Chapter 5
Long-Term Care Reforms in the Netherlands

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5.1 Introduction

During the "golden age" of the welfare state, the Netherlands developed a hybrid social protection system, encompassing both universalistic and conservative–corporatist features (Arts and Gelissen 2002; Esping-Andersen 1999; Goodin and Smitsman 2000). In the field of care policy, this mixed approach is particularly evident. While care services for children have long been neglected by the Dutch welfare state, which assumed that (mostly nonworking) mothers would take care of their children, policy developments in the area of care for older people and people with disabilities have been strikingly different. A comprehensive and universalistic scheme aiming to offer support for long-term care (LTC) was started as early as 1968, when a national compulsory social insurance aimed at covering the costs of "exceptional medical expenses" (AWBZ, *Algemene Wet Bijzondere Ziektekosten*) was introduced. This LTC insurance scheme, together with basic pensions and family allowances, represents the core of the "universalistic" features of the Dutch welfare system.

With the introduction of the scheme, the Dutch welfare state assumed most of the financial and organizational responsibilities in supporting (older) people in need of continuous care, leading to the defamilization of care to a considerable extent.

The early development and universalistic features of the AWBZ are reflected in comparatively high coverage rates of services with respect to the target population and the high level of social expenditure for LTC. According to OECD data from 2006, around 20 % of people aged 65 or above in the Netherlands were in receipt of either homecare (13 %) or residential care services (7 %), one of the highest proportions in the OECD together with Norway (21 %). This can be juxtaposed with lower coverage rates in Italy (3 %), the United Kingdom (11 %), Germany (10 %), France (13 %), Denmark (14 %), Austria (16 %), and Sweden (17 %; OECD 2009, p. 115).

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In 2008, expenditure on LTC programs as a percentage of GDP reached 3.5 % in the Netherlands and 3.6 % in Sweden, in contrast with between 1 % and 2 % in most of the countries mentioned above (OECD 2010).

As a result, the distinct and possibly conflicting objectives of guaranteeing accessible and good quality care and keeping costs under control have both been at the core of the political debate and of policymaking in the field of LTC in the last 30 years in the Netherlands.

It has been argued that specific features of the Dutch political system make radical reforms somewhat challenging (Schut 1995); the relative weakness of successive governments and the relative strength of one set of actors would together make it difficult to pass substantial reforms. No political party has had an absolute majority in parliament since Second World War and so all governments have been coalition cabinets, where compromises between political parties are the key. At the same time, strong interests tend to crystallize around existing policies, particularly in a nationally structured and integrated policy field such as LTC. However, as outlined below, the LTC system has been undergoing a continuous process of "incremental" reform over the past 20 years.

5.2 The AWBZ as the Pillar of the Dutch LTC System

As mentioned above, the foundation of the current Dutch LTC system dates back to the end of the 1960s. LTC policies in the Netherlands have subsequently developed around the AWBZ, the national insurance for "exceptional medical expenses." It is worth noting that, in the Dutch debate, the AWBZ is usually seen as part of the "care" (*zorg*) system, which encompasses (acute and nonacute) health and social care.

A brief reconstruction of the rise and development of the LTC system within the healthcare system will help to provide an understanding of the original logic of the policy and the stakes in the later reforming process.

5.2.1 The Original Logic of the Dutch "Care" System and the LTC Policy Field

Despite several government projects, the Netherlands did not have a comprehensive collective health insurance system before the Second World War: while most of the working population participated in voluntary sickness funds, the poor were taken care out of municipal funds and the better off relied on private insurance. In 1941, the German-occupying forces introduced a Bismarkian type mandatory health insurance scheme for employees (with the exception of civil servants, for whom insurance remained voluntary) and their families below a certain income threshold. At the same time, insurance companies continued to offer private insurance to citizens whose income exceeded the income ceiling (Van der Velden 1996).

After the war, a debate on the transformation of social policy toward a Beveridgean orientation took place in the Netherlands. This did not lead to an encompassing transformation of the Dutch welfare state, but the emerging program obtained some success in the pension system with the introduction of "people's insurances" (including a flat rate basic citizen's pension and child benefits) and a national social assistance scheme, alongside so-called "worker's insurances" (Van Oorschot 2006). The dual acute healthcare system emerged during the war period was confirmed with the 1964 Sickness Fund Act (*Ziekenfondswet*, ZFW), ratified in 1966. Finally, the debate about the need to cover "exceptional" health care risks also led to the development of a universal citizenship-based system through a national compulsory social insurance scheme.

