Netherlands

Long-term Care

18 May 2011

Key Facts

- About 15.2% of the population is over the age 65 and 3.9% of the population over the age of 80. By the year 2050, demographic projections forecast that one in four people will over the age of 65.
- According to OECD Health Data, the Netherlands spent 3.5% of it GDP on long-term care in 2008, of which 1.2% was for health related long-term care.
- In 2008 approximately 6.7% of the Dutch population over the age of 65 received long-term care in an institution setting, while 12.9% of this population received long-term care at home.
- The Netherlands reported 8.2 long-term care workers per 1 000 population over the age of 65 for 2009, above the OECD average of 6.4 workers per 1 000.
- In 2008 there were 69.5 beds per 1 000 population over the age of 65, above the OECD average of 44.5 beds (OECD Health Data, 2010)

Background

Long-term care (LTC) coverage is provided and organised nationally under a statutory social-insurance programme. The Netherlands is a representative democracy. As no political party will gain a majority vote, coalitions are the standard in shaping governments. The Netherlands was the first amongst OECD countries to introduce compulsory Social Health Insurance for LTC in 1968 and since 1994, has been one of the few countries to advocate personal care budgets. One long standing challenge for the country is the ever-increasing rise in LTC expenditure, a top priority of the current policy efforts. Delegation of the delivery of LTC services to the local authorities as well as acute health care insurance has peen put forward.

Benefits and Eligibility Criteria

The Dutch Exceptional Medical Expenses Act (AWBZ) is a compulsory insurance for – amongst others – the risk of long-term care, covering care for disabled, chronic mental health care, and care for the elderly. AWBZ insurance premiums are maximized as a percentage of workers' wages, currently making up 2/3 of the overall budget; the remaining 1/3 comes from taxes and is rising since LTC expenses grow faster than wage increases.

Eligibility to provisions is needs-based but income-dependent co-payments are required from the beneficiaries, apart from children. The eligibility check is based on national standardized *indication* procedures, developed by the CIZ (Centre for Indications Care), which translates legal guiding principles into detailed procedures. CIZ-decisions will typically lead to an eligibility decision regarding functions and hours of care required. Functions can be ADL, nursing, treatment, residence, and guidance. The indication procedure leads to a risk-adjusted capitation payment to the provider. In 2007 IADL-support was transferred from the AWBZ to the domain of local authorities (some of which use CIZ procedures). Recently eligibility to the "guidance" function has been restricted.

Benefits can be provided as cash personal budget or as provision in kind. Personal budgets are lower than the amount provided when care in kind is chosen. For both cash and in-kind benefits personal co-payments are calculated depending on need for care, income, household situation and age. With the CIZ-indication, those in need can go "shopping" for care provision according to their personal priorities. However, quite often outpatient care has already started as a result of an immediate need.

For people with chronic illnesses, that is an LTC indication, a special cash benefit exists to contribute to the additional costs of living due to a disability or chronic disease (including co-payments in LTC), which amounts to between EUR 150 and EUR 500 annually. The arrangement replaces a previously existing tax deductible. Continuous ongoing adjustments of the AWBZ are aimed at increasing efficiency, consumer influence and targeting of services. At the same time debate is continuing about a major overhaul of LTC financing. Main lines of thought include a delegation of the key extramural provisions to local authorities (in line with the WMO), or a transfer to the basic insurance scheme.

In addition to rest homes and nursing homes, trans-mural care services (semi-residential care settings) such as day care centres and short stay care centres provides nursing care to individuals with moderate to

severe ADL restrictions who still live in their own homes, but who have limited or temporarily restricted access to informal care.

Funding and Coverage

The AWBZ is funded by means of a mandatory insurance, based on employees' income and additional tax contributions. About 8% of AWBZ-expenditure is covered through user co-payments.

Family carers

There are three basic arrangements for working carers. First "the life course-arrangement" enables workers to save a percentage of annual gross salary for taking time-off in the future, amongst which the need to care. Workers very rarely participate in this voluntary scheme.

A second and statutory arrangement allows carers to take up to two weeks of leave in case of urgent need. Unless higher payment is agreed through a collective labour agreement (which is quite common), the leave will be combined with 70% of normal wages. Prolonged care leave is also possible but is typically unpaid. Maximum duration is half of the contractual working hours, during 12 weeks annually unless collective labour agreements lead to better arrangements for the employee. Depending on the sector and employer (and the respective collective labour agreement) carers can also use flexible working hours as a means to combine work and caring responsibilities.

Finally, family members can be hired through the personal budget scheme to become paid caregivers. The scheme includes arrangements for expenditure supervision, leading to legal working contracts as well as tax-collection on these expenses. When fulfilling certain requirements family carers can apply for an annual "compliment", a tax-free allowance of EUR 250.

Delivery

With increased user-choice, "traditional" care provider organizations face more competition, especially from new home care organizations that can be contracted by the schemes' payer and the health care office. Increasing consumer power is a policy goal: the idea is to upgrade the personal budgets to an official entitlement as well as to strengthen consumer rights. However, as OECD-Health data points out, the density of residential beds per 1 000 people aged 80 or over has been shrinking over the last ten years. According to the OECD the average utility rate of elderly homes and disabled institutions is still near 100%. The declining density as such is not a problem since policy makers as well as users want to live as long as possible in their own homes.

Key discussions

Beside the discussion about the place of LTC in the Dutch care financing landscape, another issue applies to the board and lodging costs of residential care and the amount and type of co-payments. There are currently two regimes: low co-payments (maximum EUR 759 per month) and high copayments (maximized at EUR 2 081 per month, 2010), depending on need, as well as on the household and income situation. A new government in 2010 may lead to additional and different changes. Currently, the central idea is to include beneficiaries' "savings" in the calculations of the co-payment. So far, these calculations had relied only on income, and are relatively small, as most elderly and disabled live on minimum wages.

References

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