ESPN Thematic Report on Challenges in long-term care

Netherlands

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European Social Policy Network (ESPN)

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Summary

Main features of the long-term care system

The laws concerning long-term care for the elderly in the Netherlands are the Social Support Act (*Wet Maatschappelijke Ondersteuning,* Wmo) and the Long-term Care Act (*Wet Langdurige Zorg,* Wlz). The Social Support Act is organised by municipalities, which can result in regional differences. This is especially the case with the contributions clients need to pay if they make use of care via this law. These undesirable differences will disappear after planned reforms that should take effect from 2019. The Long-term Care Act is implemented by regional care offices. This care includes intensive care and nursing care in healthcare institutes and also some types of care provided at home. Around 2.1 million people make use of the Wmo, which cost EUR 4.8 billion in 2016. Around 270,000 people make use of the Wlz, which cost EUR 17.7 billion in 2016. Most care is delivered in kind, but clients can also choose to contract care through a personal budget scheme (*persoonsgebonden budget,* pgb). In 2016, 38,500 people made use of a pgb.

Challenges in long-term care

The rapidly growing population of older people requires more care at home and is expected to increase the pressure on providing proper care in nursing homes. The quality of nursing homes is not up to scratch; an investment of EUR 2.1 billion yearly is necessary to meet the requirements of the quality framework for nursing homes. There are also challenges with regard to access to care. Especially care and support under the Social Support Act have become less accessible since those tasks were devolved to the municipalities in 2015. This is because of higher financial contributions and because many municipalities are less generous when attributing care than they were before 2015.

A third challenge is the growing pressure on informal care. This form of care is encouraged by the government. Municipalities support informal caregivers by providing information, advice, respite care and a token of appreciation to informal caregivers. However, 1 informal caregiver in 10 feels overburdened, and the expectation that more informal care can compensate for the intended decrease in formal care seems unrealistic.

Finally, the shortage of employees in the health and welfare sector is a pressing issue. In the coming years, it is estimated that the healthcare sector will have 100,000 to 125,000 unfilled vacancies. The government is going to take several steps to tackle this issue: it wants to attract new professionals through education programmes, keep the current workers employed in health and welfare jobs and invest in the innovation of e-health.

Available indicators for measuring long-term care

To monitor and evaluate developments in long-term care, the Dutch system uses two instruments: the Social Domain Monitor (*Monitor Sociaal Domein*) and the Long-term Care Monitor (*Monitor Langdurige Zorg*). The Social Domain Monitor gives an insight into outputs, costs and client satisfaction under (among others) the Social Support Act. It provides this information at the municipal level and therefore helps municipalities communicate information to their citizens. The actual quality and efficiency of the care provided is not measured. The Long-term Care Monitor publishes statistics on six themes: population, indication, use (including the relation between indication and use), accessibility, expenditure & volume and contribution. Again, it only provides information on outputs and access, not on the actual quality of the care provided (outcome). Both monitors are open source.

1 Description of the main features of the country's long-term care system(s)

1.1 Long-term care laws

The Dutch system for the provision of long-term care has been reformed from a national scheme covered by one law, the Exceptional Medical Expenses Act (*Algemene Wet Bijzondere Ziektekosten*, AWBZ) to create a system that is divided up among the municipal domain (the Social Support Act (Wmo) and Youth Act) for which municipalities receive a budget from the state; the national domain of the Long-term Care Act (Wlz), which has a similar construction to the AWBZ; and the domain of the health insurers (Health Insurance Act, *Zorgverzekeringswet*, Zvw), which is funded by health insurance premiums. In this report, only the Wmo and Wlz are discussed, since these are the laws concerning long-term care for the elderly.

