The policy and politics of the 2015 long-term care reform in the Netherlands

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A B S T R A C T

As of 2015 a major reform in LTC is taking place in the Netherlands. An important objective of the reform is to reign in expenditure growth to safeguard the fiscal sustainability of LTC. Other objectives are to improve the quality of LTC by making it more client-tailored. The reform consists of four interrelated pillars: a normative reorientation, a shift from residential to non-residential care, decentralization of non-residential care and expenditure cuts. The article gives a brief overview of these pillars and their underlying assumptions. Furthermore, attention is paid to the political decision-making process and the politics of implementation and evaluation. Perceptions of the effects of the reform so far widely differ: positive views alternate with critical views. Though the reform is radical in various aspects, LTC care will remain a largely publicly funded provision. A statutory health insurance scheme will remain in place to cover residential care. The role of municipalities in publicly funded non-residential care is significantly upgraded. The final section contains a few policy lessons.

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1. Introduction

The Dutch system of LTC features a central role of the state in the regulation of LTC, a high level of public spending, services instead of cash transfers as major instrument, a generous service package for clients, and an emphasis on residential care [1–5]. The Netherlands is the second highest spender on LTC after Sweden in the OECD-countries [6].

After almost two decades of political discussion and reports (e.g., [7,8]) urging for a reform of LTC to safeguard its fiscal sustainability, the government managed to build a political majority for an overhaul of LTC. The reform has come into effect as of 2015. This article offers a brief analysis of the reform from a policy perspective (objectives, instruments and assumptions) and politics perspective (stakeholders, interests and bargaining).

2. The structure and financing of LTC in the pre-reform era

LTC in the Netherlands [9] includes a broad range of health and social-care services for various categories of clients including persons with cognitive, physical or sensory handicaps, persons with long-term mental health problems and older persons with somatic and/or psychogeriatric problems. In January 2014, nearly 5% of the population received LTC with a 45–55 split between residential care and non-residential care [26]. The biggest category (56%) consisted of older persons. In total, 16%...
of the population aged 65 and older received either residential or non-residential LTC.

LTC is largely publicly funded. In 2012, private financing (mainly income-related copayments) accounted for only 8% of total expenditures (Taskforce, 2012). Public financing is combined with private delivery by mainly not-for-profit provider organizations. A marginal stand-alone private sector for the wealthy co-exists with the public LTC scheme.

Until 2015, LTC was financed by two schemes: the Exceptional Medical Expenses Act (Algemene Wet Bijzondere Ziektekosten: AWBZ), covering 95% of public expenditures for LTC, and the Social Support Act (Wet Maatschappelijke Ondersteuning: WMO), covering the remaining 5% (Zorginstituut Nederland, 2015). The AWBZ, in place since 1968, was a statutory health insurance scheme, mainly funded by income-related contributions. It paid for a broad range of services in residential and non-residential care [10]. Implementation was delegated to regional care offices run by a single health insurer (usually the regional market leader) as the representative of all insurers in the region.

The AWBZ also gave clients the option of a cash transfer or personal budget (persoonsgebonden budget: PGB) to self-purchase health services and assistance including informal care. The PGB has been a ‘growth industry’: in 2005–2008 the number of budget holders grew by an average of 28% a year [11]. People with handicaps or mental health problems constitute around two-thirds of the budget holders. In 2014, the average budget was about 22,000 euros and around 9% of all LTC expenditure was funded through a personal budget [12]. Measures to dampen the influx of clients were only partially successful.

The WMO, in place since 2007, is a tax-funded scheme run by municipalities covering various assistance programs including housekeeping services, transport services, meal services, house adjustments and social shelter for homeless people and drug addicts. Municipalities possess substantial policy discretion in the implementation of the WMO and the local co-payment regime. However, means-testing is forbidden.

From 2000–2012, total expenses of LTC for older persons and persons with a handicap rose by 115% (http://statline.cbs.nl). The expenses of the PGB scheme even quintupled (Zorginstituut Nederland, 2015). In 2010, the Netherlands spent 4.3% of its Gross Domestic Product on LTC [13].

3. The reform of long-term care

The first step in the reform of LTC took place in 2007 with the introduction of the WMO. The major reason for this reform was to call for greater individual responsibility in LTC. The reform also upgraded the role of municipalities in non-residential care. The most conspicuous alteration was that the coverage of housekeeping services was shifted from the AWBZ to the new WMO. The budget for these services was also substantially cut. It was eventually the financial crisis of 2008 opening a window of opportunity for a more radical reform [14]. An important objective of the current reform is to reign in expenditure growth. In the government’s view, the projected growth of LTC expenses from 4.3% of the GDP in 2010 to 7% or even 9% in 2040, depending on the assumptions made [13], would not be sustainable. Other stated objectives are to improve the quality of LTC by making it more client-tailored.