It should be considered that the Dutch LTC system has been traditionally characterized by the intertwined development of housing, health and social care policies (De Boer 1999). The postwar period was a crucial time for the development of both care and housing policies. As a solution to an acute housing shortage caused by the war's devastations, new housing for older people—namely, care homes (*verzorgingshuizen*)—was built so that younger families could live on their own (Van den Heuvel 1997). This development was a combination of national government action and that of nonprofit housing organizations (*woningcorporaties*). In order to properly supervise the care homes, regulations on housing and care for the elderly were subsequently released:[1] houses that met the criteria were entitled to public funding. In the 1960s, nursing homes (*verpleeghuizen*) began to develop, aimed at providing care for people with intensive (health) care needs and, at the same time, reducing the hospitalization of the chronically ill. It was at that time that insurance companies—the key element of the Dutch healthcare system—manifested a refusal to cover the care expenses of the chronically ill patients.

The introduction of the AWBZ, in 1968, settled this controversy. The social insurance basis of the healthcare system clearly exerted an influence in defining the institutional solution to the funding of LTC: instead of relying on general taxation, which would entail progressive income-related payments, the choice was made for a public insurance system, based on contribution proportional to income. However, a straightforward extension of the acute healthcare insurance system to LTC-related risks was considered unviable. As mentioned above, acute health insurance was compulsory only for workers below a certain threshold: it therefore covered only two-thirds of the population, excluding the highest income group. This feature was seen as a limit for the new LTC coverage. The governmental proposal of extending the existing mandatory healthcare insurance to the entire population and the subsequent enlargement of its scope to LTC was rejected on the basis of resistance opposed by different stakeholders. Private insurance companies foresaw the restriction of their market possibilities; employers feared an increase in labor costs; and the medical profession feared the extension of governmental controls on professional fees for the privately insured. The alternative solution was represented by a separate mandatory insurance scheme for LTC (AWBZ) for the entire Dutch population (Schut and Van den Berg 2010).

[1] The "Homes for the Elderly Act" (WBO) of 1963 established national regulations for care homes for older people.

Consequently, LTC has been financed since 1968 by a specific national compulsory insurance.[2] The latter provides coverage for the "exceptional health risks" of older people, who need nursing and care, and also for people with mental health problems and those with disabilities. The Dutch LTC system has subsequently developed around the AWBZ. Until the early 1970s, services covered by the AWBZ were mainly residential. The proportion of institutionalized older people grew considerably over the years. In fact, the Netherlands had the highest institutionalization rates of older people in Europe during the 1970s and 1980s (OECD 1996a, b). However, the AWBZ, which was originally created for funding care in nursing homes, was progressively expanded to cover the expenses of residential care and homecare services for older people. Moreover, since the 1980s, psychiatric care and other services, aids and appliances were all taken out of the insurance package covered by the Sickness Fund Act (ZFW) and placed within the scope of the AWBZ.

As a result of these developments (and until the 2006 healthcare reform), the healthcare system in the Netherlands was usually seen as structured in three "compartments" (Van Ewijk and Kelder 1999). The first compartment, the AWBZ, provided coverage for the costs of LTC for all Dutch residents, regardless of age and citizenship. Statutory public health insurance and private insurance for those excluded from the public fund constituted a second compartment, providing coverage for acute healthcare-related costs. The third compartment consisted of supplementary care insurances. In the early 2000s, the AWBZ absorbed approximately 43 % of total healthcare expenditure (Stolk and Rutten 2005).

5.2.2 Reforming the Acute Healthcare System

A committee named after its chairman, Dekker, former Chief Executive Officer of the Philips Company, was set up in 1986 to analyze and propose a reform of the structure and financing of the healthcare system. The Dekker Report proposed a set of measures aimed at reducing costs and improving the efficiency of the system through the introduction of market mechanisms, together with the unification of the acute healthcare insurance scheme under a single scheme (Commissie Dekker 1987). Despite the fact that several governments endorsed the proposal, it was, in reality, only very partially implemented in the 1990s. However, in 2001, the ideas of the Dekker plan reemerged in a later governmental plan (Helderman et al. 2005), which was the basis of the 2005 acute healthcare reform that came into effect at the beginning of 2006. The governmental decision was preceded by an influential report of the Social and Economic Council (*Sociaal Economische Raad, SER*)—a tripartite body composed of representatives of the employers, employees, and

[2] The employer withholds the employees' contributions from their wages and pays them to the tax authorities. Nonemployees liable for tax and national insurance contributions pay the AWBZ contribution based on an assessment made by the tax authorities. Insured people under the age of fifteen, and above fifteen with no personal income, are not liable to pay contributions.

experts nominated by the government—which recommended the introduction of a general mandatory insurance scheme for acute care. The report also urged the government to move away from the direct control of supply, prices, and budgets to a system based on regulation through demand, competition and market mechanisms, both on the side of the insurance companies and on the side of the suppliers. With respect to the AWBZ, the SER supported the maintenance of a unique social insurance provider. However, based on an assessment of the inefficiencies of, and lack of satisfaction with, the current system, the SER proposed that the AWBZ should focus on providing coverage for serious and long-term illness. It also suggested that market mechanisms should be introduced (SER 2000).

