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Annexes

Date: 12 June 2009
Re: The future of the AWBZ - a detailed explanation

Your letter

Please address all correspondence to the return address, quoting the date and reference of this letter.

Dear Ms Verbeet,

1. Introduction

In the Wiegman c.s. motion[1] you requested me, pursuant to my letter of 13 June 2008 entitled "*Zeker van zorg, nu en straks*" [Security of care, today and tomorrow][2], to provide a more detailed explanation of my vision of the future of the General Exceptional Medical Expenses Act (*Algemene Wet Bijzondere Ziektekosten,* AWBZ) and in doing so to address the role of the care insurers, the individual-trailing budget, the assessment of care needs, the separation of living and care and the initial results of the monitor of the package measure.
As requested, therefore, I hereby set out the details of my vision of the future of the AWBZ. First I describe the relationship between care and welfare facilities for people who are dependent on long-term care. I specifically focus on this relationship between care (both cure and care) and welfare because people with a disability generally use other facilities in addition to care in order to be able to play an active role in society. I also set out my vision of the future. In paragraph 3, as requested in the motion, I then examine the role of the care insurers, the individual-trailing budget, including the personal budget, and the assessment of care needs. I intend to write to you separately before the

[1] Parliamentary Documents II 2008-2009, 31 700 XVI, no. 56
[2] Parliamentary Documents II, 2007-2008, 30,597, no. 15

summer to inform you about the Cabinet's standpoint regarding the separation of living and care and the initial results of the monitors of the package measure.

2. My vision of long–term care and social support, now and in the future

Focusing on the client

I think it is important that the AWBZ remains available to everyone with an undisputed need for long-term care. The main principles underlying care and support for people with disabilities or chronic conditions are that:
- their wishes and needs must be central;
- they must be able to retain as much control over their own lives as possible;
- there needs to be a good correlation between care and welfare;
- there needs to be a good correlation between cure and care.

People need to be able to make their own choices about matters that are important to them, independently of others. This also applies to people with disabilities. And we are talking about a significant number of people here: there are approximately 1.5 million people with a disability in the Netherlands, and a similar number with a chronic illness. It therefore involves a total of 2.5 to 3 million people, or 15% of the Dutch population. Many of these people are elderly; some are involved in the work process despite their disabilities. Over the next few years the percentage of people with a disability or a chronic illness will increase even further, partly as a result of the ageing population.
This group of people with a disability or chronic illness is highly diverse. Some people do not have a visible disability but suffer from a chronic illness. There are approximately 700,000 people who have been diagnosed with diabetes, for example, and another 70,000 are diagnosed every year. Furthermore, it is estimated that there are 250,000 people who are unaware that they have diabetes. There is also a growing group of people with dementia. There are currently more than 230,000 people with dementia in the Netherlands, most of whom are elderly.
Some people are disabled. There are approximately 560,000 people with a physical and/or sensory disability and 110,000 people with a mental disability. Not every disabled or chronically ill person uses AWBZ care. This form of care is taken up by approximately 109,000 disabled people.

Some of these people are able to function well in society despite their disabilities. But this is not true of everyone. A significant group requires support or additional care in order to do so. I believe that caring for and supporting people with disabilities is not the preserve of care institutions but is something that involves every one of us. It is most definitely also a responsibility of 'ordinary' people and 'ordinary' social organisations: the social network, municipal provisions, housing corporations, the business community, employment provisions, the educational sector, clubs and other social organisations such as welfare organisations.

Staying in control as much as possible
I believe that it is important for people with a disability to be able to participate in society to the fullest extent possible. And to enable this to happen, we need to eliminate as many obstacles as possible. For this reason, the *Wet gelijke behandeling op grond van handicap of chronische ziekte* [Equal Treatment (Disability and Chronic Illness) Act] (WGBH/CZ) has been extended. I am also preparing a Decree to ratify the UN Convention on the Rights of Persons with Disabilities. Furthermore, the underlying principle of all government policy in this field is inclusive policy, and not without good reason. Inclusive policy improves the quality of life of people with disabilities because it focuses on participation. And I am convinced that if people participate more, helped by their social network and local tailor-made services, they will be able to delay their need for formal care. People who are extremely vulnerable must, of course, be able to continue to count on good quality individual care whenever they need it. The AWBZ is, therefore, there for everyone who has an undisputed need for long-term care.

People want to retain as much control over their lives as possible. I endorse that emphatically. We need to ensure that people are not 'medicalised' at an early age, thus avoiding any unintended stigmatisation.
The inherent power of citizens, both inside and outside their own social network, is of great value. In this context it is important to strengthen one's own social context, for example by building up a good network of neighbours. In the Netherlands there are more than 1 million informal carers who actively dedicate themselves to looking after people in their immediate environment. We also have approximately 4 million volunteers in the Netherlands. These people all play a role in creating connections, in increasing mutual involvement and social cohesion in our society. I regard the contribution made by informal carers and volunteers as extremely important, and I am therefore making efforts to strengthen the position of informal carers and volunteers. One aspect that requires further attention in this regard is the relationship between formal (professional) care and the informal care provided by volunteers and informal carers. This autumn I will be providing the House with further information on matters such as parameters and coordination, but in particular on opportunities for mutual reinforcement and cooperation, in line with my previous assurances in the context of my policy letter, '*Voor elkaar*' [Getting (It) Together].

Two examples

1. Group Living in Friesland

The *Vereniging Groepsgewijs wonen Friesland* [Group Living in Friesland] website **www.woonkracht.nu** provides information on Group Living. Group Living means living in one's own rented or purchased unit with shared meeting spaces. Group Living allows most people to remain independent for longer and keeps people active in a social environment. People are assured of attention, company and safety so they can continue to live independently of external and formal care for longer. Group Living keeps villages more liveable because it offers elderly residents the opportunity to remain in their own village.

2. "Neighbourliness" in Hoogeveen

A trial has started in Hoogeveen Zuid to encourage local residents to help one another more often and more effectively. Local residents, institutions and organisations have produced a local wish list. To ensure that these wishes are carried out, and to provide the appropriate help, a residents' group has been set up and given a coordinating role. The underlying principle is that wherever help is needed, the local residents do their bit.

Correlation between care and welfare

When people need care, it is important to provide proper coordination and cohesion between care and social support, ideally organised in close proximity to the citizen (locally). This needs to be based as far as possible on the power of disabled people to make their own choices and retain and take responsibility themselves. The focal point therefore needs to be the client's perspective, not the offerings conceived in anonymous systems. By focusing on people's strengths instead of solely on their limitations, it is also possible to bring about reciprocity. For example, a person with a physical disability has difficulty walking and receives a mobility scooter. With his new-found mobility he can now become actively involved in the local primary school as a reading assistant. This gives real meaning to the concept of participation and enables citizens to become actively involved in activities in their immediate environment.

Support

There is a range of facilities which are appropriate for social support in one's own environment, many of which are collective. People must be given the opportunity to connect with each other in the neighbourhood and their local district. These connections give rise to social networks in which people can meet, support each other and co-exist.

In the *Wet maatschappelijke ondersteuning* [Social Support Act] (WMO) municipalities are tasked with helping people to participate when they are unable to do so themselves. On a local level, connections are made such as those between care and welfare, between housing and participation and between work and income. However, there are many other opportunities to make connections, for example with housing corporations and sports organisations.

