# People with an impairment in the Netherlands

**1. Commission to draw up the report and analysis**
The Minister and Secretary of State for Health, Welfare and Sport put three questions to The Council for Public Health and Health Care (RVZ):

1. *How is 'AWBZ care' organised in other countries?*
2. *How does the Netherlands perform in this area in comparison with other countries?*
3. *How could the organisation and funding of AWBZ care be improved?*

AWBZ care and services are currently funded from resources provided under the AWBZ. In this report the RVZ regards AWBZ care as all forms of long-term care and support (long-term care in the broadest sense). This means that the report must address primary care, informal care and chronic medical care. It therefore needs to consider not only the ABWZ but also the ZVW (Medical Insurance Act) and the WMO (Social Support Act).

The RVZ commissioned an in-depth international study comparing the Netherlands with five other EU countries. The comparison shows that the information available is insufficient to allow the first two questions to be answered in a way that would lead directly to an answer to the third question. This report therefore concentrates on answering the third question. The RVZ uses the answers to the first two questions to explain and illustrate the report. The core of this report is furthermore backed up by the international comparison.

This report is based on a judgement of the AWBZ. This act has three shortcomings:

1. *The role of the AWBZ is unclear following the adoption of the Medical Insurance Act (ZVW) and the Social Support Act (WMO). This has led to fragmentation in the provision of long-term care and support.*
2. *It is unable to offer the quality of life and social involvement that people with an impairment would like.*
3. *It is not easy at first sight to define the boundaries between the AWBZ system and other structures, making the whole system difficult to manage: there is confusion between what is regarded as medical care and what are regarded as activities of daily living; it is difficult to distinguish between individual responsibility and collective responsibility. Furthermore, no-one outside central government feels responsible for cost control.*

We should also bear in mind that the Netherlands is an increasingly ageing society, and that demand for existing provision will over the next ten years outstrip the ability of care providers to meet this demand.

**2. Vision and attempts to find solutions**
This report is based on the following principles:

1. *People with an impairment should be able to take part in normal social activities.*
2. *The Equal Treatment Act can be used to impose equality of participation in many areas of life (housing, employment, communication, transport).*
3. *We can distinguish between three types of impairment with different causes: congenital or inherited impairments; those caused by an illness; and the consequences*

*of normal ageing. This distinction must be taken into account when funding and organising care.*

AWBZ care does not follow these principles.

The RVZ takes the view that we must start at the beginning when addressing issues affecting people with an impairment. This means: having control over their own lives, individual responsibility and autonomy within the context of equal treatment. If people are unable to exercise control over their own lives for reasons beyond their influence, the local authority has to step in an offer appropriate individual support in housing, employment, communication and transport. This is done in the first instance as part of standard social service structures and in the second instance under the provisions of the WMO. Compulsory medical insurance (ZVW) is often critical to the medical and nursing care provided to people with an impairment.

The RVZ draws four conclusions from this and offers various solutions.

1. The AWBZ can no longer meet the requirements that contemporary society places on the quality of life and medical care; the limits of adaptation have been reached. We need to look for a radically different approach to managing, funding and providing long-term care and support.
2. The approach must be based on:
   - citizenship and free-market enterprise as the starting position in terms of housing and welfare;
   - reinforcing the duties and extending the autonomy of local authorities in the interests of participation;
   - top-up insurance for both medical and social care.
3. Existing AWBZ entitlement can be reassigned in the light of these three guiding principles, starting with the choice between individual and collective responsibility (with the default position being individual responsibility), going on to choose between budget and insurance, and finally opting for central government or local government and private- or public-sector insurance.
4. A new approach to long-term care and support also needs a new way of deploying human capital: different professions and a different mix of formal and informal care.

**3. The answers to the question: the recommendation**

The RVZ suggests abolishing the AWBZ and funding entitlement to long-term care and support in three ways:

1. *Individuals can pay for their own housing, welfare and (a considerable proportion of) nursing care.*
2. *The WMO could cover aspects such as domestic and personal care, assistance, transport and small proportions of the services and items needed to allow an individual to live independently and take an active part in society.*
3. *The following aspects could be transferred to the ZVW: medical treatment, nursing, dietary advice and some of the services needed to allow an individual to live independently and take an active part in society.*

The RVZ suggest that the PGB (personal budget) should become part of a ’participation budget’ offered on the broadest possible basis for long-term care and support under the WMO

and (after 6 to 12 months) under the ZVW.

