One-fifth of the caregivers helped their partner, and 9% helped a child.

The sorts of informal care that were most given included emotional support (83%), assistance with visits (78%), domestic help (77%) and assistance with administrative matters (62%). Personal care and nursing care were given much less frequently (respectively, 29% and 26%). Personal care-giving to partners and children was more frequent, as may be expected. On average, the caregivers spent 22 hours per week on informal care in the period during which help was most needed. With partners and children, the average number of hours per week was much higher (respectively, 45 hours and 37 hours). Women and persons between the ages of 45 and 65 years were most over-represented in the group of caregivers, compared to the general population (see Table 3.3).

Table 3.3 Characteristics of informal caregivers and of the Dutch population of 18 years and older

	Informal caregivers	General population
Sex		
Male	39	48
Female	61	52
Age		
18 – 34	12	20
35 – 44	20	22
45 – 54	27	20
55 – 64	24	18
> 65	17	19
Opinion of own health status		
Good	81	83
Bad	19	17
Composition of the household		
Single	21	23
Two adults, no child	39	38
Two adults with child	35	35
One parent family	5	4

Source: De Boer et al. (2009), Table 2.1.

In 2001, formal home care was combined with informal care-giving in 45% of the cases (De Boer et al., 2003). Home care was most available for informal caregivers who took care of their parents (55%), and least available for those taking care of children (17%). There appeared to be a division of labour between home care and informal care-giving. The home-care help did relatively much of the washing of the dependent person, the heavy work in the household,

[65] Hoefman (2009).

dressing and undressing and help with going to the toilet. The informal caregivers did most (or practically all) of the work on shopping, administration, social activities outside the house, cooking, organising the household and keeping an eye on the care receiver.

Demand for informal care

A great deal of Dutch research concentrates on informal care*givers*, their characteristics and their burden. There is less information on persons who *receive* informal care.
According to the SCP, about 250,000 persons aged 30 years and older who live outside institutions use informal care, of which about 160,000 are elderly.[66] About 150,000 persons use informal care as the only form of care. These figures are lower than earlier figures published by SCP. The weights were changed, based on a comparison of users of formal care at home from a survey and from administrative data. As far as we know, the new SCP data are the most accurate that are available at the moment.

Table 3.4 Users of informal care, 2005

	Number of users (x1000)	%
Only informal care	146	
Total informal care	247	
Of which:		
Man, < 65	52	21
Woman, < 65	38	15
Man, ≥ 65	82	33
Woman, ≥ 65	75	30

Source: Eggink et al. (2009), table 4.1, and more detailed data SCP, delivered at the request of CPB.

3.4 Demand and supply of formal care

Formal care under the AWBZ does not just concern the elderly. Within Dutch LTC, three sectors can be distinguished:

1. Care and nursing
2. Care for the disabled
3. Mental healthcare

The sector 'care and nursing' most closely resembles the concept of long-term care for the elderly that we want to study in Ancien. However, this sector includes all care and nursing—also for younger persons who, for example, need temporary care, have a chronic disease or

[66] This section is based on data that the Dutch Social and Cultural Planning Bureau has made available to us.

suffer from problems such as autism or behavioural problems. In analysing the data, we continually have to check to what extent they fit within the Ancien concept of long-term care for the elderly.[67]

We start by looking at the AWBZ as a whole. Before 2007, practically all of the formal long-term care was covered by the AWBZ. Looking at the volume development of AWBZ expenditures over a somewhat longer period, we see that volume increases were substantial in the first half of this decade, with a volume growth of 8% in 2002 (see Table 3.5). This was partly caused by efforts to lower waiting times. The low volume growth of the AWBZ in 2007 was caused by shifting home help to the Wmo. The volume decrease of over 9% in 2008 had to do with shifting part of mental healthcare to the health insurance scheme ZVW. Corrected for shifts, the volume growth of long-term care was considerably higher than the pure demographic effect over this period.

Table 3.5 Volume changes collectively financed care

Government expenditure	2000	2001	2002	2003	2004	2005	2006	2007	2008
Care (collectively financed)	3.4	3.9	6.6	5.3	2.5	1.5	23.5*	7.3	2.0
Long-term care (AWBZ)	3.4	3.8	8.1	6.1	4.1	3.0	3.3	1.1	– 9.4
Public health insurance (ZVW)	3.4	4.0	4.9	4.5	0.8	– 0.2	47.3*	4.6	10.3
Other (including Wmo)	0	0	0	0	0	0	0	0	11.8

* Introduction of the ZVW, former private health insurance became part of public insurance
Source: *CEP 2009*

At the end of 2007, 588,000 persons used care under the AWBZ; this was 3.6% of the Dutch population (see Table 3.6). Of these persons, 500,000 used in-kind care, 70,000 used a personal budget and 18,000 used both. Of the 588,000 AWBZ users, 391,000 were elderly users, 113,000 were handicapped users and 84,000 were psychiatric patients. So, in numbers, the elderly comprised about two-thirds of the AWBZ users. Of the elderly, 42% used institutional care, and 82% used AWBZ care because of somatic problems. The remaining 18% used AWBZ care because of dementia.

Table 3.6 Number of AWBZ users, end of 2007 (excluding users of home help)

	Clients, total	Clients, institutional care	Clients, care at home
Elderly, somatic	319000	109000	210000
Elderly, dementia	72000	55000	17000
Elderly, total	391000	164000	227000
Persons with a handicap	113000	66000	47000
Psychiatric patients	84000	23000	61000
Total	588000	253000	335000

Source: Letter to the chairperson of Parliament, from the Assistant Secretary of VWS, January 29, 2009.

[67] The exact distinctions that would be ideal for our purposes are not always available in the data.

In 2007, in addition to the AWBZ users, there were many users of domestic help whose care was funded by the Wmo. In 2007, 237,000 used domestic help as the only form of LTC. [68] Of this group, 187,000 persons were 65 years and older.

The total number of formal long-term care-users, in persons, is difficult to determine (see Appendix A). At the end of 2006, 160,000 persons aged 18 and older used institutional care, which can be seen as an approximation of the number of persons using institutional care permanently (see Table 3.7). Home-based care was used by about 608,000 persons (including temporary users and handicapped or psychiatric patients, which we would like to exclude). As explained in the appendix, the upper limit of the number of older permanent formal care-users is about 650,000. If our estimation were correct (that 700,000 to 800,000 elderly need long-term care), then at least 50,000 to 150,000 elderly would only use informal care— or would use no care at all.

Table 3.7 Users of formal long-term care (excluding handicapped and psychiatric patients to the greatest extent possible, including users of home help), 2006

	Institutional, end of year (excl. handicapped and psychiatric patients)	Institutional (excl. handicapped and psychiatric patients)	At home (incl. handicapped and psychiatric patients)
Age			
65 - 70	4615	8080	41300
70 - 75	9870	16895	70235
75 - 80	21625	34650	114320
80 - 85	37885	56770	134685
85 - 90	42470	61230	90960
90 - 95	27130	39460	33610
over 95	8860	13930	7015
Total 65 and older	152455	231015	492125
Total 18 and older	160190	243910	607575

Source: CBS, statline

While institutional care plays a relatively heavy role in the Netherlands, LTC policy is aimed at substitution towards more care at home. This is considered to be more efficient and more in line with preferences of care-users. The use of LTC at home has been increasing considerably during the past few years. Between 2004 and 2007, the total demand for care at home increased annually by 3.2% in persons and by 8.6% in hours.[69] Remarkably, this is the result of a strong growth in home-care services and a *decrease* in home nursing care. We have found no explanation for this decrease. It is not quite clear to what extent a substitution took place between institutional care and care at home. Between 1998 and 2005, the number of hours of nursing and care given at home increased by 36%. The number of residents in nursing homes

[68] CBS, Statline, AWBZ/WMO-zorg zonder verblijf, consulted on March 17, 2009.
[69] CBS, Statline.

and residential care homes decreased by 8.5%, which seems to point to substitution. With constant patterns of long-term care use, we would have expected an increase in the number of users of institutional care, given the ageing of the Dutch population. However, clinical days in nursing homes increased by 13%. NZa (2008) compares regions of the Netherlands to analyse the relation between care inside- and outside institutions per person aged 75 years and older. This analysis indicates that there may even be a positive relation: regions with many beds in institutions also use more hours of care at home.[70]

Looking at a different period, figures 3.2 and 3.3 show the overall development of institutional and home-based care for the elderly between 2002 and 2006. While the number of residents has decreased (for nursing homes and residential homes together) by 0.9% per year on average, the volume of care in institutions has increased by 2.2% per year on average.[71] It seems that groups with a relatively heavy need for care (such as residents with senile dementia) became more important in the institutional population. The increase in the average severity of care is not surprising, as the elderly stay at home as long as possible. More and more, only the more severe cases end up in an institution.

