GATEWAY TO GLOBAL AGING DATA

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Gateway Policy Explorer: Long-Term Care Series

Netherlands

Long-Term Care In-Kind Benefit Plan Details

1992-2024

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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

In-Kind Benefits

Plan details 1992-2024 * †

In the Netherlands, in-kind benefits are one of the long-term care (LTC) services provided to older adults who are care dependent. In-kind benefits include home care, semi-residential care, and residential care. Until 2007, most LTC benefits were provided by The General Special Medical Expenses Act (AWBZ), which was universal and compulsory. Individuals were eligible for in-kind benefits through AWBZ as long as they were a resident of the Netherlands and they paid the income-related premium. Income-related copayments varied depending on the care benefits received. 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. Individuals were eligible for in-kind benefits 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). Semi-residential care benefits previously provided by AWBZ including day/night care and short-term stay were transferred to WMO and domestic assistance remained a benefit provided by WMO. Residential 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, they paid the income-related contribution, and they 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

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† 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 1992-2006

Overview

During this period, the Dutch Long-Term Care (LTC) System provided a wide range of in-kind benefits through home care, semi-residential care, and residential care mostly organized at the national level. Benefit eligibility was 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 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. Individuals were eligible for in-kind benefits through AWBZ as long as they were a resident of the Netherlands and they paid the income-related premium (Overheid.nl Monitor, 2002b).

Individuals paid different copayments depending on whether they were receiving care with or without accommodation. Care with accommodation included residential care and care without accommodation included home care and semi-residential care. For care without accommodation, individuals paid an hourly rate (11.80€ per hour in 2003), which was capped at a maximum amount per four-week period. For care with accommodation, there was a low and high copayment rate depending on the duration of your stay and whether the beneficiary received child benefits. In 2003, the low copayment rate was 10% of the individual's contributable income, with a minimum of 102.10€ per month and a maximum of 556€ per month. The high copayment rate was 1,624€ per month although the amount could be reduced depending on the individual's income. The evaluation of dependence was subjective[1] 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. Before 2003, dependence was defined in terms of the type of care and health care providers individuals required but after 2003, dependence was 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 personal budgets, please refer to the policy document Netherlands Long-Term Care Cash Benefit Plan Details, 1996-2024 (Gateway to Global Aging Data, 2024).

This policy period (chapter) provides details on in-kind benefits of the Dutch LTC system from 1992 to 2006.

Statutory basis

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

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, 2003b, 2003c). 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, 2002b).

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, 2002b, §5(1))
- Contribution requirement: Pays income-related premium (Overheid.nl Monitor, 2002b, §48)
  - 12.3% of the first 28,850€ or a maximum of 3548.60€ in 2003 (Overheid.nl Monitor, 2003b, 2003c)

Benefit

Home care benefit

Home care benefits include (Overheid.nl Monitor, 2002a):

- Domestic assistance: help with house-related activities such as cleaning, minor repairs, and laundry
- Personal care: help with ADLs and IADLs
- Home nursing: nursing care provided at the beneficiary's home by a community nurse (e.g., wound care, administering medications, and stoma care)

Semi-residential care

Semi-residential care benefits include[2] (Overheid.nl Monitor, 2002a, 2002d):

- Day care: provision of supportive or activating guidance during the day
  - Supportive guidance: activities that aim to promote or maintain self-reliance or integration into society. For example, helping the beneficiary with scheduling, providing practical assistance, and accompanying the beneficiary to appointments.
  - Activating guidance: activities that aim to treat or prevent conditions, limitations, or disabilities. For example, behavioral modification and practicing social skills.

Residential care

Residential care benefits include (Overheid.nl Monitor, 2002a):

- Residential home: facilities that provide personal care
- Nursing home: facilities that provide personal and/or nursing care

Other benefits

None

Provision of care

Institutional care was provided by non-profit organizations while home care was provided both by non-profit and for-profit organizations (European Commission, 2019). In-kind services were organized and procured by 32 regional care offices. The largest health insurer in an area was usually designated as the regional care office (Bakx et al., 2021).

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, 2003d).

Duration of benefit

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

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, 2003e). Table 1 describes what bases provide access to what functions.

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, 2003d, §6-§15):

- 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. Table 1 describes what bases provide access to what functions. 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).

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, 2003d, §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.). Evaluators included CIZ staff members, the applicant's physician, and other individuals and organizations that have relevant expertise pertaining to the applicant's care needs.

Benefit limitations

Can you mix LTC benefits?

Individuals can mix cash benefits and in-kind benefits if they are assigned to more than one function or type of care. For example, if an individual is assigned to 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?

From 1996, individuals receiving home care or semi-residential care benefits could choose to receive care in-kind (Zorg in Natura -ZIN) or through cash benefits (Persoonsgebonden Budget - PGB) (Overheid.nl Monitor, 2002b, 2003f).

Can you receive LTC benefits with other social security benefits?

There are no limits on receiving in-kind benefits with other social security benefits.

User costs

User charges

Individuals paid income-related copayments. The copayments varied depending on whether the individual was assigned to receive care with or without accommodation. Care without accommodation included domestic assistance, personal care, supportive guidance, activating guidance, and home nursing. Care with accommodation included residential care. In 2003, users paid 11.80€ per hour for care services without accommodation. If care was provided for part of an hour, the copayment was calculated proportionately (Overheid.nl Monitor, 2003a). Table 2 lists copayment rates per hour or half-day for care services without accommodation from 2002 to 2014. During a four-week period, an individual's or married couple's copayment could not exceed a certain amount. In 2002, this was based on contributable income (bijdrageplichtig inkomen) categories and from 2003 to 2006, this was based on a formula. Box 1 lists the 2002 contributable income categories and income-related copayment rates per four-weeks for services without accommodation from 2002 to 2006. Formula 1 provides detailed information on how to calculate the income-related copayment for care without accommodation.