The division between ’care’ (ZVW) and ’support’ (WMO) creates a distinction between medical and social assistance. This should not cause any problems to users: care should be organised so that the two systems are connected in four ways:

1. *Primary care centres should have a prominent role in coordinating care and support (the whole system should be a joint venture between ZVW and WMO).*
2. *Formal and informal care should be organised in tandem.*
3. *New professions should be developed, not necessarily in the medical or social services field, at and around the division.*
4. *Curing and caring (in the medical sense) should be connected together under the ZVW.*

The RVZ found support for this reassignment of AWBZ care in its international comparison. A distinction is drawn between medical and social care in many EU countries, but care and cure are combined, local authorities have a key role in respect of social care (which is normally budgeted for and means-tested), and attempts are made to coordinate the two systems. First-line services have a central role. New professions are being created here, aimed at supporting users. Some countries actively promote informal care. Most countries opt for decentralised management of long-term care and support. The OECD recommends that essential care should be part of a social insurance system. The breadth and depth of services provided from public funds is a matter of debate in many countries.

At present it is practically impossible to compare long-term care provision in the Netherlands with that offered by other countries. There is no uniformity of indicators or definitions. However, we can say something about the Netherlands’ performance. The Netherlands does better in ’care’ than in ’support’. People with an impairment have a relatively low participation in Dutch society. Intramural AWBZ care is more comprehensive than in other countries, and extramural care is no less extensive. This is not due to ageing: the proportion of elderly people in the Netherlands is lower than in other countries. The quality of care, staff and premises in the Netherlands is good. Expenditure on care in the Netherlands is at an average level if nursing homes are not taken into account. The ’range of care’ is relatively high in the Netherlands. The Dutch approach is unique: it is the only country to have legislation such as the AWBZ that combines care, housing and welfare in a single system and that distinguishes between curing and caring tasks. Compared to systems in other countries, the AWBZ package is generous and universally accessible. The tasks of local authorities and their financial powers are relatively limited in the Netherlands.

**4. Implementation of the recommendation**

Four conditions will have to be met if this recommendation is to be implemented.

1. The inclusion of people with an impairment in society should be brought closer as a result of various actions, including broad application of the Equal Treatment Act, the payment obligation under the WMO advocated by the RVZ, and a participation budget. This is the only way people with an impairment will be able to exert control over their lives.
2. The role of local authorities should be enhanced, their financial powers extended, and the position of users vis à vis local authorities should be strengthened. Furthermore, some tasks should be carried out at regional level.

3. The ZVW must offer provision for medical curing and caring activities that should be carried out in a much more coordinated manner. When AWBZ care is transferred to the ZVW, the fact that the system is now insurance-based and has a different dynamic should be guiding principles.
4. Bridges must be built between the WMO and the ZVW, particularly using primary care centres, by enhancing informal care and creating new professions (the report contains specific examples).

The RVZ recommends starting the transition to the new situation during the term of this government. The government should present a long-term strategy outlining an implementation programme for 2006-2010:

- gradually shifting more elements of the AWBZ to the ZVW;
- investigating private savings and insurance structures for housing, nursing and welfare care for elderly people;
- phased expansion of the WMO and a decision on whether local authorities should have taxation powers;
- further support for informal care;
- development of new professions;
- policy on the reorganisation (i.e. enhancement) of primary care;
- a public debate on the place in society of people with an impairment.

The RVZ assumes that there will be no further expansion of the ZVW or WMO during the term of this government. However, it does consider it essential for the government to present the long-term strategy referred to in 4.2. This can then be put into effect in the next coalition agreement.