Municipalities are free to choose how they organise the implementation of the Wmo. The Wmo itself states which services need to be provided. These are:

- General services: services that are the same for and accessible to every citizen, for example provision of meal services at home or daytime activities in a neighbourhood centre.
- Customised services: services that are customised to the needs, characteristics and possibilities of specific clients and that support their ability to cope (including respite care, aids, housing adjustments, domestic aid) and help them participate in society (for instance daytime activities, transport). These also include sheltered living and emergency shelter.[1]

Access to customised services under the Wmo is usually provided through 'Wmo consultants' (*Wmo-consulenten*)[2] and/or social neighbourhood teams[3] (SNTs). There is no objective standard determining what sort of need requires what forms of care and support; the professionals judge each case on its own merits and appeal to individual responsibility and the mobilisation of social networks where possible (see below for more information on informal care). The rules for access to Wmo care are laid down in local regulations, and access can also be influenced by local choices in the organisation of the care. The actual content of the care will not differ widely between municipalities, but the access procedures, the amount of care provided, the speed with which care and support are realised and (until 2019) the financial contributions that clients have to make can differ from one municipality to another. However, research into the exact differences due to municipal choices has yet to be carried out. The total costs for care and support provided under the Wmo were EUR 4.8 billion in 2016; around 2.1 million people made use of it.[4]

The Wlz is administered by 32 regional care offices (*zorgkantoren*),[5] which perform several functions, including the contracting of private provider organisations and the material control of provider organisations. Funding under the Wlz is based on 'care profiles', which specify the type (though not the amount) of care each client needs. The Dutch Healthcare Authority (*Nederlandse Zorgautoriteit*, NZa) sets the tariffs of the packages. The Care Needs Assessment Centre (*Centrum Indicatiestelling Zorg,* CIZ) assesses whether someone is eligible for care under the Wlz. This care includes intensive care and nursing in healthcare institutes, such as nursing homes, rehabilitation centres and residential homes

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[1] Social Support Act (Wmo).

[2] In 2015 these were partly replaced by consultants who cover the whole of the municipal 'social domain', which (since 1 January 2015) also covers youth care, social welfare and social services.

[3] European Commission, *Long-term care in the European Union*, Luxembourg, 2008.

[4] Source: https://www.monitorlangdurigezorg.nl (CBS)

[5] In each region, a single insurer – usually the market leader in the region – administers the Wlz on behalf of all insurers. For that purpose, they receive a concession from the government. This is the so-called representation model.

for disabled people, but also some parts of the care provided at home. The main eligibility criteria are:

- A need for long-term care, needing care close to 24 hours per day;
- A need for long-term care, needing permanent supervision.[6]

The Wlz care is funded by a collective insurance scheme, to which all Dutch citizens have access. There are income-related contributions (see below). The Wlz cost EUR 17.7 billion in 2016 and a little over 270,000 people made use of it.[7]

Elderly people continue to live at home for longer, and people are almost always over 80 years of age when they enter a nursing home. Due to the transition to the Wlz, elderly people are only allowed to move to a nursing home when they have complex and severe care needs.[8] Nursing homes have not been able to deliver the intensified and more complex forms of care and support that this particular client group needs.[9] In reaction to these problems, quality requirements have been defined by the Dutch National Health Care Institute (*Zorginstituut Nederland*, ZiN) in the quality framework for nursing home care. In order to enable the sector to meet these requirements, EUR 2.1 billion are being made available by the government. It is now important to make sure that this money is used effectively.

1.2 Personal budget

Wlz and Wmo clients who live at home and want to organise their own care can choose to apply for a personal budget (*persoonsgebonden budget*, pgb).[10] With this, people can hire and pay their own caregivers. These caregivers may also be relatives or other people from their social network. A contract, describing the care that needs to be provided, and a budget plan are mandatory when using a personal budget. This contract is provided to the Social Insurance Bank (SVB), which manages the personal budgets. The care recipient is obliged to pay the caregiver a minimum of EUR 25 per hour, and the caregiver is responsible for paying the tax on this. The personal budget scheme has existed since 1996, and around 38,500 people used it in 2016.[11] This is a much smaller figure than before the 2015 decentralisation: in 2014, around 120,000 people made use of the personal budget scheme. Both municipalities and care offices have certain reservations about the personal budget scheme, because it is more prone to fraud and it is also more difficult to control the quality of the care that is provided. They therefore apply stricter rules to the budget. This has resulted in fewer clients being deemed eligible for the scheme.