For care with accommodation, there was a low and a high income-related copayment. Married individuals whose spouse did not reside in an institution paid the low copayment rate during their entire stay in a residential or nursing home. Single individuals and married individuals who are both staying in an institution paid a low copayment rate during their first six months of stay. After the first six months, single individuals and married individuals who are both staying in an institution continued to pay a low copayment rate if they received child benefits and paid for their children's expenses or if their health insurer believed their stay at an institution is likely to be temporary. All other individuals paid a high copayment rate after their first six months of stay. In 2003, the low copayment rate was 10% of the individual's contributable income, with a minimum of 102.10€ per month and a maximum of 556€ per month. The high copayment rate for a single individual or a married couple in situations where both individuals were residing in an institution was 1,624€ per month. However, the copayment was reduced to a twelfth of an individual's or married couple's contributable income if their contributable income divided by twelve was less than 1,624€ (Overheid.nl Monitor, 2003a). Box 2 lists low copayments and Box 3 lists high copayments from 1996 to 2006. Box 4 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. Home care benefits that supported an individual in maintaining their living environment and daily domestic tasks (domestic assistance) became a municipal responsibility under WMO and were no longer a benefit provided by AWBZ. Municipalities were responsible for organizing and providing household-related home care services. They also set their own rates and conducted their evaluation of dependence. However, some home care services were still provided under AWBZ including personal care and home nursing.

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. It was 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 were eligible for in-kind benefits through AWBZ as long as they were a resident of the Netherlands and they paid the income-related premium (Overheid.nl Monitor, 2014a). Individuals paid different income-related copayments depending on whether they were receiving care with accommodation (residential care) or without accommodation (semi-residential care or home care). The evaluation of dependence was subjective[1] 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 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 in-kind benefits through WMO as long as they were a resident of the Netherlands (Overheid.nl Monitor, 2014d). 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. In 2012, the national guidelines set the maximum period contribution for single individuals at 18€ and for married individuals at 25.80€ (Overheid.nl Monitor, 2013c). 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 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 personal budgets, please refer to the policy document Netherlands Long-Term Care Cash Benefit Plan Details, 1996-2024 (Gateway to Global Aging Data, 2024).

This policy period (chapter) provides details on in-kind 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, 2014d)

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, 2014d, §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, 2014d, §2(8))

Benefit

Home care benefit

AWBZ

Home care benefits provided under AWBZ include (Overheid.nl Monitor, 2012a) —

- Personal care: help with ADLs and IADLs (e.g., dressing or bathing)
- Home nursing: nursing care provided at the beneficiary's home by a community nurse (e.g., wound care, administering medications, and stoma care)

WMO

Home care benefits provided under WMO include (Overheid.nl Monitor, 2007a) —

- Domestic assistance: help with house-related activities, specifically —
  - Grocery shopping
  - Preparing meals
  - Light housework (e.g., dusting, washing the dishes, and caring for pets)
  - Heavy housework (e.g., vacuuming, cleaning the kitchen or bathroom, and changing bed sheets)
  - Laundry including drying, ironing, and folding
  - Home modifications

Semi-residential care

AWBZ

Semi-residential care benefits provided under AWBZ include[2] (Overheid.nl Monitor, 2012a):

- Day care: provision of supportive or activating guidance during the day. From 2009, supportive and activating guidance are combined and referred to as guidance.
  - Supportive guidance: activities that aim to promote or maintain self-reliance or integration into society. For example, helping the beneficiary with scheduling, providing practical assistance, and accompanying the beneficiary to appointments.
  - Activating guidance: activities that aim to treat or prevent conditions, limitations, or disabilities. For example, behavioral modification and practicing social skills.
- Short-term stay centers: facilities that provide personal and/or nursing care for up to 3 days per week (since 2011)

WMO

None

Residential care

AWBZ

Residential care benefits provided under AWBZ include (Overheid.nl Monitor, 2012a):

- Residential home: facilities that provide personal care for more than 3 days per week
- Nursing home: facilities that provide personal and/or nursing care for more than 3 days per week

WMO

None

Other benefits

None

Provision of care

Provision of care varies by LTC system.

AWBZ

Institutional care was provided by non-profit organizations while home care was provided both by non-profit and for-profit organizations (European Commission, 2019). In-kind services were organized and procured by 32 regional care offices. The largest health insurer in an area was usually designated as the regional care office (Bakx et al., 2021).

WMO

Home care was provided by organizations that have a contract with the municipality (Overheid.nl Monitor, 2012b). These included both non-profit and for-profit organizations (European Commission, 2019). Municipalities organized and contracted providers (Bakx et al., 2023).

Benefit eligibility

Qualifying period

None

Minimum level of dependence

The minimum level of dependence varies by LTC system.

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. To be eligible for AWBZ care, an insured person must have at least one basis (Overheid.nl Monitor, 2014b, Appendix 2(2.3)).

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.

Duration of benefit

AWBZ

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

WMO

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

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, 2014b, 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, 2014b, 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 mostly based on functional conditions, limitations, and disabilities that disrupt independent functioning and one's ability to run a household (Overheid.nl Monitor, 2014d).

Evaluation of dependence

The evaluation of dependence varies by LTC system.

AWBZ

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, 2014b):

- 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, 2014b, 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 3 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 4 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. Box 5 describes other options to address care needs in detail. 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 6 provides more details about the determination of additional care needed.

