GATEWAY TO GLOBAL AGING DATA

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Gateway Policy Explorer: Long-Term Care Series

Netherlands

Long-Term Care Cash Benefit Plan Details

1996-2024

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Preface

This document is intended for researchers who want to understand the evolution of policy or the policy in place at a particular point in time. This document is not intended for financial advice or to aid in decision-making. The authors have made significant effort to identify and collect historical information pertaining to these policies, to accurately represent these policies, and to communicate how policies may interact to determine legal requirements, eligibility for benefits, and/or benefits levels. The policies presented in this document focus on rules applicable to most individuals aged 50 and older from 1992. Many systems include special policies or alternative eligibility rules for specific groups. We encourage all users to complete their own review of literature in this area depending on the research questions they have in mind.

If you have feedback or questions or identify an error, please contact policy@g2aging.org.

Background — *Gateway Policy Explorer: Long-Term Care Series*

The *Gateway Policy Explorer* (http://g2aging.org/policy-explorer) is part of the Gateway to Global Aging Data (http://g2aging.org) project. The *Long-Term Care Series* captures historical policy that affects the birth cohorts of respondents in the surveys covered by the Gateway. It was motivated by the rapid evolution of policies affecting older people across the world. As the Health and Retirement Study (HRS) began in 1992 and many of the international network of studies (HRS-INS) cover more than a decade, understanding the policies in place at the time of the survey has become more demanding for researchers.

Why are we tracking past policy? Individuals make choices based on current policies and the outcomes we see today may reflect responses to past policies. When interpreting the survey responses of individuals, an understanding of the policy environment under which those individuals operate is critical. The collection of contextual information in the *Gateway Policy Explorer* aims to support researchers who want to understand or use policy changes in their research and provide context for longitudinal or cross-country differences. Over the period 2023–2026 the *Gateway Policy Explorer* will be expanded to include information on retirement, long-term care, education, and other policies affecting the life cycle.

The key dimensions to the *Gateway Policy Explorer: Long-Term Care Series* are country and time. In the United States, policy is reported at the state level. We prioritize data collection for each country or state based on its first interview wave and are continuing to expand our data collection back in time to 1992, the earliest survey date in the HRS-INS.

A separate document, like this one, is developed for each country or state and each broad category of policies covered in the *Gateway Policy Explorer: Long-Term Care Series*.

Netherlands

Cash Benefits

Plan details 1996-2024 * †

In the Netherlands, cash benefits offered as personal budgets are one of the long-term care (LTC) services provided to older adults who are care dependent. Until 2007, LTC personal budgets were only provided by The General Special Medical Expenses Act (AWBZ), which was universal and compulsory. Individuals were eligible for personal budgets through AWBZ as long as they were a resident of the Netherlands and they paid the income-related premium. The AWBZ personal budgets were disbursed annually and distributed monthly, quarterly, semi-annually, or annually, depending on the budget size. In 2007, home care benefits that supported an individual in maintaining their living environment and daily domestic tasks (domestic assistance) were transferred to the Social Support Act (WMO) and removed as services provided through the AWBZ. Therefore, personal budgets associated with these services were also transferred to WMO. Individuals were eligible for personal budgets through WMO as long as they were a resident of the Netherlands.

In 2015, AWBZ was repealed and personal care and home nursing benefits were transferred to the Health Insurance Act (ZVW). Intensive 24-hour long-term care benefits were transferred to the Long Term Care Act (WLZ). Individuals were eligible to receive benefits under ZVW as long as they were a resident of the Netherlands, paid the income-related contribution, and paid their nominal premium (health insurance premium). Individuals are eligible to receive benefits through WLZ as long as they are a resident of the Netherlands and they pay the income-related premium. Evaluations of dependence under WLZ, WMO, and ZVW are all subjective and consider several factors including the applicant's conditions and limitations, their home and living environment, their social circumstances, and any help they already receive. There are no defined levels of dependence for eligibility or benefits. None of the benefits are taxed.

Key Dates

First law: 1968

Major changes since 1992: 2007, 2015

Contents

* If you have questions or suggestions, please contact policy@g2aging.org.

† Detailed information and definitions are provided in tables, formulas and a glossary at the end of this document. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

Chapter 1: Policy enacted 1996-2006

Overview

During this period, the Dutch Long-Term Care (LTC) System provided cash benefits through personal budgets organized at the national level. Eligibility for these benefits was mostly based on care needs.

The General Special Medical Expenses Act (Algemene Wet Bijzondere Ziektekosten - AWBZ) was created in 1968 with the goal of protecting the Dutch population against the significant costs associated with LTC. Organized at the national level by the Ministry of Health, Welfare, and Sport and at the regional level by regional care offices, AWBZ was a universal and compulsory scheme that covered a wide range of long-term care services for older adults with care needs. From 1996, personal budgets were offered as an alternative to in-kind care. Individuals were eligible for personal budgets through AWBZ as long as they were a resident of the Netherlands and they paid the income-related premium (Overheid.nl Monitor, 2002a). The personal budget payment was made monthly, quarterly (four times a year), semi-annually (twice a year), or annually (once a year) depending on the budget amount.

Individuals were paid a net personal budget, which was the gross personal budget minus their copayment. Before 2004, the copayment for a personal budget was a fixed proportion of the personal budget (17.75% in 2003) (Overheid.nl Monitor, 2003f). However, the copayment could not exceed a certain amount, which varied depending on the individual's age, marital status, and income. From 2004 to 2006, annual copayments varied depending on the function and class the individual was assigned to receive. The evaluation of dependence was subjective and considered several factors including the applicant's conditions and limitations, their home and living environment, their social circumstances, and any help they already receive. There were no defined levels of dependence for eligibility or benefits.[1] Before 2003, dependence was defined in terms of the type of care and health care providers individuals required but after 2003, dependence is based on six bases or types of conditions, limitations, and disabilities that require the applicant to rely on care. The six bases include somatic, psychogeriatric, psychiatric, physical, mental/intellectual, and sensory/psychosocial.

Individuals may purchase Voluntary Additional Insurance (Aanvullende Verzekering) for care that is not covered by the public long-term care schemes. Health insurers determine the conditions and reimbursements of the supplementary insurance, including the premium. Details of Voluntary Additional Insurance are not included in this document. Individuals are provided the option to receive benefits either in-kind or through personal budgets. For details about in-kind benefits, please refer to the policy document Netherlands Long-Term Care In-Kind Benefit Plan Details, 1992-2024 (Gateway to Global Aging Data, 2024).

This policy period (chapter) provides details on cash benefits of the Dutch LTC system from 1996 to 2006.

Statutory basis

The General Special Medical Expenses Act (Algemene Wet Bijzondere Ziektekosten - AWBZ) (Overheid.nl Monitor, 2002a)

Financing

Source of financing

AWBZ is funded by income-related premiums, taxes, and income-related copayments, which are collected in a fund called the General Fund for Special Medical Expenses (Algemeen Fonds Bijzondere Ziektekosten - AFBZ). The AWBZ premium is a fixed proportion calculated over a maximum amount of yearly taxable income. The annual AWBZ premium in 2003 was 12.3% of the first 28,850€ or a maximum of 3548.60€ (Overheid.nl Monitor, 2003a, 2003b). In 2005, it was 13.45% of the first 30,357€ or a maximum of 4,083€ (Overheid.nl Monitor, 2005a and Centraal Bureau voor de Statistiek, 2005). For salaried employees or individuals receiving state benefits, the premium is automatically deducted from their salary or benefit. Self-employed individuals pay the premium themselves when filing taxes.

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

AWBZ covers care needs related to physical, functional[6], and cognitive impairments, such as limitations in activities of daily living (ADLs) and instrumental activities of daily living (IADLs) (Overheid.nl Monitor, 2002a).

Eligible population

An individual is eligible for care coverage under AWBZ if all of the following conditions are satisfied:

- Residence requirement: Is a resident of the Netherlands or is not a resident but is subject to wage tax in The Netherlands (Overheid.nl Monitor, 2002a, §5(1))
- Contribution requirement: Pays income-related premium (Overheid.nl Monitor, 2002a, §48)
  - 12.3% of the first 28,850€ or a maximum of 3548.60€ in 2003 (Overheid.nl Monitor, 2003a, 2003b)

Benefit

Cash Benefit

A yearly personal budget is paid to eligible beneficiaries as an alternative to in-kind care except residential care. The personal budget amount varies depending on the function and class the beneficiary is assigned to. Individuals are paid the net personal budget, which is the gross personal budget minus the income-related copayment. Table 1 and Table 2 list gross personal budget amounts by function and class from 2003 to 2006. The payment is made monthly, quarterly (four times a year), semi-annually (twice a year), or annually (once a year) depending on the budget amount (Overheid.nl Monitor, 2003e, §2.5.6.9).

- Budgets that are 2,500€ or less are paid annually
- Budgets that are 5,000€ or less but more than 2,500€ are paid semi-annually
- Budgets that are 25,000€ or less but more than 5,000€ are paid quarterly
- Budgets that are more than 25,000€ are paid monthly

For example, a yearly personal budget of 10,000€ would be paid quarterly in payments of 2,500€.

Discretionary Use

The personal budget must be used to purchase care listed in the applicant's eligibility decision (Overheid.nl Monitor, 2003e, §2.5.6.8). The beneficiary decides what provider to receive help or care from.

Provision of care

The regional care office of the qualified beneficiary directly deposits the personal budget into their bank or GIRO account. Beneficiaries must pay back any unspent funds from their personal budget (College voor zorgverzekeringer, 2004).

Benefit Eligibility

Qualifying period

None

Minimum level of dependence

There are six bases or types of conditions, limitations, and disabilities that require the applicant to rely on care. The six bases include somatic, psychogeriatric, psychiatric, physical, mental/intellectual, and sensory/psychosocial. To be eligible for AWBZ care, an insured person must have at least one basis (Overheid.nl Monitor, 2003c).[5]

Duration of benefit

The benefit lasts as long as the beneficiary is eligible and their eligibility decision is valid (Overheid.nl Monitor, 2003c, §15).[4]

Means testing

Means testing exists through income-related copayments. More details are provided in the user charges section.

Age requirement

None

Care Needs Assessment

Definition of dependence

Before 2003, dependence was defined in terms of the type of care and healthcare providers individuals required to maintain, improve, or promote their functional health and living conditions. After 2003, dependence is based on six bases or conditions, limitations, and disabilities that require the applicant to rely on care. The six bases include somatic, psychogeriatric, psychiatric, physical, mental/intellectual, and sensory/psychosocial. Individuals can access different types of care depending on the type of condition, limitation, or disability. The types of care that dependent individuals can access under AWBZ, which are referred to as functions include domestic assistance, personal care, nursing, supportive guidance, activating guidance, treatment, and residence (Overheid.nl Monitor, 2003d). Table 3 describes what bases provide access to what function.

Evaluation of dependence

The evaluation of dependence begins after the applicant or someone on behalf of the applicant submits an application for an eligibility decision. The following is investigated (Overheid.nl Monitor, 2003c, §6-§15)[5]:

- The general health of the applicant
- Limitations that the applicant experiences in their physical, sensory, or mental functioning due to an illness or disability
- The applicant's home and living environment
- The applicant's psychological and social functioning
- The applicant's social circumstances
- Any professional and non-professional assistance and care currently offered to the applicant and possibilities for continuation of this assistance and care

Different individuals and organizations are contacted for their expertise depending on the applicant's circumstances. A decision is made within six weeks and if the individual has one or more conditions, limitations, and/or disabilities that requires them to rely on one or more forms of care, they are eligible to receive care under AWBZ. There are six bases or types of conditions, limitations, and disabilities that require the applicant to rely on care. The six bases include somatic, psychogeriatric, psychiatric, physical, mental/intellectual, and sensory/psychosocial. Different bases provide access to different types of care, which are referred to as functions. The functions include domestic assistance, personal care, nursing, supportive guidance, activating guidance, treatment, and residential care. Individuals cannot receive a personal budget for residential care. Table 3 describes what bases provide access to what function. An eligibility decision that contains the following information is then sent to the applicant:

- The form or forms of care the applicant will require
- The amount of care the applicant will require in terms of time
- The conditions, limitations, or disabilities that caused the applicant to rely on care

The eligibility decision states from what date the applicant is allowed to receive care and how long the decision is valid for (period of validity). Details have not yet been identified on what specific conditions, disabilities, and limitations (bases) are investigated and how time is allocated for different forms of care (functions) during this period.

Evaluators

Before 1997, healthcare providers conducted the evaluation of dependence. From 1997, regional groups conducted the evaluation of dependence (Schut and van den Berg, 2010). These groups consisted of at least five members. The applicant and the municipality were both given the opportunity to appoint at least one person as a member of the needs assessment group (Overheid.nl Monitor, 2003c, §4). Healthcare professionals were also usually consulted during the evaluation of dependence. In 2005, the Care Assessment Center (Centrum Indicatiestelling zorg - CIZ) began conducting the evaluation of dependence (Ministry of Health, Welfare, and Sport, n.d.). CIZ may ask the applicant's physician and other individuals and organizations that have relevant expertise pertaining to the applicant's care needs for their input during the evaluation.

Benefit limitations

Can you mix LTC benefits?

Individuals can mix cash benefits and in-kind benefits if they are eligible for more than one function or type of care. For example, if an individual is eligible for domestic assistance and personal care, they can choose to receive domestic assistance in-kind and personal care through a personal budget.

Is there free choice between cash and benefits in-kind?

Individuals can choose to receive care in-kind (Zorg in Natura- ZIN) or through cash benefits (Persoonsgebonden Budget - PGB). The cash benefit may be requested for all functions except treatment[11] and residential care (Overheid.nl Monitor, 2002a, 2003e).

Can you receive LTC benefits with other social security benefits?

There are no limits on receiving cash benefits with other social security benefits.

User costs

User charges

Individuals paid income-related copayments. Individuals were paid a net personal budget, which was the gross personal budget minus their copayment. Table 1 and Table 2 list gross personal budget amounts by function and class from 2003 to 2006. Before 2004, the copayment for a personal budget was a fixed proportion of the personal budget (17.75% in 2003) (Overheid.nl Monitor, 2003f). However, the copayment could not exceed a certain amount, which varied depending on the individual's age, marital status, and income. Table 4 lists maximum copayment amounts by marital status, age, and income in 2003. From 2004 to 2006, annual copayments varied depending on the function and class the individual was assigned to receive.

- 60% of the gross personal budget for domestic assistance
- 33% of the gross personal budget for personal care
- 20% of the gross personal budget for nursing care
- 27% of the gross personal budget for activating and supportive guidance

An individual's annual copayment could not exceed 15% of their contributable income (bijdrageplichtig inkomen) with a minimum copayment of 210.08€ and a maximum copayment of 6,978.40€ in 2005 (Overheid.nl Monitor, 2005b). Copayments for short-term stay have not been identified yet. Box 1 defines contributable income.

Taxation of benefits

Not subject to taxation

Chapter 2: Policy enacted 2007-2014

Policy change in 2007
In 2007, the Social Support Act (Wet maatschappelijke ondersteuning - WMO) was created. Personal budgets related to home care benefits that supported an individual in maintaining their living environment and daily domestic tasks (domestic assistance) were transferred to the Social Support Act (WMO) and removed as personal budgets provided through the AWBZ. Municipalities were responsible for organizing and providing household-related home care services. They also set their personal budget rates and conducted their evaluation of dependence.

Overview

In the Netherlands, most public long-term care (LTC) services for older adults are provided by the General Special Medical Expenses Act (AWBZ), which is compulsory. However, the creation of the Social Support Act (WMO) in 2007 transferred the responsibility of some home care benefits from AWBZ to WMO. Benefit eligibility was based on care needs.

AWBZ
AWBZ was a universal and compulsory program that covered a wide range of long-term care services for older adults with care needs, including personal budgets. It was organized at the national level by the Ministry of Health, Welfare, and Sport and at the regional level by regional care offices. Individuals were eligible for personal budgets through AWBZ as long as they were a resident of the Netherlands and they paid the income-related premium (Overheid.nl Monitor, 2014a). Individuals were paid a net personal budget, which was the gross personal budget minus their copayment. The annual copayment varied depending on the function and class the individual was assigned to receive. The evaluation of dependence was subjective and considered several factors including the applicant's conditions and limitations, their home and living environment, their social circumstances, and any help they already received. There were no defined levels of dependence for eligibility or benefits[1] and dependence was based on six types of bases or conditions, limitations, and disabilities that require the applicant to rely on care. The six types include somatic, psychogeriatric, psychiatric, physical, mental/intellectual, and sensory/psychosocial.