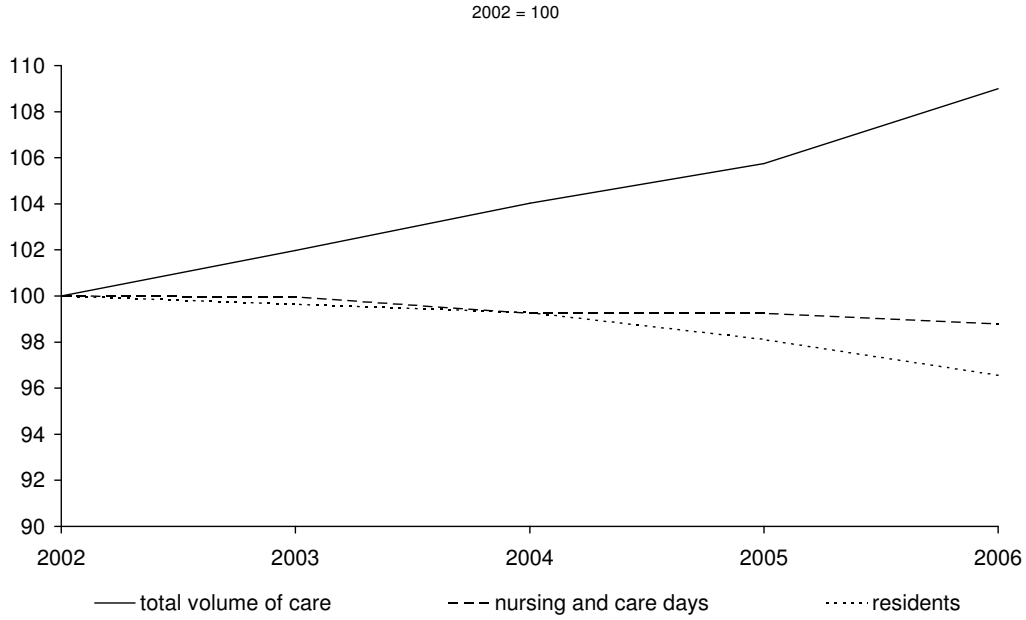
The number of elderly using care at home has increased, but the volume of care at home has increased much more. So, in the home situation the intensity of care has grown as well. In terms of volume, both institutional care and care at home have increased— but the increase of at-home care was far larger.[72]

[70] The NZa does not have all the necessary data for this analysis, and plans to do further research.

[71] CBS Webmagazine: Oudere krijgt steeds meer zorg.

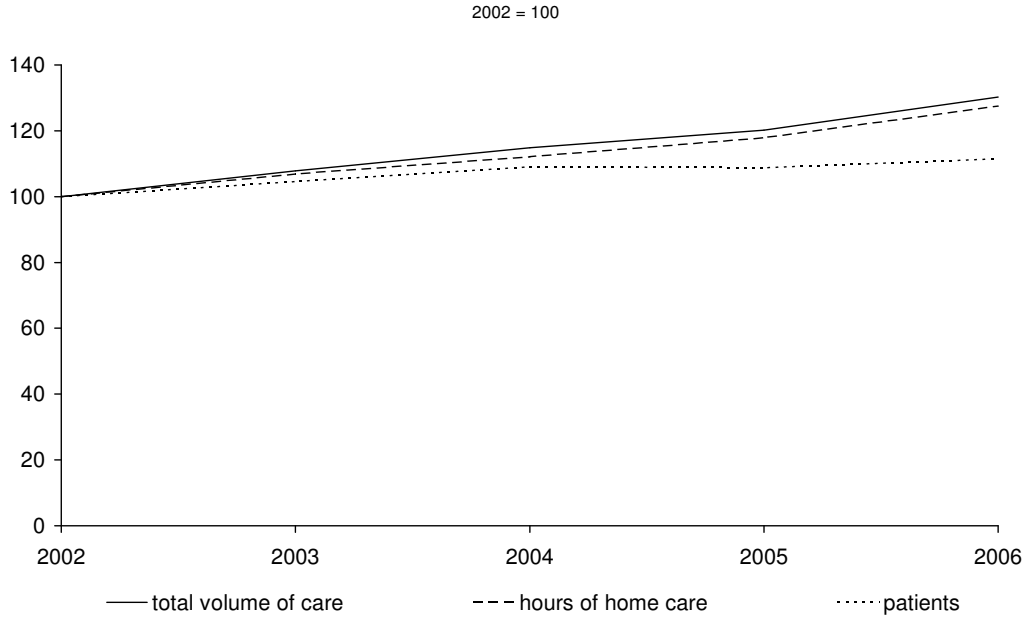
[72] The volume growth can be slightly different from the growth in number of hours, as different types of care are weighted with tariffs. More expensive types of care thus have a higher weight.

Figure 3.2 Use of institutional care by the elderly



Source: CBS, NZa, CAK-BZ.

Figure 3.3 Use of home-based care by the elderly



Source: CBS, NZa, CAK-BZ.

Institutional care

Institutional long-term care is available in several forms. The most intensive care is given in nursing homes, and less intensive care in residential homes for the elderly.[73] About 90% of the residents of nursing homes receive nursing care daily (88% in somatic nursing homes and 96% in psycho-geriatric nursing homes).[74] In homes for the elderly, 62% receive nursing care on a daily basis. The intensity of personal care is also higher in nursing homes: more than half of the residents need daily help with going to the toilet. In homes for the elderly, this is only 10%.

In homes for the elderly, the residents have their own small apartment, while in nursing homes residents still have to share a room in many cases— even though a policy goal is to increase the number of single-person rooms.[75] As might be expected, residents of nursing homes have more health problems than residents of homes for the elderly.[76] But over a longer period, there has been a convergence of the health status of residents of these two types of institutional care. In the past, the normal state of affairs was that the elderly went to live in a home for the elderly, also when their health was still good. Bad health was even seen as a barrier for admission to a home for the elderly. At that time, residents of homes for the elderly were relatively healthy. Currently, all efforts are aimed at keeping relatively healthy elderly persons at home, with the help of home care and social services. Hence, those elderly who are admitted to residential care have more health problems than the residential care-users of the past.

Part of the CIZ assessment is meant to determine whether a potential client needs institutional care, and if so, which type of care. Persons with severe physical disabilities like multiple sclerosis or severe psycho-geriatric problems are referred to nursing homes. Individuals with less-severe behavioural problems and less clinical need are referred to homes for the elderly.

As of January 1, 2006, nearly 117,000 persons aged 65 and over lived in a residential or nursing home.[77] Of all persons aged 65 and older, 5% lived in a residential home or nursing home. Of the elderly aged 80 and over, that number was 16%. In 2005, there were 366 nursing-home organisations and 538 residential care organisations.[78] The employment in residential care facilities was 73,000 full-time equivalents (FTEs); in nursing homes it was 80,000 FTEs. The

[73] Norton (2000) calls this type of residential care 'board and care homes'.

[74] De Klerk (2005).

[75] In May 2009, there were still 8,789 places in rooms with three or more beds, while the number was 27,665 in 1998 (Tweede Kamer, vergaderjaar 2008-2009, 30957, nr. 101).

[76] More than 70% of nursing-home residents suffered from severe limitations in carrying out their daily activities because of health problems in 2004. In homes for the elderly, this was about 40% (De Klerk, 2005).

[77] CBS, Statline, Personen in institutionele huishoudens; leeftijd en geslacht , 1 January. The institutional population is not the same as the users of AWBZ-funded institutional care. One difference is that AWBZ-funded institutional care also includes temporary care. Another difference is that persons who still live at their old address, according to the municipal administration, are not part of the institutional population.

[78] The 538 residential care organisations had 1625 branches (information from CBS). For comparison, the number of Dutch municipalities was 467 in 2005.

employment in institutional care for the elderly was about 2.4% of total employment. The number of beds was about 162,000 in 2005.

During the year 2006, about 244,000 persons received formal institution care (see table 3.8). Of this group, 231,000 persons were aged 65 and older; 73 percent of the older care-users were female and 27 percent were male. Nearly 50 percent of the institutional care-users among the elderly were aged 85 or older. Of this group (85 years and older), 79 percent were female and 21 percent male.