Before 2009, individuals were assigned to either nursing home care or residential home care (Mot, 2010). After 2009, individuals assigned to receive care with accommodation are assigned to a care intensity package based on their specific care needs. In 2011, there were 53 different care packages: 10 related to nursing and personal care, 13 related to mental health care, 14 related to intellectual disability, 7 related to physical disability, and 9 related to sensory disability (visual, auditory, and communication). Care intensity packages include the following information: beneficiary profile (usual characteristics of this beneficiary group), care functions required, whether or not health care provider is needed, and the estimated total time of care required. (Overheid.nl Monitor, 2011a). Table 5 describes the personal care and nursing care intensity packages in 2011.

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 6 and Table 7 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 8 lists classes by function and their associated hours of care per week. Box 7 provides an example of how care hours are calculated and how individuals are placed into classes.

WMO

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, 2012b-2012d, 2013d-2013g, 2014e). 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, 2012e, 2013h, 2013i). 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. 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).

Benefit limitations

Can you mix LTC benefits?

Individuals can receive both the AWBZ and WMO in-kind benefits.

AWBZ

Individuals can mix cash benefits and in-kind benefits if they are assigned to more than one function or type of care. For example, if an individual is assigned to 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

All individuals except for those who receive residential care benefits or treatment can choose to receive care in-kind (Zorg in Natura - ZIN) or through cash benefits (Persoonsgebonden Budget - PGB) (Overheid.nl Monitor, 2014b, §2.7(Ad.1)).

WMO

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

Can you receive LTC benefits with other social security benefits?

There are no limits on receiving in-kind 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. The copayments varied depending on whether the individual was assigned to receive care with or without accommodation. Care without accommodation included personal care, supportive guidance, activating guidance, short-term stay, and home nursing. Care with accommodation included residential care. Copayments for short-term stays are equivalent to the low copayment for care with accommodation (CAK, 2014). In 2014, users paid 14.20€ per hour for care services without accommodation. If care was provided for part of an hour, the copayment was calculated proportionately (Overheid.nl Monitor, 2014c). Table 2 lists copayment rates for care services without accommodation from 2002 to 2014. During a four-week period, copayments could not exceed more than a certain amount, which are listed in Table 9. However, the copayment per four-weeks of individuals whose income exceeded a certain amount was calculated based on a formula (Overheid.nl Monitor, 2014c). Box 8 and Box 9 list the income thresholds used to calculate the income-related copayment for care services without accommodation of individuals whose income exceeded the income limit from 2007 to 2014. Formula 2 provides detailed information on how to calculate this income-related copayment.

For care with accommodation, there was a low and a high income-related copayment. Married individuals whose spouse did not reside in an institution paid the low copayment rate during their entire stay in a residential or nursing home. Single individuals and married individuals who are both staying in an institution paid a low copayment rate during their first six months of stay. After the first six months, single individuals and married individuals who are both staying in an institution continued to pay a low copayment rate if they received child benefits and paid for their children's expenses or if their health insurer believed their stay at an institution is likely to be temporary. All other individuals paid a high copayment rate after their first six months of stay. In 2014, the low copayment rate was 12.5% of the individual's contributable income (bijdrageplichtig inkomen), with a minimum of 156€ per month and a maximum of 819.40€ per month. The high copayment rate for a single individual or a married couple in situations where both individuals were residing in an institution was 1/12 of contributable income or joint contributable for married individuals. The copayment could not exceed 2,248.60€ per month. Box 10 lists low copayments and Box 11 lists high copayments from 2007 to 2014. Box 4 defines contributable income.

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 9 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, which is the same formula used to calculate the four-week period contribution for AWBZ care without accommodation. Formula 2 provides detailed information on how to calculate this contribution. Box 8 and Box 9 list the income thresholds used to calculate the copayment 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, 2012b, 2012f-2012h, 2013e, 2013j-2013q, 2014f, 2014g). Table 10 lists the largest or second largest municipality by province and if they used the nationally set maximum period contributions in 2012 or 2013.

The hourly rates differed by municipality. For a subset of municipalities, including Groningen and Almere, there was one rate for household help category 1 (HH1) and another rate for household help category 2 (HH2) (Overheid.nl Monitor, 2013p, 2013q). 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, 2007a). For a subset of municipalities, including Leeuwarden and Maastricht, there was one hourly rate for any home care. In other municipalities, such as Assen, it varied depending on the category (HH1 or HH2) and who provided the care (healthcare professional or non-professional) (Overheid.nl Monitor, 2012h, 2013n, 20130). Table 11 lists hourly home care rates by municipality.

Taxation of benefits

Not subject to taxation

Chapter 3: Policy enacted 2015-2024

Policy change in 2015
In 2015, AWBZ was repealed. Personal care and home nursing were now provided by the Health Insurance Act (Zorgverzekeringswet - ZVW), home care services such as domestic assistance and semi-residential care such as day/night care and short-term stay were provided by WMO, and residential care was 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, 2019g)
  - 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 in-kind benefits through ZVW as long as they are a resident of the Netherlands, they pay the income-related contribution, and they pay a 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 applies to receive help 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 in-kind benefits through WMO as long as they are a resident of the Netherlands (Overheid.nl Monitor, 2023a). 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 whereas individualized services do require prior research. Many general services are free. However, in some municipalities, individuals pay the cost set by the provider for 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 copayments in 2017, which was 17.50€ per four-weeks (Overheid.nl Monitor, 2017b). A means-test is conducted to calculate the maximum period contribution for individuals whose aggregate income exceeds a certain amount. In 2019, the copayment subject to income-related 4-week period maximums was replaced with a fixed copayment called the subscription rate (abonnementstarief). Everyone has 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[1] 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 defined levels of dependence for eligibility or benefits.

