interlinks

Health systems and long-term care for older people in Europe
Modelling the interfaces and links between
prevention, rehabilitation, quality of services and informal care

Governance and financing of long-term care

Dutch National Report

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Contents

1 Key contextual factors

Long-term care in the Netherlands is primarily provided within the framework of the Exceptional Medical Expenses Act (AWBZ). The AWBZ was introduced in 1967 as a mandatory social insurance for costs of (long-term) care that citizens normally could not bear and that would otherwise not be insurable. In the last decades of the 20th century the AWBZ mainly covered nursing home care. Homes for the elderly were a responsibility of local authorities (provinces) until 1975, when a national legislation was introduced for the residential homes. In 1997 funding of residential home care was put on a par with nursing home care, and since 2001 the AWBZ is applied for residential homes as well. Until 1980 district nursing was funded by the AWBZ, and in 1990 also domestic help (by home care organisations) was included. Since 2006, home help and personal support is not covered by AWBZ regime and has been transferred to the responsibility of local authorities under the Social Support Act (WMO). Nowadays social care in the Netherlands is covered by the framework of the AWBZ (which includes treatment and residential care) and WMO (which focuses on social participation). In addition the provision of individual medical and mental health care is governed within the framework of the Health Insurance Act (ZVW). So people in need of long-term care or rehabilitation very likely will have to deal with these three frameworks.

The AWBZ with its funding system has a nationwide appreciation. Citizens expect a proper provision of LTC as they pay monthly premiums which are relatively high and the care users pay an additional user share. The premiums of the AWBZ have never been under serious public debate; there always has been willingness to pay the premiums for care, even if the exact contributions were unknown to most citizens as premiums were included in the income tax. Recently, the population is beginning to be aware of the high costs of LTC; criticisms and debate are emerging.

In the first year of the AWBZ, there were about 55,000 beneficiaries, and costs were below 1 billion euro's, making up about 20% of total health care costs. Now about 600,000 citizens use the AWBZ benefits, and costs have risen to over 22 billion euro (2010 projection), amounting to more than 40% of the total health care costs. Back in 1968, the AWBZ premiums were less than a half percent of a citizen's gross income, now it is 12.15%. The financial aspects - linked to system governance - of the AWBZ are frequently subject to public debate these days, as are the issues of efficiency and quality of LTC being considered unsatisfactory.

2 The governance and financing of long-term care services for older people

2.1 The Ministry of Health, Welfare and Sport

The minister of Health, Welfare and Sports (VWS) is politically responsible for the AWBZ. The Ministry implements political decisions that are taken by the Cabinet. The Ministry carries so called system

responsibility for health and long term care. It is responsible for the AWBZ, ZVW and WMO systems, it designs the governance system, decides on the coverage of the AWBZ expenses and entitlements, and sets an annual total budget for the AWBZ expenditures.

For the implementation of the AWBZ the Ministry uses a number of semi-independent governmental organisations associated to it:

- CIZ (Centrum Indicatiestelling Zorg), Centre for assessment of care for assessing the LTC needs,
- CVZ (College voor Zorgverzekeringen), the Health Insurance Board for advice on coverage package and financial consequences, and for overseeing regional Care Offices that allocate care,
- NZa (Nederlandse Zorg Autoriteit), the Netherlands Care Authority for monitoring conditions of competition and setting tariffs,
- CAK(Central Administratie Kantoor), the Central Administration Office for financial administration and payments,
- IGZ (Inspectie voor de Gezondheidszorg) the Health Care Inspectorate for inspection of health and quality of care.

2.2 Governmental organisations

The abovementioned bodies are dealt with in this paragraph.

2.2.1 Assessment by CIZ

LTC is a statutory and universal right under the AWBZ; all citizens are formally eligible for LTC. The AWBZ states that entitlements will be decided for every individual applicant on the basis of an assessment of needs. The assessment - for elderly care - will be done by the Centre for assessment of care needs (CIZ), which is a national organisation working with directives and under the supervision of the Ministry of Health, but independent of care providers and of the AWBZ funding system. CIZ has 24 offices making assessments free of charge for citizens. CIZ does not allocate care; the outcome of the assessment points out whether the care applicant qualifies for LTC and if so as to which type and intensity of LTC. The outcome is typically bureaucratic, allowing AWBZ expenses, but not defining individual care plans. As a relief from paperwork, from 2010 onward a claim for AWBZ services is possible via the internet. Health and care professionals will gradually be more involved in the assessment process.

In the CIZ assessment procedure one uses a national protocol; in it the 'socially accepted' duties of relatives towards the person in need are taken into account, i.e. no professional AWBZ care can be granted. The five sorts of care in the ABWZ are personal care, nursing, preventive support, residential stay, and treatment. These sorts may be combined. For residential stay combined with other types of care, the assessment is expressed in so-called 'care intensity packages' (ZZPs) that are linked to tariffs as set by NZa.

Source: **www.ciz.nl**

2.2.2 Advice by the Health Insurance Board CVZ

The Health Insurance Board (CVZ) is an organisation connected to the Ministry of Health, Welfare and Sports. It is an advisory organisation to the government and is responsible for the implementation of the statutory health and care insurances ZVW and AWBZ. Advice of CVZ affects the packages of these insurances. Recently, for instance, mental health care was shifted from (public) AWBZ to (private) ZVW. In 2009 a research has been started on the possibility to shift geriatric medical care from the AWBZ to the ZVW. The advices of CVZ including the financial consequences of change are mostly adopted by the government.

As an executive organisation, CVZ oversees the Care Offices (Zorgkantoren) and issues directives. In addition, CVZ does the financial administration of the AWBZ treasury (Algemeen Fonds Bijzondere Ziektekosten, AFBZ) and pays the running costs of the Care Offices.

Source: www.cvz.nl

2.2.3 Regional Care Offices allocate care

Allocation of care to applicants with an assessment decision of CIZ is done by these Care Offices. They are able to perform their task of allocating care to patients by purchasing care from care suppliers in the region. The budget to be spent for purchasing care is decided by the CVZ, which in turn is constricted by the national annual AWBZ budget set by the Ministry of VWS.

In the allocation, the choices of the applicant will be respected as much as possible. There is free choice of care suppliers, and the choice for a type of care less intensive than decided by CIZ will be granted provided that the cost of it will not be higher. Also, on the request of the applicant, a Care Office will convert an allocation in kind to an allocation in cash (called personal budget for care: PGB).This is however not possible for treatment or for care with a residential stay.

An applicant may apply to a special website (www.kiesbeter.nl), initiated by the Ministry of Health, to find a care provider of his or her choice. Whether an applicant does or does not succeed in finding a care provider on own account, the responsibility of the Care Offices for allocation includes the duty to see to it that the applicant will indeed receive the allocated care. The Care Office can intermediate for an applicant to find a care provider as it has an actual overview of the free capacity of care services and as it checks waiting lists.

Apart from dealing with the needs of individual applicants, the offices have a number of functions like commissioning services by annual contracts and promoting quality assessment of care providers. The means of care offices to ensure quality of care are mainly financial incentives, and regularly consulting with local care providers, patients' organisations and local authorities about developments in demand and supply of care.

The operating of the office in a region is usually commissioned by the Ministry of Health Welfare and Sports to the largest health care insurer in the region: In 2009 the 32 Care Offices have been operated by 12 health care insurers.

