LONG-TERM CARE REFORM IN THE NETHERLANDS: TOO LARGE TO HANDLE?

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Summary: To ensure the affordability, accessibility and quality of long-term care in the future, the Exceptional Medical Expenses Act (AWBZ) underwent major reform in 2015, aiming to save costs and keep people self-sufficient for as long as possible. Most forms of non-residential care were transferred to the municipalities and added to the Social Support Act and Youth Act, while insurers were made responsible for home nursing. Residential long-term care will be available under the new Long Term Care Act, which will replace the AWBZ. So far, implementation has been rocky, leading to several problems, including late payments and shortfalls in provision.

Keywords: Long-term Care Reform, Residential Care, Home Care, The Netherlands

Introduction

The Dutch long-term care (LTC) system, governed since 1968 by the Exceptional Medical Expenses Act (Algemene Wet Bijzondere Ziektekosten, AWBZ) is enormous. With expenditure amounting to €27.8 billion in 2014, it is about two-thirds the size of the curative insurance scheme (€40.1 billion in 2014)\textsuperscript{1} Almost one in twenty residents in the Netherlands are recipients. It is a single-payer programme, administered by care offices set up by regionally dominant insurers, and covers residential care and home care, mainly for older people (about 75% are over 65 years), patients with psychiatric disorders, and people with learning, sensory, or disability conditions. Until recently, individuals receiving LTC could choose between benefits in-kind or a personal care budget (20% of recipients chose the latter in 2010). The cost of this scheme has been steadily rising, with the majority funded from payroll contributions (12.7% with a maximum of about €4220 per year in 2014).

For a long time, the government has sought to control costs in LTC, a situation that is expected to worsen as the population ages. Since 2012, for example, the personal budget was drastically restricted in terms of eligibility and entitlements after strong increases in the number of new budget holders led to large spending increases.\textsuperscript{2} Concerns about spending on LTC have remained and have now culminated in a major reform that will change the financing structures but will also, in many cases, affect how people receive their care.

The 2015 long-term care reform

The old LTC scheme (AWBZ) will be integrated into three existing laws and one new law (see Figure 1). First, if living at home is no longer possible, residential
LTC will be available under the new Long Term Care Act (Wet langdurige zorg, Wlz). Second, insurers will be made responsible for home nursing (which includes personal care), which is now part of the Health Insurance Act (Zorgverzekeringswet, Zvw). Third, most forms of non-residential care (the social care part) will be transferred to the municipalities and added to the Social Support Act (Wet maatschappelijke ondersteuning, Wmo). Fourth, preventive and mental health care for children will be transferred to the completely revised Youth Act (Jeugdwet). The overall goals of this reform are to: (1) save costs, and thus keep LTC affordable, starting with €500 million in 2015, reaching savings of €3.5 billion annually in 2018; (2) keep people self-sufficient for as long as possible – also given the high Dutch institutionalisation rate; and (3) improve quality and coordination of care.

**Residential care: the all-new Long Term Care Act**
A new Long Term Care Act (Wlz) will replace the Exceptional Medical Expenses Act (AWBZ) as the main scheme for LTC but with a much lower contribution rate (9.65% with a maximum of €3241 per year in 2015). It will nevertheless absorb by far the largest share of the funding previously allocated to the old Act. Clients who, due to their limitations (functionally or mentally), are in need of permanent supervision have access to 24-hour inpatient care. Eligibility will be based upon a needs assessment. Eligible people who nevertheless would prefer to stay at home can apply for a personal budget. Previously, budget holders could manage their own budget, but following concerns about fraud, a government body, the Social Insurance Bank (Sociale Verzekeringsbank, SVB), now manages the budget on behalf of budget holders. In the future, care covered by the Wlz may also become the responsibility of health insurers. If that happens, the Dutch single-payer system for LTC would be fully abolished.

**Home nursing care (including personal care): the Health Insurance Act**
Home nursing is now included under the Health Insurance Act, i.e. the curative care insurance scheme. With this shift, home nursing is moved closer to other types of primary care, such as general practitioner care. Health insurers become responsible for the whole medical domain, from home nursing care to specialist hospital care. Ideally, this would foster a better integration of care. District nurses will play a key role in keeping people in their homes. They will visit home nursing recipients and assess whether it is possible to be more self-reliant. These nurses combine their medical tasks with improving the cohesion between prevention, care, wellbeing and housing. In addition, the Health Insurance Act will now cover the first three years of inpatient mental care, before the Wlz takes over. Previously, it covered only the first year.

**Social care: the Social Support Act 2015**
The objective of the Social Support Act is that municipalities will support citizens to participate in society. This includes, for instance, home help, transport facilities and house adjustments. According to the national government, municipalities will be better able to provide tailored solutions and to promote informal care than the previous nationally organised system. Municipalities first explore the opportunities for applicants to take care of themselves, with the help of their social network. If these are considered insufficient, publicly-funded support will become available. Interestingly, municipalities are free to organise tailor-made support for their citizens, which could lead to different solutions among municipalities. Thus, the rights-based approach of the AWBZ will be replaced with a provision-based approach. For example, municipalities may choose to substitute professional care with other solutions, such as care provided by neighbours or volunteers, whereas in the previous situation, people, if eligible, had a right to professional home care. Since municipalities are closer to their citizens and in a better position to assess their needs, they are expected to organise the care more efficiently by, among other things, appealing more strongly to self-reliance. Therefore, the state budget for non-residential LTC will be lowered. The amended Social Support Act (Wmo 2015) was approved by Parliament in April 2014.