In the third WMO progress report I announced "*Welzijn nieuwe stijl*" [New Style Welfare] with three core concepts: connection, integrality and local tailor-made solutions. Under this banner I am encouraging a number of activities, including:

- The "*Beter thuis in de buurt*" [More at home in the neighbourhood] action plan: a Living, Welfare and Care support programme for local people;
- The "*De Kanteling*" [Refocus] project, which is intended to facilitate the transition from supply-driven to demand-driven provision and to examine whether collective facilities are a better way of meeting the compensation obligation;
- The "*Beter in meedoen*" [Better at participation] programme, which aims to bring about renewal and quality improvements in the current WMO and in its relationship with other policy areas;
- The *Wmo-in-de-buurt* [WMO in the neighbourhood] programme, which focuses on creating relationships between people so that informal care and services are easier to put in place when needed.

In the fourth WMO progress report, I discuss the correlation between these and other projects in greater depth, in order to provide further substantiation of 'New Style Welfare'.

Care

Unlike welfare, care focuses much more on the individual. Care is individually enforceable because it is provided by way of a solidarity-based insurance system (the AWBZ and the *Zorgverzekeringswet* [Healthcare Insurance Act] (ZVW). The right to care arises directly from the AWBZ. Under the provisions of the AWBZ, care insurers (or in practice, care offices) are obliged to provide people who are assessed as needing care with the care they need, in good time. In this way in the Netherlands care is provided for the most vulnerable people. The solidarity underlying this is an important value. It is important that vulnerable people who are in receipt of long-term care retain their independence and are provided with the best possible quality of life. This is expressed in aspects such as the choices which clients in receipt of long-term care have to be able to make concerning the location and type of accommodation where they can receive the care they need. They must be able to choose a provider that suits them themselves instead of having others make the decision for them. Providers of intramural care must provide their clients with as much privacy and choice in terms of accommodation as possible. Making quality information widely available enables people to make these choices themselves. One example of this is the quality information that can be obtained at KiesBeter.nl, which is being constantly augmented.

I am also of the opinion that it is important to respect the professional autonomy of the people delivering the care. All professionals (such as general practitioners, care workers and nurses) who are involved with people who depend on long-term care are trained to be able to provide the best possible care. They must therefore be given the scope to do so. After all, care belongs both to those who receive it and to those who provide it.
The key criterion should not be the organisation, but the professional response to the individual demand for care. It would be most unfortunate if professionals were under the impression that their valuable time and effort were largely being spent on unnecessary bureaucracy and on accounting for their work. What is needed is greater cohesion between local organisations and more community care, so that the client can request low-threshold care involving a small number of carers; I view this as an effective way of ensuring that carers dedicate most of their time to the actual delivery of care.

Example: *Buurtzorg* (Community Care)
Buurtzorg is an example of care that is organised close to the client and that gives carers the scope to perform their duties as they see fit. This is a new care concept which involves a team of professionals providing home care to clients who live independently. *Buurtzorg* organises care for individual clients by making effective use of their own possibilities, informal care, social network and local solutions. *Buurtzorg* is also developing a new welfare concept: *Buurtdiensten* [local services], a package of individual welfare services based on the same underlying principles.

Connection
Many users of long-term care are people with multiple disabilities or conditions (co-morbidity). Because of the complexity of their disabilities or conditions, these people often receive support and care under several different systems such as the WMO, the AWBZ and the ZVW. The care and support these people receive needs to be delivered in a properly coordinated manner. This includes communicating clearly what care and support options are available and where the client can obtain them. This is already happening in many places, such as in Doetinchem and Tilburg.

Two examples
Doetinchem intends to launch a pilot scheme aimed at developing efficient and effective social service provision that focuses on care and housing specifically in the district. The objective is to provide a one-stop shop for care, operate on a demand-led basis and provide a full range of services (integrated care).

Tilburg is planning a pilot scheme to explore whether it is possible to tie in seamlessly with municipal household help and the provision of AWBZ functions. The aim is to ensure that the client does not notice the different flows of funds and receives good quality care.

In the case of long-term care, this may concern a client with co-morbidity who wants to remain in their own home, for example. This client is entitled to home modifications, a wheelchair and welfare arrangements such as meals-on-wheels or odd-job services under the WMO, personal care and nursing under the AWBZ, and medication, GP care and sometimes a hospital appointment under the ZVW. For those who have been assessed as requiring long-term specialist residential care as well, it is important to ensure that there are adapted dwellings available, that there is supervision, that they are accepted by those around them and that there is care available in the neighbourhood.

The WMO, the AWBZ and the ZVW complement each other, but each has its own financing established in law. Ultimately it is important to ensure that these systems do not operate in isolation from one another, but that they tie in with one another in line with the users' needs. The increase in the number of people with co-morbidity makes it all the more necessary to invest in ensuring cohesion between these systems.
With clear parameters the parties involved can make proper arrangements on cooperation. Besides the intention to work together, these cooperation arrangements also sometimes call for a large dose of creativity, so that the parties involved can work together to find the most effective solution. I want to explore ways of achieving a properly cohesive range of services at the interface between the AWBZ and WMO. If money proves to be an obstacle, I am willing to examine whether it would be possible and helpful to combine a small proportion of AWBZ and WMO resources with the aim of making it easier to purchase a range of services at the interface between support and care, regardless of the original source of the finance. This will result in properly coordinated care and support for the citizen. On a macro level this could also represent better value in terms of the budget. If people obtain support at an earlier stage and their social safety net is bigger, they will have less need for intensive AWBZ care.

Vision for the future

The correlation between care (ZVW and AWBZ) and welfare, in which the client is central and people's own strengths are utilised, and an AWBZ that is meant for everyone with a genuine need for long-term care, form the core of my vision for long-term care. What does this mean for care and support in the future?

Developments in care

Over the next few years the demographics, and in particular the ageing population, will have a greater impact on care than in the past. Ageing will play a significant role in the growth of care expenditure. By 2030 there will be almost 4 million people over the age of 65 in the Netherlands. The number of people with dementia is expected to rise to more than 380,000 by 2030. The number of chronically ill people will also rise. The Netherlands Institute for Social Research (SCP)[3] has estimated that the potential demand for nursing and care will increase by almost 40% between 2002 and 2020. The use of AWBZ-financed care will increase by 28%. According to the SCP, this difference is due to the fact that, relatively speaking, solutions for care problems are increasingly being sought in the informal and private sectors and in the adaptation of one's accommodation and living environment.

Expenditure on care is set to increase in the future because of the ageing population, but also because of developments in medical technology. It is important to ensure that people can count on care and support in the future as well. We need to respond to this now by keeping the system affordable and ensuring that solidarity is preserved in the long term. For this reason, I have tightened up the criteria for AWBZ guidance.

Clients will themselves play a major role in the future - even more so than today. As prosperity increases, clients will demand higher quality and freedom of choice in respect of the care they receive. This could result in unrelenting pressure to improve the level of care we provide. More and more information on the quality of care providers will be made available. There will also be greater diversity in the range of care services on offer than is now the case. By diversifying care services, we will - and must - enable people to make more choices. This is an advantage, but I would like to qualify this by adding that it is easier for people who are well-to-do, well-educated and independent to make choices than it is for the most vulnerable members of our society to do so. Freedom of choice does not always have obvious benefits for everyone. The most vulnerable among us can in fact perceive freedom of choice as a burden, since they are not always or no longer able to make those choices themselves. People want the care they need to be available close to home, particularly when long-term care is needed. This underlines the importance of providing local facilities which are embedded in local care networks involving for instance the GP.

Professionals and cooperation

Going forward, I am keen to see more care providers operating on a lower-threshold basis than they do at present and playing a major role in connecting and helping to shape the total care and support package the client uses. This can help people with multiple problems to remain at home for longer if they wish to do so. This managing, connecting and coordinating role can be fulfilled effectively by a district nurse acting as a linchpin. Where relevant, this is done by maintaining good contact with other care providers.