**5. Recommendations**

*General issues*

1. The government should create a number of conditions for a successful WMO: a payment obligation, taxation powers for local authorities (to replace the current system under which they receive part of the AWBZ premium levy), a more regional structure, a stronger role for local health services, involvement of people with impairments. In general: more focus on decentralisation and broader implementation of the Equal Treatment Act.
2. Use of a target-group approach in the relevant legislation and regulations (elderly people, psychiatric patients (as part of the group of people with chronic conditions) and handicapped people).
3. The idea that ’everyone should have access to everything’, enshrined in the AWBZ approach, should no longer be part of the way ’long-term care’ is provided. A means test should be introduced into the WMO, certainly as far as accommodation, welfare and nursing care is concerned.
4. Self-funding should apply in part to entitlement to AWBZ care, for example for nursing home costs. The remainder of these costs could be split between the ZVW (about two-thirds) and the WMO (about one-third). The report contains a specific proposal. The AWBZ could be abolished, leaving behind two statutory regimes: the ZVW and the WMO. These would have to meet a number of basic conditions, which differ from current policy in some respects.

5. Medical caring and curing activities should come under one funding structure, the ZVW, with as much uniformity between regimes as possible. The nature of the ZVW should be maintained.
6. The reassignment of AWBZ entitlements recommended by the RVZ implies unravelling the functions of the AWBZ (see also point 4).
7. The Netherlands must take steps in the EU and the OECD to increase the degree of comparability between healthcare systems.
8. Once a considerable proportion of AWBZ services have been transferred to the ZVW, both caring and curing activities must be contracted for and provided in a single, coherent system. A number of liaison functions will have to be developed between caring and curing activities, both at a professional and an institutional level (the report contains examples). The ZVW should in future not provide insurance cover specifically for curative care, but for medical care in general. Care must be an integral part of a hospital's quality indicators.
9. Primary care will have a key role to play in the future structure of long-term care and support. In the first place, it will be responsible for all the medical and nursing care provided for people with an impairment, and in that role will act as a complement to community care. It will also serve as a point of contact and support for these people. This dual role requires:
   - a robust first-line infrastructure in the form of neighbourhood or village centres for care and support;
   - an easily accessible bridge between the ZVW and WMO, funded by medical insurance firms and local authorities.
   The additional costs of these centres can be met by the abolition of existing assessment agencies and other savings relating to the implementation of the AWBZ.
10. Assessments in the context of long-term care and support should take place in the usual way: by medical professionals under the ZVW and under the responsibility of the local authority under the WMO (preferably at a regional level).
11. The government should promote informal care (provided by patients' friends or relatives and by voluntary workers) more actively. The RVZ sees this as an essential condition if the care structure is to function in the future.
    There are at least six ways of achieving this:
    - obliging local authorities under the WMO to buy in sufficient respite care from healthcare providers or voluntary organisations;
    - encouraging the creation of first-line centres, in conjunction with medical insurance firms and local authorities, and making them responsible for supporting carers;
    - investigating whether the Medical Facilities Approval Act can be used to encourage the linkage of formal and informal care;
    - asking healthcare providers to include support for carers (as additional clients) in their diagnosis/treatment combinations;
    - reward carers by exemptions, assistance, help with transport, a voucher scheme for respite care and a slightly higher PGB entitlement (see the report and background study for specific suggestions);
    - asking representatives of employers and employees to introduce provisions in collective agreements to make it easier for people to combine paid employment and informal care.
12. New professions and training programmes will be needed as part of the long-term care and support structure. These relate to various aspects, including the transition from the ZVW and WMO, and will including, in particular, activities such as coaching, arranging care, and helping users participate in society. Examples from other countries

could act as a guide. The Ministry for Health, Welfare and Sport should draw up a detailed plan of action.

13. The PGB should become part of a ’participation budget’. This option should be made more widely available, under the ZVW as well (for instance, after six or twelve months for chronically ill people). The government should develop policies aimed at meeting the costs of care and support via participation budgets where possible. These budgets must cover the actual costs in order to be competitive with the purchase of care by insurance firms.
14. The government should produce a plan of action for the AWBZ as quickly as possible on the basis of this report and other information. This plan should contain a long-term strategy and a vision for the role of people with an impairment in Dutch society. The plan should cover the ZVW, AWBZ and WMO. It should describe how the AWBZ is to be dismantled gradually over the next few years (the RVZ’s report contains a multi-step plan).
15. Finally, the RVZ advises the current government to hold a public debate on the role in society of people with an impairment. This should aim at generating public support for a policy on care and support for people with an impairment. The final decision on the ’residual’ AWBZ will be a matter for the next government.