



Health Reform Monitor

The 2015 long-term care reform in the Netherlands: Getting the financial incentives right?[☆]

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ABSTRACT

In 2015 the system of long-term care (LTC) financing and provision in the Netherlands was profoundly reformed. The benefits covered by the former comprehensive public LTC insurance scheme were split up and allocated to three different financing regimes. The objectives of the reform were to improve the coordination between LTC, medical care and social care, and to reinforce incentives for an efficient provision of care by making risk-bearing health insurers and municipalities responsible for procurement. Unintentionally, the reform also created a number of major incentive problems, however, resulting from the way: (i) LTC benefits were split up across the three financing regimes; (ii) the various third party purchasers were compensated; and (iii) co-payments for the beneficiaries were designed. These incentive problems may result in cost shifting, lack of coordination between various LTC providers, inefficient use of LTC services and quality skimming. We discuss several options to get the financial incentives better aligned with the objectives of the reform.

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1. Introduction

The ageing population, declining availability of informal caregivers, and demand for high quality of care pose many problems for OECD-countries [1–5]. Ensuring fiscal and financial sustainability is most frequently mentioned as the most important policy goal by policymakers in 28 OECD countries [1]. Furthermore, in several OECD countries (e.g. Canada, Denmark Japan, Norway, Sweden and Switzerland) elderly people and policy makers increasingly prefer receiving home care rather than institutional care, resulting in a steadily declining percentage of people aged over 80 years in LTC institutions and more and more frail people living in the community [1,6]. This trend of ageing-in-place requires different care arrangements, which is reflected by other frequently mentioned high-priority policy goals within OECD countries, such as “encouraging home care arrangements” and “better coordination between health care and LTC” [1].

Improving the organization of care in the community and ensuring financial sustainability of LTC also are of paramount importance in the Netherlands, given the expected increase of people over 75 years old (from 1.3 million in 2015 to 2.1 million in 2030) in combi-

nation with high public expenses on LTC (accounting for 2.6% of GDP in 2015, which is about twice the OECD average) [7]. Furthermore, the percentage of people 80 years and older in LTC institutions is decreasing (from 21.6% in 2004 to 16.0% in 2014) [6] while the relative share of potential informal caregivers is declining too (the ratio of people aged 50 to 75 to those of 85 years or older is projected to decline from 15 in 2015 to 6 in 2040) [8]. For these reasons, in 2015 the system of LTC financing and provision in the Netherlands was profoundly reformed [9]. The former comprehensive public LTC insurance scheme was split up, and its benefits were allocated to three different financing regimes: (i) a new public LTC insurance scheme for covering institutional care and intensive home health care (24 h supervision or care in proximity); (ii) the existing mandatory basic health insurance scheme for covering home health care and community nursing; (iii) the existing Social Support Act (Wmo) for providing social support and assistance in daily life for people with disabilities and chronic psychic or psychosocial problems. The idea behind this split-up is to improve the coordination between LTC, medical care (e.g. primary care and hospital care) and social care (e.g. domiciliary care, participation and housing) and to reinforce incentives for an efficient provision of care by making risk-bearing health insurers and municipalities responsible for the procurement.

A first evaluation of the Dutch LTC reform was recently performed by the Netherlands Institute for Social Research (SCP) [10]. The SCP found evidence of a reinforced trend of ageing-in-place and

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a lower growth of public LTC expenditure during the first years following the reform. However, the researchers also concluded that it is too early for a full evaluation of the reform [10]. Maarse and Jeurissen argue that different incentives generated by the reform may result in coordination problems and strategic cost-shifting, jeopardizing its potential success [11]. In a study about pros and cons of the LTC reform, the Netherlands Bureau of Economic Policy Analysis (CPB) pointed out several problems in the coordination of care between municipalities and health care insurers [12]. In this paper, we build on these studies to investigate whether the reform offers appropriate incentives to stakeholders (clients, caregivers, providers and payers) to realize the goals of the reform.