WMO
WMO provided home care services to older adults with care needs. It was organized at the municipal level. There were 415 municipalities in 2012 (Government of the Netherlands, n.d.). Individuals were eligible for personal budgets through WMO as long as they were a resident of the Netherlands (Overheid.nl Monitor, 2014b). Beneficiaries paid a copayment for home care services under WMO, which was capped at a maximum amount per 4-week period called the maximum period contribution. Municipalities could use the maximum period contributions set in national guidelines or set their own maximum period contributions. However, they were only allowed to lower the national maximum period contribution, not increase it. In 2012, the national guidelines set the maximum period contribution for single individuals at 18€ and for married individuals at 25.80€ per 4-week period (Overheid.nl Monitor, 2013p). The largest or second largest municipalities in each of the 12 provinces in the Netherlands all used the nationally set contributions in 2012 and/or 2013. The evaluation of dependence was subjective and considered several factors including the applicant's conditions and limitations, their home and living environment, their social circumstances, what they have done to improve their situation, and any help they already receive. There were no nationally defined levels of dependence for eligibility or benefits.

Individuals may purchase Voluntary Additional Insurance (Aanvullende Verzekering) for care that is not covered by the public long-term care schemes. Health insurers determine the conditions and reimbursements of the supplementary insurance, including the premium. Details of Voluntary Additional Insurance are not included in this document. Individuals are provided the option to receive benefits either in-kind or through personal budgets. For details about in-kind benefits, please refer to the policy document Netherlands Long-Term Care In-Kind Benefit Plan Details, 1992-2024 (Gateway to Global Aging Data, 2024).

This policy period (chapter) provides details on cash benefits of the Dutch LTC system from 2007 to 2014.

Statutory basis

The General Special Medical Expenses Act (Algemene Wet Bijzondere Ziektekosten - AWBZ) (Overheid.nl Monitor, 2014a)

Social Support Act (Wet maatschappelijke ondersteuning - WMO) (Overheid.nl Monitor, 2014b)

Financing

Source of financing

Financing varies by LTC system.

AWBZ

AWBZ is funded by income-related premiums, taxes, and income-related copayments, which are collected in a fund called the General Fund for Special Medical Expenses (Algemeen Fonds Bijzondere Ziektekosten - AFBZ). The AWBZ premium is a fixed proportion of a maximum amount of their yearly taxable income. The annual AWBZ premium in 2013 was 12.65% of the first 33,363€ or a maximum of 4,220.40€ (Overheid.nl Monitor, 2013a, 2013b). For salaried employees or individuals receiving state benefits, the premium is automatically deducted from their salary or benefit. Self-employed individuals pay the premium themselves when filing taxes.

WMO

WMO is funded by municipal budgets, which are mainly financed by national and municipal taxes, and copayments subject to income-related 4-week period maximums. Copayments vary by municipality as they set their own rates but the Dutch Health Authority (Nederlandse Zorgautoriteit - NZa) sets a maximum amount every year (Mot, 2010).

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

The risk covered definition varies by LTC system.

AWBZ

AWBZ covers care needs related to physical, functional[6], and cognitive impairments, such as limitations in activities of daily living (ADLs) and instrumental activities of daily living (IADLs) (Overheid.nl Monitor, 2014a).

WMO

WMO covers care needs related to physical, functional[6], and cognitive impairments that disrupt independent functioning and participation in society (Overheid.nl Monitor, 2014b, §13(41)). This includes limitations in ADLs and IADLs.

Eligible population

The eligible population varies by LTC system.

AWBZ

An individual is eligible for care coverage under AWBZ if all of the following conditions are satisfied:

- Residence requirement: Is a resident of the Netherlands or is not a resident but is subject to wage tax in The Netherlands (Overheid.nl Monitor, 2014a, §5(1))
- Contribution requirement: Pays income-related premium (Overheid.nl Monitor, 2014a, §49)
  - 12.65% of the first 33,363€ or a maximum of 4,220.40€ in 2013 (Overheid.nl Monitor, 2013a, 2013b)

WMO

An individual is eligible for care coverage under WMO if all of the following conditions are satisfied:

- Residence requirement: Is a resident of the Netherlands or is not a resident but is subject to wage tax in The Netherlands (Overheid.nl Monitor, 2014b, §2(8))

Benefit

Cash Benefit

AWBZ

A yearly personal budget is paid to eligible beneficiaries as an alternative to in-kind care. The personal budget amount varies depending on the function and class the beneficiary is assigned to. Individuals are paid the net personal budget, which is the gross personal budget minus the income-related copayment. From 2007 to 2009, there were two guidance functions: supportive guidance and activating guidance. In 2010, there was only one guidance function and from 2011 to 2014, the guidance function was separated into individual and group guidance. Table 5 and Table 6 list gross personal budget amounts by function and class from 2007 to 2009, Table 7 in 2010, and Table 8 from 2011 to 2014. The payment is made monthly, quarterly (four times a year), semi-annually (twice a year), or annually (once a year) depending on the budget amount (Overheid.nl Monitor, 2007a, §2.6.10).

- Budgets that are 2,500€ or less are paid annually
- Budgets that are 5,000€ or less but more than 2,500€ are paid semi-annually
- Budgets that are 25,000€ or less but more than 5,000€ are paid quarterly
- Budgets that are more than 25,000€ are paid monthly

For example, a yearly personal budget of 10,000€ would be paid quarterly in payments of 2,500€.

WMO

A personal budget is paid to eligible beneficiaries as an alternative to non-residential in-kind care. Amounts vary by municipality as they determine their rates. Rates will sometimes vary depending on the type of provider (formal or informal) and municipalities also determine what conditions formal providers must meet. Some municipalities have different rates for household help category 1 (HH1) and household help category 2 (HH2). HH1 included buying groceries based on a list provided by the user, preparing light meals, heating up and serving hot meals, light housework such as dusting and washing the dishes, heavy housework such as vacuuming and cleaning the bathroom, and washing and folder clothing. HH2 included planning household activities and managing resources necessary to run a household such as compiling a grocery list and buying groceries based on household needs (Overheid.nl Monitor, 2007b). Therefore, the amount also varies widely by individual because the budget is calculated based on the hours of care needed and the municipality's rates. The following lists the rates for domestic assistance in some of the largest municipalities in 2013 (Overheid.nl Monitor, 2013j-20130):

- Utrecht
  - Informal provider: 15€ per hour
  - Formal provider: maximum rate of the cheapest contracted provider for in-kind household help
- Leeuwarden: 15.50€ per hour
- Groningen: 18.78€ per hour
- The Hague
  - Household category 1: 14.40€ per hour
  - Household category 2: 18.80€ per hour
- Assen
  - Household category 1 & 2 (informal provider): 16.13€ per hour
  - Household category 2 (formal provider): 18.69€ per hour
- Almere
  - Household category 1: 15.20€ per hour
  - Household category 2: 19.60€ per hour

Discretionary Use

Discretionary use varies by LTC system.

AWBZ

The personal budget must be used to purchase care listed in the applicant's eligibility decision (Overheid.nl Monitor, 2011c, §2.6.9). The beneficiary decides what provider to receive help or care from.

WMO

Discretionary use varies by municipality but most municipalities require the personal budget to be used to purchase care listed in the applicant's eligibility decision. The beneficiary decides what provider to receive help or care from (Per Saldo, n.d.).

Provision of care

Provision of care varies by LTC system.

AWBZ

The regional care office of the qualified beneficiary directly deposits the personal budget into their bank account. Beneficiaries must pay back any unspent funds from their personal budget (Overheid.nl Monitor, 2013i, §2.6,10).

WMO

We have not yet identified how the WMO personal budget is provided to beneficiaries during this period.

Benefit Eligibility

Qualifying period

None

Minimum level of dependence

The minimum level of dependence varies by LTC system.

AWBZ[5]

There are six bases or types of conditions, limitations, and disabilities that require the applicant to rely on care. The six bases include somatic, psychogeriatric, psychiatric, physical, mental/intellectual, and sensory. To be eligible for AWBZ care, an insured person must have at least one basis (Overheid.nl Monitor, 2014c, Appendix 2(2.3)).

WMO[7]

There is no minimum level of dependence as there are no dependence or care levels. Municipalities decide whether an individual is eligible to receive municipal home care benefits based on various factors including the applicant's conditions, limitations, and disabilities, the help they receive from those around them, the willingness and capability of these individuals to continue to provide help, and the applicant's income.

Duration of benefit

AWBZ

The benefit lasts as long as the beneficiary is eligible and their eligibility decision is valid (Overheid.nl Monitor, 2014c, §2.5).[4]

WMO

The benefit lasts as long as the beneficiary is eligible and their eligibility decision is valid.[4]

Means testing

Means testing exists through copayments. Copayments were income-related for AWBZ and subject to income-related 4-week period maximums for WMO. More details are provided in the user charges section.

Age requirement

None

Care Needs Assessment

Definition of dependence

The definition of dependence varies by LTC system.

AWBZ

Dependence is based on conditions, limitations, and disabilities that require the applicant to rely on care. Conditions, limitations, and disabilities must be linked to one of six bases: somatic, psychogeriatric, psychiatric, physical, mental/intellectual, and sensory (Overheid.nl Monitor, 2014c, Appendix 2(2.1)). Different bases provide access to different care services, which are referred to as functions.

- 1) Somatic
  - This basis is established if a physician determines that an individual has limitations as a result of disorders of the nervous system and the musculoskeletal system that are stable or can be improved by medical or paramedical treatment. Alternatively, it is also established if a physician determines that an individual has a permanent limitation that is not caused by disorders of the nervous system or the musculoskeletal system (e.g., kidney or heart failure).
- 2) Psychogeriatric

  - This basis is established when an individual has a brain disease, condition or disorder that impacts thinking ability, emotional regulation, and memory, and decreases motor function and social independence.
- 3) Psychiatric:
  - This basis is established when an individual is diagnosed with a mental disorder where one or more symptoms stem from factors originating within the psyche. Psychiatric conditions are often diagnosed according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV TR) and usually if an individual's limitations are caused by problems listed in Axis I of the DSM-IV TR, this basis is established.
- 4) Physical
  - This basis is established if a physician determines that an individual has limitations as a result of disorders of the nervous system and the musculoskeletal system but the situation is not terminal and no functional improvement is possible (deterioration may still occur).
- 5) Mental/intellectual
  - This basis is established according to DSM-IV TR. Specifically, an individual with an IQ score lower than 85 is considered to have a mental/intellectual basis.
- 6) Sensory
  - This basis is established when an individual has a visual or auditory-communicative disability or a serious speech/language problem. A sensory basis due to speech/language problems is only established if the issue arises from a neurobiological or neuropsychological factor. No basis is established if the issue is due to an environmental factor (e.g., educational problems or speaking another language) (Overheid.nl Monitor, 2014c, Appendix 2(3)).
    * Visual impairment is defined as having at least one of the following: a visual acuity of < 0.3 in the better eye, a field of view < 30 degrees, or visual acuity between 0.3 and 0.5 in the better eye with associated serious limitations in daily functioning.
    * Auditory-communicative impairment is defined as having a threshold loss on the audiogram of at least 35 dB.

WMO

Dependence is based on physical, functional[6], and cognitive conditions, limitations, and disabilities that disrupt independent functioning and one's ability to run a household (Overheid.nl Monitor, 2014b).

Evaluation of dependence

The evaluation of dependence varies by LTC system.

AWBZ[5]

CIZ evaluates dependence based on a comprehensive framework that initially examines the applicant's care situation. They investigate the applicant's care situation based on the following (Overheid.nl Monitor, 2014c):

- Diseases, conditions, and disorders
- Limitations and participation problems
- Home and living environment
- Benefits currently receiving (e.g., housing, welfare, healthcare, work, education)

The applicant's conditions, limitations, and disabilities must be linked to one of six bases for them to receive care. The six bases include: somatic, psychogeriatric, psychiatric, physical, mental/intellectual, and sensory (Overheid.nl Monitor, 2014c, Appendix 2(2.1)). Any diseases, conditions, disorders, limitations, and participation problems are recorded and scored using a four-point scale. The scale used for diseases, conditions, and disorders is different than the one used for limitations and participation problems. Both scales range from 0 to 3 but the descriptions associated with the scores are different. A score of 1, 2, or 3 on both scales indicates a need for care. Table 9 lists the scores and the descriptions associated with each score for both scales. Evaluators use the International Classification of Diseases - ICD, International Classification of Functioning, Disability and Health - ICF, and Diagnostic and Statistical Manual of Mental Disorders - DSM-IV TR to help determine a basis. Different bases provide access to different care services, which are referred to as functions. There are seven functions: personal care, nursing, guidance (separate functions of supportive and activating guidance before 2009), treatment, residence, short-term stay (added in 2011), and continued residence on a psychiatric basis. Individuals can have multiple bases but CIZ determines a dominant basis based on the applicant's most important care needs. Table 10 describes what bases provide access to what functions.

CIZ assesses the applicant's needs, exploring care options like treatment, environmental adaptations, and informal care. They calculate the gross need for AWBZ care, considering available usual care. Additionally, CIZ calculates the net need for AWBZ care by accounting for voluntary care that exceeds usual care. Lastly, CIZ notes what kind of care is necessary, how often it is needed, and the delivery conditions and decides on care with or without accommodation. Box 2 describes other options to address care needs and provides more details about the determination of additional care needed.

Individuals assigned to receive care without accommodation are assigned to a class. Classes range from 0 to 9 and are indicated in terms of how much care an individual needs in hours of care per week or half days (consecutive period of up to four hours) per week. The estimated time of care needed is calculated based on a table that lists the average time it takes to conduct an activity. The tables are different by function and they are only used in functions that are associated with classes (care without accommodation). The tables include a list of recommended activities and are not meant to be exhaustive. Table 11 and Table 12 list the recommended personal care activities, the estimated time per activity, and the frequency in 2014. For every function that CIZ decides the applicant needs, the total care time needed is calculated by summing the average activity times. Individuals are then placed into a class based on this total care time. Table 13 lists classes by function and their associated hours of care per week. Box 3 provides an example of how care hours are calculated and how individuals are placed into classes.

WMO[7]

Municipalities conduct the evaluation of dependence using their own assessment frameworks, which are determined by municipal executive boards. In 2012, there were 415 municipalities divided into 12 provinces (Government of the Netherlands, n.d.). Assessment frameworks are similar across many municipalities even though municipalities set up their own policy rules. The largest municipalities in eight provinces had similar assessment frameworks: Leeuwarden, Emmen, Almere, Nijmegen, Utrecht, Terneuzen, Eindhoven, and Maastricht (Overheid.nl Monitor, 2012a-2012c, 2013c-2013f, 2014d). In these municipalities, assessments began with a conversation where the following matters are discussed:

- The types of conditions, limitations, or disabilities that may require the applicant to receive municipal compensation
- Activities the applicant can do despite these difficulties
- Obstacles the applicant experiences due to these difficulties
- What the applicant has done to resolve these obstacles
- Outcomes the applicant wants to achieve from those stated in the guidelines (e.g., a clean and livable house)
- Options the municipality can offer the applicant to achieve those outcomes

This is not an exhaustive list and some municipalities added or removed certain discussion points. A conversation report is then written based on these points and the assessment begins. The assessments focus on three outcomes that relate to home care: a clean and livable house, availability of goods for basic needs, and having clean, wearable and effective clothing. For each outcome, the municipality evaluates whether the applicant can achieve that outcome on their own or with the help of people (or aids) around them by investigating any usual care. Applicants are not entitled to receive home care benefits from their municipality if there is usual care. Lastly, the municipality will make a decision on benefit entitlement for each outcome.

The largest municipalities in the other four provinces were slightly different in their assessments although usual care is still investigated in all of them. In these municipalities, which included Groningen, Enschede, Amsterdam, and The Hague (the second largest municipality in the South Holland province), specific home care related outcomes were not assessed (Overheid.nl Monitor, 2011b, 2012d, 2013g, 2013h). Instead, any demonstrable limitations in self-reliance and social participation that created difficulties in household activities were investigated. These conditions could be due to physical conditions, psychological issues, or psychosocial issues. The municipality would then assess which services the applicant is entitled to receive based on their limitations.

Evaluators

Evaluators vary by LTC system.

AWBZ

The evaluation of dependence is conducted by an evaluation team, which includes CIZ assessors, medical specialists, general practitioners, nurse specialists, health psychologists, and orthopedagogues. Team membership varies based on the basis being evaluated (CIZ, 2014).

WMO

Evaluators vary by municipality. For example in Amsterdam, a private social-medical consulting company called Argonaut Advice (formerly known as Advice Bureau Amsterdam or IAB Amsterdam) conducts the evaluation of dependence for WMO (Amsterdam Local Authority, n.d.). In Nijmegen, an organization that works on behalf of the municipality of Nijmegen called the Social Neighborhood Team (Sociaal Wijkteam) conducts the evaluation (Overheid.nl Monitor, 2014d).