The reform consists of four interrelated pillars: a normative reorientation, a shift from residential to non-residential care, decentralization of non-residential care and expenditure cuts [15].

3.1. Normative reorientation

In the government’s view, the broad coverage of LTC and its high level of public funding had created a supply-driven and ‘over-medicalized’ system with clients positioned in a mainly dependent role. Universal access and solidarity in LTC-financing can only be upheld as its normative cornerstone, if people, where possible, take on more individual and social responsibility [16,17]. The underlying policy assumption is that various social care services may be provided by family members and local community networks. This normative reorientation and its underlying assumption are disputed. An important line of criticism is not only that informal care is already provided at a large scale, but also that the potential of ‘unexplored’ informal care is overestimated. Furthermore, the negative externalities for caregivers who deliver intense informal care are underestimated [18]. Interestingly, however, one can presently observe the emergence of a diverse set of community initiatives (‘co-operative’ networks) at the local level to give assistance to persons in their home setting. Many of these funds use the PGB-arrangement as an important funding source [19].

3.2. From residential care to non-residential care

The reform aims at a substantial shift of clients from a residential to a non-residential setting. Residential care will only remain available to clients for whom non-residential care is no realistic option. Clients with only mild health problems are no longer eligible for residential care. The shift is based upon the assumption that persons with mild problems may better be cared for in their home-setting and that even more people prefer ‘ageing in place’. In other words, the shift will make LTC more client-centered.

The reform includes the introduction of a new Long-term Care Act (Wet Langdurige Zorg, WLZ) which replaces the AWBZ. The WLZ, which has come into effect in 2015, provides a new regulatory framework for residential care. Just like the former AWBZ, it is set up as a statutory health insurance scheme. Applicants are subject to a nationally organized needs assessment procedure according to uniform and strict standards. Residential care is intended for clients who need permanent supervision to avoid escalation or serious damage and clients who need 24 h care because of physical problems or self-control problems. Under the new law, clients may also apply for a personal budget. A new option is to organize full care at home [17]. The payroll premium is set at 9.5% of taxable income beneath 33,600 euros. The transition of the AWBZ into the WLZ is in accordance with earlier policy recommendations.
to re-focus the AWBZ on long-term care in a residential setting.

3.3. Decentralization of non-residential care

The provision of all non-residential care, formerly covered by the AWBZ, has been devolved to either insurers or municipalities (see also Scheme 1). Under the 2006 Health Insurance Act (Zorgverzekeringwet, ZVW), insurers are now made responsible for contracting community nursing (e.g., diabetes care, administration of medicines, wound care and injections) and 'body-related' personal care (e.g., support in washing, dressing and shaving).

All other non-residential care including, among others, services for older persons, persons with a handicap, addicts and persons with social psychiatric problems, have been decentralized to municipalities under the new WMO, known as WMO 2015. Municipalities receive a state budget to carry out their tasks under the new law. The reform has drastically upgraded the role of local government in LTC (as of 2015 child welfare has also been decentralized to municipalities). Upgrading is based on the policy assumption that municipalities are not only best informed about their locality, but also best capable to deliver an efficient, tailor-made and integrated package of services in the social domain to LTC-clients given their responsibility for various adjacent policy areas including housing, welfare programs, transport and local planning [17].

The WMO 2015 gives applicants a right to publicly funded support if they cannot run a household on their own and/or participate in social life. However, it is left to each municipality whether they qualify for assistance. Municipalities also possess much policy discretion as regards the type and extent of assistance to be delivered. For instance, each municipality is free to organize non-residential care and its need assessment procedure. The procedure may include an assessment of the capability of the applicant’s social network to provide informal care. Municipalities may also introduce their co-payment regime, but means-testing remains forbidden.

3.4. Expenditure cuts

Initially, it was the government’s intention to implement large expenditure-cuts in LTC, but during the follow-up negotiations (see the section on politics) the size of these cuts was gradually scaled back. The expenditure cuts in the WMO and ZVW are 0.7 billion and 0.4 billion euro, respectively. They are politically sold as ‘efficiency cuts’. The government assumes that municipalities and insurers are able to organize LTC more efficiently than the regional care offices under the AWBZ. Residential care is imposed an expenditure cut of 0.5 billion. This cut follows from the government’s decision to close nursing homes for clients with only mild problems. Due to these expenditure cuts the total budget available for LTC drops to 30.6 billion euro in 2015 which is 5% less than it would have been without reform.