2. The road to the LTC reform

In 1968, the Netherlands was the first country to implement a universal public long-term care insurance scheme (abbreviated as AWBZ). Initially, the AWBZ covered primarily nursing home care and institutionalized care for the mentally handicapped, but in due course coverage was expanded to home health care (1980), ambulatory mental health care (1982), social assistance in case of frailty, psychosocial problems and after childbirth (1989) and residential care for the elderly (1997) [13]. In comparison to other European countries, the resulting public financing scheme for LTC was very generous and comprehensive, a trait shared with the Nordic countries [14]. Contributions and co-payments were income-related. Provider contracts were negotiated by regional procurement offices within a fixed regional budget constraint, set by the government. In almost all regions, the health insurer with the largest market share has been designated as regional procurement office. The central government was the single risk-bearing entity, implying that regional procurement offices were not at risk for long-term care expenses covered by the AWBZ scheme.

The comprehensive and generous public LTC insurance scheme has resulted in a high share of older people receiving formal care within LTC institutions relative to all other OECD countries, with the exception of Sweden, Norway, Switzerland and Austria having comparable shares of formal care [1]. Furthermore, from 2000 to 2013 the average annual growth of public expenditure on LTC was 4.3% in real terms [9]. The broad entitlements, heavy reliance of formal (institutionalized) care, and limited incentives for efficiency resulted in increasing political concerns about the financial sustainability of the system. The year 2007 was a pivotal year, setting the stage for reforming the entire LTC financing system in 2015. After decades of expansion, this was the first year in which the scope of the public LTC insurance scheme was reduced. Domiciliary care (e.g. household help), which was used by about 400,000 to 450,000 people [15] and accounted for about 4% of AWBZ expenses, was excluded from coverage of public LTC insurance and transferred to the responsibility of the municipalities under the new Social Support Act. The aim of the Act was to make people (more) self-supporting and to facilitate that they can effectively participate in society. All municipalities in the Netherlands were made responsible for assisting citizens who are unable to independently arrange the care and support they need. Municipalities received a non-earmarked block grant to provide domiciliary care and were allowed to charge income and means related copayments for individual provisions up to a legal maximum amount. Since municipalities were fully at risk for the expenses on domiciliary care and budgets were not earmarked, they had strong incentives for cost containment and were able to realize substantial savings on domiciliary care expenditures [16].

In 2013, another important contraction of the public insurance scheme took place by the implementation of much stricter admission criteria to institutional care. New clients with relative mild

impairments (i.e. the first three scales of a eight scales severity index) were no longer entitled to institutional care. The decline in demand and stricter admission criteria resulted in overcapacity and closure of residential care homes, and in a transformation of residential homes to nursing homes. The association of LTC providers (Actiz) concluded from a survey among its members that 150–200 LTC institutions with a total capacity of about 10,000 elderly, were closed in the period 2013–2016 [17].

3. Key elements of the 2015 LTC reforms

With the 2015 LTC reform parts of the benefits covered by the public LTC insurance scheme were shifted to the responsibility of municipalities and health insurers (see Table 1).

A first key element of the reform was the decentralization of social LTC to municipalities under the scope of the Social Support Act (Wmo 2015). The Social Support Act was revised to strengthen the role of people's social network in providing care. Only when people or their social network are not capable of arranging sufficient support to fulfill their needs, they are eligible to receiving formal care. The total budget municipalities received from the national government was about 11% lower than the expenses on social LTC under the former AWBZ scheme. In addition, the budget for providing domiciliary care was reduced by 32% [18]. The idea behind these budget cuts was first of all that less people need household help (or people need less hours of care) because people and their social network were supposed to carry out more of these tasks. Moreover, the risk-bearing municipalities would have stronger incentives to negotiate lower prices than the non-risk-bearing regional care offices and have more instruments to tailor the provision of care and facilities to the specific needs of the municipal population.

A second key element was to make health insurers responsible for contracting community nursing, by including this benefit in the mandatory health insurance scheme under the Health Insurance Act (abbreviated as Zvw) [9]. The mandatory health insurance scheme is carried out by competing private health insurers that are allowed to selectively contract with healthcare providers. Health insurers are fully at risk for the medical expenses of their enrollees. People have an annual free choice of health plans offered by the insurers at community rated premiums. Given that premiums are community rated and no selection of applicants is allowed, insurers are compensated for differences in the expected costs of their insured by a system of risk equalization. People do not have to pay any copayment for community nursing, since this benefit is exempted from the mandatory deductible [13]. The idea behind the transfer of community nursing to the health insurance scheme is to improve incentives for coordination between primary care, hospital care, rehabilitation and community nursing for the frail elderly. Furthermore, since health insurers are at risk and have to compete for customers, they may have strong incentives to contract good quality care at the lowest possible price.