Benefit limitations

Can you mix LTC benefits?

Individuals can receive both the AWBZ and WMO personal budgets.

AWBZ

Individuals can mix cash benefits and in-kind benefits if they are eligible for more than one function or type of care. For example, if an individual is eligible for domestic assistance and personal care, they can choose to receive domestic assistance in-kind and personal care through a personal budget.

WMO

Individuals cannot mix cash benefits and in-kind benefits.

Is there free choice between cash and benefits in-kind?

AWBZ

Individuals can choose to receive care in-kind (Zorg in Natura- ZIN) or through cash benefits (Persoonsgebonden Budget - PGB) for all functions except treatment[11] and certain care packages for residential care (ZZP LVG 4, ZZP LVG 5, ZZP SGLVG, the ZZPs GGZ-B and ZZP VV 9B). For all other care packages in residential care, individuals can choose a PGB. The amount is calculated based on the value of a package of home care services minus a 25% discount (Overheid.nl Monitor, 2014c, §2.7(Ad.1) and Tenand et al., 2020).

WMO

Individuals can choose to receive care in-kind (ZIN) or through cash benefits (PGB) (Overheid.nl Monitor, 2014b, §2(5)).

Can you receive LTC benefits with other social security benefits?

There are no limits on receiving cash benefits with other social security benefits.

User costs

User charges

User charges vary by LTC system. User charges are means-tested and how the means-test is implemented also varies by system. AWBZ has a copayment rate that depends on an individual's income whereas WMO has a copayment that is subject to an income-related 4-week period maximum.

AWBZ

Individuals paid income-related copayments. Individuals were paid a net personal budget, which was the gross personal budget minus their copayment. In 2010, there was only one guidance function and from 2011 to 2014, the guidance function was separated into individual and group guidance. Table 5 and Table 6 list gross personal budget amounts by function and class from 2007 to 2009, Table 7 in 2010, and Table 8 from 2011 to 2014. The annual copayment varied depending on the function and class the individual was assigned to receive:

- 33% of the gross personal budget for personal care
- 20% of the gross personal budget for nursing care
- 27% of the gross personal budget for guidance

The copayment of individuals whose income exceeded a certain amount was calculated based on a formula (Overheid.nl Monitor, 2014e). Box 4 and Box 5 list the income thresholds used to calculate the copayment of individuals whose income exceeded the income limit from 2007 to 2014. Formula 1 provides detailed information on how to calculate this copayment. Copayments for short-term stay have not been identified yet.

WMO

Individuals paid copayments subject to income-related 4-week period maximums. For home care services under WMO, there was a maximum amount individuals paid every 4 weeks called the maximum period contribution. A user's copayment was the number of hours of help they received times the hourly rate determined by their municipality. If a user's copayment during a 4-week period was higher than the maximum period contribution, they paid the maximum period contribution amount instead. Municipalities could use the maximum period contributions set in national guidelines or set their own maximum period contributions. Table 14 lists the maximum period contributions set in national guidelines from 2007 to 2014.

The maximum period contribution of individuals whose aggregate income exceeded a certain amount was calculated based on a formula (Overheid.nl Monitor, 2013p). Formula 2 provides detailed information on how to calculate this contribution. Box 6 and Box

7 list the income thresholds used to calculate the copayment for care services without accommodation of individuals whose income exceeded the income limit from 2007 to 2014. The same formula was used across all municipalities although they could change the income limits. The largest or second largest municipality in each of the 12 provinces used these income limits in 2013 except for the municipality of Enschede whose 2013 guidelines have not been identified yet. This included the municipalities of Groningen, Leeuwarden, Assen, Almere, Nijmegen, Utrecht, Amsterdam, The Hague, Terneuzen, Eindhoven, and Maastricht (Overheid.nl Monitor, 2012a, 2012f-2012h, 2013d, 2013j-2013o, 2013q, 2013r, 2014f, 2014g). Table 15 lists the municipality by province and if they used the nationally set maximum period contributions in 2012 or 2013.

Taxation of benefits

Not subject to taxation

Chapter 3: Policy enacted 2015-2024

Policy change in 2015
In 2015, AWBZ was repealed, which resulted in significant shifts in the provision of personal budgets. Personal care and home nursing personal budgets were transferred to the Health Insurance Act (Zorgverzekeringswet - ZVW). Personal budgets related to household home care services such as domestic assistance were still provided by WMO and personal budgets related to residential care or 24-hour care at home were now provided by the Long Term Care Act (Wet langdurige zorg - WLZ).

Other reforms during this period include:

- The Social Support Act 2015 (Wet maatschappelijke ondersteuning 2015 - WMO 2015), effective January 2015, replaced the Social Support Act (WMO) (Overheid.nl Monitor, 2014i)
  - Services provided by WMO were separated into general and individualized care services
  - General services are accessible without a care needs assessment into the beneficiary's needs, personal characteristics, and capabilities whereas individualized services require a care needs assessment
- Amendment to Social Support Act 2015, effective January 2019, replaced the copayment subject to income-related 4-week period maximums with a fixed copayment rate called the subscription rate (abonnementstarief) (Overheid.nl Monitor, 2019f)
  - The subscription rate is a maximum monthly copayment that is the same for everyone regardless of their income or assets, marital status, or care use

Overview

In the Netherlands, long-term care (LTC) services for older adults are provided by the Social Support Act (WMO), the Health Insurance Act (ZVW), and the Long Term Care Act (WLZ). Benefit eligibility is based on care needs.

ZVW
ZVW provides personal care and home nursing services to older adults with care needs. It is organized by health insurers. Individuals are eligible for personal budgets through ZVW as long as they are a resident of the Netherlands, they pay the income-related contribution, and they pay their nominal premium (health insurance premium) (Overheid.nl Monitor, 2023a). Beneficiaries pay a nominal premium for basic insurance, which is compulsory, and covers both home nursing and personal care. Health insurers determine their own nominal premiums and the average annual nominal premium for basic health insurance in 2023 is 1,657€ (138.10€ per month) (Government of the Netherlands, n.d.). For the evaluation of dependence, a community nurse from the organization where the applicant applied to receive help from evaluates their dependence based on their conditions, limitations, and disabilities and using clinical frameworks such as ICF, Gordon's health patterns, the North American Nursing Diagnoses Association (NANDA), the Nursing Intervention Classification (NIC), and the Nursing Outcomes Classification (NOC). There are no defined levels of dependence for eligibility or benefits.

WMO
WMO provides a wide range of LTC services including home care and semi-residential care. It is organized by municipalities. There are 390 municipalities in 2023 (Government of the Netherlands, n.d.). Individuals are eligible for personal budgets through WMO as long as they are a resident of the Netherlands (Overheid.nl Monitor, 2023a). In 2015, services provided by WMO were separated into general and individualized care services. General services are accessible without a care needs assessment into the beneficiary's needs, personal characteristics, and capabilities whereas individualized services require a care needs assessment. Beneficiaries pay a copayment for home care services under WMO, which is capped at a maximum amount per 4-week period called the maximum period contribution. Municipalities could use the maximum period contributions set in national guidelines or set their own maximum period contributions. The largest or second largest municipality in each of the 12 provinces in the Netherlands all used the nationally set contributions in 2017, which was 17.50€ per four-weeks (Overheid.nl Monitor, 2017f). An income test is conducted to calculate the maximum period contribution for individuals whose aggregate income exceeded a certain amount. In 2019, the copayment subject to an income-related 4-week period maximum was replaced with a fixed copayment rate called the subscription rate (abonnementstarief). Everyone had the same subscription rate or maximum monthly copayment regardless of income or assets, marital status, or use. From 2020 to 2023, the subscription rate was 19€ per month. The evaluation of dependence is subjective and considers several factors including the applicant's conditions and limitations, their home and living environment, their social circumstances, what they have done to improve their situation, and any help they already receive. There are no nationally defined levels of dependence for eligibility or benefits.

WLZ
WLZ provides residential care to all persons with intensive care needs. It is organized at the national level by the Ministry of Health, Welfare, and Sport and at the regional level by regional care offices and health insurers. Individuals are eligible to receive cash

benefits through WLZ as long as they are a resident of the Netherlands and they pay the income-related premium. Individuals pay an income-related copayment for personal budgets. In 2023, the copayment is 10% of contributable income divided by 12 with a minimum of 26€ and a maximum of 808.60€ per month (Overheid.nl Monitor, 2015e). The evaluation of dependence is subjective and considers several factors including the applicant's healthcare situation, their need for permanent supervision or 24-hour care, and other care options besides WLZ care. There are no defined levels of dependence for eligibility or benefits[1] and dependence is based on five types of bases or conditions, limitations, and disabilities that require the applicant to rely on care. The five types include somatic, psychogeriatric, physical, mental/intellectual, and sensory/psychosocial.

Individuals may purchase Voluntary Additional Insurance (Aanvullende Verzekering) for care that is not covered by the public long-term care schemes. Health insurers determine the conditions and reimbursements of the supplementary insurance, including the premium. Details of Voluntary Additional Insurance are not included in this document. Individuals are provided the option to receive benefits either in-kind or through personal budgets. For details about in-kind benefits, please refer to the policy document Netherlands Long-Term Care In-Kind Benefit Plan Details, 1992-2024 (Gateway to Global Aging Data, 2024).

This policy period (chapter) provides details on cash benefits of the Dutch LTC system from 2015 to 2024.

Statutory basis

Health Insurance Act (Zorgverzekeringswet - ZVW) (Overheid.nl Monitor, 2023b)

Social Support Act 2015 (Wet maatschappelijke ondersteuning 2015 - WMO 2015) (Overheid.nl Monitor, 2023a)

Long Term Care Act (Wet langdurige zorg - WLZ) (Overheid.nl Monitor, 2015a)

Financing

Source of financing

Financing varies by LTC system.

ZVW

ZVW is funded by taxes, income-related contributions, and nominal premiums (health insurance premiums), which are collected in a fund called the Health Insurance Fund (Zorgverzekeringsfonds - ZVF). The income-related contribution is calculated over a maximum amount of income, which is 66,956€ in 2023. The income-related contribution of individuals who are employed is 6.68% of income up to the maximum amount (4,472.60€) and is paid by their employer. For pensioners and beneficiaries of other benefits (e.g., ANW or Dutch National Survivor Benefit) the income-related contribution is 5.43% of income up to the maximum amount (3,635.70€) and is paid by the benefits agency. Self-employed individuals also have an income-related contribution of 5.43% and pay it themselves when filing taxes (Tax and Customs Administration of the Netherlands, 2023). Basic health insurance is compulsory for individuals over the age of 18. Individuals pay the nominal premium for basic health insurance to their health insurer who determines the rate. The average annual nominal premium for basic health insurance in 2023 is 1,657€ (138.10€ per month) (Government of the Netherlands, n.d.).

WMO

WMO is funded by municipal budgets, which are mainly financed by national and municipal taxes, and copayments subject to income-related 4-week period maximums. Copayments vary by municipality as they set their own rates but the Dutch Health Authority (Nederlandse Zorgautoriteit - NZa) sets a maximum amount every year (Mot, 2010). In 2019, copayments subject to income-related 4-week period maximums were replaced by a fixed copayment rate called the subscription rate (abonnementstarief) (Overheid.nl Monitor, 2019f). The subscription rate is a maximum monthly copayment that is the same for everyone regardless of their income or assets, marital status, or care use. From 2019 to 2023, the subscription rate was 19€ per month.

WLZ

WLZ is funded by income-related premiums, taxes, and income-related copayments (Healthcare Institute of the Netherlands, n.d.). The WLZ premium is a fixed proportion of a maximum amount of their yearly taxable income. The annual WLZ premium in 2023 is 9.65% of the first 37,149€ or a maximum of 3,584.90€. The WLZ premium rate from 2021 to 2023 has been 9.65% although the maximum amounts have increased. In 2021, the maximum amount of yearly taxable income considered in the calculation was 35,129€, and in 2022 it was 35,472€ (Tax and Customs Administration of the Netherlands, n.d.).

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

The risk covered definition varies by LTC system.

ZVW

ZVW covers care needs mostly related to physical and functional impairments that may require nursing and/or personal care, such as limitations in activities of daily living (ADLs) and instrumental activities of daily living (IADLs) (Overheid.nl Monitor, 2023b, §3(10-11)).

WMO

WMO covers care needs related to functional[6] and cognitive impairments that disrupt independent functioning and participation in society (Overheid.nl Monitor, 2023a, §2(2.1.2)). This includes limitations in ADLs and IADLs.

WLZ

WLZ covers care needs related to physical, functional, and cognitive impairments, such as limitations in ADLs and IADLs that require permanent supervision or 24-hour care (Healthcare Institute of the Netherlands, n.d.).

Eligible population

The eligible population varies by LTC system.

ZVW

An individual is eligible for care coverage under ZVW if all of the following conditions are satisfied:

- Residence requirement: Is a resident of the Netherlands or is not a resident but is subject to wage tax in The Netherlands (Overheid.nl Monitor, 2023b, §4)
- Contribution requirement:
  - Pays the nominal premium (health insurance premium) (Overheid.nl Monitor, 2023b, §16)
    - Health insurers determine their rates and the average annual nominal premium for basic health insurance in 2023 is 1,657€ (138.10€ per month) (Government of the Netherlands, n.d.)
  - Income-related contribution requirement: Pays the income-related contribution (Overheid.nl Monitor, 2023b, §39)
    - 6.68% of income up to the maximum amount (4,472.60€) for employed individuals
    - 5.43% of income up to the maximum amount (3,635.70€) for pensioners, beneficiaries of other benefits (e.g., ANW or Dutch National Survivor Benefit), and self-employed individuals (Tax and Customs Administration of the Netherlands, 2023)

WMO

An individual is eligible for care coverage under WMO if all of the following conditions are satisfied:

- Residence requirement: Is a resident of the Netherlands or is not a resident but is subject to wage tax in The Netherlands (Overheid.nl Monitor, 2023a, §2(1.2.1))

WLZ

An individual is eligible for care coverage under WLZ if all of the following conditions are satisfied:

- Residence requirement: Is a resident of the Netherlands or is not a resident but is subject to wage tax in The Netherlands (Overheid.nl Monitor, 2015a, §1(2.1.1))
- Contribution requirement: Pays income-related premium (Overheid.nl Monitor, 2015a, §3(3.2.5))
  - 9.65% of the first 37,149€ or a maximum of 3,584.90€ in 2023

Benefit

Cash Benefit

ZVW[2]

A personal budget is paid to eligible beneficiaries as an alternative to nursing and personal care provided in-kind. The personal budget is calculated based on the hours of care needed, the health insurer's rates, and the type of care provider the individual decides to receive care from. Health insurers determine their rates and there are separate rates for formal and informal care providers. Health insurers set their own rates for formal care whereas for informal care there are nationally set maximum rates. The maximum rate for informal care in 2022 was 24.96€ per hour and in 2023 it was 26.52€ per hour (Ministry of Health, Wealth, and Sport, n.d.). Box 8 lists hourly rates for formal and informal care of some of the largest health insurers in 2023. Box 9 lists individuals who are considered to be informal care providers.

WMO[3]

A personal budget is paid to eligible beneficiaries as an alternative to non-residential in-kind care. The personal budget is calculated based on the hours of care needed and the municipality's rates. Amounts vary by municipality as they determine their rates. Rates will sometimes vary depending on the type of provider (formal or informal). Some municipalities have different rates for household help category 1 (HH1) and household help category 2 (HH2). Box 10 explains the difference between HH1 and HH2. The following lists the rates for domestic assistance in some of the largest municipalities in 2017-2018 (Overheid.nl Monitor, 2017b, 2017d, 2017e, 2018d):

- Utrecht
  - Informal provider: 15€ per hour
  - Institution-employed formal provider: 21€ per hour
  - Self-employed formal provider: 17.50€ per hour
- Leeuwarden
  - Informal provider: 13€ per hour
  - Formal provider: 17.80€ per hour
- Groningen
  - Informal provider: 16€ per hour
  - Formal provider: 19.42€ per hour
- The Hague
  - Household category 1: 14.66€ per hour
  - Household category 2: 19.14€ per hour

WLZ[10]

A personal budget is paid to eligible beneficiaries as an alternative to intensive long-term care provided in-kind, which includes residential care and 24-hour care at home. There are separate rates for formal and informal care providers. Box 9 lists individuals who are considered to be informal care providers. Maximum hourly rates for both informal and formal care are set nationally by the Dutch Government (Overheid.nl Monitor, 2023f). Table 16 lists the maximum rates per hour for informal and formal care set by the government from 2015 to 2020:

- 2023
  - Informal: 22.98€ per hour
  - Formal: 72.39 € per hour or 66.64€ per half day (consecutive period of up to four hours)
- 2022
  - Informal: 21.68€ per hour
  - Formal: 68.30€ per hour or 62.88€ per half day
- 2021
  - Informal: 21.14€ per hour
  - Formal: 66.60€ per hour or 61.32€ per half day

Similarly, yearly maximum rates are set by function (type of care) and care profile. In 2023, there were 40 care profiles: 6 related to nursing and care, 6 related to mental disability, 6 related to mild mental disability, 5 related to physical disability, 7 related to sensory disability, and 10 related to mental health (Overheid.nl Monitor, 2023e, 2023f). Table 17 and Table 18 list the maximum yearly rates by function and care profile from 2016 to 2023 for the nursing and care profiles (4 VV to 8 VV). In 2015 and 2016, domestic assistance for those with a WLZ personal budget included cleaning the house, cooking, and grocery shopping. From 2017, domestic assistance only includes cleaning the house (Naar-Keuze, 2016).