WLZ

WLZ provides residential care to older adults 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 in-kind benefits through WLZ as long as they are a resident of the Netherlands and they pay the income-related premium. Individuals pay a low or a high income-related copayment depending on their duration of stay, whether they receive child benefits, and whether their insurer believes

their stay is likely to be temporary. 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.[5] There are no defined levels of dependence for eligibility or benefits 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. WLZ also provides care to individuals who need continuous 24-hour care nearby and/or permanent monitoring at home. For details about the 24-hour home care benefit, please refer to the policy document The Netherlands 24-Hour Long-Term Care Benefits Plan Details, 2015-2024 (Gateway to Global Aging Data, 2024).

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 personal budgets, please refer to the policy document Netherlands Long-Term Care Cash Benefit Plan Details, 1996-2024 (Gateway to Global Aging Data, 2024).

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

Statutory basis

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

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, 2015c)

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 contribution 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, 2019g). 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, 2023d, §3(10-11)).

WMO

WMO covers care needs related to functional 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, 2023d, §4)
- Contribution requirement:
  - Pays the nominal premium (health insurance premium) (Overheid.nl Monitor, 2023d, §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, 2023d, §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, 2015c, §1(2.1.1))
- Contribution requirement: Pays income-related premium (Overheid.nl Monitor, 2015c, §3(3.2.5))
  - 9.65% of the first 37,149€ or a maximum of 3,584.90€ in 2023

Benefit

Home care benefit

ZVW

Home care benefits provided under ZVW include[2] (Healthcare Institute of the Netherlands, n.d.):

- Home nursing: nursing care provided at the beneficiary's home by a community nurse (e.g., wound care, administering medications, and stoma care)

- Personal care (only if needed alongside nursing care): help with ADLs and IADLs (e.g., dressing, bathing)
- Domestic assistance (only if needed alongside nursing care): preparing meals
- Palliative care

WMO

Home care benefits provided under WMO include (Overheid.nl Monitor, 2023a):

- Domestic assistance: help with house-related activities, specifically:
  - Grocery shopping
  - Preparing meals
  - Light housework (e.g., dusting, washing the dishes, and caring for pets)
  - Heavy housework (e.g., vacuuming, cleaning the kitchen or bathroom, and changing bed sheets)
  - Laundry including drying, ironing, and folding
  - Home modifications

WLZ[6]

None

Semi-residential care

ZVW and WLZ[4]

None

WMO

Semi-residential care benefits provided under WMO include[3] (Overheid.nl Monitor, 2017k):

- Day care: guidance provision during the day
  - Guidance: activities that aim to promote or maintain self-reliance or integration into society or activities that aim to treat or prevent conditions, limitations, or disabilities. For example, helping the beneficiary with scheduling, providing practical assistance, accompanying the beneficiary to appointments, and practicing social skills.
- Short-term stay centers: facilities that provide personal and/or nursing care for up to 3 days per week

Residential care

ZVW and WMO

None

WLZ[6]

Residential care benefits provided under WLZ include (Overheid.nl Monitor, 2015c):

- Residential home: facilities that provide personal care
- Nursing home: facilities that provide personal and/or nursing care

Other benefits

None

Provision of care

Provision of care varies by LTC system.

ZVW

For-profit and non-profit organizations provide home nursing and personal care. The beneficiary's health insurer can help organize the care.

WMO

Home care is provided by organizations that have a contract with the municipality (Overheid.nl Monitor, 2012b). These include both non-profit and for-profit organizations (European Commission, 2019). Municipalities organized and contracted providers (Bakx et al., 2023).

WLZ

Institutional care is provided by non-profit organizations (European Commission, 2019). Services are organized and procured by 31 regional care offices (before 2017 there were 32 offices) (Ministry of Health, Wealth, and Sport, n.d.). The largest health insurer in an area is usually designated as the regional care office (Bakx et al., 2021). Home care benefits, documented separately as 24-hour

home care benefits, can be for-profit. For details about the 24-hour home care benefit, please refer to the policy document The Netherlands 24-Hour Long-Term Care Benefits Plan Details, 2015-2024 (Gateway to Global Aging Data, 2024).

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).

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.

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, 2015d, Appendix 1(1.2)).

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.

WLZ

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

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

WMO

Dependence is mostly based on physical and functional[6] 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, 2015d, 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 12.

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 13 outlines how the evaluation of dependence varies by municipality.

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, 2015d):

- 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 3 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 14.

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.[5] 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 15 further explains care profiles.

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. 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, 2015d).

Benefit limitations

Can you mix LTC benefits?

Individuals cannot mix cash benefits and in-kind benefits.

ZVW, WMO, and WLZ

It is possible to mix WMO benefits with either ZVW or WLZ benefits. For example, someone can receive domestic assistance through WMO and simultaneously receive home nursing through ZVW. Similarly, someone can live in a WLZ residential care institution and use municipal transportation services specifically for older adults that are provided through WMO. It is not possible to mix WLZ benefits with ZVW benefits (Centraal Planbureau, 2015).

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, 2022).

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, 2015c, §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 in-kind 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 copayments that vary depending on the insurer and 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 home nursing and personal care (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.). Box 16 lists monthly nominal premiums for basic health insurance plans of the ten largest health insurers in the Netherlands in 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. Box 17 explains the difference between general and individualized services. For general services, individuals paid the cost set by the provider who is offering the general service in most municipalities. For individualized services, the largest or second largest municipality in each of the 12 provinces in the Netherlands all used the nationally set copayment rates in 2017, which was 17.50€ per four-weeks for both single and married individuals (Overheid.nl Monitor, 2017b). 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, 2015a, 2015b, 2017c-2017g, 2018b-2018d, 2019c, 2019d).

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 18 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, 2015a, 2015b, 2017c-2017g, 2018b-2018d, 2019c, 2019d).

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, 2019f). 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 12 lists WMO copayment rates from 2015 to 2023.

