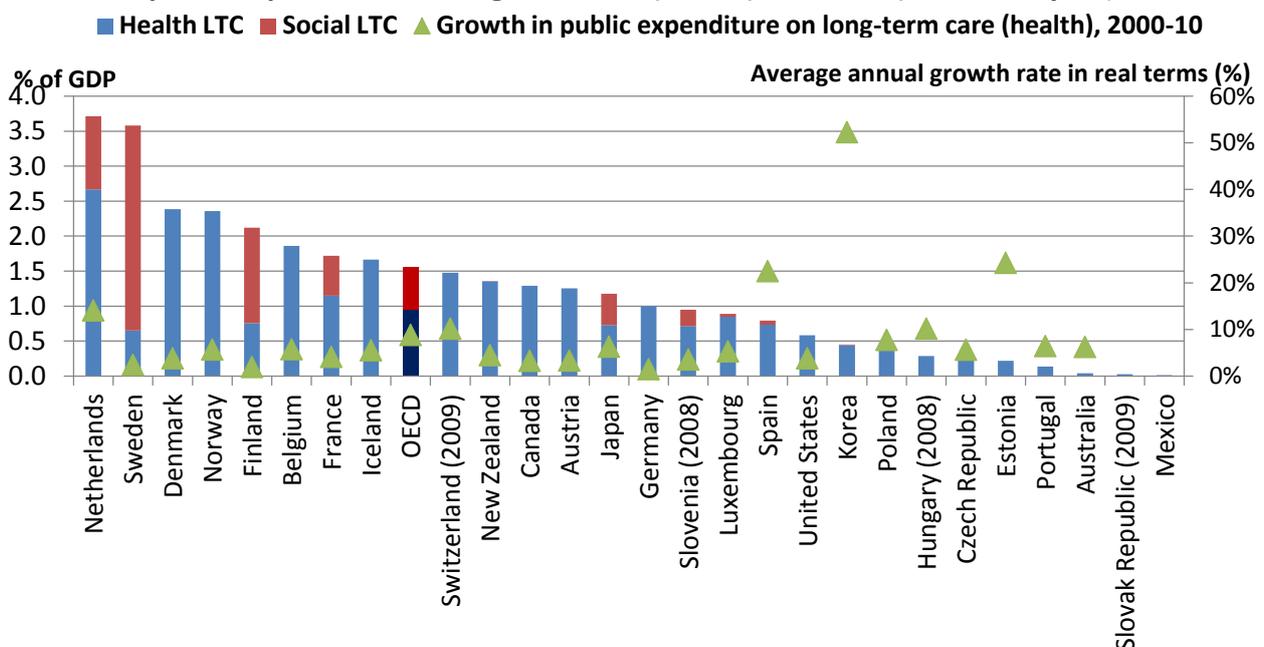


The Netherlands

Highlights from *A Good Life in Old Age? Monitoring and Improving Quality in Long-Term Care*, OECD Publishing, 2013.

- Long-term care in the Netherlands has comprehensive coverage, the possibility to choose services in cash, and a high availability of home care services. Such comprehensive system is under stress to demonstrate high quality and value for money from high levels of spending. The Netherlands spends 3.7% of GDP on LTC, the highest of the OECD countries (Table 1). The growth in public expenditure on LTC has been above 10% in real term during 2000-10. Projections suggest that expenditure might at least double by 2050.
- Nearly 13% of population aged 65 and over receives care at home, compared to the OECD average of 4.9%). However, the number of care workers in home care was only 14 per 1 000 people aged 65, relative to a ratio for workers in institutions of 63 LTC workers per 1 000 people.
- The Netherlands is one of the few OECD countries, along with England, to monitor care recipient experiences in long-term care (e.g. care plans, autonomy, privacy).

Table 1 Public long-term care expenditure (health and social components), as a share of GDP, 2010 (or nearest year) and Growth in public expenditure on long-term care (health), 2000-10 (or nearest year)



Source: OECD Health Data 2012.

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Key facts

- In 2011, 16% of the Dutch population was over the age of 65 (OECD average 15% in 2010), and 4% of the population was over the age of 80 in line with the OECD average. By 2050, 26.9% of the population is projected to be over the age of 65 and 11.3% of the population to be over the age of 80 (OECD Historical Population Data and Projections Database, 2013).
- In 2010, total spending on LTC was 3.7%, the highest among OECD countries, and well above the OECD average of 1.6% of GDP (OECD Health Data 2012).
- In 2010, 6.5% of the population over the age of 65 received long term care in institutions (4% OECD average) while 12.8% of the population received care at home (OECD average 7.9%) (OECD Health Data 2012).
- The Netherlands had 63 LTC workers in institutions per 1000 people aged 65 years old and over, and 14 LTC workers in working in home care settings in 2009, both higher than the OECD average of 31 workers at home and 32 workers at institutions) Personal care workers make up 73% of the total LTC workforce in 2009 (OECD Health Data 2012).

Background

The Netherlands was the first amongst OECD countries to introduce compulsory Social Health Insurance for LTC in 1968. Since 1994, it has been one of the few countries to advocate personal care budgets. LTC coverage is provided and organised nationally, under a statutory social-insurance programme. Like other European and OECD countries, local authorities are responsible for the delivery of LTC services.