Discretionary Use

Discretionary use varies by LTC system.

ZVW

The personal budget must be used to purchase nursing or personal care (Per Saldo, 2021).

WMO

Discretionary use varies by municipality but most municipalities require the personal budget to be used to purchase care listed in the applicant's eligibility decision. The beneficiary decides what provider to receive help or care from (Per Saldo, 2021).

WLZ

The personal budget must be used to purchase care (Government of the Netherlands, 2016).

Provision of care

Provision of care varies by LTC system.

ZVW

Individuals submit their service invoice to their health insurer. The insurer reviews the invoice and reimburses the corresponding amount into the beneficiary's bank account. The beneficiary is then responsible for directly settling the payment with their healthcare provider (Sociale Verzekeringsbank, 2023).

WMO

The personal budget is deposited into an account with the Social Insurance Bank (SVB) and not the individual's personal bank account. After the individual receives the help, SVB will pay the provider (Overheid.nl Monitor, 2023a). SVB is an organization that implements national social insurance schemes, such as Algemene Ouderdomswet (AOW) state pension, child benefit (AKW), and the personal budget (PGB).

WLZ

Individuals decide what provider they want to receive care from but the personal budget is not deposited into their bank account. Rather, the PGB Service Center of the Social Insurance Bank administers payments on behalf of the individual, contingent upon the received care and the chosen care provider (Overheid.nl Monitor, 2015a).

Benefit Eligibility

Qualifying period

None

Minimum level of dependence

The minimum level of dependence varies by LTC system.

ZVW

There is no minimum level of dependence as there are no dependence or care levels. A community nurse from the organization where the applicant applies to receive help will evaluate their dependence based on their conditions, limitations, and disabilities and using clinical frameworks such as ICF, Gordon's health patterns, the North American Nursing Diagnoses Association (NANDA), the Nursing Intervention Classification (NIC), and the Nursing Outcomes Classification (NOC). Additionally, individuals must meet certain conditions to choose cash benefits or in-kind benefits under ZVW.[8]

WMO

There is no minimum level of dependence as there are no dependence or care levels. Municipalities decide whether an individual is eligible to receive municipal home care benefits based on various factors including the applicant's conditions, limitations, and disabilities, the help they receive from those around them, the willingness and capability of these individuals to continue to provide help, and the applicant's income. Additionally, individuals must meet certain conditions to choose cash benefits or in-kind benefits under WMO.[9]

WLZ

There are five bases or types of conditions, limitations, and disabilities that require the applicant to rely on care. The five bases include somatic, psychogeriatric, physical, intellectual, and sensory. To be eligible for WLZ care, an insured person must have at

least one basis (Overheid.nl Monitor, 2015b, Appendix 1(1.2)). Additionally, individuals must meet certain conditions to choose cash benefits or in-kind benefits under WLZ.[10]

Duration of benefit

ZVW

The benefit lasts as long as the beneficiary is eligible.

WMO

The benefit lasts as long as the beneficiary is eligible and their eligibility decision is valid.[4]

WLZ

The benefit lasts as long as the beneficiary is eligible and their eligibility decision is valid.[4]

Means testing

ZVW

None

WMO and WLZ

Means testing exists through copayments. Copayments were income-related for WLZ and subject to income-related 4-week period maximums for WMO before 2019. More details are provided in the user charges section.

Age requirement

None

Care Needs Assessment

Definition of dependence

The definition of dependence varies by LTC system.

ZVW

Dependence is based on physical and functional conditions[6], limitations, and disabilities that require assistance from a nurse (Healthcare Institute of the Netherlands, n.d.).

WMO

Dependence is based on physical, functional[6], and cognitive conditions, limitations, and disabilities that disrupt independent functioning and one's ability to run a household (Overheid.nl Monitor, 2023a).

WLZ

Dependence is based on conditions, limitations, and disabilities that require the applicant to rely on care. Conditions, limitations, and disabilities must be linked to one of five bases: somatic, psychogeriatric, physical, mental/intellectual, and sensory (Overheid.nl Monitor, 2015b, Appendix 1(1.2)).

- Somatic
  - This basis is established if a physician determines that an individual has limitations as a result of disorders of the nervous system and the musculoskeletal system that are stable or can be improved by medical or paramedical treatment. Alternatively, it is also established if a physician determines that an individual has a permanent limitation that is not caused by disorders of the nervous system or the musculoskeletal system (e.g., kidney or heart failure).
- Psychogeriatric
  - This basis is established when an individual has a brain disease, condition or disorder that impacts thinking ability, emotional regulation, and memory, and decreases motor function and social independence. The most common condition under this basis is dementia.
- Physical
  - This basis is established if an individual's physician determines that they have limitations as a result of disorders of the nervous system and the musculoskeletal system but the situation is not terminal and no functional improvement is possible (deterioration may still occur).
- Mental/Intellectual
  - This basis is established according to DSM-IV TR. Specifically, an individual with an IQ score lower than 85 is considered to have a mental/intellectual basis.

- Sensory
  - This basis is established when an individual has a visual or auditory-communicative disability or a serious speech/language problem. A sensory basis due to speech/language problems is only established if the issue arises from a neurobiological or neuropsychological factor. No basis is established if the issue is due to an environmental factor (e.g., educational problems or speaking another language).
    - Visual impairment is defined as having at least one of the following: a visual acuity of < 0.3 in the better eye, a field of view < 30 degrees, or visual acuity between 0.3 and 0.5 in the better eye with associated serious limitations in daily functioning.
    - Auditory-communicative impairment is defined as having a threshold loss on the audiogram of at least 35 dB.

Evaluation of dependence

The evaluation of dependence varies by LTC system.

ZVW

The evaluation of dependence is based on a framework written by The Nurses and Caregivers Association in the Netherlands (Verpleegkundigen & Verzorgenden Nederland - V&VN) (Healthcare Institute of the Netherlands, n.d.). Community nurses use the framework to determine what care and how much care the individual will require. The framework lists questions that the evaluator can initially ask the applicant to better understand their situation such as (Verpleegkundigen & Verzorgenden Nederland, 2014, 2019):

- What are your personal goals?
- What issues do you face to achieve these goals?
- Why do you face these issues and what can you do yourself?
- Do you have any informal caregivers, family, or other social support?
- How can a community nurse help you achieve those goals?

Moreover, the evaluator asks clarifying questions, conducts follow-up research on specific limitations (e.g., observing the applicant's ability to conduct certain activities), and makes diagnoses that include the problem, etiology, signs, and symptoms. When reporting conditions or limitations, the evaluators use frameworks such as ICF, Gordon's health patterns, NANDA, NIC, and NOC. These are frameworks used to describe and organize information on functioning and disability in clinical settings. Lastly, when creating a care plan for the applicant, the evaluator will describe the nature of the problem, the extent, duration, goals of care, desired result, and how a community nurse can help the applicant with their problems and goals. The complete framework outlines six key standards for assessing dependence, which are detailed in Box 11.

Following the evaluation of dependence, applicants will receive a decision on whether they are eligible for community nursing. If the applicant wishes to receive cash benefits, this eligibility decision must have been made by a qualified community nurse within the past 3 months. Additionally, applicants are required to explain why they are opting for a personal budget over care provided in-kind and demonstrate their ability to effectively manage it. This entails negotiating contracts with healthcare providers, scheduling, and ensuring providers adhere to agreed-upon terms. Applicants may seek assistance from a legal representative or family member in this process (Ministry of Health, Welfare, and Sport, n.d.).

WMO

Municipalities conduct the evaluation of dependence using their own assessment frameworks, which are determined by municipal executive boards. In 2023, there were 390 municipalities divided into 12 provinces (Government of the Netherlands, n.d.). Assessment frameworks are similar across many municipalities even though municipalities set up their own policy rules. The largest or second largest municipality in each of the 12 provinces had similar assessment frameworks during this period: Maastricht, Terneuzen, Almere, Enschede, Groningen, Nijmegen, Eindhoven, Utrecht, Amsterdam, The Hague, Leeuwarden, and Emmen. In these municipalities, relevant and accessible information about the applicant and their situation was collected as a starting point of the assessment. This included having a conversation with the applicant where the following matters were discussed:

- The types of conditions, limitations, or disabilities that may require the applicant to receive municipal compensation
- The type or types of municipal support the applicant wants to receive
- How likely it is for the applicant to maintain or improve their self-reliance and social participation on their own, with usual help, or with general services
- How likely it is for the applicant to maintain or improve their self-reliance and social participation through informal care or help from individuals in their social network
- What individualized services could help address the applicant's care needs
- What contributions the applicant would have to pay

This is not an exhaustive list and some municipalities added or removed certain discussion points. A conversation report was then

written based on these points. If the applicant's care needs could be addressed through general services, the municipality would not investigate any further. However, the assessment continued if the applicant needs individualized services. Municipalities conduct this part of the assessment in different ways. General services are accessible without a care needs assessment into the beneficiary's needs, personal characteristics, and capabilities whereas individualized services require a care needs assessment. Box 12 outlines how the evaluation of dependence varies by municipality. After an individual receives a decision from their municipality regarding their eligibility for individualized care, they must also demonstrate their capability to manage the allocated personal budget. This includes their ability to procure necessary support services independently or through authorized representatives. They must exhibit proficiency in selecting effective and safe support services aimed at enhancing their independence. Additionally, individuals are required to provide a justification for opting for a personal budget over in-kind care (Ministry of Health, Welfare, and Sport, n.d.).

WLZ

CIZ evaluates dependence based on a comprehensive framework that initially examines the applicant's care situation. They investigate the applicant's care situation based on the following (Overheid.nl Monitor, 2015b):

- Understanding the applicant's healthcare situation
- Determining their need for permanent supervision or 24-hour care
- Determining whether the need for care is permanent
- Considering other options besides WLZ care

Diseases, conditions, disorders, and limitations are recorded and scored using a four-point scale. The scale used for diseases, conditions, and disorders is different than the one used for limitations and participation problems. Both scales range from 0 to 3 but the descriptions associated with the scores are different. A score of 1, 2, or 3 in both scales indicates a need for care. Table 9 lists the scores and the descriptions associated with each score for both scales. CIZ will record what disorders and limitations the applicant has and will determine what bases the applicant has using the information collected. Experts use the ICD, ICF, DSM-IV, and DSM-V to help determine a basis. CIZ then decides whether the diseases, conditions, disorders, and limitations require either permanent supervision or 24-hour care nearby. The differences between these are described in Box 13.

After deciding whether the individual needs permanent supervision or 24-hour care nearby, CIZ determines whether the care will be permanent. Individuals are not eligible to receive WLZ care if functional improvement or recovery is possible. Lastly, CIZ will consider other options besides WLZ care. There are three situations where individuals are not able to receive WLZ care because there is another option. Two situations only apply to children and the third situation relates to palliative terminal care. The palliative terminal care situation states that individuals who do not have a WLZ eligibility decision should receive palliative terminal care under the Health Insurance Act (ZVW). However, those who do have a WLZ eligibility decision already do not need a new decision to receive palliative terminal care under WLZ. CIZ will then send the applicant an eligibility decision that states whether they are entitled to WLZ care, the results of their investigation, the diseases, conditions, disorders, and limitations that require them to receive care, their care profile, and the period of validity of their eligibility decision. Box 14 further explains care profiles.

Lastly, individuals are required to explain to their care office why a personal budget better fits their specific needs compared to in-kind care options. They must outline their intended care purchases and selected care provider(s) within a budget plan. Subsequently, they must establish healthcare agreements with each chosen provider, including hourly rates and, if needed, a care description outlining the specifics of the care to be provided. Individuals have the option to appoint a representative to manage their personal budget on their behalf (Ministry of Health, Welfare, and Sport, n.d.).

Evaluators

Evaluators vary by LTC system.

ZVW

Community nurses conduct the evaluation of dependence (Verpleegkundigen & Verzorgenden Nederland, 2014, 2019). Community nurses complete four years of higher professional education in nursing (BKV, n.d.).

WMO

Evaluators vary by municipality. For example in Amsterdam, a private social-medical consulting company called Argonaut Advice (formerly known as Advice Bureau Amsterdam or IAB Amsterdam) conducts the evaluation of dependence for WMO (Amsterdam Local Authority, n.d.). In Nijmegen, an organization that works on behalf of the municipality of Nijmegen called the Social Neighborhood Team (Sociaal Wijkteam) conducts the evaluation (Overheid.nl Monitor, 2014e).

WLZ

Evaluators include a CIZ assessors, physicians, and experts in the field (if needed) (Overheid.nl Monitor, 2015b).

Benefit limitations

Can you mix LTC benefits?

Generally, individuals cannot combine cash benefits and in-kind benefits, with the exception of those who are eligible for a partial benefits package (modulair pakket thuis - MPT) and a care profile that allows personal budgets under WLZ.

ZVW and WMO

Individuals can receive both the ZVW and WMO personal budgets (Ministry of Health, Welfare and Sport, n.d.). Individuals cannot combine a WLZ personal budget with either a WMO or ZVW personal budget (Overheid.nl Monitor, 2020c, §5.7a). Individuals are not eligible for personal care and nursing care covered by ZVW if they are also eligible for WLZ care. Additionally, individuals who are eligible for WLZ receive most of their care from WLZ, regardless of whether they are eligible for other programs. For instance, if someone requires both personal care and nursing assistance and is eligible for both WLZ and WMO, they typically receive these services through WLZ. However, the municipality may still offer additional services, such as transportation (e.g., regional taxi services), assistive devices like wheelchairs, and home modifications. The benefits provided under WMO while receiving WLZ care can vary depending on factors such as the individual's place of residence—whether in a care institution, at home, or both (part-time residence).

WLZ[3]

Individuals can use 24-hour in-kind care benefits along with personal budgets if they have a partial benefits package (modulair pakket thuis - MPT) and a care profile that allows personal budgets. Individuals with complete care packages cannot use 24-hour care benefits with personal budgets regardless of their care profile. In 2023, there were 40 care profiles: 6 related to nursing and care, 6 related to mental disability, 6 related to mild mental disability, 5 related to physical disability, 7 related to sensory disability, and 10 related to mental health (Overheid.nl Monitor, 2023a, 2023b). Personal budgets are allowed for all care profiles related to mental disability, physical disability, and sensory disability. However, some care profiles related to nursing and care, mild mental disability, and mental health are not eligible to receive personal budgets (Ministry of Health, Wealth, and Sport, n.d.). The following lists the specific care profiles that are not eligible to receive personal budgets:

- Nursing and care: care profile 9b
- Mild mental disability: all care profiles
- Mental health: care profiles 3b, 4b, 5b, 6b, 7b, and mental health care living 5

Is there free choice between cash and benefits in-kind?

ZVW

Individuals who require community nursing (home nursing and personal care) for more than one year can choose to receive care in-kind (Zorg in Natura - ZIN) or through cash benefits (Persoonsgebonden Budget - PGB) (Overheid.nl Monitor, 2022b).

WMO

Individuals can choose to receive care in-kind (ZIN) or through cash benefits (PGB) (Overheid.nl Monitor, 2023a, §1(1.1.1)).

WLZ

Individuals can choose to receive care in-kind (ZIN) or through cash benefits (PGB) depending on the care profile they are assigned to (Overheid.nl Monitor, 2015a, §3(3.3.1)). In 2023, there were 40 care profiles: 6 related to nursing and care, 6 related to mental disability, 6 related to mild mental disability, 5 related to physical disability, 7 related to sensory disability, and 10 related to mental health (Overheid.nl Monitor, 2023e, 2023f). Personal budgets can be provided for all care profiles related to mental disability, physical disability, and sensory disability. However, some care profiles related to nursing and care, mild mental disability, and mental health are not eligible to receive personal budgets (Ministry of Health, Wealth, and Sport, n.d.). The following lists the specific care profiles that are not eligible to receive personal budgets:

- Nursing and care: care profile 9b
- Mild mental disability: all care profiles
- Mental health: care profiles 3b, 4b, 5b, 6b, 7b, and mental health care living 5

Can you receive LTC benefits with other social security benefits?