Source: www.hetcak.nl

2.2.4 Financial administration: CAK

The financial administration of the AWBZ is carried out by the Central administration Office (CAK) The CAK calculates and cashes user shares. It takes into account the income tax data, as it has access to the national tax office (which the Care Office does not have). The CAK also finances care organisations within the agreements made between them and the Care Office in their region. The CAK sees to some minor allowances to individual disabled persons as well. Personal budgets (PGB) however, are calculated by CAK but paid via the Care Office.

2.2.5 Health Inspectorate: IGZ

The Health Care Inspectorate (IGZ) promotes public health through effective enforcement of the quality of health services, prevention measures and medical products.

It gives advice, encourages and stimulations quality measures, However, if necessary it may use force. The inspectorate uses the following methods: enforcement measures, phased supervision, investigation of incidents and monitoring based on themes

It intensively monitors negligent suppliers, and even may close the care organisation in case of repeated violation of rules. All care suppliers will submit annually their quality indicator figures to IGZ.

Source: www.igz.nl

2.2.6 NZa oversees the market of care

The Netherlands Care Authority (Nederlandse Zorg Autoriteit / NZa) monitors whether all care providers and care insurers on the market of long-term follow legislation.

NZa sets budgets, rules and regulations for that part of long-term care that has been regulated within the care market, and sets conditions for liberalisation of the market and competition. It does so in concordance with the Nederlandse Markt Authoriteit (NMa, Netherlands Market Authority), that monitors competition on a the free market in general, in which as a cause of European legislation also health care is operating. NZa has an important role in enabling choice (on the market) as services are being made transparent for care applicants.

For community home care and for residential care the five sorts of care that CIZ uses in assessing the needs of clients are linked by NZa to funding rules. For residential stay combined with other types of care, the CIZ assessment is expressed in 'care intensity packages' (ZZPs) linked to tariffs as set by NZa. These tariffs each have a maximum: in a care provider's bid to a Care Office the tariff may be lower, in the final contract eventually still lower. In a research by ActiZ[1], about 75% of the residential care providers said they had used the maximum tariffs in the bid to the Care Office, and of the home care providers only 7% (Mandour/van Eijken, 2009). Still they were all subjected to deductions of the tariff. In these care settings now several problems with operational logistics and with innovation of care are foreseen.

Source: **www.nza.nl**

2.3 Services and support

This paragraph looks into the providers of LTC services and the personal budget for care (PGB) as a financial substitute. For an overall understanding of the system, also a brief explanation is given on the social support by local authorities working under the regime of the WMO.

2.3.1 LTC services and care professionals

AWBZ covers a variety of services, amongst them those provisions which usually are referred to as ' elderly care': nursing homes, residential homes and home care. This coincides with what formally is termed as the branch of 'caring, nursing and home care' (verzorging, verpleging en thuiszorg / VV&T). Other groups that may benefit from AWBZ are persons with care needs on the basis of a severe long-term mental or psychiatric condition, or a severe disability.

LTC services are mainly provided by private not for profit care organisations. There are no service providers on a public or voluntary basis. In home care, there are some minor private for profit organisations. The latter operate basically on the basis of services that the customers pay for with PGB money. Care organisations operating within the framework of AWBZ need a permit by the Ministry of Health.

There are three main varieties of care organisations in VV&T: nursing homes, residential homes and home care organisations. A nursing home can be compared to a skilled care facility in the United States. Nursing home residents have long term health problems, including conditions like (advanced) dementia, for which treatment and nursing is required; hence, apart from care assistants there are a number of qualified nurses(auxiliaries), (nursing home) doctors and paramedical staff such as physiotherapists, speech therapists, psychologists.

[1] Most AWBZ care providers are organised in the largest national umbrella organisation on long term care: ActiZ.

Residential homes have developed from a type of facility that formerly used to be called homes for the elderly. The residents of these homes no longer are able to run a household, often because of disabilities or chronic conditions combined with the lack of family care: For them home care and social support (from local authorities) would not suffice.

Home care organisations provide nursing, support, personal care, also in various types of care focused to user groups, like case management for dementia patients or specialised diabetes nurses. Often they also cater for assistive devices. Domestic help may be provided by home care organisations, but nowadays not under AWBZ but under WMO which for users may cause problems of fragmentation of care and support.

Care organisations are supposed to operate on a regulated market: they have to compete on the basis of price and quality for their annual contracts with the Care Office. In the contract a annual budget is included and if this budget is exceeded an uptake of new clients may be temporarily suspended and waiting lists may ensue. Nursing homes, residential homes and home care organisations lately tend to merge with similar organisations, but also with other health care organisations like hospitals. This has resulted in a large variety of scale and focus of care organisations. A secondary effect of this merging is the opportunity to achieve integrated care within one broad organisation.

2.3.2 Care in cash: PGB

The personal budget for care (PGB) is an amount of money allowed to an individual person in order to purchase care. It can be requested from the Care Office instead of care in kind that is indicated after assessment by CIZ. By application of conversion rules the CAK calculates the charge and with a deduction of the users share the amount (with a maximum of euro 300 per day) will be paid by the Care Office. The total amount of money available for PGB is limited by directives of the Ministry of Health, however.

Beneficiaries can purchase various types of care and assistance, not necessarily limited by the CIZ care decision (except treatment and residential stay). Care and assistance may be given by persons and organisations that have no AWBZ permit; not only from family members, but also from for-profit care providers. In all cases a care agreement is mandatory. A further requirement is that the PGB-holder will keep an account of expenditures. For administrative duties, PGB-holders can apply for support at a number of organisations, amongst which the Social Insurances Bank (Sociale Verzekerings Bank / SVB) that pays state pensions and a national umbrella organisation of PGB-holders (Per Saldo).

The total number of PGB-holders was about 115.000 by the end of 2009. The average PGB was € 18,000. This personal budget is not an income or compensation. For the beneficiary, it is free from income tax. The PGB is explicitly not a compensation to family members for helping a relative in need; in the CIZ assessment procedure the usual ‘socially accepted’ duties of relatives towards the person in need are taken into account. For additional tasks that informal carers normally would not do a payment by the beneficiary (coming from his or her personal budget) is possible.

2.3.3 The role of families in care

When dealing with care provision, the role of families should not be forgotten. Almost one million family carers (about 5.3 % of the population) say to care for a relative at least eight hours a week during at least a three months a year. About 40% of those who receive family care are above the age of 65 (de Boer et al, 2009). Family care is often combined with professional nursing and personal care, but not with professional home help (Bonsang, 2009). For Dutch families and relatives of a person in need there are no care duties beyond those that exist between relatives in general.

2.3.4 Social support: WMO

Many users of LTC are likely to be in need of social support. Services like home help, transportation, assistive devices (e.g. the supply of wheelchairs), personal support, pass-time services, are provided by local authorities in the framework of the Act on Social Support (Wet Maatschappelijke Ondersteuning / WMO). The users of LTC services often are faced with fragmentised care provision. The administrative intake and assessment have to be done twice, and allocations of WMO support may not match with AWBZ care.

2.3.5 Quality of care

Mandatory improvement of quality of care was introduced in 2006. Main element of this was the obligation of care organisations to deliver so-called 'responsible care' (verantwoorde zorg). This should be achieved by an active quality policy, a quality implementation system, and the publication of an annual quality report, to be sent specifically to the Minister of Health and to the regional organisation of patients and care customers. A System of mandatory quality performance measurement was introduced in 2009. It is based on a specification of what is meant by 'responsible care'.

In the Dutch health care policy a paradigm shift is becoming quite evident: Quality of care towards quality of life. This shift that started in the care for persons with (mental)disabilities in the mid nineties is being adopted now by long term care for the elderly (Schalock, 1994; WHOQOL, 1993).