The Dutch Exceptional Medical Expenses Act (AWBZ) is a compulsory insurance for – amongst others – the risk of long-term care, covering care for disabled, chronic mental health care, and care for the elderly. AWBZ premiums are a percentage of workers' wages. Workers' contributions currently make up 2/3 of the overall budget; the remaining 1/3 comes from taxes. As LTC expenses grow faster than wages, the tax share of the budget is increasing. A challenge for the country is the ever-increasing rise in LTC expenditure.

Measuring Quality in LTC

The Steering Committee Responsible for Care set ten quality domains under the 2007 National Quality Framework. These are:

- care/life plan to assure LTC recipients' involvement in care and life planning;
- communication and information to ensure that providers keep communication open and make efforts to listen to recipients' wishes;
- physical well-being for recipients to receive adequate support and to feel satisfied with the care provided;
- safety of care to prevent avoidable harms and restriction of freedom of movement;

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- domestic and living conditions to respect recipients' privacy and their living atmosphere;
- participation and autonomy to ensure sufficient opportunities to participate in various activities;
- mental well-being to provide mental support (loneliness or depression) and pay attention to their choices and sense of purpose;
- safety of living environment;
- sufficient and competent personnel to ensure availability of qualified staff and sufficient care time; and
- care co-ordination across health and adult social care.

Each domain includes a set of indicators reflecting the structure, process and outcomes of care (Steering Committee Responsible Care, 2007).

In 2006 the Dutch Ministry of Health, Welfare and Sport mandated the development of a national standard for the measurement and comparison of consumer experiences in healthcare, called the Consumer Quality-index or CQ-index[®]. All LTC facilities are required to carry out surveys of users' experience using the so-called CQ-Index Long-Term Care (Steering Committee Responsible Care, 2007). This national tool, used to measure and compare consumer experience, was developed based on the abovementioned ten quality domains (Triemstra et al., 2010). Each domain has an associated set of indicators developed on the basis of the structure-process-outcome concept. The indicators provide a picture of what users find important and what their experience with care is (van der Veen and Mak, 2010).

Audits and Inspections

Each LTC institution reports on an annual basis to the Healthcare Inspectorate (IGZ), which has an advisory and monitoring role.

Regulation and control over inputs

Monitoring quality

Responsibility for quality lies with the providers. Two laws directly concern the quality of care, namely the Law on quality in care organisations (Kwaliteitswet zorginstellingen; KWZ) and Law on professions in personal healthcare (Wet op de Beroepen in de Individuele Gezondheidszorg; Wet BIG).

Accreditation and certification of providers and organizations

The national quality organisation (NZA) monitors the quality of care in home based care and also in institutions. The accreditation of facilities is carried out by the Dutch Institute for Accreditation, and it is based on the following dimensions of care: client's perceptions, outcomes for informal care, service utilisation, care workers' qualifications and satisfactions, and clinical outcomes. Accreditation is mandatory for reimbursement/contract.

The Healthcare Inspectorate (IGZ), monitors the quality of LTC services. The IGZ uses the information that is given by organisations on the basis of the Responsible Care Quality framework and uses the results

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to form judgement on safe, effective and responsible care. The process begins with determining possible risks. Each year, a percentage of units to be inspected is determined. This does not only concern high-risk organisations but also about a selection of mid-risk and best practice organisations. If necessary, IGZ may decide after the inspection visit to carry out strict control or to proceed to further enforcement. Finally, IGZ carries out supplementary theme-based research, which are determined annually (Kwaliteitskader Verantwoorde Zorg, 2007).

Monitoring and standardisation of processes

Needs assessment and care planning

Eligibility to care is needs-based but income-dependent co-payments are required from the beneficiaries, apart from children. The eligibility check is based on national standardised procedures, developed by the CIZ (Centre for Indications Care), which translate legal guiding principles into detailed procedures. CIZ-decisions will typically lead to an eligibility decision regarding functions and hours of care required, as well residence. The indication procedure leads to a risk-adjusted capitation payment to the provider. In 2007 IADL-support was transferred from the AWBZ to the domain of local authorities (some of which use CIZ procedures).

Practice guidelines

The Netherlands has national dementia strategies that stress the importance of specific care guidance for LTC providers.

Public reporting of outcomes and performance

Care providers' performance is monitored and governments' accountability reports make information available to the public. Public reporting is mandatory and includes indicators of care effectiveness and safety and user experiences.

System improvement through incentives

User direction and choice

Benefits can be provided as in kind services or as personal budget aimed at tailoring care to consumer preferences. Personal budgets are set at lower amount than the amount provided when care in kind is chosen. People receiving budgets are free to choose who should deliver their care: an official institution, an independent care worker, a family member, friend, neighbour etc. For most of the budget, patients are obliged to be able to show that they spent the money on care (Mot et al, 2010). For both cash and in-kind benefits, personal co-payments are calculated depending on need for care, income, household situation and age. For people with chronic illnesses, a special cash benefit exists to contribute to the additional costs of living due to a disability or chronic disease.

References

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