In fact, the 2005 reform eliminated the dualism in the second compartment by introducing a unique compulsory scheme for all residents. The government opted for risk coverage by private insurance companies, while maintaining the social nature of the health insurance system. In this compartment, the insured can freely choose an insurance company. The insured person pays a flat rate for normal care, while the employer's share is calculated in relation to the employee's income. Each insurer sets the premium, which should be identical for all of its insured clients, for the same health basket, regardless of the person's age or health status. Insurers cannot refuse to insure a client, whatever his or her risk profile, and must offer a basic insurance without extra benefits. The insurer is therefore expected to generate competition between care providers so as to obtain the best price.[3] On the supply side, the system for financing hospitals is being modified, moving from an overall budget to a system of DRG reimbursements to allow competition between hospitals, which had previously been very limited.

The reform that came into effect in 2006 neither eliminates nor radically transforms the AWBZ. The competitive mechanisms introduced in the acute healthcare system are not extended to the AWBZ. However, following the SER's advice, the scope of the insurance is now limited to serious and chronic illnesses, often considered as uninsurable. For instance, short-term psychiatric care, which over the years came under the coverage of the AWBZ, has been moved to the second healthcare compartment (see the following section).

5.2.3 Reforming LTC: Actors, Discourses, Stakes, and Modus Operandi

The fact that the 2006 reform has only marginally interested, the AWBZ does not mean that LTC has not undergone a reform process throughout the years. On the contrary, considerable transformations took place either within the existing broad framework of the AWBZ or due to the interaction and shifting boundaries between

[3] There is only one exception allowed regarding this rule for equal premiums for all under the same insurer: the case of collective insurance by employers for all their employees. The reduction, however, cannot exceed 10 %.

the AWBZ and new or reformed schemes in other policy areas. The debate that has been the basis of the reform of the Dutch LTC system has been dominated by different intertwined discourses since the late 1980s.

First, the theme of cost containment has been central and still is evident in the government's policies. This emphasis on the need to contain social spending in the field of LTC has been accompanied by two distinct trends. On the one hand, cost containment met the spreading ideas (well beyond the care sector) of "new public management" (NPM) and of the need to introduce individual choice and market principles as a way to foster efficiency. On the other hand, the idea that people should be made more responsible for their own care, and for each other, gained popularity. In the political arena, combined discourses about individual choice, individual responsibility and general financial sustainability have been supported by the neoliberal right and (liberal) left alike in the past 20 years (Kremer 2006). Social partners represented in the SER also fostered the idea of managed competition in healthcare and of the reduction in scope of insurance for LTC in order to ensure its long-term sustainability (see Sect. 5.2.2). At the same time, a neocommunitarian ideology among the Christian Democrats further supported the idea of horizontal subsidiarity, namely, participation as responsibility for one's own and others' wellbeing. The purported need to shift from a "welfare state" (*verzorgingstaat*) to a "welfare society" (*verzorgingsmaatschappij*; Kuiper and Bremmer 1983, 1987) dates back to the 1980s among the Christian Democrats and was increasingly emphasized until it became the conceptual basis for an all-encompassing reform of social welfare in the mid-2000s. The WMO (*Wet Maatschappelijk Ondersteuning*) or Social Support Act was ratified by a coalition government led by the Christian Democrats and the Social Democrats. The reform was specifically aimed at fostering individual responsibility within the "community," informal care and the decentralization of care policies, also in order to ultimately reduce the LTC budget. Similar to other contexts (Pennings 2010), even if liberal and conservative parties started supporting market-oriented and other retrenchment-based reforms much earlier, these principles were soon embraced by the Social Democrats as well. It has been argued that this type of welfare reform in the Netherlands has been highly consensual because of the key role played by the centrist Christian Democratic Party: political consensus was built around cost saving, individualization of risks and choice. Furthermore, party competition made the Labour Party accept the welfare reforms as a means to regain government power (Green-Pedersen 2001).

Second, organizations representing people with disabilities (and later older people) have been demanding greater independence, empowerment and choice for the users of LTC services since the 1980s (Kremer 2006). From that time, users' movements grew considerably in membership—they counted far more than one million members by the early 2000s (Sociaal en Cultureel Planbureau (SCP) 2002)—and in organizational capacity. The core idea put forward by these organizations under the strong influence of the "American Independent Living Movement" is that people in need of (health) care should be able to make decisions about their own lives and exert the same rights as any other citizen. Thus, organizations for people with disabilities in the Netherlands campaigned for people with disabilities to determine and choose

their own care arrangements. They aimed to override a burdensome bureaucracy, which was making decisions about people's care needs and offering solutions with limited transparency and inadequate consideration of individuals' wishes and self-determination. The increasing visibility of users' organizations represents one of the most important developments in the structure of organized interests in the field of (health) care in the Netherlands in the last 20 years, together with the decline of the power of trade unions. It has been shown that successive—differently colored—governments have explicitly supported users' organizations as a strategy to reduce the influence of professionals (Trappenburg 2005). Governmental support for users' rights started in the 1970s and was fully expressed in several laws passed in the 1990s. As health and social care users can experience challenges in advocating on their own behalf, users' organizations have also progressively assumed an important role in representing the user at the level of care institutions, hospitals, etc. At the same time, users' organizations have been asked by the public administration to "collect data on professional performance and hospital output and to translate these data in accessible information (quality rankings and option menus), so as to enable future patients to choose between healthcare providers" (Trappenburg 2005, p. 233).