There are no limits on receiving cash benefits with other social security benefits.

User costs

User charges

User charges vary by LTC system. User charges are means-tested in WMO and WLZ and how the means-test is implemented varies by system. WLZ has a copayment rate that depends on an individual's income whereas WMO has a copayment that is subject to an income-related 4-week period maximum before 2019 and a non-income related copayment from 2019. ZVW is a traditional health insurance system with nominal premiums (health insurance premiums) that vary depending on the insurer and type of health insurance plan.

ZVW

Individuals over the age of 18 pay a nominal premium (health insurance premium) for basic insurance, which is compulsory, and covers both home nursing and personal care. Although some care services under ZVW require individuals to pay a deductible, this does not apply to personal budgets (Healthcare Institute of the Netherlands, n.d.). The Dutch Health Authority (NZa) regulates maximum prices for personal care and nursing. In 2019, the regulated maximum rate per hour for nursing was 55.56€ and 72.25€ for home nursing (Bakx et al., 2021). Depending on the health insurer and type of basic insurance plan, individuals may have some out-of-pocket payments for home nursing and personal care. Health insurers determine their own nominal premiums and the average annual nominal premium for basic health insurance in 2023 is 1,657€ (138.10€ per month) (Government of the Netherlands, n.d.). In 2023, ten of the largest health insurers in the Netherlands had the following nominal premiums per month for their basic health insurance plan:

- Zilveren Kruis: 131.95€ (cheapest plan); 152.75€ (most expensive plan) (Zilveren Kruis, 2023)
- Interpolis: 129.95€ (cheaper plan); 138.95€ (more expensive plan) (Interpolis, 2023)
- FBTO: 126.95€ (cheapest plan); 141.95€ (most expensive plan) (FBTO, 2023)
- De Friesland: 130.95€ (cheaper plan); 138.95€ (more expensive) (De Friesland, 2023)
- Univé: 127.45€ (cheaper plan); 132.95€ (more expensive plan) (Univé, 2023)
- Zekur: 122.95€ (cheaper plan); 155.15€ (more expensive plan) (Zekur, 2023)
- UMC: 141.95€ (cheaper plan); 147.85€ (more expensive plan) (UMC, 2023)
- Nationale Nederlanden: 137.45€ (Nationale Nederlanden, 2023)
- IZA: 132.95€ (IZA, 2023)
- OHRA: 135.95€ (OHRA, 2023)

WMO

Individuals paid copayments subject to income-related 4-week period maximums before 2019. There is a distinction between general and individualized care services starting from 2015. General services are accessible without prior research into the beneficiary's needs, personal characteristics, and capabilities. For example, grocery or meal delivery services. Individualized services do require prior research and may include activities such as domestic assistance or home modifications. Day/night care and short-term stay are classified as individualized services. Municipalities decide what services they consider to be general versus individualized. Individuals are only eligible for personal budgets if they require individualized services, not general services. For individualized services, the largest or second largest municipality in each of the 12 provinces in the Netherlands all used the nationally set copayment rate in 2017, which was 17.50€ per four-weeks for both single and married individuals (Overheid.nl Monitor, 2017f). If the cost of the service was lower than 17.50€ per four-weeks then the individual paid the lower amount. This included the municipalities of Groningen, Leeuwarden, Emmen, Enschede, Almere, Nijmegen, Utrecht, Amsterdam, The Hague, Terneuzen, Eindhoven, and Maastricht (Overheid.nl Monitor, 2015c, 2015d, 2017d, 2017g-2017j, 2018e-2018g, 2019a, 2019b).

The copayment per four-weeks of individuals whose aggregate income exceeded a certain amount was calculated based on a formula. Formula 3 provides detailed information on how to calculate this copayment from 2015 to 2016 and Formula 4 provides detailed information on how to calculate this copayment from 2017 to 2018. Box 15 lists the income thresholds used to calculate the maximum period contribution of individuals whose income exceeded a limit from 2015 to 2018. The same formula was used across all municipalities although they could change the income limits. The largest or second largest municipality in each of the 12 provinces used these income limits in 2017. This included the municipalities of Groningen, Leeuwarden, Emmen, Enschede, Almere, Nijmegen, Utrecht, Amsterdam, The Hague, Terneuzen, Eindhoven, and Maastricht (Overheid.nl Monitor, 2015c, 2015d, 2017d, 2017g-2017j, 2018e-2018g, 2019a, 2019b).

In 2019, the copayment subject to income-related 4-week period maximums was replaced with a fixed copayment rate called the subscription rate (abonnementstarief). Everyone had the same subscription rate or maximum monthly copayment regardless of income or assets, marital status, or care use. From 2019 to 2023, the subscription rate was 19€ per month for all individualized services and general services where there is a sustainable care relationship, which is defined as receiving permanent guidance or help for a prolonged period (Overheid.nl Monitor, 2019c). The subscription rate is a maximum rate and therefore municipalities

could set lower copayments. However, the largest or second largest municipality in every province used the nationally set rate from 2020 to 2023. Table 19 lists WMO copayment rates from 2015 to 2023.

WLZ

Individuals pay an income-related copayment rate. In 2023, it was 10% of contributable income divided by 12 with a minimum of 26€ and a maximum of 808.60€ per month (Overheid.nl Monitor, 2015e). Table 20 lists the copayment rates and minimum and maximum rates from 2015 to 2023. Contributable income is defined as aggregate income minus the compensation for an undone tax break plus 4% of savings and investments if that amount is more than 31,340€ for single individuals and 62,680€ for married individuals in 2021. Income from 2 years ago is used to calculate the copayment (e.g., income from 2021 is used to calculate the 2023 copayment). Aggregate income includes taxable income from work and home, benefits, shares, dividends, savings, and investments. The compensation for an undone tax break is an amount deducted from the copayment among those who have reached state pension age and have savings or investments. The maximum amount deducted is 1,700€ per person in 2022 (CAK, n.d.).

Taxation of benefits

Not subject to taxation

Tables and Formulas

Table 1: AWBZ Gross Personal Budget Yearly Amounts (2003-2006) (Part 1 of 2)

Function	Class	2003	2004	2005	2006
Domestic Assistance	1	847.60€	856€	870€	884€
	2	2,542.80	2,569	2,611	2,654
	3	4,661.80	4,711	4,788	4,866
	4	7,204.60	7,280	7,399	7,520
	5	9,747.40	9,850	10,011	10,175
	6	12,290.20	12,419	12,621	12,828
Personal Care	1	1,326	1,340	1,362	1,384
	2	3,978	4,020	4,086	4,153
	3	7,293	7,369	7,489	7,612
	4	11,271	11,389	11,575	11,764
	5	15,249	15,409	15,660	15,916
	6	19,227	19,428	19,745	20,068
	7	23,868	24,118	24,511	24,912
	8	29,835	30,148	30,639	31,140
Nursing Care	0	1,144	1,156	1,175	1,194
	1	3,413.80	3,450	3,506	3,563
	2	6,825	6,897	7,009	7,124
	3	12,511.20	12,642	12,848	13,058
	4	19,338.80	19,541	19,860	20,185
	5	26,161.20	26,435	26,866	27,306
	6	32,988.80	33,334	3,3877	34,431
	7	40,950	41,379	42,053	42,741
Supportive Guidance (hours)	1	1,656.20	1,674	1,701	1,729
	2	4,968.60	5,021	5,103	5,186
	3	9,110.40	9,206	9,356	9,509
	4	14,079	14,227	14,459	14,696
	5	19,047.60	19,246	19,560	19,880
	6	24,016.20	24,268	24,664	25,068
	7	29,811.60	30,124	30,615	31,116
	8	37,265.80	37,656	38,270	38,896
Supportive Guidance (half-day)	1	2,152.80	2,175	2,210	2,246
	2	4,305.60	4,351	4,422	4,494
	3	6,458.40	6,526	6,632	6,741
	4	8,611.20	8,701	8,843	8,988
	5	10,764	10,877	11,054	11,235
	6	12,916.80	13,052	13,265	13,482
	7	15,069.60	15,228	15,476	15,729
	8	17,222.40	17,403	17,687	17,976
	9	19,375.20	19,578	19,897	20,223

Source: Overheid.nl Monitor (2003e, 2004, 2005b, 2006)

Notes: Function (functies) refers to the type of care. A half day is defined as a consecutive period of up to four hours. Personal budget amounts before 2003 have not been identified yet.

Table 2: AWBZ Gross Personal Budget Yearly Amounts (2003-2006) (Part 2 of 2)

Function	Class	2003	2004	2005	2006
Supportive Guidance (half-day) With Transport	1	2,412.80€	2,438€	2,478€	2,519€
	2	4,825.60	4,876	4,955	5,036
	3	7,238.40	7,314	7,433	7,555
	4	9,651.20	9,752	9,911	10,073
	5	12,064	12,190	12,389	12,592
	6	13,956.80	14,103	14,333	14,568
	7	16,369.60	16,541	16,811	17,086
	8	18,522.40	18,716	19,021	19,332
	9	20,675.20	20,892	21,233	21,580
Activating Guidance (hours)	1	2,540.20	2,567	2,609	2,652
	2	7,620.60	7,700	7,826	7,954
	3	13,972.40	14,119	14,349	14,584
	4	21,593	21,819	22,175	22,538
Activating Guidance (half-day)	1	2,475.20	2,501	2,542	2,584
	2	4,950.40	5,002	5,084	5,167
	3	7,425.60	7,503	7,625	7,750
	4	9,900.80	10,005	10,168	10,334
	5	12,376	12,506	12,710	12,918
	6	14,851.20	15,007	15,252	15,502
	7	17,326.40	17,508	17,793	18,084
	8	19,801.60	20,009	20,335	20,668
	9	22,276.80	22,510	22,877	23,251
Activating Guidance (half-day) With Transport	1	2,735.20	2,764	2,809	2,855
	2	5,470.40	5,528	5,618	5,710
	3	8,205.60	8,292	8,427	8,565
	4	10,940.80	11,055	11,235	11,419
	5	13,676	13,819	14,044	14,247
	6	15,891.20	16,058	16,320	16,587
	7	18,626.40	18,822	19,129	19,442
	8	21,101.60	21,323	21,671	22,026
	9	23,576.80	23,824	24,212	24,608
Short-term Stay	1 day per week	4,680	91€ per day	92€ per day	94€ per day
	2-3 days per week	9,360			

Source: Overheid.nl Monitor (2003e, 2004, 2005b, 2006)

Notes: Function (functies) refers to the type of care. A half day is defined as a consecutive period of up to four hours. Personal budget amounts before 2003 have not been identified yet.

Table 3: AWBZ Basis and Function (2003-2006)

Type of condition, disability or limitation (Basis - Grondslag)	Type of care (Function - Functies)
Somatic	Provides access to all functions
Psychogeriatric	Provides access to all functions
Psychiatric	Provides access to all functions except activating guidance
Intellectual	Provides access to all functions except nursing
Physical	Provides access to all functions
Sensory	Provides access to all functions except nursing
Psychosocial	Provides access to the domestic care, personal care, supportive guidance, and residential care functions

Source: Overheid.nl Monitor (2003d)
Notes: The functions include domestic assistance, personal care, nursing, supportive guidance, activating guidance, treatment, and residential care.

Table 4: Personal Budget Copayment by Age, Marital Status, and Income (2003)

Annual Income (€)	Age	Copayment - Married (€)	Copayment - Single (€)
Below 12,042	65+	2.20	2.20
12,042-15,556		2.80	6.80
15,556-17,562		10.40	24.80
17,562-20,072		28.40	38.40
20,072-24,086		56.60	58.80
24,086-39,140		86.20	99.80
Above 39,140		113.40	124.60
Below 14,552	Less than 65	2.20	2.20
14,552-18,568		2.80	6.80
18,568-22,080		10.40	24.80
22,080-25,592		28.40	38.40
25,592-30,610		56.60	58.80
30,610-46,668		86.20	99.80
Above 46,668		113.40	124.60

Source: Overheid.nl Monitor (2003f)
Notes: Before 2004, the copayment was a fixed proportion of the personal budget (17.75% in 2003). However, the copayment could not exceed a certain amount, which varied depending on the individual's age, marital status, and income.

Box 1: Contributable Income

Contributable income (bijdrageplichtig inkomen) was an individual's or married couple's joint income minus the following: taxes, 15% of the expected net proceeds from work performed in the current calendar year or from continued payment of wages or salaries due to illness or from a benefit under the Sickness Benefits Act, pocket and clothing allowance, premiums for health insurance, and certain tax credits for older individuals and younger individuals with disabilities. Income included income from work, benefits, shares and dividends, investments, and savings. The pocket and clothing allowance was an amount for individuals to use for their personal expenses, which varied depending on their personal situation (e.g., marital status, receiving disability benefits) and was set annually by the Ministry of Health, Welfare and Sport. Older individuals received tax credits if they reached state pension age and their income was under a certain amount. The amount varied depending on their marital status. Younger individuals with disabilities received tax credits if they were entitled to receive a Work and Employment Support for Young Disabled Persons Act (Wajong) benefit.

Source: Overheid.nl Monitor (2005b, 2009a) and Netherlands Government (n.d.)

Table 5: AWBZ Gross Personal Budget Yearly Amounts (2007-2009) (Part 1 of 2)

Type of care (Function - Functies)	Class	2007-2008	2009
Personal Care	1	1,416€	1,471€
	2	4,248	4,414
	3	7,785	8,089
	4	12,033	12,502
	5	16,279	16,914
	6	20,526	21,327
	7	25,480	26,474
	8	31,850	33,092
Nursing Care	0	1,221	1,269
	1	3,645	3,787
	2	7,286	7,570
	3	13,356	13,877
	4	20,645	21,450
	5	27,928	29,017
	6	35,216	36,589
	7	43,716	45,421
Supportive Guidance in Hours	1	1,768	1,837
	2	5,305	5,512
	3	9,726	10,105
	4	15,031	15,617
	5	20,333	21,126
	6	25,639	26,639
	7	31,825	33,066
	8	39,783	41,335
Supportive Guidance in Half-days	1	2,297	2,387
	2	4,597	4,776
	3	6,894	7,163
	4	9,193	9,552
	5	11,491	11,939
	6	13,789	14,327
	7	16,088	16,715
	8	18,386	19,103
	9	20,684	21,491

Source: Overheid.nl Monitor (2007a, 2008a, 2009a)
Notes: A half day is defined as a consecutive period of up to four hours.

Table 6: AWBZ Gross Personal Budget Yearly Amounts (2007-2009) (Part 2 of 2)

Type of care (Function - Functies)	Class	2007-2008	2009
Supportive Guidance in Half-days With Transport	1	2,576€	2,676€
	2	5,151	5,352
	3	7,727	8,028
	4	10,303	10,705
	5	12,879	13,381
	6	14,900	15,481
	7	17,476	18,158
	8	19,773	20,544
	9	22,072	22,933
Activating Guidance in Hours	1	2,712	2,818
	2	8,135	8,452
	3	14,916	15,498
	4	23,052	23,951
Activating Guidance in Half-days	1	2,642	2,745
	2	5,285	5,491
	3	7,926	8,235
	4	10,570	10,982
	5	13,212	13,727
	6	15,855	16,473
	7	18,496	19,217
	8	21,139	21,963
	9	23,781	24,708
Activating Guidance in Half-days With Transport	1	2,920	3,034
	2	5,840	6,068
	3	8,760	9,102
	4	11,679	12,134
	5	14,599	15,168
	6	16,965	17,627
	7	19,885	20,661
	8	22,528	23,407
	9	25,169	26,151
Short-term Stay	Per day	96	100

Source: Overheid.nl Monitor (2007a, 2008a, 2009a)
Notes: A half day is defined as a consecutive period of up to four hours.

Table 7: AWBZ Gross Personal Budget Yearly Amounts (2010)

Type of care (Function - Functies)	Class	2010
Personal Care	1	1,495€
	2	4,487
	3	8,223
	4	12,710
	5	17,195
	6	21,681
	7	26,913
	8	33,641
Nursing Care	0	1,290
	1	3,850
	2	7,696
	3	14,107
	4	21,806
	5	29,499
	6	37,196
	7	46,175
Guidance in Hours	1	1,984
	2	5,952
	3	10,912
	4	16,864
	5	22,817
	6	28,769
	7	35,712
	8	44,641
Guidance in Half-days	1	2,452
	2	4,905
	3	7,357
	4	9,811
	5	12,263
	6	14,715
	7	17,168
	8	19,621
	9	22,073
Guidance in Half-days With Transport	1	2,746
	2	5,492
	3	8,239
	4	10,982
	5	13,732
	6	16,184
	7	18,637
	8	21,090
	9	23,542
Short-term Stay	Per day	102

Source: Overheid.nl Monitor (2010a)
Notes: A half day is defined as a consecutive period of up to four hours.