A perspective is emerging that focuses on the client in his natural network rather than on the care providers' interests; the change from a focus on process towards a focus on outcome as expressed in the experience of the client. It would mean a shift from management of care services to social support and its effects on the personal life of a client. Other focus points of ' quality of life' in the care for disabled persons are not adopted (yet) in the elderly care, such as inclusion, personal development, self-determination, personal support if it requires changing traditional care structures.

3 Key barriers to joint working

3.1 Structural

3.1.1 The role of care insurers

There is a number of disadvantages in the current structure of Care Offices in the AWBZ. A major stumbling block is the fact that the offices have inadequate incentives to implement the AWBZ in a client-centred manner. For example, there is no direct relationship between the care office and the insured party, and there is no intrinsic interest in keeping the AWBZ premium affordable. This is because the Care Offices themselves do not have a financial interest in implementing the AWBZ. A further disadvantage of the system of these offices is that people who make use of AWBZ care often have to deal with three different points of contact as said before: the municipality for the WMO, the care office for the AWBZ and the care insurer for the ZVW. Yet another disadvantage is the fact that the current implementation structure, in which care insurers implement the AWBZ on behalf of the other insurers (and their policy-holders) but compete against each other in the care purchasing market for ZVW care, is difficult to sustain on the long run. Finally. although care offices are responsible for implementation under the AWBZ, their policy-holders are dependent on their regional care office for service and purchasing of AWBZ care.

These disadvantages have persuaded the State Secretary in 2009 to consider a different structure which might have fewer disadvantages in terms of implementation. The State Secretary was convinced that the AWBZ is the best possible instrument for guaranteeing availability and quality of care for people who have a long-term or permanent disability or condition which prevents them from living a fully independent life.

One option for tackling the disadvantages inherent in the current structure of care offices could be to allow the AWBZ to be implemented by the care insurers on behalf of their own policy holders. The advantage of allowing the AWBZ to be implemented by the care insurers is that this would reduce the number of points of contact for clients to one single point for all entitlements to care - both under the AWBZ and the ZVW - namely the care insurer with whom the client is insured. Implementation by the insurers on behalf of their own policy holders would contribute to achieving cohesion between the AWBZ and the ZVW and ensuring the financial viability of the AWBZ in the longer term. This option ties in with the advice of the Social and Economic Council (SER), namely that care insurers should start implementing all or part of the AWBZ on behalf of their own policy holders by 2012 at the latest, and does not rule out the option of transferring parts of the AWBZ to the ZVW and the WMO.

The Dutch government could ensure that implementation of the AWBZ by care insurers on behalf of their own policy holders plays a role in achieving certain underlying principles.

On the one hand, the organisation of a single point of contact for entitlements to care under both the AWBZ and the ZVW should produce a significant number of advantages for the provision of services to clients and the organisation of integrated care. It will place clients' wishes and needs more firmly at centre stage. This measure is also expected to give small, new providers more opportunities, since care insurers will wish to differentiate themselves in the implementation of the AWBZ. Care insurers will also

have a greater interest in ensuring a good correlation between cure and care and, from a preventive point of view, will be more inclined to invest in achieving a good correlation between care and welfare.

On the other hand, however, a structure of this kind raises certain concerns. For example, the Dutch government needs to consider what effect abolishing the Care Offices would have on coordination and compatibility with the municipal sphere, keeping in mind that the current care office plays a regional role. Municipalities would then have to deal with several different care insurers, which could be troublesome for them. Other considerations relate to the issue of how the municipality would be able to influence building plans and how diversity in housing provision could be stimulated. Whereas implementation by care insurers will improve coordination between cure and care, it is less obvious whether it would have the same effect on coordination between care and welfare, and additional effort could perhaps be required. The government would also need to guard against undesirable risk selection. If care insurers implement the AWBZ, they must be willing to do so for all clients. They must not give preference to the elderly over people with multiple, complex disabilities, for example. The key issue will be to exploit the benefits and avoid any potential disadvantages.

3.2 Procedural

3.2.1 Preconditions for the implementation of the AWBZ by care insurers

In 2008, the Cabinet announced its intention to assess in mid-2010 whether the preconditions have been met to allow care insurers to implement at least part of the AWBZ on behalf of their own clients in 2012. The Cabinet stated not yet to have reached a decision in this regard, because it only intends to take this step once a number of preconditions have been met, such as the introduction of risk-bearing for insurers, individual-trailing instead of institution-based funding, stable rates for care provision, and administration and expenditure statements at individual client level. Also a discussion is ongoing that the AWBZ should be implemented separately from the ZVW. The assessment of care needs should be improved, client payments must encourage appropriate use and the aforementioned points for consideration need to be met. Legal feasibility is another precondition. The above measures are partly aimed at ensuring that the budget remains controllable.

Together with the Netherlands Association of Health Care Insurers (ZN) the State Secretary has drawn up a step-by-step plan which outlines what needs to be done in order to decide whether or not to allow care insurers to implement the AWBZ. The State secretary shall also be examining how care insurers would be financed if they were to implement the AWBZ on behalf of their own policy holders, with the aim of keeping financial control at its present level whilst allowing for implementation by care insurers. In order to ensure that the budget remains controllable, it is important to establish what incentives could be put in place for care insurers to improve efficiency. By introducing a certain level of risk-bearing and/or scope in the purchase of care, care insurers could be given an additional incentive to monitor the efficiency of their care purchasing. In exploring efficiency incentives, the State Secretary intends to look at the options for allowing expenditure for alternative purposes which benefit the AWBZ indirectly, such as stimulus projects in integrated care, prevention, innovation, the use of care brokers and client information.

In order to respond to the points for consideration mentioned above, the government wants to see an explicit comparison of the envisaged advantages and disadvantages, that clearly demonstrates which clients would be better or indeed worse off in terms of added value if the AWBZ were to be implemented by care insurers on behalf of their own policy-holders. It is expected that care insurers play an active role towards their clients in the decision-making process in the upcoming period. Last year care insurers worked with client organisations to establish the best way to meet the wishes and needs of vulnerable clients. Care insurers also pay specific attention to their relationship with municipalities. ZN should consult with the umbrella organisation of municipalities (VNG) to work out an appropriate form of collaboration which could ensure that needs are met as fully as possible on a local level. It is conceivable that care insurers will opt for a representation model in which the market leaders make the arrangements on behalf of all care insurers. ZN and the VNG can ascertain jointly how municipalities can play a role in this in a practical way.

In reaching a final decision on implementation of the AWBZ from 2012 onwards, priority of the government will be to ensure that it is not only clients who are willing and able to do so who can express their preferences, but also - and primarily - that care and support for the most vulnerable groups (such as those with multiple severe disabilities) are properly regulated and guaranteed at all times and are coordinated with each other. Before the AWBZ is taken into an environment involving a higher level of risk-bearing, this will have to be properly ensured.

In order to assess whether the preconditions for a proper regulation and coordination of care and support can be met, the State Secretary had the intention to work together with the care insurers to enable a well-considered decision on the implementation of the AWBZ from 2012 onwards to be taken by 1 July 2010 at the latest. However, as the current Cabinet has resigned this operation will be seriously delayed or even cancelled.

3.2.2 Simplification of the assessment of care needs

The assessment of care needs under the AWBZ is necessary in order to determine whether it is appropriate for the applicant to claim for AWBZ care financed from collective resources. At the same time, the assessment must be such that it allows people to obtain the care they need. It is no more than an instrument.