Interestingly enough, it appears that these organizations have been far more concerned with the introduction of demand-driven and choice-based interventions than with the changing degree of universalism of the LTC system. According to this logic, users' organizations have become the most important allies of the government in the attempts to restructure the LTC system and reduce its costs, via deprofessionalization, enhancement of informal care and the introduction of customer-driven interventions.

It is at the intersection of these different claims, strengthened by the alliance between successive governments and users' organizations, that the Dutch care model began undergoing significant reform. Indeed, since the early 1990s, there has been a continuous process of reform of LTC policies in the Netherlands, which has resulted in a series of policy innovations and retrenchments (De Boer 1999; Knijn 2001). In what follows, we shall trace the most important reform trends, highlighting how the different reforms followed different logics and instruments.

We distinguish between three types of reforms. First, a set of innovations was aimed at redefining the eligibility criteria for accessing LTC services and the allocation of various resources with the explicit aim of cost containment (Sect. 5.3). Second, a set of reforms has introduced transformations in the governance of LTC interventions (Sect. 5.4). Third, the most recent set of reforms is aimed at redefining the boundaries of LTC policies (Sect. 5.5).

5.3 Direct and Indirect Cost Containment

The first type of reforms we distinguish aimed to reduce the costs of the LTC system by restricting access to collectively funded care. Switching from more to less costly forms of care, providing incentives to access informal and privately paid care were seen as less costly alternatives to formal care. These instruments are also largely

consistent with other goals, such as responding to the wishes of the cared for, who are assumed to prefer specific types of care to others (homecare to institutional care, informal care to formal care, commercial care to formal care).

5.3.1 Deinstitutionalization

The deinstitutionalization process represents the first and, by now, more traditional challenge to the Dutch care system. The first signs of change in Dutch LTC policies can be traced to concerns about the large proportion of older people and those with disabilities living in institutional settings. The process of "extramuralization" (i.e., the replacement of institutional settings with community-based settings) was predicated on arguments that disabled people preferred to live independently for as long as possible. While this idea became explicit in the policy arena in the mid-1970s, it was only in the late 1980s that new policies affecting the independence of older people and people with disabilities began to be implemented and affect the living circumstances of the former (Van den Heuvel 1997). In 1965, institutional settings housed 6.7 % of the population of those aged 65 and more; the figure rose to 8.8 % in 1970 and 9.7 % in 1975. Moreover, if we add the capacity of nursing homes, the total institutionalization rate rises to over 12 % in 1975. Ten years later, the rate was still 10 % of people aged 65 and more; however, this figure had dropped to 6 % by 2003 (de Boer 1999, p. 30).

Besides the argument that people prefer homecare, deinstitutionalization is also based on the assumption that homecare services are less costly than institutional services. However, there are some crucial implications of this assumption. Although deinstitutionalization plays a considerable role in cost reduction strategies, it also represents a major challenge, as increased support for homecare has to be provided somehow (Jacobzone et al. 1999). Community care may appear to be less expensive when a vast range of informal services are called upon to replace much more expensive professional care, yet it may be as expensive as institutional care if all of the costs are taken into account (Weissert and Cready 1989). This sharp deinstitutionalization trend therefore challenged the organization of homecare services and required more involvement of informal caregivers.

New forms of homecare services evolved, including round-the-clock and weekend support. The expansion of the homecare sector throughout the 1990s can be seen in the increasing number of homecare employees: 126,000 in 1995 and 580,000 in 1999 (Arts 2002, p. 10). The development of homecare services uncovered an even greater population of dependent older people living at home who were eligible for these services. This put even more strain on homecare services (and informal caregivers) and led to increased calls for further cost containment and measures to increase productivity such as the "Taylorisation" of tasks (Knijn 2001) or the introduction of competition among the providers (see Sect. 5.4). These contradictions were made evident by cutbacks on the one hand and labor shortages in the homecare sector on the other (Arts 2002).

5.3.2 Direct Cost Controls

The struggle to keep costs under control has a long history in the Netherlands and has been characterized by alternate periods of stringent direct cost containment (with consequent waiting list expansion and perceived "quality" problems) and of removed controls. This tradeoff is still on the agenda.