Table 3.8 Formal institutional care in the nursing and care sector, 2006

	Total	Male	Female
Persons receiving formal institutional care in total	243910	69245	174665
Persons receiving formal institutional care by age group			
65-70	8080	3725	4355
70-75	16895	6855	10040
75-80	34650	11710	22940
80-85	56770	15980	40790
85+	114620	24250	90360
Total 65+	231015	62520	168485
% Persons aged 65 and older receiving institutional care	100	27	73
% Persons aged 85 and older receiving institutional care	100	21	79

Source: CBS, Statline

Waiting list and waiting times for institutional care

At the start of this century, policymakers in the Netherlands placed the waiting lists for residential care high on the political agenda. Their intention was to reduce drastically the waiting times for applicants for various types of residential care services. To further this goal, a new measurement system was introduced to monitor accurately the inflow and outflow from the waiting list.[79]

It seems likely that waiting has become less of a problem since the start of the century. However, it is not possible to obtain clear insight into the developments over time. Registers, estimation methods and cleaning methods have changed over time. As a result, the figures from different years cannot be compared.[80]

On January 1, 2005 nearly 35,000 persons were waiting for residential care or nursing-home care. About 79% of these persons had a somatic disease and approximately 21% a psycho-geriatric disease. The average age of the persons on the waiting list was 80 years. Nearly 80 percent of elderly persons on the waiting list for institutional care were 75 years and older. 50% of the elderly persons on the waiting list were between the ages of 80 and 90 years. 65% of this group received 'transitional care'. Transitional care is temporary care that the waiting persons

[79] This was called "fase 3 van de AWBZ brede zorgregistratie (AZR)".

[80] RIVM : Dutch Healthcare Performance Report 2008.

receive until the appropriate care determined in the assessment procedure is available. Transitional care consists mainly of home care.

Because of the availability of transitional care and other reasons, only a small share of persons on the waiting list faced a really problematic situation. Both in 2005 and in 2007, the share of persons on the waiting list who were eligible for institutional care but who could not receive the appropriate care within a reasonable period of time was estimated at 5% to 10%.[81] Almost all persons concerned had multiple care needs.

At the start of 2007, the average waiting time for institutional care ranged from 13 to 48 days, respectively, for activating assistance and for long-term residential care.[82] This calculation concerns persons who had already started to receive care. A second method of calculation was based on information from persons still on the waiting list: between 130 and 361 days, respectively, for activating assistance and for long-term residential care.[83]

Hartmans et al. (2009) tries to present greater insight into the waiting-list situation by cleaning the raw data from the administrative system (AZR). On January 1, 2008, of the persons who were waiting for institutional care, about 51,000 persons (of all ages) needed care for mostly somatic or psycho-geriatric reasons.[84] Some 12,000 persons waited for care at home for mostly somatic or psycho-geriatric reasons. For most of those waiting, the fact that they had to wait was not a real problem. Many persons with an entitlement to institutional care did not want to make use of their entitlement yet— either because they wanted to delay the move to an institution (and used care at home in the meantime) or because they were waiting for a place in their preferred institution.[85] Furthermore, a considerable number of persons classified as "waiting" either chose to use less care at home than their entitlement indicated, were still waiting for a shorter period than the arranged acceptable waiting time, or chose a personal budget after all— even though they were entitled to institutional care.[86] In total (including handicapped persons), there were 4,500 persons for whom waiting was considered to be problematic (about 5% of the total waiting list). Of these, 1600 were elderly persons with dementia problems on January 1, 2008.[87] A year earlier, 2750 elderly with dementia problems were in a problematic waiting situation. The situation for this group had thus improved in 2007.

In 2007, about 81% of all non-handicapped persons who started to use institutional care had to wait less than the accepted waiting period. This is about the same share as in 2006. 89% of non-handicapped persons who started to use care at home got their care within the accepted timeframe in 2007 (86% in 2006).

[81] RIVM: Zorgbalans 2008.

[82] Landelijke wachtlijstrapportage AWBZ: peildatum January 1, 2007.

[83] At the time, the start of care delivery was not always correctly documented.

[84] In other words, this number does not include persons who needed care mainly because of physical or intellectual handicaps.

[85] This concerns more than half of all persons waiting on January 1, 2008 (including handicapped persons).

[86] As there are in principle no personal budgets for institutional care (except for the "full package at home"), this may mean that these people chose to organise their own care with a smaller amount of publicly financed funds.

[87] The other 'problematic waiters' were younger persons with light mental handicaps and behavioural problems (2125), and older persons with special care needs (750) (e.g. elderly with psychiatric problems or handicaps).

All in all, it seems that for most of the elderly who need long-term care, waiting does not constitute a real problem. There is, however, a problem for elderly persons with more advanced dementia that are in need of institutional care.

Home-based care

Home care in general

Expenditures on home-based care are increasing rapidly: from 5.3 billion euros in 2004 to 7.4 billion euros in 2007. This is care for the elderly, handicapped and psychiatric patients, including personal budgets but excluding home help.[88] The volume of home-based care for just the elderly has increased considerably between 2002 and 2006 (see figure 3.3).
In 2005, there were 264 home-care organisations in the Netherlands. Employment was about 76,000 labour years, of which about 9% were nurses.

Formal home care can be given in the form of domestic help, assistance, personal care, nursing or treatment. Assistance is a rather broad and somewhat difficult-to-define type of LTC. It includes day care in groups as well as personal assistance (one-on-one). It can be given in the form of care in kind, but also in the form of cash. This used to be the only form of AWBZ funded care without cost-sharing.[89]At the moment, the entitlements to assistance are being reduced. In the past, the assistance was not just aimed at being able to live independently (for example, help with organising the household or with administration), but also at social participation (for example, walking, going to the shops or to church, going out). Originally, this type of LTC was only used by the handicapped. In 2003, all types of AWBZ care became equally available for all AWBZ users. From that moment on, the use of assistance has been growing very rapidly. Since assistance is usually nice to have, moral hazard may play a role.

The increase in the use of assistance has probably more to do with increasing use of this type of care by young persons with psychiatric or behavioural problems than with changes in use by the elderly. There were two types of assistance: supportive and activating.[90] Supportive assistance (for all age categories) was the fastest growing category of care at home between 2004 and 2007: with growth of 200% and of 290 million euros.[91] This was almost exclusively volume growth. To curb the cost increases, assistance for social participation and assistance for persons with minor limitations will no longer be given. Assistance will become more targeted to enable users to keep on living independently. Cost-sharing will be introduced for the function assistance (from 2010 on). Persons with psychosocial problems will no longer be eligible for AWBZ care. This concerns, for example, problem families and homeless persons, whose care is arranged by the local government.

[88] CVZ (2008b).
[89] For young persons under the age of 18, no co-payments had to be made at all. Growth in the use of assistance was especially large for the young.
[90] From 2009 on, only one category is available: assistance.
[91] CVZ (2008). This was in the sector 'nursing and care', so it excluded care for the disabled and mental healthcare.

For most other types of care at home, growth was more modest. Growth of nursing-care expenditure was even negative— even though prices increased. Compared to 2004, fewer elderly persons used nursing care in 2007 and the average number of hours per user was lower (41 hours in 2007 and 45 hours in 2004).[92]

Providing an impression of the magnitude of the different services, Table 3.9 shows the expenditure on AWBZ care at home in the nursing and care sector in 2006 and 2007.[93] In 2006, expenditure on home help and personal care was about equal (about 1.2 billion euros). In 2007, home help was taken out of the AWBZ. Expenditure on nursing care was lower, but still considerable (about 0.7 billion euros). Expenditure on supportive assistance was relatively modest in 2006 (340 million euros), but fast growing. Expenditure on treatment and activating assistance was very low.

Table 3.9 Expenditures AWBZ care at home in the sector nursing and care (millions of euros)

	2006	2007
Home help	1198	.
Personal care	1163	1,263
Nursing care	758	712
Supportive assistance	342	429
Activating assistance	47	30
Treatment	19	21
Day activities	314	367
Other outputs	88	74
Transportation costs	47	51
Travel costs	0.8	0.9
Full package at home	.	0.1
Total	3978	2948

Source: website CVZ

Home care for the elderly

Table 3.10 shows the frequency of use of different types of care at home for elderly persons.[94] The group that uses home help only is the largest, followed by the group that uses home help in combination with personal and nursing care.

[92] CBS, Statline. The decrease in the volume of nursing care can partly be explained by a change in the definition of nursing care. Some activities are now reimbursed under the heading 'personal care'.

[93] These figures do not include expenditures on personal budgets, as there is a separate subsidy for those expenditures.

[94] The data of the Dutch statistical office, CBS, only concern home help, personal care and nursing. The CBS does not have data for assistance and treatment, as there are no co-payments for those types of care and the data are collected through the organisation that manages the co-payments (CAK).

Table 3.10 Number of persons 65 and older, with care at home in 2006, by type of care	
Home help only	184255
Personal care only	26540
Nursing care only	35935
Domestic and personal care	4640
Domestic and nursing care	22110
Personal and nursing care	54930
Domestic, personal and nursing care	119710
Total care at home	492125

Source: CBS, Statline.

Within the group of elderly users of care at home, the largest group of users was found among 80-85 year olds (135,000 persons). Only 7,000 persons aged 95 and older were using formal home care. As could be expected, the oldest users used more hours. The largest average number of hours of care at home was used by women aged 95 and older: 347 hours per year (see Table 3.11).