Professionals, care providers and clients should experience as few obstacles as possible in the process of assessing care needs under the AWBZ. Government policy is therefore aimed at making the process of assessing care needs transparent and simplifying it significantly. In essence, this boils down to the fact that care professionals and care providers are being given a more active role in the process of assessing care needs under the AWBZ. These may include the GP, but also the district nurse or a care provider such as a residential or nursing home. This change challenges the aim of independent objective judgement, which is the cornerstone of the Dutch needs assessment system.

Nevertheless, this measure is understandable, since these professionals have access to the clients' medical records, and are able to send a digital assessment recommendation to the CIZ, which issues the assessment decision. In 2008 almost 1,300 care providers used this option resulting in 150.000 assessment recommendations. For that matter, the professionals and providers will have to make significant efforts to supply the minimum digital dataset in full and properly. GPs' attention has been

specifically drawn to the standard assessment protocols (SIPs) and the urgent procedure. The secondment of assessors to larger health centres is now gradually being rolled out in 24 centres. The aim of all of the above is to rid the care assessment process of unnecessary bureaucracy, to reduce the time it takes to process applications, to inform clients of the status of their applications sooner, and, if they are entitled to care, to enable them to access it more quickly. Since January of this year citizens are able to apply AWBZ-care themselves via a web page of the CIZ.

3.3 Financial

3.3.1 Housing and care

Housing and care in LTC will be separated financially. In principal, there are two ways to achieve this separation, namely a once-only change in the regime or a gradual implementation. In the case of a regime change, housing and care are financially separated from each other in one go through the modification of care agreements and funding. Housing would then no longer be funded through the AWBZ (even in the existing care organisations). With a gradual implementation, the current development policy will be carried forward in order to promote the division of housing and care, and then where necessary intensified. Both methods of implementation have advantages and disadvantages.

There are a number of changes in the funding of the long-term care which are relevant with regard to the chosen route in order to achieve financial separation of housing and care. Thus, the Ministry for Health, Welfare and Sport is currently implementing another form of funding, namely the funding for care intensity (Care Intensity Packages, ZZP) With this new method of funding, the care homes will receive their money based on the care intensity of their clients. This results in a re-allocation of the development budgets amongst the care homes. This re-allocation will take place gradually. As of 2009, the construction regime has been phased out. Then in 2011, a prescriptive accommodation component will be added to the ZZP tariffs. As a result of which, the care homes no longer have their actual capital charges compensated separately, but they will have to finance these from an integrated tariff. These measures will make an important contribution to increasing the diversity in housing; however they will also form a considerable (policy) demand for the care homes at the same time. Apart from these measures, the homes will also have to deal with the credit crisis, which is making it more difficult to get financing for construction projects.

When the direct implementation of financial division between housing and care is added to these already existing and scheduled policy modifications, it means a considerable (policy)challenge as well as additional uncertainty for the institutions. The risk, that a large number of care homes would not be able to efficiently absorb this accumulation of measures with such regime change, must not be underestimated. The majority of these care homes do not avail of sufficient capital for example to be able to adequately absorb such a risk. This can have consequences for continuity and quality of care (GUPTA, 2009).

3.4 Professional

3.4.1 Coordination

It has been pointed out frequently that care providers have insufficient knowledge to enable them to effectively provide the care and support that elderly patients need, particularly if their problems are complex. The provision of care in general operates reactively; intervention only takes place when problems get out of hand. Care professionals operate in an organisational context, and mainly look at a particular part of the clients' problems, often with no or very limited coordination between one another. This gives patients the feeling that they are not getting sufficient help and are being sent from pillar to post. No-one is making a decision as to what combination of care from the cure, care and social services would provide the best outcome for them. It is in everyone's interests that joint approaches improve the quality of care for the elderly in these areas. More acceptance of what the other professional could contribute in a collaborative process would improve the efficiency and effectiveness of care. Recently a set of guidelines has been launched as to assist professionals (and care providers) in better cooperation as their division of tasks and responsibilities are not yet as clear as they should be in integrated care (KNMG et al, 2009).

3.4.2 Labour market

The care industry currently faces an enormous challenge in the labour market - one that is set to increase in the future. The demand for care will continue to rise, and the potential supply of manpower will not keep pace with this increased demand. In the letter on the labour market which was presented in the House of Representatives at the end of 2008, the analysis of the labour market in great depth was examined. The long-term problems are many and varied. For example, a person with dementia will need two years of institutional care on average, preceded by five years of support in their own home with a great deal of informal and home care. In order to avoid serious shortages in the labour market, both in the short and long term, there is an urgent need to put a range of measures in place.

Some examples with great potential include the Traineeship Fund, which is designed to increase the number of traineeships and provide better support for trainees. There are also regional pilot projects which recruit and train people at the lower end of the labour market and others which recruit and train immigrants as carers, and investments are being made in strengthening the regional structure (cooperation between care institutions, the employment agency, municipalities, Calibris[2], schools and colleges). These measures are primarily aimed at training more people for jobs in care and encouraging the movement of staff within the care sector. In the midst of the credit crisis, these are also efficient tools for getting people who are unemployed back to work quickly.

In addition to increasing the influx of personnel, it is also important to invest substantially in retaining care personnel. The foundation of all care provided under the AWBZ is, after all, the professional care worker who is in direct contact with the clients. If the professionals are satisfied, this will have a positive effect on the clients. Furthermore, satisfied staff do not take unnecessary sick leave. It is therefore important to focus on the people who provide the care and their needs in terms of how they want to do their work, and to create the conditions that will enable them to do it. The boards and management of

2 National expertise centre for learning on the job in care, welfare and sports

the institutions will therefore not only need to pay attention to newcomers to the profession, but also to the welfare of existing staff in their organisation.

3.5 Issues of status and legitimacy

3.5.1 Informal care

People want to retain as much control over their lives as possible. The system needs to ensure that people are not 'medicalised' at an early age, thus avoiding any unintended stigmatisation. The inherent power of citizens, both inside and outside their own social network, is of great value. In this context it is important to strengthen one's own social environment, for example by building up a good network of neighbours. In the Netherlands there are more than 1 million informal carers who actively dedicate themselves to looking after people in their immediate vicinity. Also there are approximately 4 million volunteers. These people all play a role in creating connections, in increasing mutual involvement and social cohesion in our society. The government regards the contribution made by informal carers and volunteers as extremely important, and it is making efforts to strengthen the position of informal carers and volunteers. One aspect that requires further attention in this regard is the relationship between formal (professional) care and the informal care provided by volunteers and informal carers.

3.5.2 Client's perspective

At various levels legislation exists to strengthen the position and rights of clients (Nies, 2002):

- The Medical Treatment Agreement Act (1994) requires care providers in client-professional interactions to inform the client about the pros and cons of the treatment (informed consent). This act also covers fundamental patients' rights in areas such as patient autonomy and the responsibilities of care providers.
- The Complaints Act (1995) requires care providers to implement specific procedures to handle patients complaints.
- The Mentorship Act (1995) and the Exceptional Admissions in Psychiatric Hospitals Act (1994) ensure the rights and protection of people who are unable to take responsible decisions by themselves and/or who are admitted in institutional care without their explicit consent (for instance people with dementia).
- The Clients' Participation in Care Providing Organisations Act (1996) renders a significant say to clients and/or their representatives in the management and policy making of care providing organisations; amongst others the advisory boards of clients have the right to nominate a member in the board of these organisations and they are entitled to give advice on the appointment of the management, reorganisations, matters of religious denominations, quality of care and so on.

Most of this legislation stems from the nineties. A new act – the Rights of Client in Care Act – is due to unify as much as possible the existing legislation on clients' rights in 2010.

