THE REFORM OF LONG-TERM CARE IN THE NETHERLANDS

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Summary: Over the last few years long-term care (LTC) has rapidly become a major policy issue in Dutch health care policymaking. An important reason for this development is concern about the future financial sustainability of LTC. Fundamental reform of LTC is deemed necessary to curb the growth of LTC expenditures. This article gives a brief overview of current LTC reforms. The focus is on LTC for older people and others in need of long-term nursing or personal care because of physical and/or sensory disabilities or other chronic conditions.

Keywords: Long-term Care, Personal Budgets, Older People, The Netherlands

In the Netherlands LTC is provided by private not-for-profit organisations, in particular nursing homes, residential homes and home care provider organisations. Clients can also apply for a personal budget to organise LTC for themselves. In 2010 about 3.6% of the population made use of home care or institutional care in a nursing or residential home. In Europe only Austria, Sweden, Norway and Switzerland have higher rates of use of care, while the average for Organisation for Economic Cooperation and Development (OECD) countries is 2.8%.

LTC is mainly funded with public resources. In 2009 only 8% of total expenditure for LTC was paid privately by means of user charges. The percentage of Gross Domestic Product (GDP) spent on LTC is 3.5%, which is high compared to other European countries. There are three schemes in operation for the funding of LTC. The Exceptional Medical Expenses Act (AWBZ: Algemene Wet Bijzondere Ziektekosten), in place since 1968, pays for the bulk of LTC. It is a national mandatory, contribution-based health insurance scheme which pays for personal and nursing care, counselling, medical treatment and accommodation. Clients are required to make co-payments based upon their incomes, age, family situation (single or married) and type of care. The minimum monthly co-payment is €145 and the maximum €2,097. Currently, a person in a nursing or residential home on average makes co-payments of €6,400 per annum. One recent plan that has been put forward by the government is to include a person’s capital in the calculation of this co-payment.

The Social Support Act (WMO: Wet Maatschappelijke Ondersteuning), in place since 2007, pays, amongst other things, for domiciliary care. It is run by municipalities which receive a tax-funded state grant to provide services, which previously were covered by the AWBZ. Clients are also required to make an income-related co-payment for domiciliary care.
Personal budgets (PGB: persoonsgebonden budget) constitute the third pillar in the funding of LTC. This publicly funded arrangement was introduced in the mid-1990s to give clients a choice on how to organise their own tailor-made care packages. Expenditure on this instrument has ‘exploded’ over the last decade from €413 million in 2002 to about €2.3 billion in 2010. However, these figures require qualification. A specific characteristic of the personal budget system in the Netherlands is that many young people with disabilities make use of the system in addition to older people. A recent report demonstrated that the bulk of the cost explosion is attributable to the increase in the number of young people applying for personal budgets. Table 1 shows overall growth in LTC expenditure in the Netherlands between 2003 and 2009. While total expenditure grew by 34.5%, expenditure on personal budgets rose by 186%.6,7

Table 1: Trends in LTC expenditure, 2003–2009 (€ billions)

<table>
<thead>
<tr>
<th></th>
<th>2003</th>
<th>2005</th>
<th>2007</th>
<th>2009</th>
<th>Total Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>AWBZ</td>
<td>10.9</td>
<td>11.4</td>
<td>11.4</td>
<td>12.6</td>
<td>15.6%</td>
</tr>
<tr>
<td>WMO</td>
<td>–</td>
<td>–</td>
<td>1.0</td>
<td>1.1</td>
<td>10.0%</td>
</tr>
<tr>
<td>PGB</td>
<td>0.7</td>
<td>0.9</td>
<td>1.3</td>
<td>2.0</td>
<td>185.7%</td>
</tr>
<tr>
<td>Total</td>
<td>11.6</td>
<td>12.3</td>
<td>14.0</td>
<td>15.6</td>
<td>34.5%</td>
</tr>
</tbody>
</table>

Source: 8,9

Needs assessment

Traditionally, provider organisations were charged with the assessment of client needs under the AWBZ. This changed in the mid-1990s, when the government opted instead for a standardised procedure by means of universal and objective criteria. Needs assessment was institutionally split from provision and shifted to independent regional assessment bodies. The centralisation of needs assessment again culminated in 2005 with the creation of a national body for needs assessment to which the existing regional bodies were to be subordinate. This national body sets guidelines to determine who is eligible for what type and how much LTC they will receive.

The assessment of clients, often only by telephone contact, and which had been delegated to regional bodies, has always been criticised. In recent years, one can observe a trend to make provider organisations more responsible again by delegating the assessment of a number of client categories. The main purpose of this decentralisation is to reinforce professional self-responsibility in provider organisations and reduce bureaucracy. Municipalities may delegate the needs assessment of clients applying for WMO care to regional bodies, but are not obliged to do so and may set their own assessment criteria.