I would like to see care facilities becoming a more integrated part of the neighbourhood and many social players (such as municipalities, schools, care and welfare institutions, childcare, sports clubs and local communities) taking responsibility for people's welfare. It is therefore important to be sufficiently aware of the importance of volunteers and informal carers, both now and in the future.

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[3] Timmermans, J. (2004), '*Verzorging en Verpleging verklaard*', Netherlands Institute for Social Research, The Hague

Two examples: BonVie and the 'service shop'

1. BonVie in Culemborg

BonVie is an apartment complex comprising owner-occupied and rented dwellings located in the centre of the district. It has a central service point with a wide range of facilities such as childcare, a care centre, youth care, day activities for the elderly and a grand café. BonVie is not intended solely for elderly people or people with disabilities, but for everybody. The apartments are designed in such a way that people who are initially relatively healthy can continue to live there when they start needing care. They can be equipped with ambient intelligence in every room, for example. Ambient intelligence includes devices such as personal alarms and stair lifts which are designed to enable people to continue to live at home safely, comfortably and independently.

2. Service shop in Osdorp

A good example of participation is the Service Shop in Osdorp. This is a place where people with disabilities can go to do odd jobs and services for local residents. The aim is to provide structured activities for people with disabilities and to give them somewhere where they can use or develop their skills. It also gives them the opportunity to participate in the social life of the local community. The Service Shop also plays a role in improving the local residential and social climate.

Labour market

The care industry currently faces an enormous challenge in the labour market - one that is set to increase in the future. The demand for care will continue to rise, and the potential supply of manpower will not keep pace with this increased demand. In the letter on the labour market which the Minister and I presented to your House on 23 December 2008, we examined the analysis of the labour market in great depth[4]. The long-term problems are many and varied. For example, a person with dementia will need two years of intramural care on average, preceded by five years of support in their own home with a great deal of informal and home care. In order to avoid serious shortages in the labour market, both in the short and long term, we urgently need to put a range of measures in place now.
Some examples with great potential include the Traineeship Fund, which is designed to increase the number of traineeships and provide better support for trainees. There are also regional pilot projects which recruit and train people at the lower end of the labour market and others which recruit and train immigrants as carers, and investments are being made in strengthening the regional structure (cooperation between care institutions, the UWV (Institute for Employee Benefit Schemes) employment agency, municipalities, Calibris, schools and colleges). These measures are primarily aimed at training more people for jobs in care and encouraging the movement of staff within the care sector. In the midst of the credit crisis, these are also efficient tools for getting people who are made redundant back to work quickly.

In addition to increasing the influx of personnel, it is also important to invest substantially in retaining care personnel. The foundation of all care provided under the AWBZ is, after all, the professional care worker who is in direct contact with the clients. If the professionals are satisfied, this will have a positive effect on the clients. Furthermore, satisfied staff do not take unnecessary sick leave. It is therefore important to focus on the people who provide the care and their needs in terms of how they want to do their work, and to create the conditions that will enable them to do it. The boards and managements of the institutions will therefore not only need to pay attention to

[4] Parliamentary documents II 2008-2009, 29 282, no. 79

newcomers to the profession, but also to the welfare of existing staff in their organisation.

Modernisation and innovation
The development of medical technology is regarded as one of the key factors contributing to the growth in healthcare expenditure. In the Netherlands, technological developments have accounted for approximately half of all growth in healthcare expenditure in the past. And technological innovation will not stop in the future.

Modernisation and innovation are also needed to meet the challenges I mentioned above: the increasing demand for care, the shortages in the labour market and the affordability of care. And in addition modernisation and innovation are needed to ensure that we continue to fulfil the client's wishes and needs.
To encourage modernisation and innovation both now and in the future, the transition programme on long-term care has been launched in tandem with sectors and other parties. This programme includes a series of experiments designed to stimulate the correlation between housing, care and welfare on a local level, such as *Buurtzorg*, screen to screen communication in home care and monitoring with video and sensors.
The Care Innovation Platform (ZIP) is also a strong proponent of innovation in care.
This platform, which was set up last year, is made up of content specialists from the care sector, the business community, science and government authorities. The ZIP aims to inspire and where possible accelerate innovation in care. Its primary target groups are the elderly and the chronically ill. The underlying aim is to ensure that we can continue to offer quality in long-term care for vulnerable people in the future.

Three examples

1. *Val Preventiebus* [fall prevention bus] and *OOGbus* [eye bus]

A promising innovation that is currently being worked on is fall prevention. Every day some 360 elderly people suffer falls that require urgent hospital attention. By providing elderly people who are at risk of falling with practical advice, many incidents of falling can be prevented. With this in mind, Delta Lloyd has created the *Val Preventiebus* which enables nurses to visit elderly people in their homes and give them practical advice. Another client-focused innovation is the *OOGbus*. This eye bus takes primary eye care to people in their homes.

2. Alarm mat

An alarm mat is a mat which people such as dementia sufferers can place by their beds and which alerts staff when the person gets out of bed and wanders off at night. It enables the staff to react quickly and prevent accidents.

3. Screen-to-screen (video) communication combined with message service

Screen-to-screen communication enables residents to communicate with one another and with family or friends. The message service allows messages to be distributed automatically throughout the entire complex from a central point. It can be used to distribute the week's menus, for example. When the menu is available, residents can simply click their choices on the screen. It helps combat feelings of loneliness as residents can communicate directly with their fellow residents, family and friends. The message service also saves the care institution money by making communication more efficient and reducing paperwork.

3 What do we need to do to safeguard long-term care now and in the future?

Client-centred delivery

My vision for the future, which I have outlined above, will not be achieved without a struggle, of course. In fact, the AWBZ needs to be properly maintained to ensure that it is not a victim of its own success, as it were. This is something the Cabinet wishes to avoid, so a series of short-term concrete policy measures and long-term policy developments which are designed to make the AWBZ future-proof were identified in the aforementioned letter of 13 June 2008. The test in all of these measures and policy developments will always be whether they help us meet the objectives and vision I have described in section 2.

Later on in this letter I shall address the subjects explicitly requested in the Wiegman c.s. motion, namely the role of the care insurers, the individual-trailing budget and the assessment of care needs. Before doing so, I feel it is important to emphasise that the preservation of long-term care not only calls for a range of technological and legislative measures. It is equally important to think creatively and adapt the sector to meet clients' wishes and expectations. I intend to do my bit by putting people in touch with one another wherever possible and encouraging them to enter into dialogues. In this context I have already organised a conference on the current state and the future of long-term care which took place on 5 June 2009. This conference gave clients and client organisations, care offices, care insurers and long-term, welfare and curative care providers, but also knowledge institutes, municipalities and representatives of the business sector the opportunity to meet and discuss topics such as those outlined in this letter. My aim in doing so is to hammer home the need to work together to improve long-term care and to discuss what we need to do to safeguard it in the future. Because the AWBZ delivers care for a target group that includes some extremely vulnerable people, its implementation must take sufficient account of the sensitivities this vulnerability brings with it. Of relevance in this regard are the underlying principles in section 2, namely that clients' wishes and requirements must remain central, that clients must retain as much control over their own lives as possible, and that there needs to be a good correlation between care and welfare and between cure and care. The AWBZ must be implemented in such a way that this can be achieved.

I discussed the position of the care offices with the House in a General Consultation on 13 November 2008. We specifically focused on the issue of how implementation by care insurers for their own insured clients would compare with a (highly developed) system of individual-trailing funding, possibly partly or entirely in the form of a system of vouchers, as proposed in the advice of the Scientific Institute of the CDA[5].