Table 3.11 Average number of hours care at home per care-user per year, 2006

	Women	Men	Total
Age			
65 - 70	130	105	122
70 - 75	139	114	132
75 - 80	154	124	146
80 - 85	176	141	167
85 - 90	212	168	201
90 - 95	268	205	253
Over 95	347	262	329

Source: CBS, Statline

Home help

Since home help became part of the Wmo, it has had a special position within home-based care. The purchasers are no longer the regional care offices, but the municipalities. As local governments have much stronger incentives to save money, price competition has intensified to the point where many providers have begun to offer home help below the cost price. PWC (2008) shows that the average cost price for an hour of home help was 21.54 euros in 2008, while the average tariff that local government paid was 19.14 euros. Thus, on average, the providers lost 2.40 euros per hour of home help. The relative loss was largest for small providers and those working in the four biggest cities.[95] Because of the Wmo, the providers started to work more with cheaper freelancers (the 'alfa hulpen') instead of employees entitled to all forms of social security. The ministry of VWS considered this to be an undesirable effect.

[95] PWC (2008).

Measures have been taken to redress this situation: providers of care in kind will no longer be allowed to deliver home care with freelancers. There has been some debate about deterioration in the quality of home help, but as yet there is no empirical basis for this concern.
The obligation that the local authorities have to compensate their citizens for limitations in their ability to take care of their household seems to work reasonably well. In 2008, only 13% of the persons with a limitation in domestic tasks who asked for Wmo support felt that they were not sufficiently capable of running their household. For persons of 75 years and older, this was only 6%. Especially younger persons, and those with psychiatric problems, had difficulties.[96]

Waiting times

At the start of the century, waiting times were seen as problematic, not just for institutional care, but also for care at home. Unfortunately, it is not possible to construct a time series for waiting times with truly comparable data. Over time, different sources have been used; these will hopefully become more reliable. But the changes that have taken place in data collection hinder comparability. However, results for care at home seem to be favourable when real waiting times are compared to the standard for acceptable waiting times (what is known as the "Treek-normen"). For home-based care in the nursing and care sector, 95% of waiting times in the period October 2004 to January 2007 conformed to the standard. Hartmans et al. (2009) give somewhat lower figures for 2006 and 2007 (respectively, 86% and 89%).

Competition

Competition between home-care providers plays a role in both the AWBZ and the Wmo. Competition is fiercer in the Wmo, as municipalities (as purchasers) have much stronger financial incentives than regional care offices. However, the care offices do negotiate with the providers on price, and they try to get a reduction in maximum prices. In 2008, the regional care offices realised a reduction of 2.5% on the maximum prices (on average) for all home-based AWBZ care (meaning that home help was excluded). This reduction was smaller than in the preceding years. In 2006, the reduction was 4.3%. This decrease in reductions does not mean that the efforts of the care offices decreased. First of all, there is a technical reason for the decrease. Furthermore, national price cuts as well as the strong price competition on home help in the Wmo played a role.[97] The providers felt that they simply could not afford to agree on any further reductions.

The personal budget can be seen as a separate type of funding. It stimulates competition because care recipients can contract the providers themselves. Providers will need to compete in order to be chosen.

[96] De Klerk et al. (2009).
[97] NZa (2008).

4 LTC policy

4.1 Policy goals

The goals of Dutch health and LTC policy are quality, accessibility and affordability of care. The general policy goal for LTC was formulated in 2008 as follows: "*To ensure that for persons with a long-term or chronic disorder of a physical, intellectual or psychological nature, care of good quality is available and that the cost level of this care is acceptable to society.*"[98] This general goal can be made operational and testable. The current government, shortly after the start of the coalition, drew up a policy program (for the 2007-2011 period) that featured a number of more or less testable goals for LTC:

- A substantial increase of the number of voluntary caregivers and of the number of informal caregivers in 2011 (government goal #35);
- Clients judge the quality of care as sufficient for 90% of providers of AWBZ care (government goal #45c);
- The legal rights and obligations of patients and clients are established in 2011, and information on this point is accessible to everyone (government goal #45d);
- More responsive care by modernizing care concepts and innovation (government goal #46).

In the policy plans for 2009, a number of goals for LTC were made operational by determining performance indicators and the desired value for these indicators in 2009 and 2011:[99]

- Strengthening the position of citizens in the system of LTC (in 2009, information about supply and quality on the internet for 100% of LTC providers);
- Necessary care is available for every patient (quantitative goals for assessment and waiting times);
- The care is effective and safe and is experienced positively by the client (good quality care) (quantitative goals for quality and quality information: for example, 2.8% pressure ulcers (decubitus) in 2009 and 2% in 2011);
- The costs of care are acceptable to society (21.8 billion euros in 2009 and 22.5 billion euros in 2011).

[98] Tweede Kamer, vergaderjaar 2008-2009, 31700 hoofdstuk XVI, nr. 2.
[99] Tweede Kamer, vergaderjaar 2008-2009, 31700 hoofdstuk XVI, nr. 2.

4.2 Integration policy

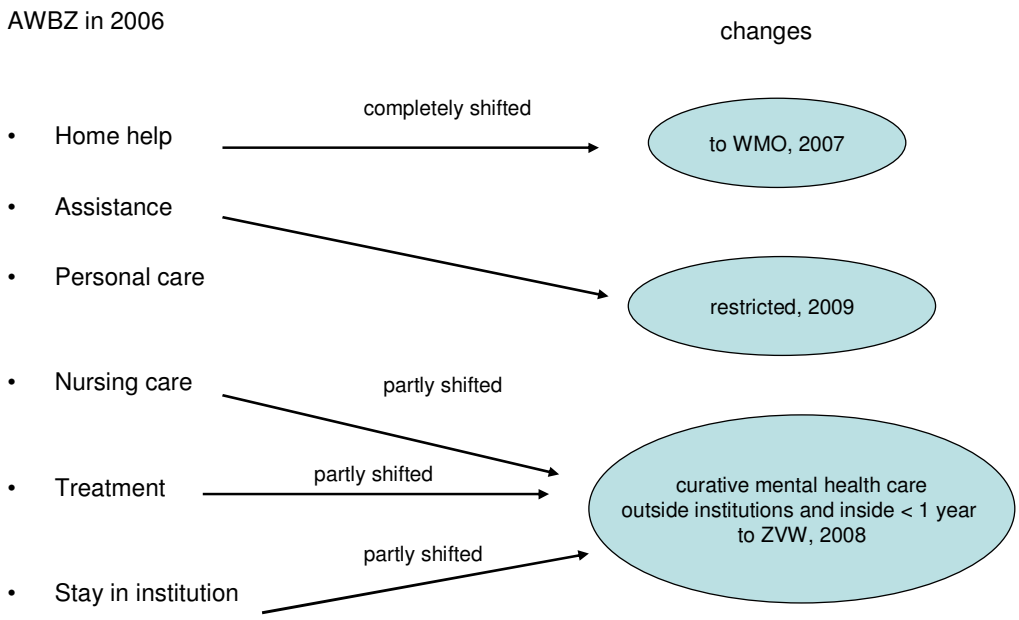
Although the Dutch government has as yet not formulated a clear policy with respect to integration of LTC services, an analysis of the decisions with regard to integration shows which considerations play a role. Integration policy appears to be aimed at bringing together (in one system) services that have similar characteristics in order to improve coordination and efficiency. As mentioned before, domestic help was removed from the AWBZ in 2007 and shifted to the new Wmo scheme for social assistance. Several reasons were cited for this shift. The government expected the shift from an open-ended to a budgeted scheme to improve financial sustainability. The shift would not only provide an incentive for potential users to take more responsibility for solving their problems with housekeeping, but would also give the council leeway for more integral provision of social and other services for persons with limitations, fine-tuned to local circumstances. The local council also bears responsibility for housing, transport, social participation, facilities for the handicapped (including adjustments to their house) and services like meals-on-wheels. While this policy thus created more scope for integration within local services, it also created a new partition within long-term care, between domestic help and other LTC at home.

In 2008, curative psychiatric care (mental healthcare), which used to be covered by the AWBZ, was shifted to the health insurance scheme (ZVW). This form of mental healthcare is aimed at curing psychological or psychiatric problems or disorders, and the government therefore considered it to be more 'at home' within healthcare insurance, than in a public insurance that is aimed at long-term care for chronic problems. The government expects that this shift will improve the consistency of the AWBZ scheme, since it means that exceptions on the general AWBZ rules with regard to mental healthcare can be abolished. Furthermore, bringing more curative care together under the same scheme will hopefully stimulate the delivery of integrated curative care. In the longer run, health insurers will ideally start to bear financial risk on mental healthcare, which might give them an incentive to organise the care more efficiently.[100]

As mentioned in 1.6, the government has plans to partly shift temporary care for rehabilitation that is necessary after a hospital admission from the AWBZ to the ZVW in 2011 or 2012. This is part of the attempt to limit the AWBZ scheme to chronic problems.