When people need care, it is important to provide proper coordination and cohesion between care and social support, ideally organised in close proximity to the citizen (locally). This has to be based on the power of disabled people to make their own choices and retain and take responsibility themselves. The focal point therefore should be the client's perspective, not the offerings conceived in anonymous systems. By focusing on people's strengths instead of solely on their limitations, it is also possible to bring about reciprocity. For example, a person with a physical disability has difficulty walking and receives a mobility scooter. With this new-found mobility he can now become actively involved in the local primary school as a reading assistant. This gives real meaning to the concept of participation and enables citizens to become actively involved in activities in their immediate environment.

3.5.3 Support

There is a range of facilities which are appropriate for social support in one's own environment, many of which are collective. People must be given the opportunity to connect with each other in the neighbourhood and their local district. These connections give rise to social networks in which people can meet, support each other and co-exist.

In the Social Support Act municipalities are tasked with helping people to participate when they are unable to do so themselves. On a local level, connections are made such as those between care and welfare, between housing and participation and between work and income. However, there are many other opportunities to make connections, for example with housing corporations and sports organisations.

3.5.4 Solidarity and choice

Unlike welfare, care focuses much more on the individual. Care is individually enforceable because it is provided by way of a solidarity-based insurance system (AWBZ and ZVW). The right to care arises directly from the AWBZ. Under the provisions of the AWBZ, care insurers (or in practice, care offices) are obliged to provide people who are assessed as needing care with the care they need, in good time. In this way in the Netherlands care is provided for the most vulnerable people. The solidarity underlying this is an important value. It is important that vulnerable people who are in receipt of long-term care retain their independence and are provided with the best possible quality of life. The underlying values and principles are that people have a fundamental right for selfdirection and living their own lives This is expressed in aspects such as the choices which clients in receipt of long-term care have to be able to make concerning the location and type of accommodation where they can receive the care they need. They must be able to choose a provider that suits them themselves instead of having others make the decision for them. Providers of institutional care must provide their clients with as much privacy and choice in terms of accommodation as possible. Making quality information widely available enables people to make these choices themselves. One example of this is the quality information that can be obtained at www.KiesBeter.nl, which is being constantly augmented.

Access to LTC in the Netherlands is not a subject of debate, since all citizens – regardless of age or health status – are universally insured for the cost of LTC, and access is possible via objective procedures. There may be slight problems with access (e.g. occasional waiting lists), but although there are differences in society with respect to service utilization (ethnic minorities, high SES) there is not a sense of differential

access for groups. Furthermore, freedom of choice is respected and facilities of various denominations are available: for strict religious groups, for ethnic groups, and even for homosexuals.

4 Key enablers

4.1 Shared vision

The correlation between care (ZVW and AWBZ) and welfare, in which the client is central and people's own strengths are utilised, and an AWBZ that is meant for everyone with a genuine need for long-term care, form the core of the Dutch government's vision for long-term care. What could this mean for care and support in the future?

Developments in care

Over the next few years the demographics, and in particular the ageing population, will have a greater impact on care than in the past. Ageing will play a significant role in the growth of care expenditure. By 2030 there will be almost 4 million people over the age of 65 in the Netherlands (25% of the population). The number of people with dementia is expected to rise to more than 380,000 by 2030. The number of chronically ill people will also rise. The Netherlands Institute for Social Research (SCP) has estimated that the potential demand for nursing and care will increase by almost 40% between 2002 and 2020. The use of AWBZ-financed care will increase by 28%. According to the SCP, this difference is due to the fact that, relatively speaking, solutions for care problems are increasingly being sought in the informal and private sectors and in the adaptation of one's accommodation and living environment.

Expenditure on care is set to increase in the future because of the ageing population, but also because of developments in medical technology. It is important to ensure that people can count on care and support in the future as well. The Government needs to respond to this now by keeping the system affordable and ensuring that solidarity is preserved in the long term. For this reason, the State Secretary has tightened up the criteria for eligibility for the AWBZ function 'guidance' last year.

4.2 Clarity of roles and responsibilities

Clients

Clients will themselves play a major role in the future - even more so than today. As prosperity and educational levels increase, clients will demand higher quality and freedom of choice in respect of the care they receive. This could result in unrelenting pressure to improve the level of care that is provided. More and more information on the quality of care providers will be made available. There will also be greater diversity in the range of care services on offer than is now the case. By diversifying care services, the government must enable people to make more choices. This is an advantage, but this is easier for people who are well-to-do, well-educated and independent to make choices than it is for the most vulnerable members of our society to do so. Freedom of choice does not always have obvious benefits for everyone. The most vulnerable among the Dutch population can in fact perceive freedom of choice

as a burden, since they are not always or no longer able to make those choices themselves. People want the care they need to be available close to home, particularly when long-term care is needed. This underlines the importance of providing local facilities that are embedded in local care networks involving for instance the GP.

Furthermore, the role of self-management is increasing, primarily in disease management programs. This redefines the role of the patient/client towards the (health) care professionals, not in a legislative manner but in practical terms.

Professionals and cooperation

More care providers operating on a lower-threshold basis than they do at present and playing a major role in connecting and helping to shape the total care and support package the client uses. This can help people with multiple problems to remain at home for longer if they wish to do so. This managing, connecting and coordinating role can be fulfilled effectively by a district nurse acting as a linchpin. Where relevant, this is done by maintaining good contact with other care providers.

Care facilities should become a more integrated part of the neighbourhood and many social players (such as municipalities, schools, care and welfare institutions, childcare, sports clubs and local communities) taking responsibility for people's welfare. It is therefore important to be sufficiently aware of the importance of volunteers and informal carers, both now and in the future.

The government finds it also important that there is respect for the professional autonomy of the people delivering the care. All professionals (such as general practitioners, care workers and nurses) who are involved with people who depend on long-term care are trained to be able to provide the best possible care. They must therefore be given the scope to do so. After all, care belongs both to those who receive it and to those who provide it.

The key criterion should not be the organisation, but the professional response to the individual demand for care. It would be most unfortunate if professionals would feel that their time and effort were largely spent on unnecessary bureaucracy and on accounting for their work. What is needed is greater cohesion between professional local organisations and the community, so that the client can request low-threshold care involving a small number of carers. This could be an effective way of ensuring that carers dedicate most of their time to the actual delivery of care.

This implies that linear links and networks become increasingly important as inter-organisational structures (Minkman et al, 2008). In dementia care there is a large program in which regional networks are contracted on the basis of their collaborative efforts (Nies et al, 2009).

4.3 Appropriate incentives and rewards

A new system in care

The government's intention is to create a new long-term care and support system; a socially acceptable system which also meets the requirement that individuals and institutions should take on more

responsibility for themselves. This system also should provide a powerful impetus for shifting the emphasis onto care in the community, and in doing so meeting people's wishes to continue to live independently in their own environment as much and for as long as possible.

Unlike social care, long-term care under the legislation of health care focuses much more on the individual. Rights are individually enforceable as it is provided in the framework of a solidarity-based insurance system (the AWBZ and the ZVW). The right to care arises directly from the AWBZ. Under the provisions of the AWBZ, care insurers (or in practice, care offices) are obliged to provide people who are assessed as needing care with the care they need, in good time. In this way in the Netherlands care is provided for the most vulnerable people. The solidarity underlying this is an important value. It is important that vulnerable people who are in receipt of long-term care retain their independence and are provided with the best possible quality of life. This is expressed in aspects such as the choices which clients in receipt of long-term care have to be able to make concerning the location and type of accommodation where they can receive the care they need. They must be able to choose a provider that suits them themselves instead of having others make the decision for them. Providers of institutional care must provide their clients with as much privacy and choice in terms of accommodation as possible. Making quality information widely available enables people to make these choices themselves. One example of this is the quality information that can be obtained at www.kiesBeter.nl, which is being constantly augmented.