The AWBZ is currently implemented by regional care offices on behalf of the care insurers. The current concession expires in 2011. Between now and 2011 I intend to focus predominantly on achieving the switch to client-centred care. For this reason, I have chosen not to close the care offices with effect from 1 January 2009, as I had previously intended, but to give them a role in effecting the switch to client-centred care up to 2011. I have made arrangements with the care insurers concerning the remit of the care offices for the period 2009-2011[6] in order to achieve client-centred implementation of the AWBZ.
I shall first describe the arrangements I have made with the care insurers in order to achieve client-centred implementation of the AWBZ. Then I shall explain the individual-trailing funding and the role of the care insurers in implementing the AWBZ.

Client information
I have agreed with the care insurers that the care offices (as implementers of the AWBZ) will improve the service and information they provide for clients. One way they can do this is by posting general public information on the AWBZ services that are available in

[5] '*Naar een toekomstbestendige AWBZ: een christendemocratische visie op de langdurige zorg*' (30 June 2008)
[6] Parliamentary documents II, 2008-2009, 30597, no. 38 en no. 63

the region and up-to-date information on waiting times on a website that is accessible to all. Care offices also provide information to primary care facilities and the National Care Assessment Centre (CIZ), for instance, which clients can consult to find out more about how the AWBZ operates.

Purchasing care and quality policy

Care offices have a duty to make every effort to remain within the financial contracting framework when purchasing care, and they play a key role in achieving cost-effectiveness and in purchasing care with a good price/quality ratio. I believe it is important that the care that is purchased and delivered is of good quality. For this reason, the arrangements made by care offices with the care providers are in line with the national quality frameworks (the standards for responsible care). This is also laid down in the care offices' joint purchasing guideline. The standards for responsible care in nursing, care and mental healthcare have been completed, but those for care for the disabled are still in progress. When purchasing care in 2010, therefore, care offices will, wherever possible, follow the standards for responsible care and ensure that these standards are applied in their organisation. This will avoid a situation in which it is not possible to calculate a quality score for some care providers. In the near future we will be able to work increasingly with process and output indicators based on the standards for responsible care.

Regional situations differ, however, so regional purchasing policies may need to focus on different aspects. For this reason, care offices consult regional client and consumer organisations when formulating their purchasing policy. This is something the care offices will be investing in more intensively in the future.

Integrated care

Because care provision must always be centred around the client, it is important for organisations to work together to ensure that integrated care is available wherever it is needed. An example of organising integrated care is the purchase of dementia care. The quality of the care which people with dementia receive is determined among other things by the extent to which care providers approach the totality of their situation. For this purpose, the Integrated Dementia Care programme (a joint venture between VWS, Alzheimer Nederland, the Netherlands Association of Care Insurers (ZN) and, recently, ActiZ) has developed a purchasing guideline for dementia services. Sixteen spearhead regions were set up in mid-2008. I shall be informing you of the initial results shortly.

In 2010 the purchase of integrated dementia care must be rolled out to all care office regions. A major challenge in 2010 will be to achieve coordination with the cure sector (particularly GPs and mental health services) and the WMO.

For this purpose care offices want to seek and encourage cooperation with bodies such as municipalities, welfare organisations and housing corporations with the intention of providing a more cohesive range of services (integrated care) for all dementia sufferers by 2011.

Various experiments have been initiated with a view to providing more integrated care and improving cooperation between the different domains (ZVW, WMO and AWBZ). One example is the Frieslab experiment in Friesland, in which a collaborative centre has been set up to explore and improve cohesion between the various care laws and regulations. The objective of the Frieslab is to gain a better understanding of the ways in which we can organise integrated care and improve the quality of service and care provision. An experiment is currently being prepared in Rotterdam, in which a number of target groups are being identified as groups in need of greater cohesion and integrated care. The core component of the approach in Rotterdam will be matching care purchasing to the selected target groups.

Cooperation with municipalities, welfare organisations and housing corporations
Cooperation with bodies such as municipalities, welfare organisations and housing corporations is an important point for consideration in the implementation of the AWBZ. If municipalities and other parties offer comprehensive tailor-made solutions and give people the opportunity to participate, this could in many cases prevent people from needing to use AWBZ services. In all of this, the care office plays a major role in the municipalities' and other parties' ambitions to enable people to lead active lives in the local community by providing the appropriate care and support, since it can help encourage the care providers to do so.

Example: Partnership between municipality and care office
The municipality of Ede is aiming to provide sufficient suitable independent housing for various special target groups such as elderly people in need of care, physically disabled people, homeless people, mentally disabled people and former psychiatric patients. These dwellings are well spread out among its local villages, districts and neighbourhoods. The integration of care in society is an important criterion in this endeavour. The municipality of Ede and the Arnhem care office are together examining housing needs up to 2015 in consultation with housing corporations and care providers. They are not restricting their study to care and housing alone but are also including welfare.

Less bureaucracy
I have agreed with the care insurers that they will limit the amount of information they request from care providers, since this represents a bureaucratic burden. For this purpose, the care offices have jointly drawn up a set of standard requirements which tie in with the statutory frameworks. These have been incorporated in the care offices' joint purchasing guideline which ZN has agreed with the care providers and client organisations. From this year onwards, care providers are required to issue a management statement confirming that they meet the requirements. Additional information may only be requested in cases of serious doubt or in the event of a spot check or inspection. In all other cases the information provided in the management statement and the annual corporate social responsibility statement will suffice.

Individual-trailing funding
The funding in the AWBZ is undergoing a development 'from bed to client' (from a supply-led to a demand-led scenario). By this I mean that in the past institutions received money for the number of beds they operated, whereas we are now working towards funding based on the number and type of clients receiving care from an institution. The funding for care in kind is therefore increasingly taking on the form of an individual-trailing budget. Below is a description of the old and the desired future funding scenarios.

	Care in kind	**Budget controlled by client**
'Old' situation	Organisation-based funding	Personal Budget
Present and future situation	Individual-trailing funding (PVB): - Step 1 on 1 January 2009: introduction of care level packages (ZZPs) for intramural care and survey of the introduction of ZZPs for extramural care - As a possible follow-up step, the possibility of vouchers will	Personal Budget

	be investigated (for some forms of care in kind).	

In the case of individual-trailing funding it is commonly believed that the client organises their own care based on a sum of money which is provided after the assessment of their care needs. This is not the case, however, since the client receives their care in kind. With individual-trailing funding the client does not have an actual budget at their disposal, as is the case with the personal budget (PGB). With individual-trailing funding the budget follows the client, even if they switch to a different care provider, for example. The individual-trailing budget is therefore not an amount of money which the client can manage themselves and which is paid out to them. Individual-trailing funding plays a major role in focusing on a client's care needs and the associated care plan. I expect individual-trailing funding for care in kind to act as an incentive for care providers to provide effective, good quality care in the form of a care arrangement that meets the client's preferences, since the funding is not based on the institution but on the client with a particular care need.

In the context of purchasing care in kind, I envisage the care office or the care insurer playing a role in a system of individual-trailing funding as well. Care offices and care insurers play a major role in monitoring efficiency and purchasing care at a good price/quality ratio. Under the provisions of the AWBZ, care insurers (or in practice, care offices) are obliged to provide people who are assessed as needing care with the care they need when they need it.