Table 8: AWBZ Gross Personal Budget Yearly Amounts (2011-2014)

Type of care (Function - Functies)	Class	2011	2012-2013	2014
Personal Care	1	1,450€	1,483€	1,409€
	2	4,352	4,450	4,226
	3	7,976	8,155	7,748
	4	12,329	12,606	1,1975
	5	16,679	17,054	16,201
	6	21,031	21,504	20,428
	7	26,106	26,693	25,358
	8	32,632	33,366	31,698
Nursing Care	0	1,251	1,279	1,272
	1	3,735	3,819	3,817
	2	7,465	7,633	7,634
	3	13,684	13,992	13,995
	4	21,152	21,628	21,629
	5	28,614	29,258	29,263
	6	36,080	36,892	36,896
	7	44,790	45,798	45,802
Guidance (Individual)	1	1,924	1,967	1,869
	2	5,773	5,903	5,608
	3	10,585	10,823	10,282
	4	16,358	16,726	15,891
	5	22,132	22,630	21,499
	6	27,906	28,534	27,107
	7	34,641	35,420	33,651
	8	43,302	44,276	42,063
Guidance (Group)	1	2,378	2,432	2,310
	2	4,758	4,865	4,622
	3	7,136	7,297	6,932
	4	9,517	9,731	9,244
	5	11,895	12,163	11,555
	6	14,274	14,595	13,865
	7	16,653	17,028	16,177
	8	19,032	19,460	18,487
	9	21,411	21,893	20,798
Guidance (Group With Transport)	1	2,664	2,724	2,588
	2	5,327	5,447	5,175
	3	7,992	8,172	7,763
	4	10,653	10,893	10,348
	5	13,320	13,620	12,939
	6	15,698	16,051	15,248
	7	18,078	18,485	17,561
	8	20,457	20,917	19,871
	9	22,836	23,350	22,183
Short-term Stay	Per day	99	101	101

Source: Overheid.nl Monitor (2011c, 2012e, 2013i, 2014e)
Notes: A half day is defined as a consecutive period of up to four hours.

Table 9: AWBZ and WLZ Disorders and Limitations Scale

	Score	Description
Disorders	0	There is no disorder or the disorder does not require care because it is already managed by a treatment, medication or aid
	1	The disorder requires care 1 to 6 times a week
	2	The disorder requires care 1 to 2 times a day
	3	The disorder requires care 3 or more times a day
Limitations and participation problems	0	Has no restrictions
	1	Needs another person who supports, guides, encourages and instructs them
	2	Can carry out the activity partially and/or only with great difficulty
	3	Cannot perform the activity at all

Source: Overheid.nl Monitor (2014c)

Table 10: AWBZ Basis and Function (2014)

Type of condition, disability or limitation (Basis - Grondslag)	Type of care (Function - Functies)
Somatic condition/disability	Provides access to all functions
Psychogeriatric disorder/disability	Provides access to all functions
Psychiatric condition/disability	Provides access to the personal care and guidance functions
Physical handicap	Provides access to all functions
Mental disability	Provides access to all functions except nursing
Sensory disability	Provides access to all functions except nursing

Source: Overheid.nl Monitor (2014c)

Notes: The functions include personal care, nursing, guidance (separate functions of supportive and activating guidance before 2009), treatment, residence, short-term stay (added in 2011), and continued residence on a psychiatric basis.

Box 2: AWBZ Evaluation of Dependence - Options to Address Care Needs (2007-2014)

After investigating the applicant's conditions, limitations, and disabilities, CIZ considers what options can address the applicant's care needs other than AWBZ care. Options include treatment, rehabilitation, reactivation, learning, or adaptation of the applicant's environment or resources. Additionally, CIZ considers any usual care the applicant currently receives, other welfare benefits that can help address their care needs, and general facilities available to all individuals that can help address their care needs. If care needs can be addressed through usual care, other welfare benefits, or general facilities, these options take precedence over AWBZ care. Usual care is defined as the normal and daily informal care that partners, parents, children, and/or housemates living at home are expected to provide to each other. Informal personal care and guidance provided is classified as usual care if the individual requires short-term care, which is defined as up to three months. Moreover, the helper should not feel overwhelmed by the care they are expected to provide and they should not have to acquire any knowledge or obtain additional skills to provide care. Usual care does not apply to nursing care, treatment, residence, short-term stay, or continued residence on a psychiatric basis. CIZ then determines the gross need for AWBZ care, taking into account usual care available, and notes what kind of care is necessary, how often it is needed, and the delivery conditions.

CIZ then determines the net AWBZ care needed by considering any voluntary care provided. Any informal care that exceeds usual care is defined as voluntary care. Voluntary care is deducted from the gross determined AWBZ care if the informal caregiver can and wants to continue to provide voluntary care in the future and the insured person wants to continue to receive their care. Similar to the previous step, CIZ determines the net need for AWBZ care and notes what kind of care is necessary, how often it is needed, the period of validity of the assessment, and the delivery conditions.

Source: Overheid.nl Monitor (2014c)

Table 11: AWBZ Personal Care Function Recommended Activities (Part 1 of 2)

Activities	Subgroup	Average time (minutes)	Frequency per day
Bathing	Parts of the body	10	1
	Entire body	20	1
Dressing	Fully dressing/undressing	15	2
	Partial undressing	10	1
	Partial dressing	10	1
	Putting on support stockings	10	1
	Removing support stockings	7	1
Getting in and out of bed	Help getting out of bed	10	1
	Help getting into bed	10	1
	Help with sitting on the couch	10	1
	Help with standing up from the couch	10	1
Help with moving around the house		20	According to necessity
Going to the toilet		15	According to necessity
Food and drink	Help with eating cold food	10	2
	Help with eating hot food	15	1
	Help with drinking	10	6
Support for excretion	Ostomy care for locally intact skin	20	According to necessity
	Changing the ostomy bag	10	According to necessity
	Emptying/changing the catheter bag	10	According to necessity
	Bladder irrigation via existing catheter	15	According to necessity
	Applying uritip	15	According to necessity
	Enema microlax	15	According to necessity

Source: Overheid.nl Monitor (2014c)

Table 12: AWBZ Personal Care Function Recommended Activities (Part 2 of 2)

Activities	Subgroup	Average time (minutes)	Frequency per day
Tube feeding	Tube feeding (including connecting and disconnecting)	20	According to necessity
	Tube feeding via PEG (Percutaneous endoscopic gastrostomy)	40	According to necessity
Medication	Providing medication	5	According to necessity
	Administering medications (orally/via tube)	5	According to necessity
	Applying medicated plaster	5	According to necessity
	Administering ear or nose drops or eye gel	10	According to necessity
	Nebulization	20	According to necessity
Personal care for teeth, hair, nails, skin	Taking care of teeth	5	2
	Taking care of hair	5	1
	Taking care of nails	5	1 (per week)
	Inspecting skin for deformations, inflammation, and/or infections	10	According to necessity
	Applying ointments	10	According to necessity
	Caring for blemishes	10	According to necessity
	Caring for skin near body openings near catheters, tracheostomies, or tubes	10	According to necessity
Prosthesis	Applying a prosthesis/aid	15	1
	Removing a prosthesis/aid	15	1
	Applying a dental prosthetic	5	According to necessity
	Removing a dental prosthetic	5	According to necessity
	Applying a transcutaneous electrical nerve stimulation	5	According to necessity
	Removing a transcutaneous electrical nerve stimulation	5	According to necessity
Teaching and supervising personal care activities	Teaching the usual caregiver and/or informal caregiver about a certain personal care activity	Same as the activity	Same as the activity
	Guiding the caregiver on how to properly deliver care	30 minutes a week	Distribute average time over the week depending on the situation

Source: Overheid.nl Monitor (2014c)

Table 13: AWBZ Hours of Care by Function and Class (2014)

Type of care (Function - Functies)	Class	Hours per week
Personal Care	1	0 - 1.9
	2	2 - 3.9
	3	4 - 6.9
	4	7 - 9.9
	5	10 - 12.9
	6	13 - 15.9
	7	16 - 19.9
	8	20 - 24.9
Nursing Care	0	0 - 0.9
	1	1 - 1.9
	2	2 - 3.9
	3	4 - 6.9
	4	7 - 9.9
	5	10 - 12.9
	6	13 - 15.9
	7	16 - 19.9
Individual guidance	1	1 - 1.9
	2	2 - 3.9
	3	4 - 6.9
	4	7 - 9.9
	5	10 - 12.9
	6	13 - 15.9
	7	16 - 19.9
	8	20-24.9
Group guidance	1	1 half day
	2	2 half days
	3	3 half days
	4	4 half days
	5	5 half days
	6	6 half days
	7	7 half days
	8	8 half days
	9	9 half days
Short term stay	1	1 day
	2	2 days
	3	3 days

Source: Overheid.nl Monitor (2014c)
Notes: A half day is defined as a consecutive period of up to four hours.

Box 3: Personal Care Function Care Hours Calculation Example

In 2014, suppose Jan receives an eligibility decision from the Care Assessment Center (CIZ) that states that he can receive 4 to 6.9 hours of care per week through the personal care function. According to Table 13, 4 to 6.9 hours of care per week corresponds to Class 3. Classes range from 1 (0-1.9 hours) to 8 (20-24.9 hours) for the personal care function. The 4 to 6.9 hours of care per week were estimated based on Jan's care needs and a table that lists the average time it takes to conduct an activity. The tables differ by function and are only available for functions that are associated with classes (care without accommodation) such as the personal care function. The tables are published in the Policy Rules for AWBZ Assessment 2014. The following activities are listed under the personal care function:

- Bathing
- Dressing
- Getting in and out of bed
- Moving around the house
- Going to the toilet
- Food and drink
- Support with excretion
- Tube feeding
- Medication
- Personal care for teeth, hair, nails, and skin
- Prosthesis
- Teaching and supervising personal care activities

Each activity is associated with an average time to conduct the activity and frequency that indicates how many times the activity should be conducted in a day. Some activities have subgroup activities such as bathing, which is separated into bathing certain parts of the body or bathing the entire body. Other activities do not have subgroup activities such as going to the toilet. For activities that have subgroups, each subgroup has its associated average time and frequency. The last activity of teaching and supervising personal care activities is only applicable if there is a usual caregiver. The activities, average times, and frequencies for personal care are listed in Table 11 and Table 12. Based on these tables, CIZ will determine how many hours of personal care Jan requires per week. Jan only requires help with bathing, dressing, and getting in and out of bed. For bathing, he only needs help bathing parts of the body, once a day, and 5 days a week. Since the average time for bathing parts of the body once a day is 10 minutes and Jan needs help 5 days a week, he needs 50 minutes of help for bathing per week (10 minutes x 1 time per day x 5 days per week). For dressing, he needs partial help dressing and partial help undressing both twice a day and five days a week. Both partial dressing and partial undressing have an average time of 10 minutes once a day. For partial help dressing Jan needs 100 minutes of help per week (10 minutes x 2 times per day x 5 days per week). Similarly, for partial help undressing Jan needs 100 minutes of help per week (10 minutes x 2 times per day x 5 days per week). Therefore, Jan requires 200 minutes of help per week with dressing. Lastly, for getting in and out of bed, he needs help getting out of bed once a day and getting into bed once a day five days a week. Both getting into bed and getting out of bed have an average time of 10 minutes once a day. For getting into bed Jan needs 50 minutes of help per week (10 minutes x 1 time per day x 5 days per week). Similarly, for getting out of bed he needs 50 minutes of help per week (10 minutes x 1 time per day x 5 days per week). His total help time for getting in and out of bed is 100 minutes of help per week.

- Bathing: 50 min.
- Dressing: 200 min.
- Getting in and out of bed: 100 min.
- Moving around the house: 0 min.
- Going to the toilet: 0 min.
- Food and drink: 0 min.
- Support with excretion: 0 min.
- Tube feeding: 0 min.
- Medication: 0 min.
- Personal care for teeth, hair, nails, and skin: 0 min.
- Prosthesis: 0 min.
- Teaching and supervising personal care activities: 0 min.

Based on Jan's care needs, CIZ calculates the total care time needed for personal care by summing the average activity times and then placing him into a class. His total care time for the personal care function is 50 minutes of bathing + 200 minutes of dressing + 100 minutes of getting in and out of bed = 350 minutes of care per week (5.8 hours of care per week). Jan's total care time of 5.8 hours of care per week corresponds to Class 3 (4 to 6.9 hours of care per week).

Source: Overheid.nl Monitor (2014c)

Box 4: AWBZ Annual Copayment Income Thresholds (2007-2010)

2007

- Single individuals under retirement age
  - If their annual income exceeded 16,137€, their copayment was calculated as follows: 216.39€ + .15 x (income - 16,137€)
- Single individuals retirement age or older
  - If their annual income exceeded 14,162€, their copayment was calculated as follows: 216.39€ + .15 x (income - 14,162€)
- Married individuals under retirement age
  - If their annual income exceeded 20,810€, their copayment was calculated as follows: 310.25€ + .15 x (income - 20,810€)
- Married individuals retirement age or older
  - If their annual income exceeded 19,837€, their copayment was calculated as follows: 310.25€ + .15 x (income - 19,837€)

2008

- Single individuals under retirement age
  - If their annual income exceeded 16,301€, their copayment was calculated as follows: 219€ + .15 x (income - 16,301€)
- Single individuals retirement age or older
  - If their annual income exceeded 14,365€, their copayment was calculated as follows: 219€ + .15 x (income - 14,365€)
- Married individuals under retirement age
  - If their annual income exceeded 21,002€, their copayment was calculated as follows: 315.46€ + .15 x (income - 21,002€)
- Married individuals retirement age or older
  - If their annual income exceeded 19,759€, their copayment was calculated as follows: 315.46€ + .15 x (income - 19,759€)

2009

- Single individuals under retirement age
  - If their annual income exceeded 21,703€, their copayment was calculated as follows: 224.21€ + .15 x (income - 21,703€)
- Single individuals retirement age or older
  - If their annual income exceeded 14,812€, their copayment was calculated as follows: 224.21€ + .15 x (income - 14,812€)
- Married individuals under retirement age
  - If their annual income exceeded 26,535€, their copayment was calculated as follows: 320.68€ + .15 x (income - 26,535€)
- Married individuals retirement age or older
  - If their annual income exceeded 20,431€, their copayment was calculated as follows: 320.68€ + .15 x (income - 20,431€)

2010

- Single individuals under retirement age
  - If their annual income exceeded 22,222€, their copayment was calculated as follows: 229.43€ + .15 x (income - 22,222€)
- Single individuals retirement age or older
  - If their annual income exceeded 15,256€, their copayment was calculated as follows: 229.43€ + .15 x (income - 15,256€)
- Married individuals under retirement age
  - If their annual income exceeded 27,222€, their copayment was calculated as follows: 328.50€ + .15 x (income - 27,222€)
- Married individuals retirement age or older
  - If their annual income exceeded 21,058€, their copayment was calculated as follows: 328.50€ + .15 x (income - 21,058€)

Source: Overheid.nl Monitor (2007a, 2008a, 2009a, 2010a)

Box 5: AWBZ Annual Copayment Income Thresholds (2011-2014)

2011

- Single individuals under retirement age
  - If their annual income exceeded 22,636€, their copayment was calculated as follows: 232.04€ + .15 x (income - 22,636€)
- Single individuals retirement age or older
  - If their annual income exceeded 15,838€, their copayment was calculated as follows: 232.04€ + .15 x (income - 15,838€)
- Married individuals under retirement age
  - If their annual income exceeded 27,902€, their copayment was calculated as follows: 331.11€ + .15 x (income - 27,902€)
- Married individuals retirement age or older
  - If their annual income exceeded 22,100€, their copayment was calculated as follows: 331.11€ + .15 x (income - 22,100€)

2012

- Single individuals under retirement age
  - If their annual income exceeded 22,905€, their copayment was calculated as follows: 234.64€ + .15 x (income - 22,905€)
- Single individuals retirement age or older
  - If their annual income exceeded 16,007€, their copayment was calculated as follows: 234.64€ + .15 x (income - 16,007€)
- Married individuals under retirement age
  - If their annual income exceeded 28,306€, their copayment was calculated as follows: 336.32€ + .15 x (income - 28,306€)
- Married individuals retirement age or older
  - If their annual income exceeded 22,319€, their copayment was calculated as follows: 336.32€ + .15 x (income - 22,319€)

2013

- Single individuals under retirement age
  - If their annual income exceeded 23,208€, their copayment was calculated as follows: 242.46€ + .15 x (income - 23,208€)
- Single individuals retirement age or older
  - If their annual income exceeded 16,257€, their copayment was calculated as follows: 242.46€ + .15 x (income - 16,257€)
- Married individuals under retirement age
  - If their annual income exceeded 28,733€, their copayment was calculated as follows: 346.75€ + .15 x (income - 28,733€)
- Married individuals retirement age or older
  - If their annual income exceeded 22,676€, their copayment was calculated as follows: 346.75€ + .15 x (income - 22,676€)

2014

- Single individuals under retirement age
  - If their annual income exceeded 23,295€, their copayment was calculated as follows: 247.68€ + .15 x (income - 23,295€)
- Single individuals retirement age or older
  - If their annual income exceeded 16,456€, their copayment was calculated as follows: 247.68€ + .15 x (income - 16,456€)
- Married individuals under retirement age
  - If their annual income exceeded 29,174€, their copayment was calculated as follows: 354.57€ + .15 x (income - 29,174€)
- Married individuals retirement age or older
  - If their annual income exceeded 22,957€, their copayment was calculated as follows: 354.57€ + .15 x (income - 22,957€)

Source: Overheid.nl Monitor (2011c, 2012e, 2013i, 2014e)

Formula 1: Calculation of AWBZ Annual Personal Budget Copayment (2007-2014)

$$PC_{i,t} = A_t + .15(CI_{i,t} - I_t)$$

- $PC_{i,t}$ = Individual's i's annual copayment at time t
  - $PC_{i,t}$ can never be less than zero
- A_t = Amount stated in national guidelines at time t —FC_t values are provided in Box 4 and Box 5
- $CI_{i,t}$ = Individual's i's annual contributable income at time t —the definition of contributable income is provided in Box 1
- I_t = Annual income threshold at time t —I_t values are provided in Box 4 and Box 5

Source: Overheid.nl Monitor (2007a, 2014e)
Notes: The annual copayment for the AWBZ personal budget of individuals whose income exceeded a certain amount was calculated based on a formula.