Direct mechanisms for budget control were already implemented in the 1970s, especially with respect to the number of "beds" in residential care: authorizations were needed in order to start new investments in the sector. As a result, the level of expenditure was controlled through the direct definition of the capacity of nursing homes. However, it was only in the 1980s that a comprehensive budgeting system for residential care was introduced, which was later extended to the homecare sector. With respect to other service sectors, the productivity of labor in the care sector has quite exceptionally increased on a continual basis since the early 1990s. This is thanks to both wage moderation and the introduction of tight budgets for care organizations, which were compelled to reduce managerial and organizational costs and to introduce systems of time management aimed at increasing the efficiency in service delivery (Eggink et al. 2008).

In the 1990s, this strategy was extended to the homecare sector and so the real costs of the AWBZ were effectively contained (Schut and Van den Berg 2010). However, the side effect of this strategy was the increase in waiting lists and a general perception of the deterioration of the quality of care, which became a wide public concern.

An important court decision concerning waiting lists in 1999 paved the way toward the suspension of this strategy: as Dutch residents were entitled to a "right to care" (which was also supposed to be timely) based on the social insurance legislation, the government was held responsible for ensuring this right, also against budgetary considerations. As a consequence of public and political pressure together with the court decision, the direct cost containment mechanisms were lifted in 2000: over the next few years the waiting lists were considerably reduced (Van Gameren 2005) at the cost of a steep increase in the AWBZ expenditure (Schut and Van den Berg 2010).

New attempts to put the AWBZ budget under control were introduced starting from 2005. Together with the increase in users' copayments (see the following section), regional budgets for the AWBZ were imposed based on past expenditure: regional care offices were responsible for administering these budgets, negotiating the tariff levels and the maximum production level with care providers. This strategy is, again, at risk of producing waiting lists and the deterioration of quality.

5.3.3 Limiting Access

One indirect way of restricting access to care services is through the introduction of users' copayments. While they were virtually nonexistent in the traditional health and social care sectors (De Boer 1999), copayments by homecare recipients (income-related tariffs per hour of homecare received) developed rapidly in the 1990s. Some

argued that these developments would limit the use of homecare by both the low- and high-income groups, as, although low income earners have the right to social assistance when they cannot afford the individual payments themselves, they would increasingly attempt to access informal care (therefore free of charge) instead of requesting social assistance. High income earners, on the other hand, would try to solve their care problems via the market (Knijn 2001, p. 172). According to government advisory boards, these developments threatened to alter the nature of the AWBZ as a general collective insurance (Commissie Sociaal-Economische Deskundigen (CSED) 1999).

A more direct way of achieving the same objective is to restrict the eligibility criteria themselves. One of the features of the universalistic approach of the Dutch LTC system is that the assessment of needs and the attribution of care resources do not depend on the (economic or care) resources of the claimant. However, several attempts of formalizing and enlarging what should be expected from the coresident family members in terms of informal care have been put in place (Landelijke Vereniging van Indicatieorganen (LVIO) 2003; Centrum Indicatiestelling Zorg (CIZ) 2005).

5.3.4 Effects of the Cost Containment Strategy

If we look at expenditure developments over the long term, the above-mentioned cost containment strategy has shown some limited effects. Real costs (nominal costs adjusted for inflation) almost doubled between 1985 and 2005: the increases are evident in homecare (25 % over 20 years), but are more apparent in the residential care sector (more than a 100 % growth; Eggink et al. 2008, p. 21). However, the direct cost containment strategy did have the effect of limiting yearly growth of expenditure until the early 2000s, since most of the growth took place in the period 2001–2005. The consequences produced by lifting the direct cost controls previously imposed in order to reduce the waiting lists are quite clear in the development of the overall costs. While the AWBZ-related costs as a percentage of the GDP were relatively stable at the level of 3.5 % between 1985 and 2001, this proportion subsequently increased to 4 % over a 2-year period. Only a quarter of this steep increase in such a short period of time can be explained by a slowdown of the economy in the same period (Eggink et al. 2008, p. 22).

It is important to note, however, that the increase in cost has affected the various subsectors of the LTC system in different ways. Most of the increase in costs in the homecare sector can be attributed to the increasing volume of services produced rather than to the increase in prices for these services. Yet the opposite has happened in the residential care sector, where the volume of production has increased much less (care homes) or even decreased (nursing homes); increasing prices are instead more responsible for the overall cost growth (Eggink et al. 2008, p. 24). This demonstrates that, particularly in the homecare sector, a strong cost containment of the labor costs (or an increase in productivity) is responsible for preventing the overall costs from increasing even more than they already have (Eggink et al. 2008, p. 31). This

labor cost containment might have had a considerable influence on the quality of the services provided.