WLZ

Individuals paid income-related copayments. There is a low and a high copayment rate. Married individuals whose spouse did not reside in an institution paid the low copayment rate during their entire stay in a residential or nursing home. Single individuals or married individuals who are both staying in an institution pay a low copayment rate during their first four months of stay in an institution. After the first four months of stay in an institution, single individuals or married individuals who both reside in an institution continued to pay a low copayment rate if they received child benefits and paid for their children's expenses or if their health insurer believed their stay at an institution is likely to be temporary. All other individuals paid a high copayment rate after their first four months of stay in an institution (six months before 2019). In 2023, the low copayment rate was 10% of contributable income (bijdrageplichtig inkomen) divided by 12 with a minimum of 184€ and a maximum of 966€ per month. The high copayment rate was contributable income divided by 12 and could not exceed 2,652.40€ per month (Overheid.nl Monitor, 2015e, §3.2). Table 13 lists the minimum and maximum low copayment rates and Table 14 lists the maximum high copayment rates from 2015 to 2023.

Contributable income is defined differently for the low and high copayments. Box 19 defines contributable income for low copayments. Box 20 defines contributable income for high copayments.

Taxation of benefits

Not subject to taxation

Tables and Formulas

Table 1: 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 (2003e)
Notes: The functions include domestic assistance, personal care, nursing, supportive guidance, activating guidance, treatment, and residential care.

Table 2: AWBZ Copayments for Care Without Accommodation (2002-2014)

Year	Copayment per hour or half day (€)
2002	4.40
2003	11.80
2004	11.80
2005	11.80
2006	12.0
2007	12.20
2008	12.40
2009	12.60
2010	13.0
2011	13.0
2012	13.40
2013	13.60
2014	14.20

Source: Overheid.nl Monitor (1996, 1999, 2002c, 2003a, 2004, 2005b, 2006a)
Notes: Before 2007, care without accommodation includes domestic assistance, personal care, supportive guidance, activating guidance, and home nursing. Copayments for care without accommodation before 2002 have not been identified yet. From 2007, 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. A half-day is a consecutive period of up to four hours. Guidance and short-term stay is awarded in terms of half-days or days. Box 4 defines contributable income.

Box 1: AWBZ Copayments Per 4 Weeks for Care Without Accommodation (2002-2006)

2002

The copayment per four-weeks of individuals who were under the age of 65 could not exceed:

- If their contributable income was less than 14,552€, 2.20€
- If their contributable income was between 14,552€ and 18,568€, 2.80€ for married and 6.80€ for single
- If their contributable income was between 18,568€ and 22,080€, 10.40€ for married and 24.80€ for single
- If their contributable income was between 22,080€ and 25,592€, 28.40€ for married and 38.40€ for single
- If their contributable income was between 25,592€ and 30,610€, 56.60€ for married and 58.80€ for single
- If their contributable income was between 30,610€ and 46,668€, 86.20€ for married and 99.80€ for single
- If their contributable income was over 46,668€, 113.40€ for married and 124.60€ for single

The copayment per four-weeks of individuals who were 65 years or older could not exceed:

- If their contributable income was less than 12,042€, 2.20€
- If their contributable income was between 12,042€ and 15,556€, 2.80€ for married and 6.80€ for single
- If their contributable income was between 15,556€ and 17,562€, 10.40€ for married and 24.80€ for single
- If their contributable income was between 17,562€ and 20,072€, 28.40€ for married and 38.40€ for single
- If their contributable income was between 20,072€ and 24,086€, 56.60€ for married and 58.80€ for single
- If their contributable income was between 24,086€ and 39,140€, 86.20€ for married and 99.80€ for single
- If their contributable income was over 39,140€, 113.40€ for married and 124.60€ for single

2003

- The copayment per four-weeks will not exceed 15% x (contributable income per four-weeks- 140€) (1/13). The minimum copayment per four-weeks is 16€ and the maximum is 528.20€.

2004

- The copayment per four-weeks will not exceed 15% x (contributable income per four-weeks- 140€) (1/13). The minimum copayment per four-weeks is 16€ and the maximum is 528.20€.

2005

- The copayment per four-weeks will not exceed 15% x (contributable income per four-weeks- 142.20€) (1/13). The minimum copayment per four-weeks is 16.2€ and the maximum is 536.80€.

2006

- The copayment per four-weeks will not exceed 15% x (contributable income per four-weeks- 144.20€) (1/13). The minimum copayment per four-weeks is 16.4€ and the maximum is 544.20€.

Source: Overheid.nl Monitor (2002c, 2003a, 2004, 2005b, 2006a)
Notes: Care without accommodation includes domestic assistance, personal care, supportive guidance, activating guidance, and home nursing. Copayments for care without accommodation before 2002 have not been identified yet. Box 4 defines contributable income.

Formula 1: Calculation of AWBZ 4-Week Period Copayment for Care Without Accommodation (2003-2006)

$$PC_{i,t} = .15(C_{i,t} - A_t)(1/13)$$

- $PC_{i,t}$ = Individual's i's maximum 4-week period copayment at time t
  - $PC_{i,t}$ can never be less than zero
- $C_{i,t}$ = Individual's i's contributable income per four weeks at time t —the definition of contributable income is provided in Box 4
- A_t = Defined amount at time t
  - 2003-2004: 140€
  - 2005: 142.20€
  - 2006: 144.20€

Source: Overheid.nl Monitor (2003a)

Box 2: AWBZ Low Copayments for Care With Accommodation (1996-2006)

1996

1,085ƒ but individuals with the following contributable income had different copayments:

- If their contributable income was less than 27,601ƒ, a copayment of 210ƒ
- If their contributable income was between 27,601ƒ and 31,201ƒ, a copayment of 345ƒ
- If their contributable income was between 31,201ƒ and 36,001ƒ, a copayment of 520ƒ
- If their contributable income was between 36,001ƒ and 54,001ƒ, a copayment of 865ƒ