[100] VWS, Overheveling ggz per 1 januari 2008, July 11, 2007.

Figure 4.1 Changes in the AWBZ



4.3 Recent reforms and the current policy debate

A short recent history

Policymakers are often confronted with trade-offs between goals. To a certain extent, this explains why changes in LTC policy take place on a more or less continuous basis: in some periods the goal of cost containment gets more attention; in other periods the emphasis might be more on such goals as client responsiveness. In the 1990s, affordability was ensured by government regulation aimed at budgeting providers. This caused problems with waiting lists and waiting times that were seen as unacceptably long. These problems were addressed from 2000 on by making extra funds available within the same system to increase production and reduce waiting times. In 2003, the government realised an important reform of Dutch long-term care: the 'modernisation' of AWBZ. This reform aimed at increasing the client responsiveness of the care system. The distinction between different types of providers and different groups of AWBZ users (institutional and home care, elderly, mentally handicapped and psychiatric patients) became less pronounced, because all providers could offer their services to all client groups. LTC services were no longer defined as the products of certain LTC institutions, but in terms of the functions they were supposed to serve. All of the designated AWBZ functions became available for all users and could be provided by all suppliers. The possibilities for using personal budgets were standardised over client groups, and the regulation for personal budgets became clearer, thereby expanding the role of personal budgets. The modernisation improved the position of care-users, but made it more difficult to stay within the macro budget for AWBZ

care.[101] Costs began to increase: part of formerly unpaid informal care became paid care that was funded from personal budgets, and other client groups started using certain AWBZ functions (like assistance), which were formerly used mostly by the handicapped. Concern grew over the seemingly uncontrollable increases in AWBZ costs. In 2003, the costs increased by 10% (see Table 2.1), and there were no indications that cost increases were slowing down. In 2004, co-payments for clients were raised to control cost increases. In 2005, regional budgets for AWBZ care were introduced in order to contain costs within the macro budget. Despite all of this policy activity, reforms are far from over.

Current situation and policy discussion

In its 2008 evaluation of the Dutch care system, the RIVM (2008) summarised the results with respect to LTC as follows:

> "A number of positive developments have taken place in the broad and diverse field of long-term care, yet for other aspects both clients and personnel express, sometimes serious, concerns. Since 2003 the incidence of decubitus in nursing homes, residential homes and home care has decreased. In nursing homes the figure was 10.3% in 2003 and 6.9% in 2006. The percentage of malnourished patients has also decreased. The number of places in small-scale residential facilities more than doubled between 2005 and 2007. In 2006, clients gave *residential homes and care for the disabled* a score of 7.8 out of 10 and *nursing homes* received an average score of 7.4. Compared to other types of care, the figure for *nursing homes* in particular is on the low side. The aspects *provision of information* (5.0) and *participation* (6.0) score low. The *availability of sufficient personnel* is the most important point for improvement. Less than 4 out of 10 clients in residential and nursing homes indicated that a member of staff "sometimes struck up a conversation in passing". That percentage is particularly low and large differences between organizations were observed. The personnel in residential and nursing homes also assign a moderate score to the quality of care they provide and indicate a slight deterioration compared to 2003." (pages 11-12).

Despite the amount of reform that has taken place from 2000 on, policymakers and researchers still identify a number of problems in Dutch LTC. Important problems that play a role in the policy discussion include the following:

[101] See Douven et al. (2004) for a discussion of the situation just after the modernisation.

1. Increasing costs of LTC and doubts about long-run sustainability
2. A lack of incentives for efficiency in the LTC system
3. Difficulties in finding sufficient LTC workers to compensate for the expected increase in LTC demand
4. Concerns about the quality of care[102]

The AWBZ has few mechanisms to contain costs or to ensure greater efficiency in care provision. The regional care office is an important buyer of LTC, but this office bears no financial risks on the costs of LTC. It does, however, have incentives to contain the operating costs (fixed budgets). It can purchase LTC and pass the bill on to the LTC fund. From 2007, when the local council became the buyer for domestic help, more efforts have been made to save money on home help, making it clear that financial incentives do make a difference.[103] Furthermore, the assessment process contains few incentives for efficiency. There are no financial incentives for the assessment body; administrative means, like standards and protocols, are used to guide the assessment process. However, at the turn of the century there were still relatively large differences in assessment results among regions.[104] It is not clear whether and to what extent this has changed. In any case, the assessment organisation has been centralised in order to make the assessments more uniform. Especially where the entitlements in the AWBZ are not entirely clear, it is difficult to concentrate AWBZ expenditures on those "vulnerable groups that really need them".[105]

Regarding the labour market in the care sector, the expectation is that ageing of the population will increase the demand for long-term care, on the one hand, and decrease the supply of care workers, on the other. The consensus is that the care labour market needs some attention in order to prevent ever-increasing shortages of labour.

Quality problems in the care sector have played a rather prominent role in the earlier part of this decade. In 2004, the IGZ published an alarming report on nursing homes. Only 20 percent of the nursing homes could meet the mutually agreed-upon minimum requirements for good care. In more than a quarter of nursing homes, the quality of certain crucial aspects of daily care was not assured. Almost two-thirds of the nursing homes lacked permanent supervision in dementia units, which sometimes led to the physical restraint of residents. This report gave extra impetus to attempts firstly to formulate standards for good long-term care, and then subsequently to comply with those standards (see below). Recently, an investigation of the quality of some entrants on the home-care market showed serious quality problems, as mentioned in 1.4 (IGZ, 2009). The expertise of the staff was inadequate, and this was less than fully communicated to the providers and the clients. Moreover, shortcomings in medication

[102] Until recently, a lack of quality data was also a problem.
[103] However, part of these efforts was not to the liking of the central government, since they involved worsening the labour market position of home help workers.
[104] Van Campen and Van Gameren (2003).
[105] This is an expression that can regularly be found in policy papers.

policy meant that safety was not ensured. Guidelines and standards for nursing were unknown and were not used. Records were not kept systematically.

At the moment, the government is seeking the solution to the problems in long-term care in a combination of ongoing policy efforts and policy changes in the short-, medium- and long term, which will be described below. As regards the ongoing policy efforts, the government has been working on some problems for a number of years (quality of care, the care labour market), and will continue to do so. A short description of the relevant policy efforts appears below. Furthermore, policy changes are being implemented or contemplated. In the short- or medium term, the entitlements are limited and clarified (see the next section), and changes in funding are foreseen. In the longer run, authorities will have to implement the results of the fundamental discussion about the LTC system that has been taking place in the last few years. There seems to be a consensus that important changes must be made in the organisation of the AWBZ in the long run. It is unclear as yet in which direction these changes must be sought,[106] but the government is considering giving health insurers more responsibility for long-term care. An important advisory body of the government, the Social and Economic Council (SER) of the Netherlands, has sketched some broad outlines for the long run: for persons with early handicaps, the AWBZ would continue to exist in its current form (SER, 2008). For the elderly, several reform options are mentioned: health insurers could take over the organisation of the AWBZ for persons who choose to have their ZVW insurance with them; a separate publicly regulated but privately run care insurance scheme could be developed; or care for the elderly could be included in the health insurance scheme (ZVW). The latter solution would imply that health insurers bear financial risks on LTC expenditure. The government expects that implementation of the short- and medium-term policy agenda will help to clarify in which direction long-term changes should take place.

A letter of the Assistant Secretary to the Dutch parliament of June 12, 2009 (Nadere uitwerking toekomst van de AWBZ) showed that she was considering the measure of having health insurers carry out the AWBZ for the persons who are insured with them. The Assistant Secretary foresaw several advantages in this construction, but also possible disadvantages. A host of conditions would have to be met before health insurers would really be entrusted with this task. In her letter, the Secretary mentioned also a number of conditions: insurers should bear financial risk, the funding had to be adjusted, stable tariffs should be determined for care, administration and billing should occur on the level of individual clients, separate execution of AWBZ and ZVW should take place, improvements must be made in assessment, and co-payments should stimulate the right use of care. By April 1, 2010, she wanted to decide on the organisation of the AWBZ from 2012 onwards. However, this decision has been delayed by the fall of the Balkenende IV cabinet.

[106] Several reports were published about the problems in LTC and possible solutions. See, for example: CVZ (2004), CVZ (2005), RVZ (2005), Pomp, Mot and Douven (2006), IBO (2006), NZa (2007), RVZ (2008).