It should be noted, moreover, that despite all the attempts to limit access to the AWBZ benefits, formal care provided through the national insurance system remains the key pillar of LTC in the Netherlands. The absolute number of homecare users remained stable around 260,000 per year in the period 1985–1997 and it increased to 410,000 in 2005. The number of care workers (expressed in fulltime equivalent) in the homecare sector grew from 50,000–60,000 between 1985 and 1997 and then to 80,000 in 2005 (Eggink et al. 2010, pp. 51–52). Therefore, the user–worker ratio remained relatively stable at around five to one, showing that there was no decrease in the average intensity of the services provided. There is no evidence—until the first half of the 2000s—about reduced access to the system and the substantial substitution of formal care with informal and market care (Da Roit 2010). However, there are signs that the introduction of formal protocols on "common care" and the recent steep increase in copayments may have an effect on, respectively, the recourse to informal care (Cardol et al. 2008, pp. 21–22; Cardol and Rijken 2010, p. 25; De Klerk et al. 2010, p. 215) and on the reduction of the access to formal care (Eggink et al. 2008, p. 23). Moreover, concerns about the quality of the services provided and the deprofessionalization of the care workers remain.

5.4 Changing Governance in the Dutch LTC in the 1990s: Users' Empowerment and Market Arrangements

The second type of reforms we distinguish was aimed at changing the ways in which the resources for LTC were allocated and at modifying the relationships between the users, the professionals, the providers, and the collective funding system. These encompass mainly the introduction of consumer-directed care and of market-based principles.

5.4.1 The Personal Budget (PGB)

Until 1995, LTC was only provided in kind. In 1995, with the introduction of the "Personal budget" (*Persoonsgebonden budget*, PGB) a limited number of those eligible for homecare were provided with a cash allowance instead of in kind services. This allowance was not a direct cash payment, but rather a budget that beneficiaries could use to arrange their own care (Kraan et al. 1991). Since 1995, a limited but increasing proportion of the annual AWBZ budget has been going to PGB applicants for homecare. By 2001, everyone who had been approved for homecare for at least 3 months was declared eligible for a PGB. The number of budget holders rose steeply since the second half of the 1990s: from slightly more than 5,000 to 60,000 in 2003 (De Boer and De Klerk 2006, p. 151) and 80,000 in 2007 (Ministry of Health, Welfare, and Sport (VWS) 2007).

Since its inception, opting for a PGB seemed to be more popular among younger people with disabilities than among older dependent people (Miltenburg and Ramakers 1998). Estimates show that in 2007, the younger clients represented approximately 10 % of all those receiving AWBZ-compensated care and 5 % of older people in receipt of AWBZ-financed care (7 % of the elderly receiving AWBZ-reimbursed home-based care).[4]

PGB beneficiaries can spend the available resources to compensate nonprofessional caregivers, private professional services or traditional homecare services. Claimants who are entitled to care have a choice of receiving it 'in kind' or in the form of a personal care budget (or a combination of both). The value of the personal budget is set at about 75 % of the average cost of the corresponding care 'in kind', given the fact that at least part of the budget is expected to be spent on less expensive informal care or contracted privately paid care. An early study found that approximately 25 % of PGB holders purchased care from the traditional (not-for-profit) homecare organizations but they used commercial homecare services or self-employed caregivers more frequently. In about 20 % of cases, care was provided by informal caregivers (Miltenburg and Ramakers 1998). In 2007, one-third relied solely on informal care, one-third on formal care, and one-third on a combination of the two (VWS 2007).

Successive evaluation reports have highlighted the high level of satisfaction of the users (Miltenburg and Ramakers 1998; Ramakers et al. 2007; Van den Wijngaart and Ramakers 2004). On the other hand, the possible implications for informal caregivers (Grootegoed et al. 2010), for professionals and for the system of care delivery (Knijn and Verhagen 2007; Kremer 2006) have attracted little attention in the debate. At the same time, the PGB was long considered an effective strategy for cost reduction as the unitary cost of services is lower than that paid by the AWBZ for services in kind.

However, recent developments have shown the possible fallacy of this assumption. Despite the fact that the clients using a personal budget are still a small minority of the AWBZ users, the increase in both the number of clients opting for this form of care delivery and the relative budget have risen exponentially in the past few years. In 2010, for the first time, the government announced that from the second semester of the year it would not be possible to pay a personal budget to new clients of the AWBZ: new claimants could either opt for services in kind or would be put on a waiting list. This type of development unveils possible contradictions in the implementation of the PGB: a scheme implemented to reduce bureaucracy, empower the users and at the same time save collective resources, ends up not being viable because of budgetary overruns. From the perspective of the supporters of the cost containment strategy, the question is whether the recourse to a PGB is fostering the substitution of traditional formal care with (cheaper) informal and paid care or if it is increasing the overall demand for financial support. If the institutional design of the PGB ensures a reduction of cost *per user*, there is the risk that it increases the number of users by unveiling a demand that would not be there if only traditional