2002

535.46€ but individuals with the following contributable income had different copayments:

- If their contributable income was less than 13,677.39€, a copayment of 102.10€
- If their contributable income was between 13,677.39€ and 20,352.50€, a copayment of 170.17€
- If their contributable income was between 20,352.50€ and 33,920.52€, a copayment of 256.39€
- If their contributable income was between 33,920.52€ and 42,590€, a copayment of 426.55€

2003

- 10% of the contributable income with a minimum of 102.10€ and a maximum of 556€

2004

- 12.5% of the contributable income with a minimum of 130.60€ and a maximum of 685.40€

2005

- 12.5% of the contributable income with a minimum of 132.60€ and a maximum of 696.60€

2006

- 12.5% of the contributable income with a minimum of 134.40€ and a maximum of 706€

Source: Overheid.nl Monitor (1996, 1999, 2002c, 2003a, 2004, 2005b, 2006a)

Notes: Care with accommodation includes residential care. There is a low and a high income-related copayment for individuals who are assigned to receive care with accommodation. Individuals pay a low copayment rate during their first six months of stay in a residential or nursing home. After the first six months, individuals continue to pay a low copayment rate if they receive child benefits and pay for their children's expenses or if their health insurer believes their stay at an institution will be temporary. All other individuals pay a high copayment rate after their first six months of stay. Except for 1996, copayment rates for care with accommodation before 2002 have not been identified yet. Box 4 defines contributable income.

Box 3: AWBZ High Copayments for Care With Accommodation (1996-2006)

1996

- 3,150ƒ but the copayment is reduced to 1/12 of the beneficiary's contributable income if their contributable income divided by 12 is less than 3,150ƒ

2002

- 1,561€ but the copayment is reduced to 1/12 of the beneficiary's contributable income if their contributable income divided by 12 is less than 1,561€

2003

- 1,624€ but the copayment is reduced to 1/12 of the beneficiary's income if their income divided by 12 is less than 1,624€

2004

- 1,700€ but the copayment is reduced to 8.5% of the beneficiary's income if their income divided by 12 is less than 1,700€

2005

- 1,728€ but the copayment is reduced to 8.5% of the beneficiary's income if their income divided by 12 is less than 1,728€

2006

- 1,751.4€ but the copayment is reduced to 8.5% of the beneficiary's income if their income divided by 12 is less than 1,751.40€

Source: Overheid.nl Monitor (2007b, 2008, 2009, 2010, 2011c, 2012i, 2013r, 2014h)
Notes: Care with accommodation includes residential care. There is a low and a high copayment for individuals who are assigned to receive care with accommodation. Individuals pay a low copayment rate during their first six months of stay in a residential or nursing home. After the first six months, individuals continue to pay a low copayment rate if they receive child benefits and pay for their children's expenses or if their health insurer believes their stay at an institution will be temporary. All other individuals pay a high copayment rate after their first six months of stay. Except for 1996, copayment rates for care with accommodation before 2002 have not been identified yet. Box 4 defines contributable income.

Box 4: 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 (2003a, 2014c) and Netherlands Government (n.d.)

Table 3: 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 (2014b)

Table 4: 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 (2014b)

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 5: 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.

Source: Overheid.nl Monitor (2014b)

Box 6: AWBZ Evaluation of Dependence - Options to Address Care Needs (2007-2014)

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. Lastly, CIZ decides on care with or without accommodation. Care with accommodation is assigned when the applicant requires a protective living environment, a therapeutic living environment, or permanent supervision and they need accommodation more than 3 days a week. If the applicant does not meet the aforementioned conditions, they are assigned care without accommodation. AWBZ care without accommodation includes the following functions: personal care, nursing, guidance, and short-term stay. AWBZ care with accommodation includes the residence and continued residence on a psychiatric basis functions. The residence and continued residence functions also provide access to personal care, nursing, guidance, and treatment.

Source: Overheid.nl Monitor (2014b)

Table 5: AWBZ Personal Care and Nursing Care Intensity Packages (2011)

Care Intensity Package	Type of Care (Functions)	Care hours per week
ZZP 1 VV: some guidance	Guidance and personal care	3 to 5
ZZP 2 VV: guidance and care	Guidance, personal care, and nursing care	5.5 to 7.5
ZZP 3 VV: guidance and intensive care	Guidance, personal care, nursing care, and treatment	9.5 to 11.5
ZZP 4 VV: intensive guidance and extensive care	Guidance, personal care, nursing care, and treatment	11 to 13.5
ZZP 5 VV: intensive dementia care	Guidance, personal care, nursing care, and treatment	16.5 to 20
ZZP 6 VV: intensive care and nursing	Guidance, personal care, nursing care, and treatment	16.5 to 20
ZZP 7 VV: specific conditions with an emphasis on supervision	Guidance, personal care, nursing care, and treatment	20 to 24.5
ZZP 8 VV: specific conditions with an emphasis on care and nursing	Guidance, personal care, nursing care, and treatment	24.5 to 29.5
ZZP 9 VV: recovery-oriented treatment with nursing and care	Guidance, personal care, nursing care, and treatment	18 to 22
ZZP 10 VV: intensive palliative-terminal care	Guidance, personal care, nursing care, and treatment	26.5 to 32.5

Source: Overheid.nl Monitor (2011a)

Notes: We have not yet identified who provides care in the care intensity packages where no healthcare practitioners are involved in care provision.

Table 6: 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 (2014b)

Table 7: 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 (2014b)

Table 8: 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 (2014b)
Notes: A half day is defined as a consecutive period of up to four hours.