If people want to make use of Wmo facilities, they can apply for a personal budget in their municipality. The municipality decides whether they are eligible and funds the personal budgets from the Wmo budget. If someone needs more intensive, long-term care, they have to have a referral from the CIZ before they can apply for a personal budget. Since care recipients and their social network are responsible for managing the budget, they have to account for the care they receive. The municipality (Wmo) or care office (Wlz) is responsible for monitoring whether the care that clients receive is in accordance with their referral. A person can receive both a personal budget and care via the Social Support Act; it is not possible to draw a personal budget under the Wmo and a second personal budget under the Wlz.

[6] Long-term Care Act (Wlz).

[7] https://www.monitorlangdurigezorg.nl (CBS)

[8] SCP, Gelukkig in een verpleeghuis?, September 2017.

[9] https://www.rijksoverheid.nl/onderwerpen/verpleeghuizen-en-zorginstellingen/inhoud/zorg-ouderen-verpleeghuizen-verbeteren

[10] https://www.pgb.nl/

[11] https://www.monitorlangdurigezorg.nl/kerncijfers/gebruik/gebruik-persoonsgebonden-budget

1.3 Contribution of care recipients

To make use of the facilities of the Wmo and Wlz (including the personal budget scheme), people have to make a contribution. In the case of the Wmo, municipalities have some freedom to determine the level of these contributions (within a range that is set out in law). In the case of the Wlz, the amount of the contribution is set at the national level. In both cases, the contribution is calculated and collected by CAK,[12] based on the client's income, wealth, household, age and the type of care received. The contribution people make is never higher than the cost price, and so municipalities do not make a profit on this.

1.4 Informal care policy

The government encourages informal care in various ways. In the Netherlands, people are not obliged by law to take care of a family member. However, the principle that people are first and foremost responsible for their own care is enshrined in the law: the safety net that is provided collectively through Wmo and Wlz is in addition to what is seen as 'generally common care' that people and families give each other – a concept, however, that has not been defined.[13] In practice, this means that both municipalities and care offices will always take into account the possibilities of informal care in a given case, but will not make informal care compulsory.

Research by the Netherlands Institute for Social Research (*Sociaal en Cultureel Planbureau*, SCP) shows that 5 million people (aged 16+) provide informal care in the Netherlands.[14] According to this study, informal care is regarded both as care for a person in one's social network (32%) and voluntary work (6%). People who care for a family member, neighbour or friend do so for on average 7 hours per week for more than 5 years. The 45-64 age group provides most informal care. This – the SCP suggests – is because they often have an older parent (or parent-in-law) to take care of.

The same SCP study shows that 1 informal caregiver in 10 feels heavily (over)burdened. In order to deal with this, both the national government and the municipalities invest in intensified support for informal caregivers. The main forms of support are: information and advice through municipal councillors and interest groups, respite care which temporarily relieves them of the burden of care, and a yearly token of appreciation via the municipality they live in.[15] One informal caregiver in six receives a form of this kind of support.[16]

In the Netherlands, care leave is organised under the Employment and Care Act (*Wet arbeid en zorg*, Wazo). This gives carers the right to take leave to care for a sick partner, child or parent, siblings, grandparents, grandchildren, housemates or acquaintances. The Wazo Act provides short-term care leave, emergency leave (not relevant with regard to informal care) and long-term care leave. To make use of these types of leave, the employee is asked to inform the employer either beforehand or afterwards. The employer is allowed to ask for additional information about the situation.

- Short-term care leave gives an annual right to 10 days of care leave if the employee works full time (40 hours/week). It can be taken over several spells during the year, so long as it does not exceed the maximum 10 days. During this leave, 70% of the wage is maintained and payed by the employer. The percentage may be higher if this is arranged in a collective agreement or other employer regulations.