Current policy and short-term proposals

As described in 3.3, at the start of 2009 cost cuts were implemented with respect to the function "assistance" in the AWBZ care outside of institutions. The government plans to save 800 million euros in 2010 on AWBZ expenditures by restricting entitlements to assistance and some other measures (e.g. restricting the use of AWBZ care by youths with a mild intellectual handicap and psychiatric problems).[107] With the introduction of ZZPs, the government strives to ensure that 'money follows clients' to a larger degree in institutional care (see 1.4 and 2.4). The government plans to take other short- or medium-term measures:

1. Deregulation of the planning of institutional care capacity;
2. Measures to disconnect care decisions from housing decisions;
3. Development of a funding system that rewards quality of care;
4. Development of integrated care for specific diseases (e.g. dementia);
5. Shifting of some curative and rehabilitative care following hospital admissions to the health insurance system (ZVW);
6. Simplification of the assessment procedure.

From January 1 2009, providers can freely decide on their own institutional capacity. Before 2009, providers had to apply for permits before they could carry out building plans. At the moment, providers are free to build, but the capital costs are still reimbursed automatically. Before 2009, this reimbursement was combined with the system of permits. In a few years' time, the reimbursement for capital costs will be included in the tariffs. This means that providers may run into financial difficulties in the future if they do not have sufficient clients to cover their capital costs.

Concerning the second point (separating care decisions from housing decisions), the traditional view is that anyone who needed intensive- or round-the-clock care had to be admitted to an institution. The government wants to create more opportunities to stay at home and receive the necessary care there. Alternatively, a client can move to a facility where care can more easily be given and where the client still chooses and pays for her or his own housing. This would give clients more choices concerning their living situation— and it would enable them to live more comfortably without extra funding from public means.

Thirdly, the government wants to link the funding to the quality of the care that is delivered. However, according to the Nza, more validation of the available data on quality will have to take place, before this is possible (see below).

Fourthly, in developing integrated care, the government adopts a supporting role, while care offices and providers have to do the real work. Most of the attention is given to dementia care at this stage. In the preceding years, expertise has been built up in the National Dementia Programme. In 2008, the ministry presented a plan for dementia care that described what it

[107] VWS, Zeker van zorg, nu en straks, June 13, 2008.

considers to be good dementia care and which actions should be taken to deliver such care.[108] The actions are funded out of the existing means for several programs. The regional care offices are to purchase care in such a way that integrated dementia care in the region will be created. The care office should make the availability of case management one of the requirements. Guidelines for delivering and buying high quality, integrated dementia care have been developed in cooperation by the ministry, the organisation of health insurers, a patient organisation (Alzheimer Nederland) and an organisation of care providers (Actiz).[109]

Regarding the fifth point (the shift of rehabilitative care to the ZVW): after a hospital admission some groups of patients (including stroke patients and orthopaedic patients) still need rehabilitation. At the moment, rehabilitation care in a nursing home is funded from the AWBZ. The government wants to shift this care to the health insurance scheme, ZVW. Goals are to improve the quality of care (more continuity), to improve the financial sustainability of the AWBZ and to concentrate the AWBZ more on persons who need chronic care.[110] For the time being, shifting rehabilitative care at home to the ZVW is considered unfeasible, as the functions for care at home cannot be split up in rehabilitative and other care.

Finally, the central government wants to make the processes for assessment and care delivery in the AWBZ less bureaucratic, so that efficiency will improve. A number of pilot projects have been carried out with this goal in mind.[111] One of the reforms to be implemented involves fewer checks being carried out on the assessment advice of care providers and professionals. This works as follows: The professionals deliver a digital minimal data set to CIZ. CIZ uses a filter to see whether checking is necessary. If the request for AWBZ care seems to concern a simple matter, the advice of the professional can be followed without further action. Systematic testing of these simple requests takes place. If it turns out that professionals or providers deliver correct data, they can gain the status of trusted partner. Their assessment proposals will be checked with a lower frequency by CIZ. This could mean that in many cases CIZ simply follows the advice of the providers and professionals. The goal is that 70% of the assessments will be qualified as ‘low risk’. Another new measure is that more employees of the CIZ will work in healthcare centres instead of the CIZ office to improve communication. Also, the period of validity of the assessment decisions will be increased, so that fewer re-assessments have to be carried out. Clients who ask for care and provisions will have less administrative work to do, as more possibilities will be created for public organisations to share their data on applications.

[108] VWS, ‘Zorg voor mensen met dementie’, June 17, 2008.

[109] Leidraad Ketenzorg Dementie, versie 28 juli 2008, ministerie van Volksgezondheid, Welzijn en Sport, Zorgverzekeraars Nederland, AlzheimerNederland.

[110] VWS, Overheveling zorg AWBZ naar Zvw, February 10, 2009.

[111] VWS, Voorstellen tot vereenvoudiging van de indicatiestelling, July 7, 2008.

Ongoing policy efforts

Over the past several years, the government has been developing policies to make the quality of long-term care more transparent and to improve the quality of care. Working together, the parties involved in the LTC sector (including organisations of clients, professionals, providers and health insurers, as well the Healthcare Inspectorate (IGZ) and the ministry of Health, Welfare and Sports (VWS)) have developed a set of performance indicators for good care.[112] The set includes two types of indicators: those concerning the technical quality of care (e.g. prevalence of decubitus) and those representing the experiences of clients. From 2007 on, care providers have been measuring the technical indicators every year and client experiences every two years. Reports on these indicators feature in their annual reports. Information on individual providers is made available through a website for clients, www.kiesbeter.nl. As stated above, the government has determined specific goals for some of the values of quality indicators for the Netherlands as a whole. Also, the government wants to link the funding, to some extent, to the quality of the care that is delivered. When it asked the NZa whether this would be possible, the NZa responded that it might be somewhat precipitate to use the results for the set of indicators for such a goal, since only one measurement (for 2007/2008) is available yet, and the results have yet to be evaluated.[113]

A number of new policy measures are also under development to stimulate the quality of LTC. In May, the government established an entity (called the Directing Council) to uphold quality of care. This council of independent experts should stimulate the development and implementation of standards and guidelines.[114] Furthermore, the government has drafted a new law aimed at clearly determining and safeguarding the rights of clients (the Wet Cliëntenrechten Zorg, Act on Client's Rights in Care). Several existing laws can be mentioned here as relevant for the rights of clients and patients, as described earlier. The government is of the opinion, however, that the position of clients needs strengthening— and that this can best be done by drafting a new law. One of the problems is that the existing laws leave some aspects of quality less well accounted for in the current situation. An example is the case of integrated care, where several providers are concerned. While the rights of curative patients are described in the Wet op de Geneeskundige Behandelingsoverkomst (WGBO; Law on Medical Treatment Agreement), it is less clear to what extent this law applies to clients needing care like personal care and nursing. Another problem is that the rights of patients and clients can only be deduced from the obligations of providers. The government prefers to give patients an enforceable right to quality of their own.[115]

[112] De toon gezet: een taal voor kwaliteit, Rapport van de Stuurgroep Kwaliteitskader Verantwoorde zorg Verpleging, Verzorging en Zorg Thuis (VV&T), September 2008.

[113] NZa, Uitvoeringstoets Best Practices: kwaliteit en bekostiging AWBZ, July 18, 2008.

[114] VWS, Regieraad Kwaliteit van Zorg, Kamerstuk, 20 February 2009.

[115] Memorie van toelichting Wet clientenrechten zorg (Wcz), concept d.d. March 12, 2009.

From 2008 on, providers have to make a care plan in consultation with their clients. The plan describes the arrangements on treatment and care for the client. All in all, there are many smaller and larger policy changes aimed at improving the quality of care.

Regarding labour market policy for the care sector, no reform measures have been planned; rather, the existing policy efforts are maintained. The government puts the primary responsibility for the care labour market with the providers and the organisations for employers and employees. However, the central government accepts a general responsibility for the goals of care policy, education and the labour market. The government has introduced a fund to financially support apprenticeship in the care sector. And the government supports and stimulates a number of actions that are aimed at increasing labour productivity in the care sector, retaining employees working in care and attracting new trainees and employees.

4.4 Critical appraisal of the LTC system

One of the most important strengths of the system is that every resident of the Netherlands is insured against situations involving catastrophic expenses. This makes long-term care accessible for people who need it. People do not have to save a large amount of money for LTC expenses, they do not have to spend down when they become care-users and they do not have to be afraid they will end up destitute in their old age or when their newborn baby turns out to have a handicap. Also, people do not have to struggle with private LTC insurance that leaves most of the risk with the person who takes out the insurance.[116] Through the AWBZ, the risks are shared between persons who need a large amount of LTC over their lifetime and persons who need a small amount. To make this possible, a considerable amount of LTC premiums and taxes have to be paid.