Box 7: 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 8, 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 6 and Table 7. 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 (2014b)

Table 9: WMO National Maximum Period Contributions / AWBZ 4-week Copayments for Care Without Accommodation (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 (2013c)

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. The WMO maximum period contribution is the same as the AWBZ 4-week copayment for care without accommodation.

Box 8: AWBZ and 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 (2007b, 2008, 2009, and 2010)

Notes: The income thresholds used to calculate the WMO maximum period contribution from 2007 to 2014 are the same as the thresholds used to calculate the AWBZ copayments for care without accommodation. 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. Copayments for care without accommodation could not exceed a certain amount during a four-week period, which varied depending on marital status and age. Care without accommodation includes personal care, nursing, guidance, and short-term stay. Box 4 defines contributable income.

Box 9: AWBZ and 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 (2011c, 2012i, 2013r, and 2014c)

Notes: The income thresholds used to calculate the WMO maximum period contribution from 2007 to 2014 are the same as the thresholds used to calculate the AWBZ copayments for care without accommodation. 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. Copayments for care without accommodation could not exceed a certain amount during a four-week period, which varied depending on marital status and age. Care without accommodation includes personal care, nursing, guidance, and short-term stay. Box 4 defines contributable income.

Formula 2: Calculation of AWBZ and WMO 4-week Copayment (2007-2014)

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

- $PC_{i,t}$ = Individual's i's 4-week period copayment at time t
  - $PC_{i,t}$ can never be less than zero
- FC_t = 4-week period copayment set in national guidelines at time t —FC_t values are provided in Table 9
- $CI_{i,t}$ = Individual's i's annual contributable income at time t —the definition of contributable income is provided in Box 4
- I_t = Annual income threshold at time t —I_t values are provided in Box 8 and Box 9

Source: Overheid.nl Monitor (2014c)

Notes: For both AWBZ care without accommodation and WMO, the four-week period copayment (referred to as maximum period contribution in WMO) of individuals whose aggregate income exceeded a certain amount was calculated based on a formula.

Box 10: AWBZ Low Copayments for Care With Accommodation (2007-2014)

2007
- 12.5% of the contributable income with a minimum of 136.20€ and a maximum of 715€

2008
- 12.5% of the contributable income with a minimum of 138.60€ and a maximum of 727.60€

2009
- 12.5% of the contributable income with a minimum of 141.20€ and a maximum of 741.20€

2010
- 12.5% of the contributable income with a minimum of 144.40€ and a maximum of 758.60€

2011
- 12.5% of the contributable income with a minimum of 145.60€ and a maximum of 764.40€

2012
- 12.5% of the contributable income with a minimum of 148.20€ and a maximum of 778.60€

2013
- 12.5% of the contributable income with a minimum of 152€ and a maximum of 797.80€

2014
- 12.5% of the contributable income with a minimum of 156€ and a maximum of 819.40€

Source: Overheid.nl Monitor (2007b, 2008, 2009, 2010, 2011c, 2012i, 2013r, 2014h)

Notes: Care with accommodation includes residential care. There is a low and a high copayment for individuals who are assigned to receive care with accommodation. Individuals pay a low copayment rate during their first six months of stay in a residential or nursing home. After the first six months, individuals continue to pay a low copayment rate if they receive child benefits and pay for their children's expenses or if their health insurer believes their stay at an institution will be temporary. All other individuals pay a high copayment rate after their first six months of stay. Box 4 defines contributable income.

Box 11: AWBZ High Copayment for Care With Accommodation (2007-2014)

2007
- 1773.40€ or if the beneficiary's contributable income divided by 12 is less than this amount then the copayment is reduced to 8.5% of contributable income

2008
- 1804.60€ or if the beneficiary's contributable income divided by 12 is less than this amount then the copayment is reduced to 8.5% of contributable income

2009
- 1838.60€ or if the beneficiary's contributable income divided by 12 is less than this amount then the copayment is reduced to 8.5% of contributable income

2010
- 1/12 of the beneficiary's contributable income with a maximum copayment of 2,081.60€

2011
- 1/12 of the beneficiary's contributable income with a maximum copayment of 2,081.60€

2012
- 1/12 of the beneficiary's contributable income with a maximum copayment of 2,081.60€

2013
- 1/12 of the beneficiary's contributable income with a maximum copayment of 2,189.20€

2014
- 1/12 of the beneficiary's contributable income with a maximum copayment of 2,248.60€

Source: Overheid.nl Monitor (2007b, 2008, 2009, 2010, 2011c, 2012i, 2013r, 2014h)
Notes: Care with accommodation includes residential care. There is a low and a high personal copayment for individuals who are assigned to receive care with accommodation. Individuals pay a low copayment rate during their first six months of stay in a residential or nursing home. After the first six months, individuals continue to pay a low copayment rate if they receive child benefits and pay for their children's expenses or if their health insurer believes their stay at an institution will be temporary. All other individuals pay a high copayment rate after their first six months of stay. Box 4 defines contributable income.

Table 10: 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 (2012b, 2012f-2012h, 2013c, 2013e, 2013j-2013q, 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.

Table 11: WMO Hourly Rates in Largest Municipalities (2013)

Province	Largest Municipality	Household care rates (hourly)
Groningen	Groningen	HH1: 21.76€, HH2: 24.82€
Flevoland	Almere	HH1: 15.20, HH2: 19.60
Friesland	Leeuwarden	22.40
Limburg	Maastricht	23.20
Drenthe	Assen (second largest)	HH1 & HH2 non-professional healthcare worker: 16.13, HH2 professional health care worker: 18.69

Source: Overheid.nl Monitor (2012h, 2013n-2013q)
Notes: The hourly rates for home care services in 2013 for the municipalities of Enschede, Nijmegen, Utrecht, Amsterdam, The Hague, Terneuzen, and Eindhoven have not been identified yet.