Municipal responsibilities

Dutch municipalities are legally obliged to provide care services for the elderly and the disabled - transport, wheelchairs and special facilities in houses. Patients can apply to a special municipal agency for care services of for an allowance with which to purchase the care themselves. This has resulted in greater flexibility and a more demand-driven approach among care providers.

Less bureaucracy

An agreement has been made with the care insurers that they will limit the amount of information they request from care providers, since this represents a bureaucratic burden. For this purpose, the care offices have jointly drawn up a set of standard requirements which tie in with the statutory frameworks. These have been incorporated in the care offices' joint purchasing guideline ZN has agreed upon with the care providers and client organisations. From this year onwards, care providers are required to issue a management statement confirming that they meet the requirements. Additional information may only be requested in cases of serious doubt or in the event of a spot check or inspection. In all other cases the information provided in the management statement and the annual corporate social responsibility statement will suffice.

4.4 Accountability for joint working

Connection

Many users of long-term care are people with multiple disabilities or conditions (co-morbidity). Because of the complexity of their disabilities or conditions, these people often receive support and care under several different systems such as the WMO, the AWBZ and the ZVW. The care and support these people

receive needs to be delivered in a properly coordinated manner. This includes communicating clearly what care and support options are available and where the client can obtain them.

In the case of long-term care, this may concern a client with co-morbidity who wants to remain in his/her own home, for example. This client is entitled to home modifications, a wheelchair and welfare arrangements such as meals-on-wheels or odd-job services under the WMO, personal care and nursing under the AWBZ, and medication, GP care and sometimes a hospital appointment under the ZVW. For those who have been assessed as requiring long-term specialist residential care as well, it is important to ensure that there are adapted dwellings available, that there is supervision, that they are accepted by those around them and that there is care available in the neighbourhood.

5 The funding of long-term care services

The AWBZ enables care to be delivered to the most vulnerable people in our society. Those who are dependent on such care must not feel that they are being obstructed by the very systems that have been put in place to deliver this care. The future of the AWBZ will be determined by the demand for care from the most vulnerable members of our society, the care services the professionals can deliver to meet this demand, and the solidarity that society can muster for caring for these people. But LTC is becoming a national financial burden.

Projected expenditures for ABWZ in 2010 amount to € 23.2 billion, of which € 12.4 billion for oler people's care (VV&T sector: nursing homes, residential homes and home care). About € 1.4 billion is paid for PGBs.

LTC services are funded from the central AWBZ treasury (AFBZ, Algemeen Fonds Bijzondere Ziektekosten), which receives its finances from AWBZ premiums (68%, through the national tax office), governmental contributions (24%, e.g. for persons below age 18, who pay no income tax) and user co-payments (8%).

Care providers are funded mainly by AWBZ, the amount of which depends on the quantity of care to be delivered, as agreed with the regional Care Office. Payment to care providers is done by CAK.

AWBZ insurance is universal and mandatory; contributions of citizens are levied through income tax, along with contributions for other national insurance schemes. The premium is quite high: in 2010 it is 12.15% of taxable income with a maximum threshold of € 3,838 (no linear relationship with income). Children below the age of 18 are insured without paying contributions.

5.1 User contributions

When using AWBZ funded care and services, beneficiaries above the age of 18 are required to pay out-of-pocket contributions ("eigen bijdrage"; co-payment). Co-payments are restricted to a maximum of € 2.081,60 monthly (for residents), the amount being dependent on income, but not on assets. A forced selling of a house owned by the patient in order to pay LTC-costs does not exist in the Netherlands

anymore (it used to be the case some decades ago), nor are there lawsuits about forced selling of assets, nor are there solicitors specialising in this matter.

Service users do not pay their user share directly to the CAK that calculates the share, rather than the care providing organisation. User shares will in most cases be deducted from payment of social insurance contributions. For users of residential care, part of the income cannot be touched upon for payment of user-countributions. In 2009 this sum was € 288,37 for singles and € 448,53 for married persons per month. In this context it is important to know that virtually every citizen above the age of 65 years has a state pension, and many have a (mostly smaller) private pension on top of that. The state pension is € 1,052 for single persons and € 733 for married persons.

5.2 The provision of assistive devices

Residents of nursing homes who also receive treatment in their AWBZ package – and most of them have – are eligible for assistive devices financed by the AWBZ. This is also true for residents of residential care homes. As many of the latter do not receive treatment, they will have to apply to their health insurer or to local authorities.

The provision of aids through the AWBZ package of the nursing home is in contrast to the provision to persons in the community who need the same aids, appliances and assistive devices: these will – just like aids and devices on medical prescription - be paid by their health insurer if the aids are in the standard package. And if not so, persons have to pay for them themselves, unless the aids are included in a purchased supplementary insurance.

Still, for persons in the community who need aids on a temporary basis, many of these will be paid by AWBZ. They can be borrowed – without any assessment – from a home care shop (not necessarily managed by a home care organisation) for a maximum of 26 weeks. This service is paid by AWBZ to home care shops. Some examples are cushions and mattresses for bed ulcer prevention, bathing chairs, lavatory bowl rings, walkers, clutches, special beds, lifting equipment.

To make things complicated, for aids and devices that are connected to participation in society, both residents and persons in the community have to apply to the WMO-office of the local authorities. One popular example concerns the so-called scooters. But for a simple wheelchair also residents of residential homes that have no treatment will have to apply to the local authorities, whereas for residents of a nursing home this will be provided in the framework of the AWBZ.

In fact, to what body someone has to apply for what aid or device or equipment, is not transparent at all. It is depending on lists that the executive organisations of AWBZ, ZVW and WMO (Zorgkantoren, health insurers and local authorities respectively) employ – and these lists are changed every year by the Ministry. Attempts are therefore being made currently by CVZ to simplify respective procedures.

5.3 Individual-trailing funding

The funding in the AWBZ is undergoing a development 'from bed to client' (from a supply-led to a demand-led scenario). In the past, institutions received money for the number of beds they operated, whereas the Dutch government is now working towards funding based on the number and type of clients receiving care from an institution. It is expected that outcome will be a funding criterion in the future. At present, the government is reluctant to do so. The funding for care in kind is therefore increasingly taking on the form of an individual-trailing budget, a system which yet has to be developed. Below is a description of the old and the desired future funding scenarios.

	Care in kind	**Budget controlled by client**
'Old' situation	Organisation-based funding	Personal Budget
Present and future situation	Individual-trailing funding (PVB): - Step 1 on 1 January 2009: introduction of care intensity packages (ZZPs) for institutional care and survey of the introduction of ZZPs for care in the community - As a potential follow-up step, the possibility of vouchers will be investigated (for some forms of care in kind).	Personal Budget

In the case of individual-trailing funding it is commonly believed that the client organises his or her own care based on a sum of money which is provided after the assessment of their care needs. This is not the case, however, since the client receives their care in kind. With individual-trailing funding the clients do not have an actual budget at their disposal, as is the case with the personal budget (PGB). With individual-trailing funding the budget follows the client, even if he or she switches to a different care provider, for example. The individual-trailing budget is therefore not an amount of money which the clients can manage themselves and which is paid out to them. Individual-trailing funding plays a major role in focusing on a client's care needs and the associated care plan. Individual-trailing funding for care in kind is expected to act as an incentive for care providers to provide effective, good quality care in the form of a care arrangement that meets the client's preferences, since the funding is not based on the institution but on the client with a particular care need.