I am phasing in individual-trailing funding for care in kind. With the introduction of the care level packages (ZZPs) for intramural care on 1 January 2009, we have taken the first step towards individual-trailing funding. The introduction of ZZPs will have financial implications for all care providers and care offices in that it will increase or reduce their organisational budget (reallocation). In order to guarantee continuity of care provision to clients, this reallocation will be phased in over the period 2009-2011. In the context of individual-trailing funding, I am also engaged in further refining care level packages for extramural care, and I am exploring what subsequent steps we can take to arrive at full individual-trailing funding.

A point for consideration in future steps towards individual-trailing funding is that this system should not lead to a fully individualised model of care in which each and every client can and must demand their 'rights'. We must avoid creating a claim culture and giving rise to calculating behaviour, which would lead to a situation in which it is primarily articulate citizens who are able to demand their rights. This is not in the spirit of the AWBZ, which serves many vulnerable groups who are not always in a position to exercise proper control over their own lives.
The advantage of a model that is not fully individualised is that care (whether provided in an institution or not) is often offered on a collective or group basis. This enables added value to be achieved in the quality of care (health, well-being and independence). Care is also delivered on a group basis in small-scale housing and care facilities. This offers scope for solidarity and substitution in an institution.

In the social debate on the future shape of the AWBZ, it sometimes appears that implementation of the AWBZ by care insurers for their own policy holders and individual-trailing funding may not go well together. In essence, the question then is whether there is a role for a care insurer as an 'advocate' of its clients. In my opinion it is perfectly possible - and indeed desirable - to combine individual-trailing funding and advocacy or demand bundling in the purchasing of care.
I have already stated above that I do not wish to pursue a system of individual-trailing funding for care in kind so far that it becomes a fully individualised system. On the other hand, individual-trailing funding needs to extend far enough to enable clients who want to and are able to do so to express their wishes concerning the care options available.

Next year I will be developing further the issue of individual-trailing funding for care in kind in relation to control by insurers in collaboration with ZN and client organisations.

The general conditions relating to the further development of the individual-trailing funding are that:

1. all client groups must be able to continue to receive the care they need (this involves matters with which I am currently engaged, such as clearly defined arrangements and unequivocal, stable care assessments based on a national standard method resulting in similar outcomes and client level statements);
2. the structure of the system of individual-trailing funding must be transparent (including guaranteeing the quality of care, accessibility and financial controllability);
3. the responsibilities and incentives available for the various parties involved (including in respect of the duty of care) must be clearly understood.

As I develop individual-trailing funding for care in kind in greater depth, I shall also be examining whether vouchers could be an option for certain client groups, as proposed in the advisory report by the Scientific Institute of the CDA[7], as well as by joint client and senior citizens' organisations and Actiz. With an assessment-based voucher system, clients will receive a credit voucher with a cash value which they or their 'advocates' can surrender to professionally certified care providers, perhaps without the intervention of an insurer. This will result in tailor-made care for the client, possibly in their own home environment. It will also create a clear customer relationship between the client and the care provider. The risks involved in purchasing care will then lie with the client: if the price charged by the care provider for the care level package purchased by the client is higher than the norm (because it also contains home services, for example), the client will have to pay the excess out of their own pocket. Clients assessed as requiring care could also surrender their vouchers to purchasing organisations, insurers or care agencies which do not have a statutory duty of care but which administer the client's budget on their behalf, have developed purchasing expertise, engage the care provider and provide the client with help or advice.
As I develop individual-trailing funding for care in kind in greater depth, I am finding the concept of providing credit vouchers an interesting one. For this reason, I shall be working with involved parties next year to explore exactly what vouchers would mean for clients and for whom they may be suitable. This exploratory exercise will also be conducted on the basis of the general conditions described above. We will in particular be examining what form the further development of individual-trailing funding will take.

As the system is developed further, we will gain an understanding of the advantages and disadvantages of future steps in individual-trailing funding, enabling a final decision to be made on the time frame for its introduction and how to give shape to the system of individual-trailing funding. I will incorporate the experience gained from the pilot project in Drenthe in the development of individual-trailing funding, as I expect this experiment to deliver some valuable input. I launched this pilot project at the end of 2008 together with organisations including the Dutch Council of the Chronically Ill and the Disabled and the Dutch Association for Care and Support for People with a Handicap. Experiments with individual-trailing funding for people with mental disabilities will be conducted in 2009 and 2010. The objective of the pilot project is to formulate a demand-led care system which places the emphasis on the client and increases freedom of choice for people with mental disabilities who are assessed as requiring care in the form of a ZZP. In the pilot the aim will be to examine the implications of this for all parties involved. I also expect the experiments in Friesland and Rotterdam, which I described above, to deliver input for the further development of individual-trailing funding.

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[7] '*Naar een toekomstbestendige AWBZ: een christendemocratische visie op de langdurige zorg*' (30 June 2008)

Personal budget (PGB)
Besides purchasing care in kind (with the associated further roll-out of individual-trailing funding), the care offices also implement the PGB subsidy scheme. I regard the PGB scheme as an important variant alongside care in kind, and I therefore fully intend to retain it. The PGB enables people to manage their own care budget and to choose which care providers they wish to engage at a time that suits them best. The PGB has increased freedom of choice and control for people who are dependent on care.

At this point in time, the PGB is under pressure from negative reports of its use, particularly concerning fraud. Your House has also raised concerns about this; you have asked some written questions[8] and you have put forward seven motions[9] calling for measures to be introduced to make the PGB future-proof, solid and 'clean'.

Because I consider the PGB to be an important instrument which should not be abolished, I have recently introduced measures to prevent the inappropriate use of the PGB and to make it more solid and 'cleaner'. I informed you about this in my letter of 7 January 2009[10] and I briefed you about the support function measure with which I intend to limit the inappropriate use of the AWBZ, including PGBs, in my letters of 13 June 2008 and 16 September 2008[11].

Intermediary agencies
Following the emergence of negative reports concerning the role of some intermediary agencies, in June 2008 I asked the Healthcare Insurance Board (CVZ) to investigate the activities of intermediary agencies. The aim of the investigation was to gain a better understanding of the role intermediary agencies play in the overall 'PGB chain', from the needs assessment to the budget expenditure statement. I sent this report to your House on 9 March 2009[12].

In response to this report, the following measures have been put in place to prevent the inappropriate use of the PGB:
- From 1 July 2009, the PGB can only be paid into the account of the adult budget holder or their legal representative.
  I am thus implementing the Wolbert and De Vries motion[13];
- At the end of February 2009 the National Care Assessment Centre (CIZ) published a guideline for assessors with instructions on how to act if pressure is exerted by intermediary agencies to award an assessment involving more care than is actually required.
- Per Saldo, the Association of Personal Budget Users, and Stichting de Ombudsman, the Ombudsman Foundation, will be presenting me with a code of

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[8] Van Miltenburg and Agema on the report by the Fiscal Intelligence and Investigation Service/Economic Investigation Service (TK 2008-2009, question nos. 1649 and 1662)

[9] 1 Van Miltenburg motion on concrete steps to withdraw the PGB subsidy scheme (TK 2008-2009, 30 597, no. 21)
2. Leijten motion on measures to combat fraud in home care. (TK 2008-2009, 31 700-XVI, no. 42);
3. Wolbert/Jan de Vries amended motion on a strategy to 'clean up' the PGB (TK 2008-2009, 31 700-XVI, no. 52);
4. Van Miltenburg motion to require care offices to check whether budget holders specifically apply for a PGB (TK 2008-2009, 30 597, no. 53);
5. Wolbert motion on a quality mark for commercial care providers delivering care under a PGB (TK 2008-2009, 30 597, no. 54);
6. Wolbert and De Vries motion on payment of the PGB into the budget holder's account only (TK 2009-2009, 30 597, no. 55);

De Vries and Wolbert motion to prevent care agencies from performing a large number of tasks (TK 2008-2009, 30 597, no. 57).