Box 12: 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 13: 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 (2017h-2017j, 2018e-2018g, 2019e, 2020b, 2020c, 2021a, 2023b, 2023c)

Box 14: 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 (2015d)

Box 15: 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 (2015d)

Box 16: Basic Health Insurance Monthly Premiums - Largest Health Insurers (2023)

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

Source: Zilveren Kruis (2023), Interpolis (2023), Zekur (2023), FBTO (2023), De Friesland (2023), Univé (2023), UMC (2023), Nationale Nederlanden (2023), IZA (2023), and OHRA (2023)

Box 17: WMO General and Individualized Services

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. Municipalities had different policies for general services copayments although in most municipalities, individuals paid the cost set by the provider who is offering the general service.

Source: Overheid.nl Monitor (2017b)

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 12
- $CI_{i,t}$ = Individual's i's annual contributable income at time t —the definition of contributable income is provided in Box 4
- I_t = Annual income threshold at time t —I_t values are provided in Box 18

Source: Overheid.nl Monitor (2017b)
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) contribution at time t
  - $PC_{i,t}$ can never be less than zero
- MPC_t = Maximum period (4-week period) contribution set in national guidelines at time t —FC_t values are provided in Table80
- $CI_{i,t}$ = Individual's i's annual contributable income at time t —the definition of contributable income is provided in Box 4
- I_t = Annual income threshold at time t —I_t values are provided in Box 18

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

Box 18: 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€

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 (2017b and 2019f)
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 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. Box 4 defines contributable income.

Table 12: 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 (2017b and 2019f)

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 13: WLZ Low Copayments

Year	Low Copayment	Min. and Max. Amounts (per month)
2015	12.5% of contributable income	158.60 and 832.60€
2016	12.5% of contributable income divided by 12	159.80 and 838.60
2017	12.5% of contributable income divided by 12	160.60 and 842.80
2018	10% of contributable income divided by 12	161.80 and 850
2019	10% of contributable income divided by 12	164.20 and 861.80
2020	10% of contributable income divided by 12	168 and 881.60
2021	10% of contributable income divided by 12	171.40 and 899.80
2022	10% of contributable income divided by 12	174 and 913.20
2023	10% of contributable income divided by 12	184 and 966

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. 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.

Table 14: WLZ High Copayments

Year	Maximum Amount (per month)
2015	Could not exceed 2,284.60€
2016	2,301.40
2017	2,312.60
2018	2,332.60
2019	2,364.80
2020	2,419.40
2021	2,469.20
2022	2,506
2023	2,652.40

Source: Overheid.nl Monitor (2015e)

Notes:

- High contribution rate = contributable income divided by 12
- Contributable income for the high copayment is defined as aggregate income 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 minus the following: taxes, health insurance premiums, pocket and clothing allowance, 15% of income from current work, non-retirement age discount, disposable income deduction, non-retirement/retirement age deduction, and compensation for lapsed elderly allowance.

Box 19: WLZ Low Copayment Contributable Income

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 contribution). 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.

Source: Overheid.nl Monitor (2015e)

Box 20: WLZ High Copayment Contributable Income

Contributable income for the high copayment is defined as aggregate income plus 4% of savings and investments if that amount is more than a certain amount (31,340€ for single individuals and 62,680€ for married individuals in 2021) minus the following: taxes, health insurance premiums, pocket and clothing allowance, 15% of income from current work, non-retirement age discount, disposable income deduction, non-retirement/retirement age deduction, and compensation for lapsed elderly allowance. Aggregate income includes taxable income from work and home, benefits, shares, dividends, savings, and investments. The pocket and clothing allowance was an amount for individuals to use for their personal expenses, which varies depending on your personal situation (e.g., marital status, receiving disability benefits) and was set annually by the Ministry of Health, Welfare and Sport. The non-retirement age discount is an amount deducted from the contribution of those who have not yet reached state pension age. The discount is a maximum of 10,710€ per person in 2023. The non-retirement/retirement age deduction is a fixed additional deduction from the individual's copayment. The deduction in 2023 is 1,121€ for pensioners and 2,006€ for non-pensioners. For the disposable income deduction, if the individual's income is higher than certain limit, 25% of their disposable income above the limit is deducted. The limits vary by marital status and state pension age:

- Single and will reach state pension age in 2023: 9,847€
- Single and has not yet reached state pension age in 2023: 7,446€
- Married and will reach state pension age in 2023: 11,590€
- Married and will not reach state pension age in 2023: 15,119€

Source: Overheid.nl Monitor (2015e) and 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.

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.

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

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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. Day and night care centers and short-term stay are not usually classified as institutional care in the Netherlands.
4. Information regarding WLZ and ZVW short-term stays is not included because WLZ provides such stays to individuals who choose to access WLZ benefits at home or through a personal budget, rather than those opting for WLZ benefits in an institutional setting. Similarly, ZVW offers short-term stays to individuals requiring temporary medical care rather than long-term care. Admission to these facilities requires medical justification, such as post-hospitalization care.
5. 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. These conditions are not elaborated on in this document because they are out of scope of the current policy collection.
6. WLZ also provides care to individuals who need continuous 24-hour care nearby and/or permanent monitoring at home. For details about the 24-hour home care benefit, please refer to the policy document The Netherlands 24-Hour Long-Term Care Benefits Plan Details, 2015-2024.

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.

Mot, E. et al (2010). The Dutch System of Long-Term Care. Available in English. As of October 10, 2023.
Available at: https://www.files.ethz.ch/isn/122428/The%20Netherlands.pdf
Features: Paper that provides an overview of the Long-Term Care Insurance System in the Netherlands including the different laws under which different LTC benefits fall under. The paper describes how the schemes are different, what types of benefits they provide, and how individuals become eligible for benefits.

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