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[12] CAK is an independent public service provider that carries out legal tasks for the Ministry of Health, Welfare and Sports.

[13] Memorie van toelichting van Wet Maatschappelijke ondersteuning 2015, Ministerie van Volksgezondheid, Welzijn en Sport, 14/01/2014.

[14] SCP, Kerncijfers: informele hulp in Nederland 2016, The Hague, 2017.

[15] https://www.mezzo.nl/pagina/voor-mantelzorgers/thema-s/geldzaken/mantelzorgwaardering, information about the compensation for informal caregivers.

[16] SCP, Kerncijfers: informele hulp in Nederland 2016, The Hague, 2017.

- Long-term care leave gives people the right to care on a more substantial basis when needed by the care recipient. The maximum duration of long-term care leave is six times the weekly working hours of the employee concerned (so, in the case of a full-time contract for 40 hours/week, the maximum is 240 hours or 30 days). Long-term care leave is unpaid, unless there is a collective agreement or other regulation in which employers have made their own decisions about payment. The long-term care leave has to be taken in one go.

Due to a decrease in formal care (on a personal level), resulting from budget cuts in the healthcare sector, the care burden on informal caregivers has increased. SCP research mentions that municipalities must be aware of the fact that the decrease in formal care cannot (always) be compensated for by (more) informal care.17 Two out of three informal caregivers feel they cannot provide any more care than they are already providing.[18]

2 Analysis of the main long-term care challenges in the Netherlands and the way in which they are tackled

The main long-term care challenges that this report focuses on are concerned with the long-term care provided in nursing homes, the access to care via the Social Support Act for people with complex care needs and the struggle for social neighbourhood teams to provide the necessary arrangements for people with multiple or complex problems living at home.

2.1 Access, adequacy challenge

2.1.1 Long-term Care Act

Due to the ageing population, the rapidly growing demand for care is increasing the tension between the volume and the quality of care. A study by the SCP gives an insight into the quality of life in nursing homes throughout the years.[19] Since the Wlz came into being in 2015, the view held by professionals, the general public and politicians alike is that these homes are being transformed into establishments almost exclusively for those with very severe care needs, because only those people are now eligible to live there.[20]

This image is not fully supported by more objective sources. The Dutch National Health Care Institute (ZiN) published a report on the changes in nursing homes, based on the invoice information of nursing homes.[21] This shows that although the number of clients moving to nursing homes did indeed decline between 2013 and 2016 (from 48,267 in 2013 to 40,984 in 2016), people stayed there for a similar length of time as before (18 months), with care packages that indicated less severe care demands than before. This contradicts the SCP research, which predicted that such nursing homes would be used almost exclusively by people with very severe care needs. Possible explanations are that the range within the most common care package for nursing homes is wide, making possible a shift to more severe care needs within this package; and that the CIZ is less inclined than before to assign the more severe care packages to clients. Further research into this matter is necessary. However, none of the reactions to the ZiN study call into question the view that the care demands of nursing-home clients have indeed become greater.

[17] SCP, *Overall rapportage sociaal domein 2015*, The Hague, 2016.

[18] SCP, Zicht op Wmo 2016: Ervaringen van melders, mantelzorgers en gespreksvoerders, The Hague 2017.

[19] SCP, *Gelukkig in een verpleeghuis?*, The Hague, September 2017.

[20] SCP, *Gelukkig in een verpleeghuis?*, The Hague, September 2017.

[21] Zorginstituut Nederland, Zorgcijfers Monitor, verblijfsduur in verpleging en verzorging niet korten in de Wet langdurige zorg, Diemen, 2018.