[10] TK 2008-2009, 30 597, no. 46

[11] TK 2008-2009, 30 597, no. 29

[12] TK 2008-2009, 23,235, no. 88

[13] TK 2008-2009, 30 597, no. 55

conduct in June 2009. This will form a starting point for developing a quality mark for intermediary agencies with a view to preventing clients from falling prey to fraudulent agencies. This code of conduct will prohibit intermediary agencies from providing care themselves and will require them to restrict their activities to administering the PGB (which may not be paid for out of the PGB) and/or liaising between demand and supply (which may be paid for out of the PGB) and/or providing advice (which may not be paid for out of the PGB). I am thus implementing the De Vries and Wolbert motion[14].

Fraud and inappropriate use
Reports have emerged concerning the fraudulent use of PGBs. For this reason, the North and East Netherlands Supraregional Investigation Service and the Utrecht Fiscal Intelligence and Investigation Service and Economic Investigation Service (FIOD-ECD) undertook an exploratory investigation into PGBs and fraud[15] in 2007/2008. The FIOD recommends amending parts of the PGB scheme, improving the assessment process and tightening up detection and inspection opportunities for care offices. In my letter of 7 January 2009[16] I announced the actions I intended to set in motion. In the subsidy scheme, for example, I have stipulated that payments from the PGB should reasonably reflect Dutch market conditions, that intermediary costs for applying for a PGB can no longer be claimed for, and that only the budget holder themselves or their legal representative may sign the budget expenditure statement. In addition to the above, I shall also be introducing the following measures:

- I shall examine whether the current system of budget expenditure statements, in which only the net expenditure has to be accounted for, is the best option or whether there is room for improvement in the future. In doing so I shall take into account the broad developments around the PGB, including bringing care in kind under one contracting framework (see below), and I shall look at the considerations relating to the implementation of the Sap motion, which is giving rise to similar discussion in relation to the PGB under the WMO;
- A new protocol for the inspection of budget expenditure forms by care offices will be completed on 1 July 2009. I have asked ZN to work with the care offices' PGB managers on proposals for improving both general and intensive inspections.

The PGB as an unintentional choice
There are situations in which people apply for a PGB even though it may not be the best option for them. I shall be taking the following measures to ensure that people make a conscious decision to apply for a PGB and the responsibilities that go with it:

- I shall boost the range of youth mental health services and services for people with mild mental disabilities in accordance with the Linschoten Committee's proposals. In doing so, I shall give consideration to the question as to the extent to which the use of the PGB in youth mental health services and in care for people with mild mental disabilities is affected by waiting lists or an inadequate range of care services in kind;
- I recently met with care offices to discuss their role in assessing whether the PGB is a conscious and appropriate choice for new clients, to the extent that they are able to fulfil this role. I am thus responding to the Van Miltenburg motion[17].
- In order to make information that is already available more easily accessible, funding has been provided for developing a PGB DVD. This is expected to be completed by July 2009. I have also asked Per Saldo to investigate and advise whether there is a

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[14] TK 2008-2009, 30 597, no. 57
[15] Report *'Persoonsgebonden Zorg Verantwoord'* published by the North and East Netherlands Superregional Investigation Service and the FIOD/ECD on behalf of the Zwolle-Lelystad Public Prosecution Service. You received this report on 20 February 2009 together with the answers to questions on it by Ms Van Miltenburg, Member of the House of Representatives (DLZ-K-U-2910400).
[16] TK 2008-2009, 30 597, no. 46
[17] TK 2008-2009, 30 597, no. 53

need for specific information which would help people make a conscious decision to opt for a PGB alongside the information that is already available.

Quality of PGB care
A further priority for me is to ensure that the quality of the PGB care delivered is as high as that of care in kind. Budget holders are themselves responsible for the quality of the care they purchase with their PGBs. The starting point in this is that budgetholders themselves are able to assess the quality of the care in a reasonable manner. Of course, the fact that a PGB holder is responsible for the quality of the care they purchase does not release the care provider from the obligation to provide good-quality care.
The two main laws governing the enforcement of quality in care are the *Beroepen in de Individuele Gezondheidszorg* [Individual Healthcare Professions Act] (BIG) and the *Kwaliteitswet zorginstellingen* [Care Institutions (Quality) Act]. The first of these two laws regulates the qualification requirements for care professionals. The Care Institutions (Quality) Act designates the Netherlands Healthcare Inspectorate (IGZ) as the supervisory body for care as described in the AWBZ. It is particularly difficult for the IGZ to supervise the care purchased with a PGB in small-scale initiatives and in the informal sector. In my letter of 7 January 2009[18] I announced that I would be meeting with the IGZ to examine where the problems lie in the sphere of small-scale initiatives and where there is potential for improvement. In addition, *Branchebelang Thuiszorg Nederland* (BTN), the interest group for the Dutch homecare sector, is currently working on the development of a quality mark for individual care professionals (based on the standards for responsible care). This quality mark could be used to certify individual care providers and would enable the quality of their services to be monitored. I shall be investigating the extent to which this quality mark could also be used for care providers in the PGB market. I am thus responding to a Wolbert motion calling for such a quality mark.
Many of the people assessed as requiring care under the AWBZ are vulnerable, and many are in need of a high level of care. This places demands on the skills of the care provider, both when providing care in kind and through a PGB. Partly in response to the wishes of your House, I intend to explore whether we need to do more than I have outlined above to guarantee the quality of care for people with a PGB without tampering with the nature of the PGB.

Position of the PGB
The position of the PGB in relation to care in kind would be given a boost if these two forms of care were to be brought within one single contracting framework. As far as costs on a macro level are concerned, bringing the PGB and caring kind under the same contracting framework would in principle have no implications for either of them. In response to a motion submitted during the 2009 budget debate by Ms Van Miltenburg[19] in which she called for the PGB to be regulated, I reported that the options for achieving this were currently being investigated. In relation to this, we are also looking at what this means for the funding ceiling for the PGB. In 2009 I initiated consultations on setting up a joint study with the Dutch Healthcare Authority (NZa) to look into the options for combining the PGB and care in kind in the same contracting framework. In relation to this, we are also looking at what form of regulation of the PGB would be the most appropriate in this context. In 2009 the NZa will be publishing an advisory report on the tariff scheme for the PGB with a view to integrating it into the contracting framework. I expect the results of this study to be available by the end of September 2009. Once they are available I shall include them in the letter I will be writing to you on the subject of the PGB in the autumn.

In cooperation with the Ministry of the Interior and Kingdom Relations (BZK), the Association of Dutch Municipalities (VNG), Per Saldo and the Central Administration Office (CAK) I shall furthermore examine whether it is possible to make it easier for

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[18] Parliamentary Documents II 2008-2009, 30 957, no. 46
[19] Motion 30 597, no. 21

WMO clients to receive a PGB. We will also study the options for allowing municipalities to pay the PGB net. This latter point is partly in response to the motion put forward by Ms Sap c.s.[20]. I shall report to you on this in September.

There are still several unanswered questions regarding quality control and ensuring that the financial controllability of the PGB is sustainable in the long term, including in relation to the next steps in the introduction of individual-training funding. I shall return to these subjects in a separate letter in the autumn of 2009.

