

Summary

Monitor of long-term care use 2009-2012

A baseline measurement

This report monitors developments in the use of long-term care in the Netherlands in the period 2009-2012. During that period, long-term care was provided on the basis of the Social Support Act (Wmo) and the Exceptional Medical Expenses Act (AWBZ). The report also describes how the different forms of long-term care are distributed across Dutch municipalities, as well as municipal characteristics linked to that distribution and the relationship between different care types within municipalities. This overview is important in the light of the transfer of some of the responsibility for providing long-term care to local authorities from 1 January 2015. As this report covers the period 2009-2012, the outcomes presented here are not influenced by the radical changes to long-term care that came into effect on that date. Consequently, this report can be seen as a baseline or reference measurement.

The report provides a systematic overview of all the information available on the various forms of long-term care in the Netherlands. That information, dispersed across many administrative databases and our own SCP surveys, covers a period of four or five years and was drawn from the Central Administrative Office (CAK), the Care Needs Assessment Centre (CIZ), Statistics Netherlands (CBS), the health care statistics agency Vektis, Youth Care Offices (Bureaus Jeugdzorg), National Youth Welfare Agency (Jeugdzorg Nederland), Dutch municipalities and the research agency and consultancy I&O Research. It required very intensive and time-consuming processing to link and verify these data and render them suitable for analysis and publication. Differences of definition mean that figures may differ in some respects from figures published elsewhere, such as the Long-term Care Monitor (*Monitor Langdurige Zorg*) published by Statistics Netherlands (CBS). This general summary sets out the main findings described in the report.

Number of new clients declined while total number of clients increased

One of the key findings of the report is that the number of people getting care for the first time declined over the period studied. It makes no difference whether they sought domestic help funded through the Social Support Act (Wmo) or community-based or institutional care provided through the Exceptional Medical Expenses Act (AWBZ). The number of clients applying for care declined across the board in the period 2009-2012, and especially the number of new clients for domestic help, which fell by a fifth over the period as a whole. The decline in the number of new clients contrasted with an increase in the total demand for care in the period 2009-2012. Once again, this applied across the board, with an increase in both the total number of clients applying for Wmo-funded domestic help and

the total number of clients eligible for community-based and institutional care funded through the AWBZ.

The opposing trend in the number of new clients and the total number of clients suggests that people continued using care for longer once they started receiving it. The decline in the number of new care clients is probably due to policy changes which came into force in or before the period 2009-2012. Attempts were also made prior to 2015 to control the costs of care and place more emphasis on 'own control' and 'own responsibility'. The policy on community-based care, aimed at ensuring that people continue living independently at home for as long as possible, is an example of this. Policies such as this may have meant that people were less inclined to enter the care system and that all those who did apply for care needed that care on a long-term basis.

Clear differences between municipalities in demand for care

Another important finding of the report is that the share of the local population using a provision – the 'care intensity' – varied considerably from municipality to municipality. The differences were particularly marked when it came to new applications for Wmo-funded provisions: the care intensity for new clients (on average 0.7%) could vary by a factor of 10 from one municipality to another. For AWBZ-funded care, the care intensity (on average 2.1%) varied by a factor of (at most) three.

The variation in use of Wmo-funded provisions was lowest for domestic help in kind. There was a wider spread in use of the other provisions, mobility and medical aids, help with housework (alfahulp) and personal budgets to buy domestic help. There was also relatively wide variation in the care intensity of clients applying for a personal budget for community-based care funded through the AWBZ and clients who applied for community-based youth care services.

A few other findings

The increase in the total use of 'category 1' domestic help – which in most municipalities constitutes simple help – was substantially greater than the increase in 'category 2' help, which generally involves help with the organisation of the household. The total number of clients receiving category 1 help rose by 8% per year on average, while the total number receiving category 2 care declined by an average of 12%. These developments reflect the shift from category 2 to category 1 care which has been observed since the introduction of the Wmo in 2007. That shift is also reflected in the number of hours of care received. In addition, the prices of category 1 care rose much more sharply than for category 2 care. The average hourly price of domestic care rose from €19.10 in 2009 to €21.40 in 2012. A number of striking differences can be observed between demand for care in kind and care provided via a personal budget. Demand for care in kind followed the general trend, with the number of new clients declining and the total number of clients increasing. By contrast, both the number of new clients and the total number of clients purchasing institutional care with a personal budget increased, while among clients for community-based

care both groups contracted. This divergent development with respect to personal budgets is a result of the measures introduced in 2012 making it more difficult to obtain community-based care using a personal budget.

Studying the reason why people apply for care shows that the number of new clients for virtually all types of care followed the general trend, and therefore declined in the period 2009-2012. The only exception was AWBZ-funded community-based care requested by people aged over 65 with a somatic reason for needing care; the number of new clients in this group increased in the period studied. Population ageing is likely to have played a role here.

People needing long-term care had access to various types of community-based care. The five main AWBZ-funded provisions covered in this report are personal care, nursing care, individual support, group support and short-term residential care. These five provisions occur in differing combinations. Analysis of the trend in care combinations shows clearly that in the period 2009-2012, but especially in 2012, the number of new clients receiving (a care combination with) support declined more sharply than the total number of clients. The total number of clients receiving (a care combination with) support grew less steeply than the total number of all combinations. The measures taken in relation to the personal budget play a major role here, because these budgets are widely used to purchase support. As regards AWBZ-funded community-based care, a distinction can be drawn between intensive and extensive care users or applicants; the threshold dividing intensive from extensive is set at ten hours of care per week. This report shows that there were more applicants for extensive than intensive care during the period studied. The latter were more commonly receiving care combinations with support. This applies both for new applicants and for the total, including youth health care clients.

The decline in the number of new applicants for residential care was mostly concentrated among those requiring less intensive care packages. This does not apply for applicants with intellectual disabilities. It was not possible to investigate this for the total number of applicants because the codes for care intensity packages were not always available.

Municipalities where a relatively high proportion of clients applied for less intensive forms of care often also contained a relatively high proportion of first-time applicants for a more intensive form of care. Unfortunately, we are not able to offer an explanation for this relationship in this report. We suspect that it may be due to a relationship between specific characteristics of a municipality and the demand of the two types of care. This report does for example show that the presence of a high proportion of older people in a municipality is associated with high demand for care, and the same applies where a relatively high proportion of the municipal population have disabilities. To determine whether these factors really do offer an explanation for the association between high demand for less intensive care and increased demand for more intensive forms of care, it would be necessary to estimate a model. It would then be possible to examine how levels of demand for different care provisions interact with each other after correcting for the influence of other factors

that can affect demand for care. Such a modelling exercise is not the purpose of this report, but could be a useful addition to future monitoring of these types of long-term care.

The reforms to long-term care in the Netherlands will be evaluated over time. This report is of great value in monitoring this process. It provides a baseline measurement, which provides an insight into the situation prior to the reforms. Repeating this monitor is of great importance in assessing whether the reforms are achieving their intended goals, such as enabling people with disabilities to continue living at home for longer than in the past, but also reducing the demand for intensive/expensive care and increasing the demand for less intensive/cheaper care. Such a repetition, especially if it is combined with an explanatory model, would make it possible to identify and interpret developments in the use of long-term care provisions.