Summary and conclusions

A picture of care use

Developments in the use of domestic help, personal care and nursing care between 2004 and 2011

Community-based care in the form of domestic help, personal care and nursing care is a key pillar of the (long-term) care provided to people with disabilities living independently in the Netherlands. Expenditure on long-term care has risen sharply in recent years, and all manner of changes have taken place in the Dutch care system. This prompted a study of developments in the use of community-based care and its determinants. The study drew on data on care use produced by the Central Administrative Office for care funding (CAK; only users of care in kind aged 18 and over) and linked them to background data from health surveys carried out by Statistics Netherlands (CBS). The ability to link these two data-sets is new, and gives us access to fairly recent data on health and care use in the Dutch population aged 18 years and older, and also enables us to study changes in care use between 2004 and 2011.

Community-based care encompasses all care provided to people living independently at home. It may include help with running the household, personal care and nursing care. This care is often provided by home care organisations. To be eligible for community-based care, applicants must have an indication showing that they meet the relevant criteria (have a care need). This report only discusses care received in kind; no data are available on the use of a personal budget, privately paid help or informal care.

Between 2004 and 2011, the period for which we studied the use of community-based care, Dutch government policy was aimed at controlling the costs of long-term care and improving its efficiency. The first question addressed in this study is whether the changes in the costs of community-based care between 2004 and 2011 were accompanied by changes in the use of this care. The answer to this question is clear: there are more users of long-term community-based care. This increase can be explained entirely by population growth, and especially the increase in the number of elderly older persons (aged 80 years and over). However, if we correct for population growth and population ageing, the number of users of community-based care remains constant. This does not take into account the number of people with a personal budget. We do see an increase in the number of hours of care received on average by users of community-based care, however, particularly for domestic help and personal care. Both the number of hours of nursing care provided and the number of care recipients fell slightly over the period. This reduction can be explained by the stricter definition of what falls under nursing care: a number of tasks which were previously classed as nursing care have since 2008 been categorised as personal care. In addition, nursing care in the home setting that is provided on the basis of a medical specialisation has no longer been classed as community-based care, since 2008, when the funding of this

care was transferred from the Exceptional Medical Expenses Act (AWBZ) to the Care Insurance Act (Zvw).
Our second research question, namely whether differences can be observed in the use of community-based care between different subgroups, can be answered in the affirmative. For example, elderly older persons make the most use of community-based care, and that use increased slightly between 2004 and 2011, whereas over the same period the amount of care used by people aged under 70 years declined substantially. It may be that relatively young care recipients more often opted for a personal budget with which they could purchase care themselves. The use of community-based care by people with no physical disabilities or chronic illnesses increased slightly. It is quite possible that these people had a temporary disability or another, non-physical impairment, such as cognitive impairments in the case of dementia (we have no data on this).
The use of community-based care by single persons increased in the period 2004-2011 and fell in multiple-person households. This may be connected to the introduction of the stricter 'usual care protocol' (in particular for domestic help) in 2005, since when providers have looked more carefully when allocating care at whether there are other household members who could provide help. Unfortunately, the health surveys provide no data on the use of informal or privately funded care.
Finally, we find an effect that is probably related to the policy pursued. Co-payments made by recipients of community-based care have been increased, and people with high incomes make less use of this care, whereas people with low incomes make more use of it. This does not mean that people with high incomes and a care need do not receive any form of help. It is perfectly possible that they have chosen to pay for their own help privately, or have a personal budget with which they can purchase the care they need themselves. We do not have access to data on the use of privately funded help and personal budgets.
Our third and final research question is whether the determinants of the use of community-based care changed between 2004 and 2011. This study looked only at characteristics of care users, not at the supply (or changes in the supply) of care. Naturally, health problems (such as physical impairments) are the main reason for using care. In addition, personal characteristics (such as sex and age) and facilitating factors (such as income and the presence of other people in the household) can also influence care use. In the interplay between the various determinants and the use of community-based care, particularly the relationship of household composition and income are found to have changed. This applies to a lesser extent for age and severity of physical impairment. The role played by someone's personal situation, the presence of other household members (and thus the availability of help) and the presence of own financial resources has increased, while the role of physical impairments appears to have reduced slightly. This could indicate that the path on which the government has embarked, of making care accessible only to people who do not have their own resources or available help, is having an effect.
Summarising, the main findings from this study are that the use of community-based care did not increase between 2004 and 2011 if allowance is made for the increase in the number of (elderly) older people, and that the main change was in the role of income and

household composition (and to a lesser extent age and physical impairments) as determinants of the use of community-based care. This could be a result of the changed policy when assessing eligibility for care, in which the applicant's personal situation is given a more prominent role alongside health considerations.

This study relates to the situation up to 2012, which means that the impact of a number of recent policy changes, such as the decision no longer to admit people receiving low-intensity care to an institution, is not included. Radical changes in long-term care are being implemented with effect from 1 January 2015. The Long-term Care Act (WLZ) replaces the Exceptional Medical Expenses Act (AWBZ), and stricter access criteria apply (compared with the AWBZ). People who previously received community-based care funded through the AWBZ are since 1 January 2015 provided with care via the Care Insurance Act (Zvw) (nursing and personal care) and the Social Support Act (Wmo) (support and associated care). Domestic help is still provided under the Social Support Act, but local authority budgets are being cut (25%). Indications for nursing and care in the home setting are moreover no longer provided by the Care Needs Assessment Centre (CIZ), but by a community nurse. Local authorities remain responsible for the Social Support Act, and more and more reliance will be placed on people's own capacities and on informal help (informal carers and care volunteers). It will therefore be interesting to follow the potential effect of these system changes in comparable research.