2.1.2 Social Support Act

Research shows that access to care and support from municipalities is sometimes a difficult process.[22] One third of those asked struggle to arrange the care they need, mainly because of the high costs or because they are unfamiliar with the possibilities. In particular, people with a mental disability, people with a psychiatric illness and older people experience such problems. Research shows that there can be large differences between municipalities in terms of the level of the contributions for care under the Social Support Act.[23] Research also shows that because of these contributions, between 2015 and 2016 1 person in 4 stopped using the care they were eligible for, or else never applied for it due to financial considerations.[24]

Another concern has to do with the domestic work provided under the Social Support Act (Wmo). From 2007, municipalities became responsible for the provision of this form of care. In 2015, however, municipalities faced a 40% budget cut from the central government for the provision of domestic services. Municipalities tried to absorb these cuts by reducing the number of hours of services that clients were entitled to and by making changes in the way domestic services are organised and offered. They also asked clients to rely more on their social networks for this kind of support. However, municipalities are limited in their options. For instance, in January 2017, the Central Court of Appeal (*Centrale Raad van Beroep*, CRvB) made it very clear that there are limits on what can be expected of informal caregivers, when it ruled that informal caregiving must not be seen as compulsory for the family and friends of the recipient: municipalities should provide the necessary support, whether through compensation by a personal budget or through care in kind.[25] Informal care is not enshrined in law. This ruling will presumably make it unlikely for informal care to have a strong (limiting) effect on the total demand for formal support and care.[26] In the Netherlands there are no initiatives where informal caregivers are being trained to become formal caregivers.

2.2 Quality challenge

2.2.1 Long-term care Act

The increasingly severe care demand in nursing homes is leading to problems with regard to the quality of care, since nursing homes are struggling to deliver these intensified and complex forms of care and support.[27] In 2014, a study conducted by the Dutch Health Care Inspectorate (*Inspectie voor de Gezondheidszorg*, IGZ)[28] showed that the quality of care in nursing homes was inadequate. For example, innovation plans were written but not applied in the daily work environment; and nursing homes did not invest in improving the expertise of employees, which, for example, meant they were unable to work with the necessary care plans or to ensure a safe work environment. These conclusions were drawn after inquiries at the nursing homes with the use of an assessment framework. Knowledge, skills and availability of staff did not meet the needs of clients.

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[22] Patiëntenfederatie Nederland, Ieder(in), MIND Landelijk Platform Psychische Gezondheid, *Rapport meldactie Gemeenteraadsverkiezingen*, Utrecht, 2018.

[23] Straatmeijer, J., Van Almelo tot Zoetermeer: verschillen in koopkracht van senioren op lokaal niveau, Regioplan, Amsterdam, 2017.

[24] http://www.binnenlandsbestuur.nl/sociaal/nieuws/kwart-zorggebruikers-mijdt-dure-zorg.9518647.lynkx

[25] Central Court of Appeal, pronouncement date 11 January 2017, case number 16/2027 WMO15, ECLI:NL:CRVB:2017:17.

[26] This ruling of January 2017 is the second step that has been taken by the Central Court of Appeal in outlining the contours of the scope of the Wmo 2015. In May 2016, the Central Court of Appeal already ruled that domestic care falls under the Wmo and is therefore a responsibility of municipalities.

[27] https://www.rijksoverheid.nl/onderwerpen/verpleeghuizen-en-zorginstellingen/inhoud/zorg-ouderen-verpleeghuizen-verbeteren

[28] IGZ, Verbetering van de kwaliteit van ouderenzorg gaat langzaam, 2014.

To improve the quality of care in nursing homes, a quality framework has been developed and EUR 2.1 billion have been made available by the government to help nursing homes meet the criteria. Additionally, in 2015, the Dutch Health Care Inspectorate placed 150 institutions under supervision, because of inadequate quality. The period of supervision continued in 2016 for 50 of these institutions.[29] From January 2017,[30] the experiences of clients and the performance of nursing homes on various indicators (such as staff expertise, medication safety, consultation with the elderly and their families) have been published online, in order to improve transparency about quality.[31]