[4] In 2007 840,214 people received AWBZ-financed care. 653,300 were aged 65 and above, 490,130 of which received extramural care (CBS 2008: 122–123)

services were available. In fact, research conducted on a sample of 700 PGB users shows that only one-third would have made use of traditional services if there was no possibility of accessing the PGB (25 % would have hired a privately paid caregiver; 18 % would have received no help at all, and 17 % would have held on to existing help; Ramakers et al. 2007, p. 117). At the same time, 38 % of respondents stated that they chose a PGB because the kind of help they needed could not be provided by traditional services, 33 % because they wanted to be able to pay for preexisting informal care, and 26 % because they wanted to be able to pay for existing informal care. This evidence suggests that the PGB only partly substitutes care in kind, while at the same time increasing demand for support, which would not otherwise arise. Moreover, the PGB only partly fosters increasing involvement of informal caregivers, while it seems to be used mainly for remunerating existing family carers. Even if this can be seen as a legitimate emergence of unexpressed demand and previously unsatisfied needs, it clearly contradicts the cost containment logic.

It is precisely for cost containment purposes and the prospect of a widespread misuse of the scheme that, in the summer 2011, the Cabinet announced a drastic reduction in the scope of the PGB. Despite the protests of the users' organizations, no new PGBs have been provided to homecare users from January 2012 and the existing budget holders should stop receiving the benefit in 2014. As soon as the PGB stopped being viewed as an instrument of cost containment, a 20-year-old alliance between the users' organizations and the government apparently ceased. Further developments are still unclear.

5.4.2 Making Assessment Independent from Delivery and Standardizing the Care Tasks

In line with NPM principles, organizational changes were introduced in order to separate the functions of assessment, funding and service provision on the one hand, and to make the "production" of care measurable and controllable on the other.

Until 1998, needs assessments and service delivery were both carried out by care providers. The separation of these two functions, which took place in 1998, was deemed as a solution to multiple problems. The assessment of needs would be more independent from the available services, enhancing the opportunities of the users and it would reduce the incentives of the care provider to overassess the clients' needs in relation to the organizations' interests. The assessment task was initially assigned to regional independent organizations (RIO, *Regionale Indicatie Organen*) under the responsibility of the municipalities (Algera et al. 2003), and, since 2005, to a single national organization (CIZ) with local branches.

This process was also associated with the progressive standardization of assessment procedures and of the system of attribution of care resources to the users. The further introduction of assessment "protocols" and "benchmarking" is also expected to play a role in making the AWBZ more efficient, sustainable and transparent in the future (SER 2008). The Dutch system also ensures a wide coverage of functions

and of time for homecare recipients. The most severe dependent people, in need of constant day and night care, tend to be directed to residential care, though it is not uncommon to find care users receiving 8 to 12 hours of support per day, 7 days a week. However, this support is commonly provided by a relatively high number of professional caregivers. The multiplication of the caregivers is largely because many work part time, but more so because their work tends to be task-based. Because it is often not undertaken by formal services, the coordination of high numbers of care workers tends to remain the responsibility of the user or of the informal caregiver (Knijn and Da Roit 2008).

5.4.3 Marketization of the Supply

The marketization or liberalization of public services is a trend that has been observable in several sectors in the Netherlands since the 1990s, not just in LTC. Childcare, unemployment, and activation services have all been reformed or expanded according to market-based principles as a way to reduce bureaucracy, enhance efficiency and improve quality.

In the (home) care sector, marketization has been implemented by means of two mechanisms: the introduction of the PGB as illustrated above and the introduction of competition between providers of in kind services.

However, the introduction of an actual care market had been more difficult than expected. The PGB did not produce considerable effects in this respect: its relative weight remained limited in spite of considerable growth, a relevant proportion of the beneficiaries used it to finance informal care only and it was recently repealed (see the section above). The introduction of competition between providers also remains rather limited. Most traditional homecare organizations still hold a quasi-monopolist position, mergers in the care sector have become quite common since the early 2000s, financed by the AWBZ (similarly and even more so than in the acute healthcare sector), and the entrance of new and small providers in the market has been restricted (Kremer 2006; Raad voor Volksgezondheid en Zorg (RVZ) 2003, 2008).

5.5 Redefining the Policy Boundaries: Hollowing the AWBZ as the New Reform Strategy?

The third type of reforms implemented in the Netherlands—more recent and still ongoing—comprises a redefinition of the boundaries of the AWBZ and taking important pieces of social protection away from the scope of the AWBZ and attributing them to other sectors of the welfare state.