The role of care insurers
There are a number of disadvantages in the current structure of care offices in the AWBZ. A major stumbling block is the fact that care offices have inadequate incentives to implement the AWBZ in a client-centred manner. For example, there is no direct relationship between the care office and the insured party, and there is no intrinsic interest in keeping the AWBZ premium affordable. This is because the care offices themselves do not have a financial interest in implementing the AWBZ. A further disadvantage of the system of care offices is that people who make use of AWBZ care often have to deal with three different points of contact: the municipality for the WMO, the care office for the AWBZ and the care insurer for the ZVW. Yet another disadvantage is the fact that the current implementation structure, in which care insurers implement the AWBZ on behalf of the other insurers (and their policy holders) but compete against each other in the care purchasing market for ZVW care, is difficult to sustain in the long-term. Finally, there is the problem that policy holders are unable to 'vote with their feet'; although care insurers are responsible for implementation under the AWBZ, their policy holders are dependent on their regional care office for service and purchasing of AWBZ care.

These disadvantages have persuaded me to consider a different structure which might have fewer disadvantages in terms of implementation. I am nonetheless convinced that the AWBZ is the best possible instrument for guaranteeing availability and quality of care for people who have a long-term or permanent disability or condition which prevents them from living a fully independent life.

One option for tackling the disadvantages inherent in the current structure of care offices could be to allow the AWBZ to be implemented by the care insurers on behalf of their own policy holders. The advantage of allowing the AWBZ to be implemented by the care insurers is that this would reduce the number of points of contact for clients to one single point for all entitlements to care - both under the AWBZ and the ZVW - namely the care insurer with whom the client is insured. Implementation by the insurers on behalf of their own policy holders would contribute to achieving cohesion between the AWBZ and the ZVW and ensuring the financial viability of the AWBZ in the longer term. This option ties in with the advice of the Social and Economic Council (SER)[21], namely that care insurers should start implementing all or part of the AWBZ on behalf of their own policy holders by 2012 at the latest, and does not rule out the option of transferring parts of the AWBZ to the ZVW and the WMO.

It is a matter of importance to me to ensure that implementation of the AWBZ by care insurers on behalf of their own policy holders plays a role in achieving the underlying principles which I set out in Section 2. On the one hand, the organisation of a single point of contact for entitlements to care under both the AWBZ and the ZVW and the ability for clients to 'vote with their feet' should produce a significant number of advantages for the provision of services to clients and the organisation of integrated care. It will place clients' wishes and needs more firmly at centre stage. This measure is also expected to give small, new providers more opportunities, since care insurers will

[20] TK 2008-2009, 31795, no. 33
[21] SER advisory report: *Toekomst AWBZ* (advisory report no. 2008/03, 18 April 2008)

wish to differentiate themselves in the implementation of the AWBZ. Care insurers will also have a greater interest in ensuring a good correlation between cure and care and, from a preventive point of view, will be more inclined to invest in achieving a good correlation between care and welfare.
On the other hand, however, a structure of this kind raises certain concerns. For example, we need to consider what effect abolishing care offices would have on coordination and compatibility with the municipal sphere, where the current care office plays a regional role. Municipalities would then have to deal with several different care insurers, which could be troublesome for them. One issue is whether this would have a negative effect on the implementation of the *Stedelijke Kompassen* strategies for tackling homelessness, also with care insurers as cooperation partners. Other considerations relate to the issue of how the municipality would be able to influence building plans and how diversity in housing provision could be stimulated. Whereas implementation by care insurers will improve coordination between cure and care, it is less obvious whether it would have the same effect on coordination between care and welfare, and additional effort could perhaps be required. We would also need to guard against undesirable risk selection. If care insurers implement the AWBZ, they must be willing to do so for all clients. They must not give preference to the elderly over people with multiple, complex disabilities, for example. The art will be to exploit the benefits and avoid any potential disadvantages.

Example: Cooperation between municipality and care insurer
Under the slogan '*Utrecht gezond!*' [Healthy Utrecht], the care insurer Agis and the municipality of Utrecht's municipal medical and health service (GG&GD) are intensifying their cooperation. On 8 October 2008 the two parties signed a covenant with the aim of achieving health benefits for the residents of Utrecht. Agis and Utrecht are developing initiatives for the next five years for the pilot district of Overvecht. They are also launching various health initiatives and intend to share their knowledge.

Preconditions for the implementation of the AWBZ by care insurers
In its letter of 13 June 2008, the Cabinet announced its intention to assess in mid-2010 whether the preconditions have been met to allow care insurers to implement at least part of the AWBZ on behalf of their own clients in 2012. The Cabinet stated that it has not yet reached a decision in this regard, because it only intends to take this step once a number of preconditions have been met, such as the introduction of risk-bearing for insurers, individual-trailing instead of institution-based funding, stable rates for care provision, and administration and expenditure statements at individual client level. Also up for discussion is that the AWBZ should be implemented separately from the ZVW. The assessment of care needs also needs to be improved, client payments must encourage appropriate use and the aforementioned points for consideration need to be met. Legal feasibility is another precondition. The above measures are partly aimed at ensuring that the budget remains controllable.

Together with ZN I have drawn up a step-by-step plan which outlines what needs to be done in order to decide whether or not to allow care insurers to implement the AWBZ. In the coming period I intend to work closely with insurers to enable the preconditions to be met. For this purpose, I shall also be examining how care insurers would be financed if they were to implement the AWBZ on behalf of their own policy holders, with the aim of keeping financial control at its present level whilst allowing for implementation by care insurers. In order to ensure that the budget remains controllable, it is important to establish what incentives could be put in place for care insurers to improve efficiency. By introducing a certain level of risk-bearing and/or scope in the purchase of care, care insurers could be given an additional incentive to monitor the efficiency of their care purchasing. In exploring efficiency incentives, I intend to look at the options for allowing expenditure for alternative purposes which benefit the AWBZ indirectly, such as stimulus

projects in integrated care, prevention, innovation, the use of care brokers and client information.

In order to respond to the points for consideration mentioned above, I want to see an explicit comparison of the envisaged advantages and disadvantages which clearly illustrates which clients would be better or indeed worse off in terms of added value if the AWBZ were to be implemented by care insurers on behalf of their own policy holders. I expect care insurers to play an active role towards their clients in the decision-making process in the upcoming period. This year care insurers will work with client organisations to establish the best way to meet the wishes and needs of vulnerable clients. Care insurers will also pay specific attention to their relationship with municipalities. ZN will consult with the VNG to work out an appropriate form of collaboration which will ensure that needs are met as fully as possible on a local level. It is conceivable that care insurers will opt for a representation model in which the market leaders make the arrangements on behalf of all care insurers. ZN and the VNG can ascertain jointly how municipalities can play a role in this in a practical way.

In reaching a final decision on implementation of the AWBZ from 2012 onwards, my priority will be to ensure that it is not only clients who are willing and able to do so who can express their preferences, but also - and primarily - that care and support for the most vulnerable groups (such as those with multiple severe disabilities) are properly regulated and guaranteed at all times and are coordinated with each other. Before I take the AWBZ into an environment involving a higher level of risk-bearing, this will have to be properly ensured. In order to assess whether the preconditions for this can be and indeed are met, I intend to work together with the care insurers in the upcoming period to enable a well-considered decision on the implementation of the AWBZ from 2012 onwards to be taken by 1 July 2010 at the latest.

Follow-up report
In the autumn of 2009 I shall inform you of the current status of the implementation of the AWBZ by care offices. I shall also provide a follow-up report on the current status of preparations for the decision on the implementation of the AWBZ by care insurers on behalf of their own policy holders and the further development of the system of individual-trailing funding.