Important weaknesses in the system have to do with determination of the entitlements and the lack of incentives for efficiency. Cost increases in the system are difficult to control, and future sustainability is a problem. It turns out to be difficult to establish clear guidelines about who should be entitled to what under which circumstances. For an activity such as 'pure' nursing care, it is rather clear under which circumstances it is necessary[117]— but this is much less the case for assistance or home help. The possibility of applying for a personal budget makes this problem all the more difficult. For home help and assistance, reforms have already taken place or are about to take place. The entitlement to assistance has been limited. Local government has taken over the organisational and financial responsibility for home help. This means that the process of assessment has been put in the hands of a party that has a financial interest in limiting entitlement. The shift of home help to the Wmo seems to have increased efficiency—

[116] Cutler (1996); Brown and Finkelstein (2007).

[117] However, it may be difficult to determine whether nursing should be funded by the AWBZ or the ZVW under the current rules.

but at the cost of consequences for the employees. The government considers these consequences to be undesirable and has taken measures to repair the situation. The provision of care seems to have become more targeted.[118]

The supply side of the care market also has some problems. The market for care at home is highly concentrated, with a limited number of large providers. According to the NZa (2008), one of the factors rendering it difficult to change the situation is the way in which the regional care offices purchase care. To ensure the continuity of care, they offer guarantees to the incumbents. This makes it difficult for a small entrant to find a foothold in the market. On the basis of its analysis, the NZa concludes that continuity of care can also be ensured with a lower level of guarantees. The AWBZ system as a whole has only weak incentives for efficiency. On the other hand, it is not clear to what extent potential efficiency gains are present.

The increasing role of cash-for-care schemes (personal budgets) has both advantages and drawbacks. Certainly, personal budgets have given clients greater opportunity to influence the organisation of their care or even to take over the organisation completely. This possibility for clients to opt out of the care-in-kind system is a useful incentive for the 'official' providers to respond to clients' needs. On the other hand, personal budgets have made the system more expensive by turning some of the informal unpaid care into paid care. Personal budgets also open up possibilities for unintended use. Furthermore, they make the patients responsible for supervising the quality of care they buy, which can be difficult for some vulnerable elderly patients. Policy measures are being drafted to improve the way in which the system of cash benefits functions.

Following the SER's advice, the government proposed a structural reorganisation of the entire system of long-term care. If the above-mentioned conditions can be met, the government wants to give the health insurers a larger role and more financial responsibility. While the details of a possibly larger role for health insurers have not as yet been specified, it is clear that the government does not want to make insurers responsible for the task of assessment. This will continue to be the responsibility of the independent CIZ— although the government will take steps to simplify the process of assessment and to increase the role of health professionals in the assessments. So, the approach that was chosen with regard to home help in the framework of the Wmo (to have the assessment carried out by a party with a financial interest in limiting assessment) will not be chosen for the other types of long-term care. There is no reason to expect that the proposed changes in assessment will improve the sustainability of long-term care. But what can be expected, when the conditions are met, is that health insurers will have

[118] Under the AWBZ, many persons who were entitled to simple home help according to the assessment, received in reality more expensive home help to keep the providers out of financial problems.

stronger incentives than the current regional care offices to purchase long-term care economically. Given that we do not know at the moment whether the conditions for the proposed reform will be met and if so, how the reform will be organised, there is not much more to be said about the possible effects.

Relevant considerations for optimal funding of LTC include the following: the distribution of risks, the degree of risk aversion, preferences for equity and moral hazard. The Dutch seem to be somewhat risk-averse in their healthcare and LTC insurance choices, and their preferences are rather egalitarian. From a social-cultural perspective, the Dutch consider the care of the elderly mainly to be the responsibility of the state. This has resulted in a public insurance system in which all residents who need LTC are entitled to a package of services that is still pretty broad— even though it has recently been limited. It is not just that the insurance covers a wide range of services, but also that persons who need only a small amount of care are also entitled to publicly funded care. Co-payments are relatively modest, especially for care at home. The importance of moral hazard is not known, but this seems likely to play a role in some forms of LTC (for example, home help or assistance).

Considering the effect of the existing system on the goals of Dutch LTC policy, we may conclude that accessibility is not a problem. There are difficulties with quality, but these do not seem to be inherent to a broad system of public insurance. Affordability in the long run, however, is a serious problem— and this seems to be connected with the characteristics of the system and the political culture in the Netherlands.

In the recent period, AWBZ expenditures have grown much faster than can be explained from ageing and other demographic developments. An important aspect to consider when analysing the large growth in expenditures, is that the system is meant not just for the old, but also for the handicapped and for certain groups of people with mental illnesses. The AWBZ is set up in such a way that it can serve as a safety net for all sorts of problems in society— for example, the problems of the young with mild intellectual handicaps and disturbed behaviour or the young with autistic disorders. Naturally, this makes expenditures difficult to contain.

Another important aspect is the role of quality improvements as a driver of LTC expenditures. The notion of what is an acceptable quality level for the elderly and the handicapped has evolved over the years. The required quality level has risen— for example, as regards single-person rooms in nursing homes. In a completely egalitarian system, all quality improvements should be available for all users under public insurance. However, this would make the system rather expensive. Another approach would be to define a certain level of quality for the public insurance system and to have higher quality care be funded privately. While the system in the Netherlands is not completely egalitarian, it is not too far from it. Most of the quality improvements of the last ten years have become available for everybody, rich or poor.

The Dutch public insurance system has three main ways to control public LTC expenditures:

1. decreasing coverage
2. increasing co-payments
3. improving efficiency

The discussion above indicated that the incentives for efficiency in the Dutch system are rather weak. To the extent that efficiency can be improved, difficult choices regarding trade-offs can be avoided or at least softened. However, it is not clear how large the potential for efficiency improvement is. Improving the incentives for efficiency and analysing the results would give more information about the potential— just as happened with the changes in the organisation of home help. Under optimal incentives for efficiency, the most important trade-off in Dutch long-term care would be between elimination of private risk and maintaining solidarity, on the one hand, and financial sustainability, on the other. Such political choices are difficult to make.

The following issues will be important for policy in the coming years:

- With regard to clarifying the functions and boundaries of the LTC system: which problems should the system seek to solve?
- With regard to making political choices about solidarity: what is the extent of the responsibility of society as a whole? Do we want to shift some responsibility back to the individual and/or his family? To what extent should responsibility increase mainly for richer persons or families?
- With regard to making a political choice on the assessment process: to what extent should there be a role for financial considerations?
- Efficiency incentives should be optimised within the system: the parties involved should gain from an efficient production of LTC.
- Information on the quality of care should be improved, and clients and other purchasers should make better use of that information.
- A determination must be made as to which quality level of care should be available under the public system.
- With regard to private insurance: is there a role for this type of insurance and, if so, how could it be organised?

References

Ageing Working Group, 2009, 2009 Ageing Report: Economic and budgetary projections for the EU-27 Member States (2008-2060), European Economy 2, 2009, provisional version, Joint report prepared by the European Commission (DG ECFIN) and the Economic Policy Committee (AWG).

Bettio, Francesca and Janneke Plantenga, 2004, Comparing care regimes in Europe, *Feminist Economics* 10 (1), March 2004, 85-113.

Boer, Alice de, Marjolein Broese van Groenou and Joost Timmermans (eds), 2009, Mantelzorg, Een overzicht van de steun van en aan mantelzorgers in 2007, SCP, The Hague.

Boer, Alice de, and Joost Timmermans, 2007, Blijvend in balans, Een toekomstverkenning van informele zorg, SCP, The Hague.

Boer, A.H. de, R. Schellingerhout and J. M. Timmermans, 2003, Mantelzorg in getallen , SCP, The Hague.

Borghans, Ine and Christine van Hartingsveldt, 2007, Transmurale afdelingen, Onderzoek naar het functioneren van transmurale afdelingen in Nederland 2006, Prismant, Utrecht.

Brown, J.R. and Amy Finkelstein, 2007, Why is the market for long-term care insurance so small?, *Journal of Public Economics*, vol. 91(10), November, 1967-1991.

Campen, Crétien van (ed.), 2008, Grijswaarden, Monitor ouderenbeleid 2008, SCP, The Hague.

Campen, Crétien van, and Edwin van Gameren, 2003, Vragen om hulp, Vraagmodel verpleging en verzorging, SCP, The Hague.

Cutler, David M., 1996, Why don't markets insure long-term risk?, Harvard University and National Bureau of Economic Research.

CVZ, 2004, Toekomst AWBZ, College voor zorgverzekeringen, Diemen.

CVZ, 2005, Zorg en participatie gegarandeerd: Een uitwerking van het rapport toekomst AWBZ, College voor zorgverzekeringen, Diemen.

CVZ, 2008, Zorgcijfers kwartaalbericht 2008, Financiële ontwikkelingen in de ZVW en AWBZ, 1e kwartaal 2008, College voor zorgverzekeringen, Diemen.