The growth of demand for LTC

The ageing of the population will lead to an increase in demand for LTC. Currently 15.3% of the population are aged 65 and older; this is expected to increase to 17.5% by 2015 and 23.7% by 2030. In 2050 about 40% of people aged over 65 will be 80 plus. There is much discussion about the implications of this ageing of the population for the growth of LTC demand. According to the Office for Social and Cultural Planning (SCP), annual growth in the LTC workforce averaged 1.8% between 1995 and 2005. However, in the view of the SCP, this percentage cannot be simply extrapolated to the future. If factors like health and education are taken into account, the estimate for the period 2010–2030 is just 1.2%.7

Reform of LTC

Current reforms to LTC involve a variety of programmes and policy measures. Among the most important are measures to put more emphasis on individual responsibility, upgrade the role of local government and health insurers, introduce access reforms and partially abolish personal budgets.6

More emphasis upon individual responsibility

Solidarity will remain the moral cornerstone of LTC, but solidarity cannot be sustained without individual responsibility. The availability of a wide range of publicly funded services for LTC has created a situation in which many people too easily rely upon these facilities in LTC. Individual responsibility should therefore be reinforced. In concrete terms, more responsibility means more private payments for LTC and a larger emphasis on the provision of informal care.

Upgrading the role of local government

The introduction of the WMO, in particular the transition of domiciliary care from the AWBZ to the WMO, has significantly strengthened the role of local government (municipalities) in LTC. In 2013, local government will also be made responsible for personal care, which currently is covered by the AWBZ. The assumptions underpinning this reform are that local government is best capable to deliver efficient, client-centred and integrated support to LTC clients because it is already responsible for various adjacent policy areas including housing, welfare programmes and local planning. The upgrading of the role of local government is accompanied by significant expenditure cuts which are politically sold as ‘efficiency cuts’. Local government’s responsibility does not mean that it provides LTC services itself however. Most municipalities use tendering as a tool for contracting external provider organisations to provide domiciliary care.

Upgrading the role of health insurers

The role of health insurers will also fundamentally change. At present insurers use a representation model in implementing the AWBZ. The essence of this model is that one insurer, usually the regional market-leader, is charged with the implementation of the AWBZ in one of the 32 regions on behalf of all insurers. The main task of the insurer in charge (the care-office or zorgkantoor) is to contract providers and inform clients, but it has no involvement in needs assessment. The representation model will come to an
end in 2013 when health insurers will be charged with the implementation of the AWBZ for their own insured populations. This reform may have significant consequences for the implementation of the AWBZ, in particular when insurers incur a financial risk (as is already the case for medical care under the Health Insurance Act).

The role of local government has been significantly strengthened

Coverage under the AWBZ has been reduced somewhat by making eligibility criteria more stringent. A recently announced measure will require clients in residential care to pay a rent for their housing and living costs. Under the current regime the AWBZ pays most of the costs of residential care; clients are only required to make a co-payment. The transfer of domiciliary care services from the AWBZ to the WMO, and more generally the upgrading of the role of local government in LTC by the additional transfer of responsibility for services away from the AWBZ, also has potentially far-reaching consequences for access. Given that the AWBZ is a true social health insurance scheme, clients have a right to LTC if they are assessed as being eligible for care. This is not the case for the WMO.

In contrast to the AWBZ, the WMO is not an open-ended scheme. Legislation only obligates municipalities to compensate or support individuals up to the level where they can live autonomously and participate in social life. However, municipalities have great discretionary power on how to meet the terms of this compensation principle. For instance, they are free to decide on the size of the budget for WMO activities and if the budget is exhausted, they are not obliged to provide additional resources. They may also take the care giving potential of family members and/or the wider social network of the applicant into account and introduce some form of means-testing to determine the amount and type of compensation. In other words, compensation means that applicants should carry a greater individual responsibility for LTC.

Partial abolition of personal budgets

The cost explosion for personal budgets since 2000 was caused by various factors, including ambiguous guidelines and the generosity of the personal budget. The arrangement also attracted many new, mainly young, clients. In 1998, there were 13,000 budget holders, and in 2008 more than 148,000. A recent study concluded that about two-thirds of budget holders had opted for LTC because of personal budgets. They were not interested in care in-kind. Other factors raising concern were rumours about fraud and the so-called monetarisation of informal care: individuals who once rendered unpaid informal care are now paid for their help. In her letter to Parliament, the State Secretary for Health announced that only clients eligible for residential care (about 10% of current users) will retain the option of a personal budget. If they use this option, they can only purchase LTC services delivered by individuals or organisations which have been contracted by the regional care office in charge of the implementation of the AWBZ. Clients who no longer qualify for a personal budget will be offered care in-kind provided by contracted provider organisations. This partial abolition, which will see no new budget applications accepted from 2013 and the full restriction of the scheme from 2014, is highly disputed.

Conclusion

In summary, it can be concluded that LTC in the Netherlands is subject to various interconnected reforms. The common element of these reforms is a greater emphasis upon individual responsibility, an increase in user charges for receiving LTC and reductions in the benefit packages of publicly funded arrangements. The upgrading of the role of municipalities in LTC and the shift from entitlement (a client’s right) to compensation (an obligation of municipalities) points in the same direction. The upgrading of the role of insurers in the implementation of the AWBZ will make insurers keener to increase efficiency. It seems evident that each of these reforms conveys a politically difficult message and that it will require some time before they are accepted. Politicians well realise that the ageing of the population means that their electorate is ageing as well. The political sensitivity of the reforms was well illustrated in April 2012 after the fall of the government (Cabinet-Rutte). The subsequent new coalition agreement with three former opposition parties to restrict the public budget deficit to 3% included various measures that have affected the reform of LTC. The most visible measure has been to largely revoke the partial abolition of the personal budget system!

References

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