Older people who want to move to a nursing home and have the necessary CIZ referral can go on a waiting list. At the end of 2017, the Dutch television programme *De Monitor*[32] pointed out that this system results in problems. Elderly people who continue to live at home but go on a waiting list for a place in a nursing home are transferred from Wmo to Wlz care. In practice, this leads to them receiving less care at home than before, because the Wlz has a fixed budget for care and does not take into account the amount of care that the person received before. The government has recognised this issue, which is called the 'care trap' (*zorgval*). A possible solution is to continue to provide care for the elderly through the Wmo for as long as they live at home. The Minister of Health is currently looking into the matter.[33]

2.2.2 Social Support Act

There are a few quality challenges concerning the arrangements of care under the Social Support Act (Wmo). Because the long-term reforms are motivated partly by budgetary considerations, they were having unwelcome effects from a social investment perspective. Providers were experiencing increased pressure to keep the tariffs as low as possible, in order to secure municipal care provision contracts. Some providers went bankrupt and others were on the verge of bankruptcy. To prevent this race to the bottom (which of course would also have adverse effects on the quality of care and support), in 2017 the government introduced a regulation (*Algemene Maatregel van Bestuur,* AMvB), which identifies the factors that municipalities have to take into account in defining the 'realistic' price they are willing to pay for Wmo services.[34] The effect of this measure will be monitored over the course of 2 years.

2.3 Employment challenge

Between 2017 and 2022, the healthcare sector is expected to have between 100,000 and 125,000 unfilled vacancies.[35] This shortfall could result in the provision of inferior quality of care. To tackle this issue, the Minister of Health has formulated three strategies.[36] First, new professionals should be attracted by informing students about the possibilities of working in the healthcare sector at all levels. One example of bridging the gap between education and practice are the field labs[37] – a location in a neighbourhood where care education programmes and practitioners come together. A second strategy is to make optimal use of the people working in the sector, among other things by stimulating the

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[29] IGZ, Eindrapportage toezicht IGZ op 150 verpleegzorginstellingen, 2016.

[30] TK, 10 February 2015, 723246-133104-LZ.

[31] https://www.rijksoverheid.nl/onderwerpen/verpleeghuizen-en-zorginstellingen/inhoud/zorg-ouderen-verpleeghuizen-verbeteren, National Healthcare Institute (ZiN), 2017: https://www.zorginstituutnederland.nl/publicaties/publicatie/2017/01/13/kwaliteitskader-verpleeghuiszorg. Performances of the nursing homes available at www.kiesbeter.nl and www.zorgkaartnederland.nl

[32] *De Monitor*, https://demonitor.kro-ncrv.nl/artikelen/dementerenden-en-gehandicapten-in-de-knel-bij-overgang-naar-verpleeghuis, 26 October 2017.

[33] https://demonitor.kro-ncrv.nl/artikelen/minister-zegt-onderzoek-toe-naar-omvang-zorgval

[34] https://www.pianoo.nl/sites/default/files/documents/documents/factsheetamvbreeleprijswmojuni2017.pdf

[35] Berenschot, Aan het werk voor een betere arbeidsmarkt in de zorg!, Utrecht, 2017.

[36] file://ogdhosting.local/data/RenCBeleid/Homes/YmkeK_RenCBeleid.nl/Downloads/kamerbrief-over-aanpak-arbeidsmarkt-zorg.pdf

[37] Berenschot, Aan het werk voor een betere arbeidsmarkt in de zorg!, Utrecht, 2017.

development and deployment of innovation and new technologies. The government has invested EUR 40 million in the innovation of e-health.[38] Thirdly, everything possible should be done to make sure that people working in the sector continue to do so. That this is not an easy task is illustrated by employee satisfaction: whereas in 2011 80% of employees said they were satisfied with their work, in 2017 the figure was only 67%.[39] A report by the Social Protection Committee and the European Commission shows that the demand for healthcare workers is strong and growing, which may encourage some improvement in working conditions.[40]