In the context of purchasing care in kind, the care office or the care insurer is envisaged to play a role in a system of individual-trailing funding as well. Care offices and care insurers play a major role in monitoring efficiency and purchasing care at a good price/quality ratio. Under the provisions of the AWBZ, care insurers (or in practice, care offices) are obliged to provide people who are assessed as needing care with the care they need when they need it.

With the introduction of the care intensity packages (ZZPs) for institutional care on 1 January 2009, the government has taken the first step towards individual-trailing funding. The introduction of ZZPs will have financial implications for all care providers and care offices in that it will increase or reduce their organisational budget (reallocation). In order to guarantee continuity of care provision to clients, this reallocation will be phased in over the period 2009-2011. In the context of individual-trailing funding, the government is also engaged in further refining care level packages for care in the community, and is exploring what subsequent steps can be taken to arrive at full individual-trailing funding.

6 Financial sustainability

Financial sustainability of the system is under debate these days, and 'ageing of the population' is often mentioned as the main risk factor. However, the Netherlands Institute for Social Research (SCP) published some remarkable facts by 2009, showing that the increase in the use of LTC services is less than expected due to demographic change. The number of users of VV&T is expected to increase by 1.2%; this includes an increase by 0.4% of users due to population growth, 1.2% due to an increasing share of older people in the population, and a decrease of 0.4% due to less use of better educated and more healthy older people in the future (Timmermans, 2009).

Expenditures for LTC (VV&T) are expected to increase by about 3.4% annually. The increase is due to an annual increase of the care volume of 1.5% and a general rise of prices by 1.9% annually. The increase of the care volume is larger than growth in the number of users, because of a growing average intensity of care per individual user.

In view of the total budget for LTC and the high contributions from citizens for AWBZ insurance, it is conceivable that the expenditures for AWBZ are under debate. Additionally, there is a need for cutbacks of collective costs because of the 2009 monetary crisis. The Dutch government has already announced fierce cutbacks in AWBZ for the year 2010.

A number of policies have been launched to ensure that the AWBZ remains financially tenable; that the client has greater choice; that there is more room for professionalism; and that red-tape is reduced. The resulting consequences of these measures are negligible for the sector. The policy demands of these measures, which the institutions may encounter during this transitional period, are so considerable that the choice to financially separate housing and care in one go will be asking too much from the sector. The government deems that the inherent risks are considerable for the continuity and quality of care. In particular, it is bearing in mind the entrepreneurial and development risks for care providers, as well as the investment risks amongst the real estate sector which will only increase as a result of the changing budget system in addition to the financial-economic situation. These risks are being considered in light of the desired and necessary sustainability of long-term care.

Over the past ten years sustainability has been mainly achieved by transferring part of the coverage of the AWBZ to the local communities (social support), to the general health care insurance (mental and health care; ZVW), and to private responsibility of citizens. In the near future, the AWBZ may be abandoned altogether, i.e. partially shifted to basic health care insurance, and partially to private responsibility. This will transfer costs and efforts from a collective to an individual basis.

7 Good practice

7.1 Streamlining the assessment processes

The Minister of Social Affairs and Employment and the State Secretary have launched in 2009 the Programme to Streamline Assessment Processes in Care and Social Security, part of which is the Joint Assessment project.

A good example: The municipalities of Doetinchem and Leeuwarden are participating in this together with various implementing bodies such as the CIZ, the Institute for Employee Benefit Schemes (UWV) and the organisation for disabled people (MEE). The strategy boils down to the fact that the client only needs to be assessed once. The programme is examining the need for care, the need for support and opportunities to work. Besides paid work, it may also include voluntary work. These pilots will continue during the evaluation in 2010 Once the evaluation has been completed it has to be ascertained whether there are any opportunities to propagate the proven added value in places such as the municipalities being used as testing grounds in the near future.

7.2 Integrated care

Because care provision must always be centred around the client, it is important for organisations to work together to ensure that integrated care is available wherever it is needed. An example of organising integrated care is the purchase of dementia care. The quality of the care which people with dementia receive is determined among other things by the extent to which care providers approach the totality of their situation. For this purpose, the Integrated Dementia Care programme (a joint venture between VWS, Alzheimer Nederland, the Netherlands Association of Care Insurers (ZN) and, recently, ActiZ) has developed a purchasing guideline for dementia services. Sixteen spearhead regions were set up in mid-2008. In 2010 the purchase of integrated dementia care must be rolled out to all care office regions. A major challenge in 2010 will be to achieve coordination with the cure sector (particularly GPs and mental health services) and the WMO.

For this purpose care offices seek and encourage cooperation with bodies such as municipalities, welfare organisations and housing corporations with the intention of providing a more cohesive range of services (integrated care) for all people who suffer from dementia by 2011.

Various experiments have been initiated with a view to providing more integrated care and improving cooperation between the different domains (ZVW, WMO and AWBZ).

A good example**:** One example is the Frieslab experiment in Friesland, in which a collaborative centre has been set up to explore and improve cohesion between the various care laws and regulations. The objective of the Frieslab is to gain a better understanding of the ways in which one can organise integrated care and improve the quality of service and care provision. An experiment is currently being prepared in Rotterdam, in which a number of target groups are being identified as groups in need of greater cohesion and integrated care. The core component of the approach in Rotterdam will be matching care purchasing to the selected target groups.

7.3 Cooperation with municipalities, welfare organisations and housing corporations

Cooperation with bodies such as municipalities, welfare organisations and housing corporations is an important point for consideration in the implementation of the AWBZ. If municipalities and other parties offer comprehensive tailor-made solutions and give people the opportunity to participate, this could in many cases prevent people to apply for services under the AWBZ legislation. In all of this, the care office plays a major role in the municipalities' and other parties' ambitions to enable people to lead active lives in the local community by providing the appropriate care and support, since it can help encourage the care providers to do so.

A good example of partnership between municipality and care office: The municipality of Ede is aiming to provide sufficient suitable independent housing for various special target groups such as elderly people in need of care, physically disabled people, homeless people, mentally disabled people and former psychiatric patients. These dwellings are well spread out among its local villages, districts and neighbourhoods. The integration of care in the community is an important criterion in this endeavour. The municipality of Ede and the Arnhem care office are together examining housing needs up to 2015 in consultation with housing corporations and care providers. They are not restricting their study to care and housing alone but are also including welfare.

8 Ongoing tensions

The present policy priorities of the Dutch government for long term care are (Beleidsagenda VWS, 2010):

- To strengthen the position of clients in LTC by the so called care plan, individual trailing funding, care intensity packages and to reduce the number of restraining measures;
- Freedom of choice and diversity in housing by providing a full package of care and support at home, by developing specialized small scale housing units and the introduction of integrated tariffs;
- Improving privacy in residential by building many more one person units in residential care settings;
- The simplify the needs assessment procedures;
- To strengthen the position of care professionals because they are the core capital of LTC; specific attention is paid to put the district nurse more in a key position;
- To improve quality in LTC by using the performance indicators that are agreed by all national stakeholders (Norms of responsible care) and by connecting budgets and quality indicators in the annual contracts between care offices and care providers. Special attention is given to contracting integrated dementia care. Further, it is explored how health care insurers can take responsibility in contracting LTC (see below);
- To ensure solidarity in health and long-term care;
- To assure sustainable long-term care: the national implementation program *In for care!* has started up in order to implement on a wide scale the outcomes of a wide variety of research and development programs: the key elements for sustainability are sufficient and well qualified staff,

efficiency and solidarity, as well as citizens and clients who can take responsibility and exert autonomy. The aim is to implement fundamental transformations in LTC.