5.5.1 Moving Psychiatric Care Out of the AWBZ to the Health Insurance System

As previously noted, at the time of the introduction of 2006 healthcare reform, it was stressed that the AWBZ should be restricted to the coverage of core LTC needs, while retaining its basic principles (SER 2000). This opened up the opportunity to transfer provisions previously offered through the national LTC insurance to different social protection schemes. The first effects of this change occurred in the psychiatric care sector; short-term psychiatric care, which over the years came under the coverage of the AWBZ, has been moved to the "second healthcare compartment." Since 2008, the first year of a user's psychiatric treatments has been financed through the acute care insurance system and any additional treatment is funded by the AWBZ.

In a similar way, the process of transferring rehabilitative homecare under the acute health care insurance system has recently started.

5.5.2 The Social Support Act and the Separation of Care from Household Assistance

The Dutch care system underwent a substantial transformation in 2007 with the implementation of the new Social Support Act (WMO). Some of the services that had traditionally been covered by the AWBZ—i.e., home help—have been handed over to the municipalities. The consequences have been twofold: on the one hand, citizenship rights have been transferred to a domain of social service provision—social assistance and care, which are locally managed—where discretionary power is more important; on the other hand, a service that was once integrated (health, social and household care) has been split into distinct provisions (health and social care on the one hand, and household care on the other), which respond to different logics.

An evaluation of the effects of the implementation of the WMO with respect to the newly organized delivery of household assistance at the municipal level has shown that, while the consequences of this change has hardly affected the users (in their own view), it has had consequences on the care organizations and their workers. The municipalities reassessed the needs of the AWBZ users receiving help with household tasks: the vast majority of them continued to receive the same amount and type of help, usually from the same care organization. Only 10 % of the users declared that the amount of support diminished and was no longer sufficient. By contrast, according to the care organizations, the shift from the AWBZ to WMO financed care meant a reduction in the hourly tariffs paid, with two consequences: financial problems for the organization themselves and the reduction in hourly wages for the care workers, which in turn represented an incentive for leaving one's job (Plas et al. 2008). It seems, therefore, that the cost containment strategy embedded in the devolution of care responsibilities to the municipalities is based on the reduction of the labor costs, which in turn will produce further shortages and, as one can easily foresee, a decrease in the quality of the services provided.

5.5.3 *Hollowing out the AWBZ as a Reform Strategy?*

Similar proposals aimed at moving some risks currently covered by the AWBZ to the acute healthcare system or to other fields of social protection continue to be put forward. For instance, it has been proposed that "short-term (home) care" be taken away from the AWBZ coverage and financed by the health insurance system (Den Draak 2010; College van Zorgverzekeringen (CVZ) 2007, 2009). At the same time, the Social and Economic Council proposed a further removal of rehabilitation care and activation and supervision services from the AWBZ, which should be attributed, respectively, to the acute healthcare insurance and to the WMO (SER 2008). This would continue an ongoing trend of the revision of the boundaries between the AWBZ and the health insurance system from the point of view of the rehabilitation system (Eyck and Peerenboom 2006), similar to what has happened with parts of the psychiatric LTC system (Van Campen 2009).

5.6 Conclusion

The debate on LTC in the Netherlands is dominated by the tensions between ensuring universal, good quality services and maintaining the costs of this expensive social policy under control. Attempts to radically reform the AWBZ have proven to be difficult. By contrast, several incremental and partial reforms have been introduced: a set of different measures explicitly aimed at containing or reducing the costs of the LTC system, increasing the power of the users and redistributing the responsibility for LTC both between the public and private sector and also across the public sector more broadly.

As previously shown, despite all the attempts of limiting access to the AWBZ benefits, formal care provided through the national insurance system remains the pillar of the Dutch LTC system. There is no evidence of reduced access to the system and of the substantial substitution of formal care with informal and market care. Nonetheless, concerns about the quality of the services provided and the deprofessionalization of the care workers remain because of the direct and indirect cost containment strategy.

The new forms of governance introduced in the system, namely the cash-for-care scheme (PGB) and the introduction of market principles and NPM ideas seem to have had limited impact on the system. The PGB remained restricted to a small proportion of AWBZ users until its recent abrogation, while market mechanisms have entered the system to a limited extent.

Possibly the most disruptive transformation introduced into the system has been the shifting of some of the risks covered by the AWBZ to other fields of social protection. Since the early 2000s, the idea has become dominant that, in order to be sustainable, the AWBZ should go back to its "core business" and leave the coverage of complementary interventions to other policy domains. Not only have some "short-term" provisions been shifted to the acute healthcare system, but

long-term "noncore" activities (home help) have been removed from the AWBZ coverage to the municipal responsibility under the social support–social assistance framework. This trend represents a turning point in the pathway of reform in the field, as it involves the redefinition of the boundaries of LTC, outside of which the logics of social protection differ significantly. Interestingly enough, this appears to be a consensual development in the political arena.

In all, the tensions between responsiveness to needs, quality of care and expenditure are far from being settled and there is considerable uncertainty about the future of the AWBZ.

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