In the Netherlands, women provide more informal care than men, although the difference is not too great (36% women, 29% men).[41] Attention should be paid to making sure that the provision of informal care does not hinder opportunities in the labour market. According to SCP research, this does not seem to be happening.[42] Informal care and labour participation do have an influence on each other, but overall the combination does not seem to be problematic. However, if we look more closely at the differences between male and female caregivers, the research shows that while for men there is no conflict in combining paid employment with the provision of informal care,[43] for women – and especially those aged 25-49 – it can impede labour participation.[44] This applies to mothers, women without children and women who work part time, but there are no figures available to show how this might interfere with their labour participation.[45] The self-employed do not have access to short- or long-term care leave.[46] Research indicates that they experience difficulties due to the caring: 44% have trouble combining work and informal care, and 58% experience financial setbacks due to the caregiving.[47]

2.4 Financial sustainability challenge

To ensure sustainability of public spending on long-term care, the government formulated a long-term perspective. Under a coalition agreement, the government will invest in innovative concepts, e-health and preventive care.[48] Also the changes in the organisation of long-term care in 2015 were meant to sustain financial stability. The government decentralised care facilities, making municipalities responsible for these. It is expected that this decentralisation will result in better value for money, because the municipalities operate on a local level and, it is assumed, they have more insight into what is needed. While the government decentralised some of the care facilities, the decentralisation was accompanied by budget cuts. Older people are being encouraged to stay at home for longer – care at home can be provided with less budget than residence in a nursing home. Lastly, as mentioned above, the government aims for a more effective use of informal care, encouraging people first of all to involve their own social network in the provision of some care tasks. All in all, since 2015, the municipalities have struggled to find a balance between providing quality care and managing care budgets.

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[38] Regeerakkoord 2017-2021, *Vertrouwen in de toekomst*, The Hague, 2017.

[39] Werkgevers- en werknemersenquêtes 2017, Onderzoeksprogramma Arbeidsmarkt Zorg en Welzijn (http://www.azwinfo.nl).

[40] SPC and EC, *Adequate social protection for long-term care needs in an ageing society*. Report jointly prepared by the Social Protection Committee and the European Commission, 2014.

[41] SCP, Kerncijfers: informele hulp in Nederland 2016, The Hague, 2017.

[42] SCP, Informele zorg in Nederland. Een literatuurstudie naar mantelzorg en vrijwilligerswerk in de zorg, The Hague, 2013.

[43] Dykstra, Pearl A. and Anne van Putten, Mantelzorgende mannen: een kwestie van moeten, kunnen of willen, *TSG*, 88(6), 2010.

[44] Souren, M. et al., Zorgtaken en arbeidsparticipatie. In: Sanders, Jos, Hendrika Lautenbach, Peter Smulders, Henk-Jan Dirven (eds), *Alle hens aan dek; niet-werkenden in beeld gebracht*. Hoofddorp: TNO/CBS, 2010.

[45] SCP, Informele zorg in Nederland. Een literatuurstudie naar mantelzorg en vrijwilligerswerk in de zorg, The Hague, 2013.

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2.5 Planned reforms and policy developments

As the long-term care reforms are still very recent, no major reforms are being considered at the moment in the Netherlands. However, some small reforms are planned to reduce unwanted side-effects of the recent reforms. These are:

- A change in the calculation of financial contributions to care costs by clients: from 2019 on, the contribution to the Wmo will no longer be income based and determined by municipalities, but will be a fixed price of EUR 17.50 per 4 weeks for all Wmo services in the whole country.[49] It is too early to conclude that this will reduce the number of people who refrain from applying for care, but the Association of Dutch Municipalities (*Vereniging van Nederlandse Gemeenten*, VNG)[50] expects that the Wmo costs of municipalities will increase as a result of this measure. It reasons that whereas, under the current rules, people on middle or high incomes are motivated to arrange and pay for their own care (because their contribution would be high), the fixed and equal contribution for everyone could induce them to (re)apply for Wmo care. A possible positive effect of the new contribution scheme might be that it alleviates part of the burden on informal care.
- Extra investment in long-term care, flowing from the coalition agreement of the new Dutch government:
  - EUR 2.1 billion extra to improve the quality of nursing-home care for the elderly (Wlz). A EUR 188 million cut to the Wlz budget planned for 2018 has been scrapped;
  - a EUR 170 million budget available for preventive care and health improvement;
  - EUR 40 million for e-health innovations; and
  - EUR 180 million for implementation of the manifesto 'dignified ageing', focusing on, among other things, the prevention of loneliness and stimulation of informal care.[51]