Assessment of care needs
The assessment of care needs under the AWBZ is necessary in order to determine whether it is appropriate for the applicant to claim for AWBZ care financed from collective resources. At the same time, the assessment must be such that it allows people to obtain the care they need. It is an instrument - no more, but certainly no less.

Simplification of the assessment of care needs
I want professionals, care providers and clients to experience as few obstacles as possible in the process of assessing care needs under the AWBZ. My policy is therefore aimed at making the process of assessing care needs transparent and simplifying it significantly. In my letter of 7 July 2008[22] I informed you of the results of a number of pilots completed last year by the CIZ. To follow up on these, for the sake of brevity I refer you to the exchange in the General Consultation on modernisation of the AWBZ on 5 March 2009.
In essence, this boils down to the fact that care professionals and care providers are being given a more active role in the process of assessing care needs under the AWBZ. These may include the GP, but also the district nurse or a care provider such as a care or nursing home. This is logical, since these people have access to the clients' medical records, and are able to send a digital assessment recommendation to the CIZ, which issues the assessment decision. In 2008 almost 1300 care providers made use of this

[22] Parliamentary Documents II, 2007-2008, 26 631/30 597, no. 268

facility, resulting in 150,000 assessment recommendations. For that matter, the professionals and providers will have to make significant efforts to supply the minimum digital dataset in full and properly. GPs' attention has been specifically drawn to the standard assessment protocols (SIPs) and the urgent procedure. The secondment of assessors to larger health centres is now gradually being rolled out in 24 centres. The aim of all of the above is to rid the care assessment process of unnecessary bureaucracy, to reduce the time it takes to process applications, to inform clients of the status of their applications sooner, and, if they are entitled to care, to enable them to access it more quickly.

Streamlining the assessment processes
The Minister of Social Affairs and Employment and I have launched the Programme to Streamline Assessment Processes in Care and Social Security, part of which is the Joint Assessment project. The municipalities of Doetinchem and Leeuwarden are participating in this together with various implementing bodies such as the CIZ, the UWV, the UWV WERKbedrijf and the organisation for disabled people, MEE. The strategy boils down to the fact that the client only needs to be assessed once. The programme is examining the need for care, the need for support and opportunities to work. Besides paid work, it may also include voluntary work. We will be evaluating this strategy next summer. The pilots will continue during the evaluation so that we can build on them, if necessary, once the evaluation has been completed. I am currently consulting with SZW and BZK in order to ascertain whether there are any opportunities to propagate the proven added value in places such as the municipalities being used as testing grounds in the near future.

Example: Joint assessment
Yannar is a 50-year-old woman with a back condition which makes it difficult for her to walk. To improve her mobility, she applies to the WMO service desk in the town where she lives, Doetinchem, for a tricycle.
Her application is handled by a project team, and she is assigned a process coach. The context shows that Yannar also has other wishes and needs. Someone visits Yannar at her home, where it becomes apparent that she also has problems standing up and sitting and that her home is not actually suitable for someone with her disability.
The project team takes action immediately and initiates three needs assessments: urgent WMO help for modifications to her home and assessments for a tricycle and household help. Yannar herself has only had to visit the WMO desk once.

Enduring solidarity and budget sustainability
In my letter of 13 June 2008 I announced that I would be taking a series of steps to make the AWBZ 'crystal clear'. My policy in this regard is geared towards achieving transparent AWBZ entitlements and clarifying their implementation. This has been referred to in previous documents as a 'transparent policy'. Vulnerable people who need long-term care must always be able to obtain the care they need. The quality of care must be guaranteed now and in the future, and solidarity must be safeguarded. To achieve this, we need to prevent the unintended use of and shifting responsibility to the AWBZ. In addition, care entitlements must be clearly described so that unintended use is minimised and responsibilities are transparent.

I have taken an initial step towards making entitlements transparent and combating unintended use in the form of the AWBZ package measure which was introduced on 1 January 2009. As specified in the introduction, I will be informing you about the initial results of the monitor of the package measure before the summer. I also abolished the principle of the 'psychosocial problem' on 1 January 2009. It is likely that the target group which made use of this principle (social relief, women's shelter services and disrupted households) will now turn to the municipalities. The municipalities are being compensated financially for this.

A next step will be to transfer physical rehabilitation care. I briefed you on the status of this step recently. Another example of my efforts to make AWBZ entitlements more transparent is my intention to resolve the problems with extramural hospital care, including specialist day care facilities for disabled children and children's hospices, introduce a client co-payment for the support function on 1 January 2010, and ensure separation between this domain and education and youth welfare. I will also be examining separation issues in the experiments in Friesland and Rotterdam mentioned above. It must be said that it is not only the entitlements which I believe should be transparent; I also regarded as important to ensure transparency in the assessment of care needs and their financing.

There are also several other activities ongoing which contribute to the AWBZ becoming more focused on the people for whom it is actually intended. Better separation between this and other domains, such as youth care for instance, plays a role in this. The Linschoten Task Force, for example, has reported on youth care to the Minister for Youth and Families and myself. The Minister and I recently presented this report to you[23]. One of its recommendations was that all assessors, in other words the CIZ and the Youth Care Agency (BJZ), should work in the same way in order to minimise the unintended use of care. There will also be one protocol for people with mild mental disabilities (LVG protocol) which will enable youth care organisations to assess more effectively whether a child should be helped under the AWBZ or by a youth care organisation.

Finally, the AWBZ Care Abroad Bill is currently being prepared. The measures set out in this Bill and the legislation relating to them involve tightening up the regulations and restricting the current opportunities to receive care abroad that is financed under the AWBZ. These are an elaboration of the letter I sent you on 18 September 2007.[24]. The measures that have been introduced in this Bill are not primarily aimed at saving money but at preventing future developments that are difficult to control.

4. Boosting the transformation of the long-term care sector

In order to face the challenges I have described in this letter, long-term care will need to undergo a gradual transformation over the upcoming period. Changes are never easy, whether for the sector, for the clients or for society in general. In order to give concrete form to the transformation that is needed, I intend to do the following. Various development and improvement programmes have been introduced in the field of long-term care over the past few years. Examples include the National Programme for the Elderly, the Transition Programme for Long-term Care, the National Dementia Programme and *Zorg voor Beter* [Providing Better Care]. These programmes all have one factor in common: they are developing new knowledge which is a necessary part of this transformation. It is already possible to roll out much of what has been developed and tested in these programmes more widely in practice. In addition, a considerable body of knowledge is also being gained in the field. Various examples of this have been mentioned in this letter. At the 'Yes, we Care!' conference on 5 June 2009, referred to above, an eponymous programme was announced with the intention of encouraging long-term care institutions to implement this knowledge. I will brief you on this in more detail before the summer.

5. Finally

In this letter I have provided you with a detailed explanation of the future of the AWBZ as requested in the Wiegman c.s. motion. Over the upcoming period a great deal of effort will be needed to put the aspects I have earmarked as priorities in long-term care into practice. In doing so, I shall always take account of the importance of the quality of clients' lives and respect for the professionalism of the care providers.

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[23] Parliamentary Documents II 2008-2009, 30 597, no. 48

[24] Parliamentary Documents II 2007-2008, 30 597, no. 13

The AWBZ enables care to be delivered to the most vulnerable people in our society. Those who are dependent on such care must not feel that they are being obstructed by the very systems that have been put in place to deliver this care. The future of the AWBZ will be determined by the demand for care from the most vulnerable members of our society, the care services the professionals can deliver to meet this demand, and the solidarity that society can muster for caring for these people.

Yours faithfully,

Dr J. Bussemaker
State Secretary of Health, Welfare and Sports