**Long-term youth care: the Youth Act**
The fully revised Youth Act, which came into effect in January 2015, makes municipalities responsible for care services targeted at parenting problems, developmental problems, mental health problems and disorders for all people under 18 years and their parents. Only those who are expected to depend on 24-hour supervision after they reach the age of 18 will receive care under the Wlz. The Youth Act intends to improve coordination of care by combining all
Impact of the reform

In the run up to the reforms, many stakeholders voiced important concerns often relating to the short time provided to adequately prepare because uncertainties in the new legislation persisted well into 2014. Patient associations worried that patients who were ineligible for residential care could not stay at home because of a lack of adequately adapted housing. The associations also feared the lack of coordination in provision, which in the new situation, is split across separate institutional arrangements. Another concern was the position of informal carers and that the new arrangements would make informal care an obligation. Health insurers were more positive about the reform, but they feared not being ready for its implementation as their financial systems were not yet adapted. The association of LTC providers was positive about the reform, but also feared that 2015 was too early and voiced concerns that it was unclear who was entitled to care.

People who were already living in a residential home, but who do not meet the new, stricter entitlements, fall under transitional provision arrangements. This provision allows this group of individuals to keep their entitlements for Wlz-care for the rest of their lives. There are fears, however, that those who need a lot of care but do not meet the new criteria for Wlz-care, will not be able to organise their care themselves. Furthermore, the closure of residential homes is considered worrisome, because they also provide care to people living in the neighbourhood in the form of meals or day care. Municipalities felt that the new Social Support Act provided an opportunity for a broad and cohesive support package for citizens, but were concerned about a lack of funding and instruments to stimulate the self-reliance of citizens. The cooperation with health insurers and home nurses was another source of concern.

Half a year after the reform came into effect, it is clear that the implementation has been far from smooth. Many of the concerns and fears voiced in 2014 have become a reality. There has been continued heated political debate and media coverage. A newly published report by the Netherlands Court of Audit (Algemene Rekenkamer) called the expected savings unrealistic. Problems were reported with late payments to providers, made by the SVB on behalf of budget holders, putting both the provider and the patients into difficulty. The SVB was not ready to fulfil this task, mostly due to inadequate staffing levels, computer system problems and increased numbers of applications for a budget. The Secretary of State, who first denied the problems, finally had to apologise to parliament for the chaos and his political future is in peril. The Ministry of Health will now allocate more funds to the personal budgets than originally planned.

Another problem is finding home help (help with household chores under the Wmo), which has been the subject of a major funding cut. The government has set a savings target of 34% on the budget. Municipalities reacted in different ways: some abolished the provision of home help completely, some decreased the number of hours provided and some decided to keep the existing level of provision at the expense of other spending items in the municipal budget. To mitigate the negative effects, a transitional measure was agreed in which municipalities can temporarily apply for a higher budget for social support. Many recipients of social support (about 3000 in June 2015) have filed complaints with the municipalities and in some cases, people have sued their municipality. One court ruling stated that municipalities are not allowed to cut into home help provision without an in-depth investigation of the situation of the recipient.

Conclusion

With many countries dealing with ageing populations and exploring ways to have affordable LTC arrangements in place, the Dutch reforms are likely to receive a great deal of attention in the near future. In the short term, it seems that the ability to find quick solutions to immediate problems, which is reminiscent of the first years after the country’s major health insurance reform in 2006, will be tested. The difference with that reform, however, is that in 2006 only the payment system changed, not the provision of care. In the 2015 LTC reform, new institutions (municipalities and health insurers) have to organise types of care for which they lack previous experience and expertise. Providers of home care and youth care that had contracts with a limited number of payers, now have to negotiate with a much larger number of health insurers and municipalities, each with their own targets, budget limitations and financing systems. Moreover, the SVB, which is now responsible for paying on behalf of people with a personal budget, has shown how complex this is, as they clearly were not ready to cope with this task. It is also not yet clear to what extent municipalities will succeed in fostering informal care, since they cannot oblige people to provide it. However, in their decision to provide professional care, they can take informal care into account.

If the new system of provision is not adequately organised and funded, the repercussions for population health and health infrastructure can become enormous. A systematic evaluation of the implementation is not yet available. However, the extensive media coverage suggests that implementation has led to a great deal of debate. Since the reform affects a vulnerable group of people, it can
only be hoped that most of these issues will be resolved soon and that further social unrest will be avoided.

References


New Policy Brief: How can countries address the efficiency and equity implications of health professional mobility in Europe? Adapting policies in the context of the WHO Code of Practice and EU freedom of movement

By: I A Glinos, M Wismar, J Buchan

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The health workforce is a key factor for the performance of health systems. But many countries are facing shortages, mal-distribution and skill-mismatches of health professionals. This brief analyses the impact of the European Union’s (EU) free movement of health professionals for destination countries, source countries and the EU as a whole. It also presents the policy tools decision-makers can use to mitigate the negative and encourage the positive effects of professional mobility. The authors build on the WHO Global Code of Practice on the International Recruitment of Health Personnel that was adopted in 2010. Based on an analysis of the consequences of free mobility for equity and efficiency, they review the options for Member States to improve health workforce sustainability and for managing professional mobility. They also explore what the EU can do to address the consequences and opportunities of free mobility.

The policy brief was presented jointly with the WHO report entitled “Making Progress on Health Workforce Sustainability?: The WHO Code in the Context of the European Region” at the 65th session of the WHO Regional Committee for Europe, September 2015 in Vilnius, Lithuania.