With regard to the last point about informal care, it is important that the Dutch government (at the national and local level) should accept the limitations of informal care and seek ways both to support informal care better and to provide good-quality professional care, where necessary, within the budgetary limits.

[49] https://www.hetcak.nl/over/nieuws/2017/regeerakkoord-2017-veranderingen-eigen-bijdrage, 2018.
[50] *Binnenlands Bestuur*, http://www.binnenlandsbestuur.nl/sociaal/nieuws/vng-voorspelt-hogere-wmo-uitgaven-gemeenten.9573526.lynkx
[51] www.waardigouderworden.nl

3 Analysis of the indicators available in the Netherlands for measuring long-term care

3.1 *Monitor Sociaal Domein* (Social Domain Monitor)

- Definition: the monitor helps municipalities communicate information within their own municipality to citizens, politicians and employees.[52] Furthermore, it gives insight into (the use of) individual provisions, care use in the future and client experiences with the Wmo.
- Available in language: Dutch.
- Years available, frequency: available since 2015, updated twice a year.
- Website address: www.waarstaatjegemeente.nl
- Information on:
  - access and adequacy: delivered outputs and client satisfaction;
  - quality: not included, other than client satisfaction;
  - sustainability: information on costs and populations;
  - impact of caring responsibilities on employment: not included.
- Difficulties with such data: the monitor gives an overview of the output of policies, but does not give any insight into the actual quality or efficiency of the care and support provided. In the Netherlands, no monitor exists to measure the actual quality of care provided.

3.2 Monitor Langdurige Zorg (Long-term Care Monitor)[53]

Definition: the monitor publishes figures concerning long-term care in the Netherlands. Until 2015, this was financed via the old Exceptional Medical Expenses Act (AWBZ) and the Social Support Act. From 2015, data have been provided of the Long-term Care Act (Wlz), Social Support Act (Wmo), Youth Act (Jeugdwet) and the Health Insurance Act (*Zorgverzekeringswet*). Statistics Netherlands (*Centraal Bureau voor de Statistiek*, CBS) is responsible for this monitor, and it is commissioned by the Ministry of Health, Welfare and Sport. The information is divided into six themes: population, indication, use (including the relation between indication and use), accessibility, expenditure & volume, and contribution. These are open-access data on users, as well as on the long-term care delivered and its expenses. This information is delivered by CIZ, CAK, NZa, ZiN, the Youth Care Office (*Bureau Jeugdzorg*) and Vektis[54].

- Available in language: Dutch.
- Years available, frequency: since 2015 about Wlz.
- Information on:
  - access and adequacy: waiting times and delivered outputs;
  - quality: not included;
  - sustainability: information on costs and populations;
  - impact of caring responsibilities on employment: not included.

[52] https://www.vngrealisatie.nl/secties/gemeentelijke-monitor-sociaal-domein/gemeentelijke-monitor-sociaal-domein-het-kort

[53] www.monitorlangdurigezorg.nl

[54] Vektis provides business intelligence services to the care and cure sectors and owns a database of all declaration data in these sectors.

- Every year figures are published about long-term care in previous years and the estimated budget for the upcoming year.
- Difficulties with such data: the monitor does not give any insight into the quality of long-term care facilities, and because of the decentralisation and reformulation of the long-term care laws, it is difficult to compare the changes with the years before 2015.

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