Table 14: WMO National Maximum Period Contributions (2007-2014)

Year	Copayment for single individuals (€)	Copayment for married individuals (€)
2007	16.60	23.80
2008	16.80	24.20
2009	17.20	24.60
2010	17.60	25.20
2011	17.80	25.40
2012	18.0	25.80
2013	18.60	26.60
2014	19.0	27.20

Source: Overheid.nl Monitor (2013p)
Notes: Users paid a copayment for home care services under WMO, which was capped at a maximum amount per 4-week period called the maximum period contribution. Municipalities could use the maximum period contributions set in national guidelines or set their own maximum period contributions.

Formula 2: Calculation of WMO Maximum Period Contribution (2007-2014)

$$PC_{i,t} = MPC_t + .15(CI_{i,t} - I_t)(1/13)$$

- $PC_{i,t}$ = Individual's i's maximum period (4-week period) copayment at time t
  - $PC_{i,t}$ can never be less than zero
- MPC_t = Maximum period (4-week period) copayment set in national guidelines at time t —FC_t values are provided in Table 14
- $CI_{i,t}$ = Individual's i's annual contributable income at time t —the definition of contributable income is provided in Box 1
- I_t = Annual income threshold at time t —I_t values are provided in Box 6 and Box 7

Source: Overheid.nl Monitor (2013p)
Notes: The maximum period contribution (4-week period copayment) of individuals whose aggregate income exceeded a certain amount was calculated based on a formula.

Box 6: WMO Income Thresholds (2007-2014) (Part 1 of 2)

The maximum period contribution is increased by 15% x (contributable income - income limit) (1/13) if the individual's contributable income exceeds the income limit. The income thresholds vary by age, marital status, and year.

2007

- Single individuals under the age of 65: 16,137€
- Single individuals 65 years or older: 14,162€
- Married individuals where one or both are under the age of 65: 20,810€
- Married individuals where both are 65 years or older: 19,837€

2008

- Single individuals under the age of 65: 16,301€
- Single individuals 65 years or older: 14,365€
- Married individuals where one or both are under the age of 65: 21,002€
- Married individuals where both are 65 years or older: 19,759€

2009

- Single individuals under the age of 65: 21,703€
- Single individuals 65 years or older: 14,812€
- Married individuals where one or both are under the age of 65: 26,535€
- Married individuals where both are 65 years or older: 20,431€

2010

- Single individuals under the age of 65: 22,222€
- Single individuals 65 years or older: 15,256€
- Married individuals where one or both are under the age of 65: 27,222€
- Married individuals where both are 65 years or older: 21,058€

Source: Overheid.nl Monitor (2007c, 2008b, 2009b, 2010b)

Notes: Users paid a copayment for home care services under WMO, which was capped at a maximum amount per 4-week period called the maximum period contribution. Municipalities could use the maximum period contributions set in national guidelines or set their own maximum period contributions. A means-test was conducted to calculate the maximum period contribution for individuals whose aggregate income exceeded a certain amount. Box 1 defines contributable income.

Box 7: WMO Income Thresholds (2007-2014) (Part 2 of 2)

The maximum period contribution is increased by 15% x (contributable income - income limit) (1/13) if the individual's contributable income exceeds the income limit. The income thresholds vary by age, marital status, and year.

2011

- Single individuals under the age of 65: 22,636€
- Single individuals 65 years or older: 15,838€
- Married individuals where one or both are under the age of 65: 27,902€
- Married individuals where both are 65 years or older: 22,100€

2012

- Single individuals under the age of 65: 22,905€
- Single individuals 65 years or older: 16,007€
- Married individuals where one or both are under the age of 65: 28,306€
- Married individuals where both are 65 years or older: 22,319€

2013

- Single individuals under the retirement age: 23,208€
- Single individuals who have reached or are over the retirement age: 16,257€
- Married individuals where one or both are under the retirement age: 28,733€
- Married individuals where both have reached or are over the retirement age: 22,676€

2014

- Single individuals under the retirement age: 23,295€
- Single individuals who have reached or are over the retirement age: 16,456€
- Married individuals where one or both are under the retirement age: 29,174€
- Married individuals where both have reached or are over the retirement age: 22,957€

Source: Overheid.nl Monitor (2011d, 2012i, 2013p, 2014h)
Notes: Users paid a copayment for home care services under WMO, which was capped at a maximum amount per 4-week period called the maximum period contribution. Municipalities could use the maximum period contributions set in national guidelines or set their own maximum period contributions. A means-test was conducted to calculate the maximum period contribution for individuals whose aggregate income exceeded a certain amount. Box 1 defines contributable income.

Table 15: WMO Maximum Period Contribution in Largest Municipalities (2012-2013)

Province	Largest Municipality	Maximum period contribution (2012)	Maximum period contribution (2013)
		National guidelines: 18€ for single, 25.8€ for married	National guidelines: 18.6€ for single, 26.6€ for married
Groningen	Groningen	Same as national guidelines	Same as national guidelines
Friesland	Leeuwarden	Same as national guidelines	Same as national guidelines
Drenthe	Assen (second largest)	Same as national guidelines	Same as national guidelines
Overijssel	Enschede	Same as national guidelines	Not identified yet
Flevoland	Almere	Same as national guidelines	Same as national guidelines
Gelderland	Nijmegen	Not identified yet	Same as national guidelines
Utrecht	Utrecht	Same as national guidelines	Same as national guidelines
North Holland	Amsterdam	Not identified yet	Same as national guidelines
South Holland	The Hague (second largest)	Not identified yet	Same as national guidelines
Zeeland	Terneuzen	Same as national guidelines	Same as national guidelines
North Brabant	Eindhoven	Same as national guidelines	Same as national guidelines
Limburg	Maastricht	Same as national guidelines	Same as national guidelines

Source: Overheid.nl Monitor (2012a, 2012f-2012h, 2013d, 2013j-2013o, 2013q, 2013r, 2014f, 2014g)
Notes: Details of the largest municipality in the provinces of Drenthe (Emmen) and South Holland (Rotterdam) have not been identified yet. Therefore, details for the second largest municipality were provided instead.

Box 8: Hourly Care Rates - Largest Health Insurers (2023)

- Zilveren Kruis: 72.39€ (formal) and 22.98€ (informal)
- Interpolis and FBTO
  - Formal: 35.40€ for personal care and 54.96€ for nursing
  - Informal: 23.52€ for personal care and nursing
- Zekur
  - Formal: 39.63€ for personal care and 59.08€ for nursing
  - Informal: 24.12€ for personal care and nursing

Source: Zilveren Kruis (n.d.), Interpolis (n.d.), Zekur (n.d.), and FBTO (n.d.)

Box 9: Informal Care Providers

- A blood relative or relative in the 1st or 2nd degree
- Someone who is not registered as a nurse (level 4 or 5) in the BIG register
  - The BIG register is a legal, online and public register for healthcare professions. Healthcare professionals included in the BIG register have the right to use their designated professional titles and independently perform the specialized practices specific to their field.
- Someone who is not registered in the Trade Register or registered with a healthcare organization with SBI (Standaard Bedrijfsidentificatie) codes 86, 87 or 88 (codes from the Chamber of Commerce)

Source: Ministry of Health, Wealth, and Sport (n.d.)

Box 10: WMO HH1 and HH2

Household category 1 (HH1) included buying groceries based on a list provided by the user, preparing light meals, heating up and serving hot meals, light housework such as dusting and washing the dishes, heavy housework such as vacuuming and cleaning the bathroom, and washing and folder clothing. Household category 2 (HH2) included planning household activities and managing resources necessary to run a household such as compiling a grocery list and buying groceries based on household needs.

Source: Overheid.nl Monitor (2007b)

Table 16: WLZ Personal Budget Hourly Rates for Informal and Formal Care

Year	Informal Care Rate (hourly)	Formal Care Rate (hourly)	Formal Care Rate (half-day)
2015	20€	63€	58€
2016	20	63	58
2017	20	63	58
2018	20	63	58
2019	20	63	58
2020	20.73	65.29	60.12
2021	21.14	66.60	61.32
2022	21.68	68.30	62.88
2023	22.98	72.39	66.64

Source: Overheid.nl Monitor (2015f)
Notes: A half-day is a consecutive period of up to four hours.

Table 17: WLZ Personal Budget Yearly Rates by Care Type and Profile (Part 1 of 2)

Year	Care Profile	Personal Care	Nursing	Individual Guidance	Domestic Assistance	Total
2016	4 VV	12,764€	7,722€	10,953€	3,371€	34,810€
	5 VV	12,764	14,158	16,937	3,371	47,230
	6 VV	12,764	14,158	16,937	3,371	47,230
	7 VV	12,764	14,158	28,869	3,371	59,162
	8 VV	17,248	14,158	35,832	3,371	70,609
2017	4 VV	12,936	7,826	11,101	3,417	35,280
	5 VV	12,936	14,349	17,166	3,417	47,868
	6 VV	12,936	14,349	17,166	3,417	47,868
	7 VV	12,936	14,349	29,259	3,417	59,961
	8 VV	17,481	14,349	36,316	3,417	71,563
2018	4 VV	13,392	8,102	11,492	3,537	36,523
	5 VV	13,392	14,854	17,770	3,537	49,553
	6 VV	13,392	14,854	17,770	3,537	49,553
	7 VV	13,392	14,854	30,289	3,537	62,072
	8 VV	18,096	14,854	37,594	3,537	74,081
2019	4 VV	13,878	8,396	11,909	3,665	37,848
	5 VV	13,878	15,393	18,415	3,665	51,351
	6 VV	13,878	15,393	18,415	3,665	51,351
	7 VV	13,878	15,393	31,388	3,665	64,324
	8 VV	18,753	15,393	38,959	3,665	76,770

Source: Healthcare Institute of the Netherlands (2016-2018), Zorgverzekeraars Nederland (2019), and Naar-Keuze (2016)

Notes: In 2015 and 2016, domestic assistance for those with a WLZ personal budget included cleaning the house, cooking, and grocery shopping. From 2017, domestic assistance only includes cleaning the house for those with a WLZ personal budget. The 2015 rates have not been identified yet.

Table 18: WLZ Personal Budget Yearly Rates by Care Type and Profile (Part 2 of 2)

Year	Care Profile	Personal Care	Nursing	Individual Guidance	Domestic Assistance	Total
2020	4 VV	14,131€	8,549€	12,126€	3,732€	38,538€
	5 VV	14,131	15,673	18,750	3,732	52,286
	6 VV	14,131	15,673	18,750	3,732	52,286
	7 VV	14,131	15,673	31,959	3,732	65,495
	8 VV	19,094	15,673	39,668	3,732	78,167
2021	4 VV	14,672	8,876	12,590	3,875	40,014
	5 VV	14,672	16,273	19,468	3,875	54,289
	6 VV	14,672	16,273	19,468	3,875	54,289
	7 VV	14,672	16,273	33,183	3,875	68,003
	8 VV	19,825	16,273	41,187	3,875	81,161
2022	4 VV	15,048	9,103	12,912	3,974	41,037
	5 VV	15,048	16,690	19,966	3,974	55,678
	6 VV	15,048	16,690	19,966	3,974	55,678
	7 VV	15,048	16,690	34,032	3,974	69,744
	8 VV	20,333	16,690	42,241	3,974	83,238
2023	4 VV	15,949	9,648	13,685	4,212	43,494
	5 VV	15,949	17,690	21,162	4,212	59,013
	6 VV	15,949	17,690	21,162	4,212	59,013
	7 VV	15,949	17,690	36,071	4,212	73,922
	8 VV	21,551	17,690	44,771	4,212	88,224

Source: Overheid.nl Monitor (2020c, 2021a, 2022a, 2023f) and Naar-Keuze (2016)
Notes: From 2017, domestic assistance only includes cleaning the house for those with a WLZ personal budget.

Box 11: ZVW Evaluation of Dependence Framework

The evaluation of dependence is based on a framework written by The Nurses and Caregivers Association in the Netherlands (Verpleegkundigen and Verzorgenden Nederland - V&VN). Community nurses use the framework to determine what care and how much care the individual will require. The framework lists six standards that should be used when evaluating dependence:

- The evaluator ensures professional autonomy
- The evaluator meets the nursing education requirement
- The goal of the evaluation is to strengthen the applicant's self-reliance
- The evaluator uses clinical reasoning to make decisions
- The evaluator follows V&VN reporting guidelines
- The evaluator follows V&VN standards when transferring patient records

Professional autonomy in the first standard is defined as being guided by and making decisions based on professional knowledge and the applicant's care needs when evaluating the applicant's dependence. The evaluator should not be guided by the applicant's, health insurer, or their employer's finances. The second standard states that the evaluator should be a nurse that has either a bachelor's or master's degree. The third standard refers to the aim of the evaluation, which is to strengthen the self-management and self-reliance of the applicant. It also lists questions that the evaluator can ask the applicant to better understand their situation. The questions include: i) What are your personal goals?, ii) What issues do you face to achieve these goals?, iii) Why do you face these issues and what can you do yourself?, iv) Do you have any informal caregivers, family, or other social support?, v) How can a community nurse help you achieve those goals? The fourth standard states that the evaluator should use clinical reasoning to make decisions during the evaluation of dependence. This includes asking clarifying questions, conducting follow-up research on specific limitations (e.g., observing the applicant's ability to conduct certain activities), and making diagnoses that include the problem, etiology, signs, and symptoms. The fifth standard refers to the V&VN reporting guidelines, which recommend using the following frameworks when reporting conditions or limitations: ICF, Gordon's health patterns, NANDA, NIC, and NOC. These are frameworks used to describe and organize information on functioning and disability in clinical settings. Any care plans used alongside the frameworks should include the nature of the problem, the extent, duration, goals of care, and the desired result. Lastly, the sixth standard states that any patient electronic data transfers between nurses and caregivers should comply with V&VN standards of transfer. Using the six standards the evaluator will then decide what type of care the applicant will need and who should provide that care.

Source: Verpleegkundigen & Verzorgenden Nederland (2014, 2019)

Box 12: WMO Evaluation of Dependence Differences by Region

- Groningen, Utrecht, Enschede, Almere, Leeuwarden, Eindhoven, and Emmen
  - Eligibility for individualized services was based on certain outcomes: a clean and livable home, doing laundry, grocery shopping, and preparing meals. If there were no general services that could help address the applicant's needs and they were unable to achieve these outcomes due to limitations in self-reliance and had no usual help from their housemates or social network, they were eligible to receive individualized home care services. A house was considered to be clean and livable if it could be inhabited and used normally and met basic hygiene requirements. Specifically, the living room, bedrooms, kitchen, bathrooms, hallways, and stairs would have to be cleaned regularly. For laundry, the outcome was having clean clothing and linen and for grocery shopping, the outcome was being able to shop and have sufficient living resources in the household. Lastly, for preparing meals the outcome was being able to prepare cold and hot meals.
- Amsterdam, The Hague, Maastricht, Terneuzen, and Nijmegen
  - If there were no general services that could help address the applicant's needs and they were unable to address their care needs due to limitations in self-reliance and had no usual help from their housemates or social network, they were eligible to receive individualized home care services. The assessment is not based on those specific outcomes.