CVZ, 2008b, Zorgcijfers kwartaalbericht 2008, Financiële ontwikkelingen in de ZVW en AWBZ, 2e kwartaal 2008, College voor zorgverzekeringen, Diemen.

Douven, Rudy, Esther Mot and Kees Folmer, 2004, Momentopname van de AWBZ, Een analyse van sterke en zwakke punten, CPB Document 54, The Hague.

Draak, Maaike den, 2009, Hulpontvangers en de zorgsituatie, in: Alice de Boer, Marjolein Broese van Groenou and Joost Timmermans (eds), 2009, Mantelzorg, Een overzicht van de steun van en aan mantelzorgers in 2007, SCP, The Hague.

Eggink, Evelien, Jedid-Jah Jonker, Klarita Sadiraj and Isolde Woittiez, 2009, VeVeRa-III, Ramingen verpleging en verzorging 2005-2030, Modelbeschrijving, SCP, The Hague.

Hartmans, J.E.A., M.R. Hengeveld, G. Vernhout and C.M. IJland, 2009, Resultaten verdiepend onderzoek naar wachtlijsten voor verpleging & verzorging en gehandicaptenzorg, HHM, Enschede.

Hoefman, Renske, 2009, Aanbieders van mantelzorg, in: Alice de Boer, Marjolein Broese van Groenou and Joost Timmermans (eds), 2009, *Mantelzorg, Een overzicht van de steun van en aan mantelzorgers in 2007*, SCP, The Hague.

Houten, Gijs van, Mathijs Tuynman and Rob Gilsing, 2008, De invoering van de Wmo: gemeentelijk beleid in 2007, Eerste tussenrapportage Wmo evaluatie, SCP, The Hague.

IBO, 2006, Toekomst AWBZ: Eindrapportage van de werkgroep Organisatie romp AWBZ, Interdepartementaal Beleidsonderzoek, Interdepartementale Werkgroep Organisatie romp AWBZ 2004-2005, nr. 4, Tweede Kamer, 2006-2007, 30 597, nr. 1.

IGZ, 2004, Verpleeghuizen garanderen minimale zorg niet, The Hague.

IGZ, 2009, Grote zorgen over ‘nieuwe’ toetreders op de thuiszorgmarkt, Kwaliteit van zorg onderzocht bij niet-jaardocumentplichtige thuiszorgorganisaties, The Hague.

Jonker, Jedid-Jah, Klarita Sadiraj, Isolde Woittiez, Michiel Ras and Meike Morren, 2007, Verklaringsmodel verpleging en verzorging 2007, SCP, The Hague.

Klerk, Mirjam de, 2005, Ouderen in instellingen, Landelijk overzicht van de leefsituatie van oudere tehuisbewoners, SCP, The Hague.

Klerk, Mirjam de, Anna Maria Marangos, Martha Dijkgraaf and Alice de Boer, 2009, De ondersteuning van Wmo-aanvragers, Een onderzoek onder aanvragers en hun mantelzorgers, Derde tussenrapportage Wmo-evaluatie, SCP, The Hague.

Ligthart, Suzanne A., 2006, Casemanagement bij dementie, Aanpak en effecten van casemanagement bij dementie, Een exploratieve studie in het kader van het Landelijk Dementieprogramma, Master's research.

Norton, Edward C., 2000, Long-term care, in: Anthony J. Culyer,Anthony, and Joseph P. Newhouse (eds), *Handbook of health economics*, Elsevier.

NZa, 2007, Care voor de Toekomst: Uitvoeringstoets Overheveling zorgkantoortaken: Voorstellen voor de korte en lange termijn, Nederlandse Zorgautoriteit, Utrecht.

NZa, 2008, Extramurale AWBZ zorg, Analyse van de marktontwikkelingen in 2007 en 2008, Nederlandse Zorgautoriteit, Utrecht.

Pommer, Evert, Isolde Woittiez and John Stevens, 2007, Comparing care, The care of the elderly in ten EU countries, the Netherlands Institute for Social Research/SCP, The Hague.

Pommer, Evert, Ab van der Torre and Evelien Eggink, 2009, Definitief advies over het Wmobudget huishoudelijke hulp voor 2009, Uitgebracht door het Sociaal en Cultureel Plan bureau aan het Bestuurlijk overleg financiële verhoudingen, SCP, The Hague.

Pomp, Marc, Esther Mot and Rudy Douven, 2006, Handle with care! Sturingsmodellen voor een doelmatige ouderenzorg, CPB Document 122, The Hague.

PWC, 2008, Transparantie in de kostenstructuur van hulp bij het huishouden, PricewaterhouseCoopers, onderzoek in opdracht van VWS.

Ramakers, Clarie, Roelof Schellingerhout, Mary van den Wijngaart and Frank Miedema, 2008, Persoonsgebonden budget nieuwe stijl 2007, Vervolgonderzoek, ITS, Nijmegen.

RIVM, 2008, Dutch health care performance report 2008, National Institute for Public Health and the Environment, Bilthoven, the Netherlands.

RVZ, 2005, Mensen met een beperking in Nederland: De AWBZ in perspectief, Raad voor de Volksgezondheid en Zorg, Zoetermeer.

RVZ, 2008, Beter zonder AWBZ?, Advies uitgebracht door de Raad voor de Volksgezondheid en Zorg aan de minister en de staatssecretaris van Volksgezondheid, Welzijn en Sport, The Hague.

Schellingerhout, Roelof, 2007, Hoe groot is de vraag?, Operationalisatie van de potentiële vraag naar AWBZ gefinancierde zorg, SCP, The Hague.

SCP, 2004, Zorg en wonen voor kwetsbare ouderen, Rapportage ouderen 2004, The Hague.

SCP, 2006, Report on the elderly 2006, The Hague.

SER, 2008, Langdurige zorg verzekerd: Over de toekomst van de AWBZ, Uitgebracht aan de Staatssecretaris van Volksgezondheid, Welzijn en Sport.

Woittiez, Isolde, Evelien Eggink, Jedid-Jah Jonker and Klarita Sadiraj, 2009, Vergrijzing, verpleging en verzorging, Ramingen, profielen en scenario's 2005-2030, SCP, The Hague.

ZN, 2009, Handreiking zorgtoewijzing 2009, Indicaties verblijfszorg, Zeist.

Appendix A Number of formal long-term care-users

In this appendix, we try to estimate the total number of formal long-term care-users in 2006, in numbers of persons. This number is difficult to determine, since the data include temporary users and we cannot correct for the double counting of persons who use institutional care and care at home.

In 2006, about 244,000 persons were using formal institutional care in the form of care and nursing (not care for the handicapped or psychiatric patients) (see Table A.1). This includes persons who were temporarily admitted to an institution. At the end of 2006, 160,000 persons of 18 and older used institutional care, which can be seen as an approximation of the number of persons using institutional care permanently. Home-based care was used by about 608,000 persons (including temporary users, which we would like to exclude). Furthermore, for home-based care we cannot exclude handicapped or psychiatric patients on the basis of CBS information. In Table 3.6 we can see that those patients formed a sizeable part of the home-care-users under the AWBZ at the end of 2007. However, for the elderly, we can assume that most of the persons in this group need care because of their age, and not because of problems that existed long before they were old. In 2006, home help was still covered by the AWBZ, so the number of 608,000 users of home-based care includes users of home help.

An additional complication is that we cannot just add up the total number of users of home care and institutional users, as some people might use both types of care in a year. Nevertheless, in Table A.1 we attempt to give as much insight as possible in the number of formal care-users in the Netherlands in 2006— especially the older users of formal care. At the end of 2006, over 150,000 elderly people in the Netherlands used institutional care. This is a reasonable approximation of the number of persons who permanently used institutional care. Some 490,000 elderly persons used at-home care. Although some of these people may be disabled or have mental problems, we expect that most of them need the care because of reasons related to their age (frailty, chronic illness, dementia, etc.). The number also includes persons who use home care temporarily (sometimes only a few weeks). The upper limit of the number of older permanent formal care-users is thus about 650,000.

Table A.1 **Users of formal long-term care (excluding handicapped and psychiatric patients to the highest degree possible), 2006**

	Institutional, end of year (excl. handicapped & psychiatric patients)	Institutional (excl. handicapped & psychiatric patients)	At home (incl. handicapped & psychiatric patients)
Age (in years)			
65 - 70	4615	8080	41300
70 - 75	9870	16895	70235
75 - 80	21625	34650	114320
80 - 85	37885	56770	134685
85 - 90	42470	61230	90960
90 - 95	27130	39460	33610
over 95	8860	13930	7015
Total 65 and older	152455	231015	492125
Total 18 and older	160190	243910	607575

Source: CBS, statline.