The expenditure cuts have major consequences for contracting and tariffs. Especially municipalities negotiate much lower tariffs. Another strategy is to contract a lower volume of care. As a consequence many provider organizations are struggling with deficits which led some of them to take the radical decision of stopping their activities, particularly in housekeeping services.

3.5. The politics of LTC reform

Not surprisingly, the reform has been controversial. Provider and client organizations casted were critical because of doubts on its feasibility and the validity of the underlying assumptions. Unions were afraid of mass lay-offs and worse conditions of employment. The upgrading of their role in LTC led municipalities to support the reform, but they casted serious doubts on the feasibility of the expenditure cuts. During the legislative process in 2013 and 2014, the government started negotiations with the national peak organizations of employers and workers, insurers, municipalities, providers and clients in order to build a political majority for the reform. These negotiations resulted in several collective agreements. Also a political agreement with the three so-called ‘beloved’ opposition parties was negotiated to achieve a majority in the Upper Chamber where the coalition government had no majority of its own. The effect of these negotiations was, among others, that the total amount of expenditure cuts was significantly scaled back, that some cuts were temporarily postponed, that some measures to restrict access were attenuated and that various temporary and transitional provisions were made to accommodate a smooth transition.

An effective lobby of providers and insurers led the government to abstain from its original plan to devolve all body-related personal care to municipalities. As discussed earlier, this type of care is now covered under the ZVW for which insurers are responsible.

After the reform has come into effect (January 2015), the political game has turned into a politics of implementation and evaluation. The state secretary for Health
acknowledged the existence of implementation problems at the municipal level, but considered these as mainly transitional [20]. An independent commission installed by the government concluded, that municipalities were busy to implement their new tasks thoroughly with a focus on the continuation of existing care arrangements and that the number of major incidents had been noticeably low [21]. In its latest report, the commission underscored the need for coordination between health and other professionals in the so-called neighborhood teams to make LTC really client-centered [22].

At the same time there are signs of the contrary [15]. The Court of Audit [25] criticized the government for under-estimating the feasibility of its reforms plan including the reform of LTC. The media regularly report on municipalities failing to provide tailor-made services and on mass lay-offs and worse conditions of employment. Provider organizations complain on severe tariff cuts. The number of legal procedures of clients to appeal against a reduction of the care provided has increased significantly [23]. There are also reports on increasing administrative costs. So far, the delayed payment of many personal budgets caused the most political trouble for the state secretary. Some other concerns are about the capacity of (small) municipalities to carry out their new tasks properly and the feasibility of the budgetary cuts. The government is also criticized for being over-optimistic about the efficiency gains of decentralization.

4. Discussion

The 2015 reform is the largest overhaul of LTC since the AWBZ came into force in 1968. The emphasis on individual responsibility, the restructuring of the financing regime, the importance of non-residential care, the greater involvement of insurers and municipalities in non-residential care and the sizable expenditure cuts are its most conspicuous elements. Access to residential care will only be available to those who need permanent supervision or 24 h care. Under the WMO 2015 municipalities are obligated to give support to clients, but they have large policy discretion in making this obligation concrete. This may cause unequal access to LTC. Given the highly egalitarian culture in Dutch health care, ‘postcode rationing’ is very much disputed.

Despite the magnitude of the reform, LTC continues to be a largely publicly funded provision and a statutory health insurance scheme will remain in place for persons who need residential care. Furthermore, the benefit package of LTC continues to be generous compared to most other European countries.

The Dutch experience with the reform of LTC contains several policy lessons. The first lesson is that implementing a reform with large ramifications in only a short period of time entails many uncertainties and risks for all stakeholders involved, in particular clients. This is also true for a reform which seems well-prepared on paper. The government had to take many temporary accompanying measures to lessen these uncertainties and risks. Implementation appears the ‘Achilles heel’ of the operation.

The second lesson also regards implementation: never underestimate administrative and ICT-problems. A fundamental reform with new regulations and a new financing regime requires the set-up of a new administrative and ICT-infrastructure, but it always takes time to have such an infrastructure in place. Unfortunately, it soon turned out that the administrative and ICT structure did not work properly. These ‘technical problems’ may rapidly get a political loading as the State Secretary experienced when many personal budgets were paid out too late.

The third lesson relates to incentives. The new financing structure for LTC consists of three different regimes (see Scheme 1), each with its own implementing agencies, regulations, budgets, clients and so on. Such a structure entails a great risk of coordination problems because of different incentives. For instance, municipalities may have an interest to refer a client to the ZVW-regime or WLZ-regime in order to save money and vice versa [24]. The success of the reform will strongly depend on how coordination problems will be solved and cost-shifting from one regime to another will be avoided.

References

[18] Mezzo. [www.mezzo.nl/mantelzorgnieuws] [accessed 16.05.14].