These objectives also represent the main challenges of LTC. Some tensions will be addressed below, the others are already covered elsewhere in this paper.

8.1 Care plans

The CIZ needs assessment is widely considered as being too bureaucratic. It is a means to achieve a financial target efficiency, i.e. to see to it that AWBZ expenditures are focused as exactly as possible to the care needs of clients. For the care claimant this has nothing to do with receiving the appropriate care. After admission to a residential facility, or to district nursing or home care, the right answer to the care needs still has to be given by the care provider, and of course, within the financial limits set by the CIZ decision (and in consultation with the care claimant). The care to be provided is settled in a (mandatory) care plan, after care provider and client agree on this package of care and support.

The intention is to diminish the bureaucratic burden of CIZ by giving care professionals a role in the assessment procedure.

8.2 Bureaucracy

Bureaucracy is a major problem in Dutch health care, because of increasing demands for accountability, litigation of society, internal quality measures and incompatible monitoring systems. The present – outgoing – Cabinet has taken a number of measures to reduce the administrative burden. However, the tendency towards more bureaucracy is hard to stop. The problem has been recognized for many years, but the expenditures on bureaucracy have risen across the past decade.

8.3 Boosting the transformation of the long-term care sector to ensure sustainability

In order to face the challenges long-term care will need to undergo a gradual transformation over the upcoming period. Changes are never easy, whether for the sector, for the clients or for society in general. In order to give concrete form to the transformation that is needed, the government started to introduce various development and improvement programmes in the field of long-term care over the past few years. Examples include the National Programme for Older People, the Transition Programme for Long-term Care, the National Dementia Programme, *Zorg voor Beter* [Providing Better Care] and the National Innovation Platform. These programmes all have one factor in common: they are developing new knowledge which is a necessary part of this transformation. It is already possible to roll out much of what has been developed and tested in these programmes more widely in practice. In addition, a considerable body of knowledge is also being gained in the field. At the 'Yes, we Care!' conference on 5 June 2009 an eponymous programme was announced with the intention of encouraging long-term care institutions to implement this knowledge. This program *In voor Zorg* (In For Care) has been set up recently and is run by Vilans, the National Centre of Expertise for Long-term Care.

9 Embedding good practice in everyday practice

9.1 Cooperation arrangements

The WMO, the AWBZ and the ZVW complement each other, but each has its own financing established in law. Ultimately it is important to ensure that these systems do not operate in isolation from one another, but that they tie in with one another in line with the users' needs. The increase in the number of people with co-morbidity makes it all the more necessary to invest in ensuring cohesion between these systems.

With clear parameters the parties involved can make proper arrangements on cooperation. Besides the intention to work together, these cooperation arrangements also sometimes call for a large dose of creativity, so that the parties involved can work together to find the most effective solution. It has yet to be explored which ways there could be of achieving a properly cohesive range of services at the interface between the AWBZ and WMO. If money proves to be an obstacle, the government has to examine whether it would be possible and helpful to combine a small proportion of AWBZ and WMO resources with the aim of making it easier to purchase a range of services at the interface between support and care, regardless of the original source of the finance. This will result in properly coordinated care and support for the citizen. On a macro level this could also represent better value in terms of the budget. If people obtain support at an earlier stage and their social safety net is bigger, they will have less need for intensive AWBZ care.

9.2 Modernisation and innovation

The development of medical technology is regarded as one of the key factors contributing to the growth in healthcare expenditure. In the Netherlands, technological developments have accounted for approximately half of all growth in healthcare expenditure in the past. And technological innovation will not stop in the future.

Modernisation and innovation are also needed to meet the challenges: the increasing demand for care, the shortages in the labour market and the affordability of care. In addition modernisation and innovation are needed to ensure that the system continues to fulfil the client's wishes and needs.

To encourage modernisation in terms of technical and social innovation both now and in the future, the National Transition Programme on long-term care has been launched in tandem with a wide variety of stakeholders. This programme includes a series of experiments designed to stimulate the correlation between housing, care and welfare on a local level, such as *Buurtzorg*, screen-to-screen communication in home care and monitoring with video and sensors.

The Care Innovation Platform (ZIP) is also a strong proponent of innovation in care. This platform, which was set up in 2008, is made up of content specialists from the care sector, the business community, science and government authorities. The ZIP aims to inspire and where possible accelerate innovation in care. Its primary target groups are the elderly and the chronically ill. The underlying aim is to ensure that the Dutch professionals in care can continue to offer quality in long-term care for vulnerable people in the future.

9.3 Purchasing care and quality policy

Care offices have a duty to make every effort to remain within the financial contracting framework when purchasing care, and they play a key role in achieving cost-effectiveness and in purchasing care with a good price/quality ratio. it is important that the care that is purchased and delivered is of good quality. For this reason, the arrangements made by care offices with the care providers are in line with the national quality frameworks (the standards for responsible care). This is also laid down in the care offices' joint purchasing guideline. The standards for responsible care in nursing, care and mental healthcare have been completed, but those for care for the disabled are still in progress. When purchasing care in 2010, therefore, care offices will, wherever possible, follow the standards for responsible care and ensure that these standards are applied in their organisation. This will avoid a situation in which it is not possible to calculate a quality score for some care providers. In the near future care providers will be able to work increasingly with process and output indicators based on the standards for responsible care.

Regional situations differ, however, so regional purchasing policies may need to focus on different aspects. For this reason, care offices consult regional client and consumer organisations when formulating their purchasing policy, as now is been done in the purchase of integrated dementia care. This is something the care offices will be investing in more intensively in the future.

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11 Appendix

Five priorities in Dutch health care policy

The Ministry of VWS in 2008 has nominated five priorities in health care policy, which still are in vigour:

- *Better transparency:* The performance of the care providers must be clearly specified – both concerning the medical content and the experiences of the customers. Hospitals will have to have available information about 24 disorders or medical specialisms at the special website initiated by the Ministry. Also other sectors in health care will start with information on quality of care.
- *Safety:* Programs to decrease avoidable errors and avoidable mortality will start or have started already. The Health Inspectorate will closely oversee the norms that professional groups have imposed on themselves.
- *A stronger position for health care consumers:* In the Act on Patients' Rights of 2008, seven rights of patients are mentioned. The rights are: available and accessible care; free choice and information allowing choice; quality and safety; health information, consent, storage and privacy; co-ordination between care providers; an effective settlement of complaints and disputes, and good governance with the voice of patients heard. Various activities have been initiated to implement these rights.
- *Innovation:* Innovation is considered important to cope with an increasing and changing demand of care, to bring solutions to impending shortage of staffing, and to utilise ict and technology in care in a profitable way. To boost innovation, the Ministry has established the Platform of Care Innovation (Zorginnovatieplatform), which now is working on dissemination of knowledge and practices. Of particular importance is the coming about of electronic patient files (Electronisch Patiënten Dossier, EPD). The EPD will lead to better exchange of data in care. For citizens this will mean better and safer care. In February 2010, the said platform has made 6.7 million euros available for the development and implementation of innovative ways to improve the health of people of age 55 and above.
- *Prevention:* The increase of the number of chronic diseased persons requires a coherent and multidisciplinary care, which is extended close to the patient. The Minister will continue the improvement of health protection and prevention of diseases. Care insurers may reward health lifestyle of the insured. They will be allowed to take the mandatory annual deductable of insured persons at their own expense, if these persons participate in a program that helps their health.

Source: based on http://www.minvws.nl/dossiers/beleid/