Source: Overheid.nl Monitor (2017a-2017c, 2018a-2018c, 2019a, 2020a, 2020b, 2021a, 2023c, 2023d)

Box 13: WLZ Permanent Supervision vs. 24-Hour Care Nearby

Permanent supervision is uninterrupted supervision and active observation for 24 hours a day. Timely interventions can prevent situations from worsening. Whereas, 24-hour care nearby is defined as care that mainly consists of passive supervision and does not require permanent active observation. Supervision is necessary at both planned and unplanned moments of care and the care provider must take initiative as the individual cannot ask for help themselves. For 24-hour care nearby, there is a distinction between requiring constant guidance, nursing, and self-care due to physical problems and requiring constant guidance and taking over tasks due to serious management problems. The latter relates to individuals who have problems related to social skills, behavior, psychological functioning, memory, and orientation.

Source: Overheid.nl Monitor (2015b)

Box 14: WLZ Care Profiles

In 2023, there were 40 care profiles: 6 related to nursing and care, 6 related to mental disability, 6 related to mild mental disability, 5 related to physical disability, 7 related to sensory disability, and 10 related to mental health (Overheid.nl Monitor, 2023e, 2023f). The following describes the care profiles for nursing and care:

- 4 Nursing and Care (Verpleging en verzorging - VV): Sheltered living with intensive guidance and extensive care
- 5 VV: Sheltered living with intensive dementia care
- 6 VV: Sheltered living with intensive care and nursing
- 7 VV: Sheltered living with very intensive care, due to specific conditions, with an emphasis on guidance
- 8 VV: Sheltered living with very intensive care, due to specific conditions, with an emphasis on care/nursing
- 9 VV: Recovery-oriented treatment with nursing and care

The care profiles detail the typical traits of individuals assigned to each profile. For example, the 4 VV care profile describes that individuals within it often require assistance across various facets of social independence, communication, decision-making, and task execution. They cannot or hardly participate independently in social life. They need help, supervision or guidance with all psychosocial/cognitive functions because they have many limitations with regard to thinking, memory, orientation, and concentration. They often need supervision and stimulation to perform ADLs and have limited ability to move independently indoors and outdoors.

Source: Overheid.nl Monitor (2015b)

Formula 3: WMO Maximum Period Contribution (2015-2016)

$$PC_{i,t} = MPC_t + .15(CI_{i,t} - I_t)(1/13)$$

- $PC_{i,t}$ = Individual's i's maximum period (4-week period) copayment at time t
  - $PC_{i,t}$ can never be less than zero
- MPC_t = Maximum period (4-week period) copayment set in national guidelines at time t —FC_t values are provided in Table 19
- $CI_{i,t}$ = Individual's i's annual contributable income at time t —the definition of contributable income is provided in Box 1
- I_t = Annual income threshold at time t —I_t values are provided in Box 15

Source: Overheid.nl Monitor (2017f)
Notes: The maximum period contribution (4-week period copayment) of individuals whose aggregate income exceeded a certain amount was calculated based on a formula.

Formula 4: WMO Maximum Period Contribution (2017-2018)

$$PC_{i,t} = MPC_t + .125(CI_{i,t} - I_t)(1/13)$$

- $PC_{i,t}$ = Individual's i's maximum period (4-week period) copayment at time t
  - $PC_{i,t}$ can never be less than zero
- MPC_t = Maximum period (4-week period) copayment set in national guidelines at time t —FC_t values are provided in Table 19
- $CI_{i,t}$ = Individual's i's annual contributable income at time t —the definition of contributable income is provided in Box 1
- I_t = Annual income threshold at time t —I_t values are provided in Box 15

Source: Overheid.nl Monitor (2017f)
Notes: The maximum period contribution (4-week period copayment) of individuals whose aggregate income exceeded a certain amount was calculated based on a formula.

Box 15: WMO Maximum Period Contribution Income Thresholds (2015-2018)

The maximum period contribution in 2015 and 2016 is increased by 15% x (contributable income - income limit) (1/13) if the individual's contributable income exceeds the income limit. The income thresholds vary by age, marital status, and year.

2015
- Single individuals under the retirement age: 22,331€
- Single individuals who have reached or are over the retirement age: 16,634€
- Married individuals where one or both are under the retirement age: 27,917€
- Married individuals where both have reached or are over the retirement age or are older: 23,046€

11 **2016**
- Single individuals under the retirement age: 22,486€
- Single individuals who have reached or are over the retirement age: 16,887€
- Married individuals where one or both are under the retirement age: 28,177€
- Married individuals where both have reached or are over the retirement age or are older: 23,374€

The maximum period contribution in 2017 and 2018 is increased by 12.5% x (contributable income - income limit) (1/13) if the individual's contributable income exceeds the income limit. The income thresholds vary by age, marital status, and year.

2017
- Single individuals under the retirement age: 22,632€
- Single individuals who have reached or are over the retirement age: 17,033€
- Married individuals where one or both are under the retirement age: 35,000€
- Married individuals where both have reached or are over the retirement age or are older: 23,5254€

2018
- Single individuals under the retirement age: 22,873€
- Single individuals who have reached or are over the retirement age: 17,474€
- Married individuals where one or both are under the retirement age: 35,175€
- Married individuals where both have reached or are over the retirement age or are older: 24,128€

Source: Overheid.nl Monitor (2017f and 2019c)
Notes: Users paid a copayment for home care services under WMO, which was capped at a maximum amount per 4-week period called the maximum period contribution. Municipalities could use the maximum period contributions set in national guidelines or set their own maximum period contributions. From 2015 to 2018, a means-test was conducted to calculate the maximum period contribution for individuals whose aggregate income exceeded a certain amount. In 2019, the copayment subject to an income-related 4-week period maximum was replaced with a fixed copayment rate called the subscription rate (abonnementstarief). Everyone had the same subscription rate or maximum monthly contribution regardless of income or assets, marital status, or care use. Box 1 defines contributable income.

Table 19: WMO National Maximum Period Contributions (2015-2023)

Year	Copayment or Subscription Rate (€)
2015	19.40
2016	19.40
2017	17.50
2018	17.60
2019-2023	19.0

Source: Overheid.nl Monitor (2017f and 2019c)

Notes: From 2015 to 2018, users paid a copayment for home care services under WMO, which was capped at a maximum amount per 4-week period called the maximum period contribution. Municipalities could use the maximum period contributions set in national guidelines or set their own maximum period contributions. In 2019, the copayment subject to income-related 4-week period maximums was replaced with a fixed copayment called the subscription rate (abonnementstarief). Everyone had the same subscription rate or maximum monthly contribution regardless of income or assets, marital status, or care use.

Table 20: WLZ Low Copayments

Year	Low Copayment	Minimum and Maximum Copayments (€)
2015	12.5% of contributable income	23 and 697
2016	12.5% of contributable income divided by 12	23 and 701.80
2017	12.5% of contributable income divided by 12	23 and 705.20
2018	10% of contributable income divided by 12	23 and 711.20
2019	10% of contributable income divided by 12	23.40 and 721
2020	10% of contributable income divided by 12	23.80 and 737.40
2021	10% of contributable income divided by 12	24.40 and 752.80
2022	10% of contributable income divided by 12	24.80 and 764
2023	10% of contributable income divided by 12	26 and 808

Source: Overheid.nl Monitor (2015e)

Notes: Contributable income is defined as aggregate income minus the compensation for lapsed elderly allowance plus 4% of savings and investments if that amount is more than 31,340€ for single individuals and 62,680€ for married individuals in 2021. Income from 2 years ago is used to calculate the copayment (e.g., income from 2021 is used to calculate the 2023 copayment). Aggregate income includes taxable income from work and home, benefits, shares, dividends, savings, and investments. The compensation for lapsed elderly allowance is an amount deducted from the copayment among those who have reached state pension age and have savings or investments. The maximum amount deducted is 1,700€ per person (CAK, n.d.).

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Glossary of terms

This section summarizes key definitions from the main text. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

Activities of daily living (ADL): A common set of activities related to personal care used to assess independence, including bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating.

AWBZ: The General Special Medical Expenses Act (Algemene Wet Bijzondere Ziektekosten - AWBZ) was created in 1968 with the goal of protecting the Dutch population against the significant costs associated with LTC. Organized at the national level by the Ministry of Health, Welfare, and Sport and at the regional level by regional care offices and health insurers, AWBZ was a universal and compulsory scheme that covered a wide range of long-term care services for older adults with care needs including home care, semi-residential care, and residential care benefits.

Axis I: Axis I in the DSM categorizes clinical disorders, excluding personality and intellectual disabilities. It covers conditions like mood, anxiety, and psychiatric disorders.

Basis (Grondslag): A basis is a condition, limitation, and/or disability that requires the applicant to rely on care. The six bases include somatic, psychogeriatric, psychiatric, physical, mental, and sensory.

BIG register: The BIG register is a legal, online and public register for healthcare professions. Healthcare professionals included in the BIG register have the right to use their designated professional titles and independently perform the specialized practices specific to their field.

CIZ: The Care Assessment Center (Centrum Indicatiestelling zorg - CIZ) conducts the evaluation of dependence for AWBZ from 2005 and for WLZ from 2015.

Community Nurse: Community nurses complete four years of higher professional education in nursing (comparable to nurse practitioners in the United States).

DSM: The Diagnostic and Statistical Manual of Mental Disorders is a handbook used by healthcare professionals worldwide as a guide for diagnosing mental health conditions. The DSM outlines criteria, symptoms, and classification of various mental disorders to aid in accurate diagnosis and treatment planning.

Functions (Functies): They types of care provided by AWBZ are referred to as functions. Before 2007, the functions include personal care, nursing, supportive guidance, activating guidance, treatment, residence, and continued residence on a psychiatric basis. From 2007, the functions include personal care, nursing, guidance, treatment, residence, short-term stay (added in 2011), and continued residence on a psychiatric basis.

GIRO: A general interbank recurring order (GIRO) is an electronic payment option commonly used in Europe and Asia that allows banks to money from one account to another.

ICD: The International Classification of Diseases is a globally used system created by the World Health Organization (WHO) to classify and code various diseases, health conditions, and related factors. It provides a standardized way to diagnose and categorize illnesses and health-related issues.

ICF: The International Classification of Functioning, Disability and Health is a WHO framework that organizes information about functioning and disability. It establishes a standardized language and conceptual groundwork for defining and assessing health and disability.

Instrumental activities of daily living (IADL): Tasks related to independent living including preparing meals, managing money, shopping for groceries, performing housework, and using a telephone.

Usual Care: The normal and daily informal care that partners, parents, children, and/or housemates living at home are expected to provide to each other.

Voluntary Care: Any informal care that exceeds usual care.

WLZ: Organized at the national level by the Ministry of Health, Welfare, and Sport and at the regional level by regional care offices and health insurers, Long Term Care Act (Wet langdurige zorg - WLZ) provides LTC to older adults with intensive care needs. It was created in 2015 to provide a new policy framework for residential care after the General Special Medical Expenses Act (Algemene Wet Bijzondere Ziektekosten - AWBZ) was repealed. It also introduced 24-hour care at home, a service that wasn't offered under AWBZ previously.

WMO: Created in 2007, the Social Support Act (Wet maatschappelijke ondersteuning - WMO) provides home care benefits that support an individual in maintaining their living environment and daily domestic tasks (domestic assistance). It is organized at the municipal level.

ZVW: The Health Insurance Act (Zorgverzekeringswet - ZVW), which is organized by health insurers, provides personal care and home nursing services to older adults with care needs since 2015 when the AWBZ was repealed.

Notes

This section reports notes from the main text. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

1. The Gateway LTC series distinguishes assessments as either objective or subjective depending on their approach to evaluating an individual's eligibility for services. Objective assessments typically rely on defined scales or clear categories/thresholds. Conversely, subjective assessments do not rely on strict predetermined thresholds and often consider multiple factors of an individual's circumstances comprehensively, allowing evaluators flexibility in their judgment.
2. Individuals are not eligible for personal care and nursing care covered by ZVW if they are also eligible for WLZ care.
3. Individuals who are eligible for WLZ receive most of their care from WLZ, regardless of whether they are eligible for other programs. For instance, if someone requires both personal care and nursing assistance and is eligible for both WLZ and WMO, they typically

receive these services through WLZ. However, the municipality may still offer additional services, such as transportation (e.g., regional taxi services), assistive devices like wheelchairs, and home modifications. The benefits provided under WMO while receiving WLZ care can vary depending on factors such as the individual's place of residence—whether in a care institution, at home, or both (part-time residence).

4. An individual may be eligible, but their eligibility decision may have expired. The eligibility decision states from what date the applicant is allowed to receive care and how long the eligibility decision is valid for (period of validity).

5. In Chapter 3, individuals who qualify for WLZ benefits based on the dependence evaluation also have to meet additional conditions to choose cash benefits over in-kind benefits. While this information has been confirmed for WLZ in Chapter 3 (2015-2024), it remains unverified for AWBZ in Chapter 1 (1996-2006) and Chapter 2 (2007-2014). Nonetheless, these conditions were potentially in place during the period from 1996 to 2014 since WLZ replaced AWBZ in 2015. For example, individuals have to explain to their care office why a personal budget better fits their specific needs compared to in-kind care options. They must outline their intended care purchases and selected care provider(s) within a budget plan. They must also establish healthcare agreements with each chosen provider, including hourly rates and, if needed, a care description outlining the specifics of the care to be provided.

6. Physical conditions involve ailments, diseases, or injuries that affect the body and are diagnosed through medical tests. In contrast, functional conditions pertain to an individual's ability to perform daily tasks (e.g., how independent they are), including mobility, which may be influenced by physical health but are evaluated through functional assessments.

7. In Chapter 3, individuals who qualify for WMO benefits based on the dependence evaluation also have to meet additional conditions to choose cash benefits over in-kind benefits. While this information has been confirmed for Chapter 3 (2015-2024), it remains unverified for Chapter 2 (2007-2014). Nonetheless, these conditions were potentially in place during the period from 2007 to 2014. For example, individuals have to explain why they are opting for a personal budget over in-kind care. They also have to demonstrate their capability to manage the allocated personal budget. This includes their ability to procure necessary support services independently or through authorized representatives. Additionally, they have to show their ability to choose effective and safe support services aimed at enhancing their independence.

8. Under ZVW, individuals must receive a decision from a qualified community nurse within the past 3 months on their eligibility for community nursing to be allowed to opt for cash benefits over in-kind care. Additionally, they are required to explain why they are opting for a personal budget over care provided in-kind and demonstrate their ability to effectively manage it. This includes negotiating contracts with healthcare providers, participating in care plans, and ensuring providers adhere to agreed-upon terms.

9. Under WMO, individuals must demonstrate their capability to manage the allocated personal budget. This includes their ability to procure necessary support services independently or through authorized representatives. They must exhibit proficiency in selecting effective and safe support services aimed at enhancing their independence. Additionally, individuals are required to provide a justification for opting for a personal budget over in-kind care.

10. Under WLZ, individuals are required to explain to their care office why a personal budget better fits their specific needs compared to in-kind care options. They must outline their intended care purchases and selected care provider(s) within a budget plan. They must also establish healthcare agreements with each chosen provider, including hourly rates and, if needed, a care description outlining the specifics of the care to be provided.

11. Treatment is one of the functions or types of care provided by AWBZ. Other functions include personal care, nursing, supportive guidance, and activating guidance.

Version information

Current Version: 1.0 (June 2024)

Version History

- 1.0 (June 2024): First version.

Additional resources

The following resources provide additional details for the interested reader:

Bakx, P. et al (2021). Pricing long-term care for older persons: Case Study - Netherlands. Available in English. As of October 10, 2023.
Available at: https://extranet.who.int/kobe_centre/sites/default/files/OECD_2021_Netherlands.pdf
Features: Paper that provides a historical background of the Long-Term Care Insurance System in the Netherlands and how the different schemes are financed.

Bakx, P. et al (2023). Long-term Care in The Netherlands. Available in English. As of October 10, 2023.
Available at: https://www.nber.org/system/files/working_papers/w31823/w31823.pdf
Features: Paper that provides a comprehensive overview of the LTC system in The Netherlands including financing, care provision, and eligibility.

Overheid.nl Monitor. Available in Dutch. As of October 10, 2023.
Available at: https://wetten.overheid.nl/zoeken
Features: Legal database that provides current and historical versions of LTC laws in the Netherlands

Per Saldo. Available in Dutch. As of October 10, 2023.
Available at: https://www.pgb.nl/
Features: Website of the national association of people with a personal budget. It provides useful information about different personal budgets including those provided by AWBZ, WMO, WLZ, and ZVW.