The third key element was the replacement of the former public LTC insurance scheme (AWBZ) by a less comprehensive one (abbreviated as WLZ). The new WLZ scheme covers only a minority (about 35%) of the original AWBZ beneficiaries but still the majority of the original AWBZ expenses (Table 1). Someone is eligible for WLZ benefits when he or she structurally needs 24 h a day supervision or care in the vicinity. The benefits include institutional care and intensive home healthcare. People can opt for receiving benefits in-kind or as cash benefit and organize (and contract) care by themselves. The features of the WLZ scheme are very similar to those of the former AWBZ scheme. The idea behind the WLZ scheme is that the financial responsibility for the provision of care for the most vul-

Table 1
Main features of public schemes for LTC financing and provision before and after the 2015 reform.

Act	2014	2015	Features of Act 1. Risk bearing entity 2. Procurement 3. Needs assessment
Exceptional Medical Expenses Act (AWBZ)	Institutional care Home healthcare (intensive home healthcare and community nursing) Social LTC (social assistance)		1. Central government 2. 31 Regional procurement offices 3. Independent Needs Assessment Centre (CIZ)
Expenditure (€ bln) ^a	24.5	–	
Social Support Act (Wmo)	Domiciliary care Home adaptations Social welfare	Domiciliary care Home adaptations Social welfare Social LTC (social assistance)	1. 380 Municipalities 2. Municipalities and purchasing cooperatives of municipalities 3. Civil servants of municipalities (in most cases)
Expenditure (€ bln) ^a	4.4	8.0	
Health Insurance Act (Zvw)	Rehabilitation care	Rehabilitation care Community nursing	1. 24 health insurers ^b 2. 5 insurance concerns; 1 purchasing cooperative of 4 small insurers 3. Providers
Expenditure (€ bln) ^a	0.8	3.9	
Long-term Care Act (WLZ)		Institutional care Intensive home healthcare	1. Central government 2. 31 Regional procurement offices 3. Independent Needs Assessment Centre (CIZ)
Expenditure (€ bln) ^a	–	17.8	

^a Ultimo 2014 / January 2015; Sources: [18–21].

^b 20 health insurers are part of one of 5 insurance concerns.

nerable people, requiring very intensive care, could be best borne by the central government.

The reforms were accompanied with a projected budget cut of 3.5 billion euro over the period 2014–2017, compared to the baseline projections. The actual budget cut, however, turned out to be 2.3 billion on a total of 28.2 billion [22].

4. Appropriate incentives?

With the reform community nursing, primary care and hospital care were brought under the responsibility of the same risk-bearing entity (i.e. health insurers). This increases the possibilities of an efficient coordination of (the procurement of) these services. The same holds for the social care, assistance and social welfare, which were all brought under responsibility of the municipalities.

However, the reform unintentionally also created a number of major incentive problems, which are resulting from: (i) the way LTC benefits are allocated to the three financing regimes; (ii) the way the various third party purchasers are financially compensated; and (iii) the way co-payments for the beneficiaries are designed. As will be explained below, these incentive problems may result in cost shifting, lack of coordination between various LTC providers, inefficient use of LTC services and quality skimming.

Cost-shifting

The division of LTC benefits across three different financing regimes (WLZ, Zvw and Wmo) created opportunities for cost shifting from one regime to another. The boundaries between social care (covered by Wmo), community nursing (covered by Zvw) and intensive home healthcare or institutional care (covered by WLZ) are not clear-cut and frail elderly sometimes may be eligible for each of these services. Municipalities have particularly strong incentives for cost-shifting, since they are fully at risk for providing

tailor-made care. The distribution of the total Wmo budget allocated by the national government to the municipalities depends on objective factors like the number of inhabitants, low-income households and people over 65, and the number of frequent users of prescription drugs. However, the block grant does not depend on whether someone uses support from the Wmo or from health or LTC insurance. Therefore, municipalities have little financial incentives to prevent frail elderly from being institutionalized, for instance by investing in social assistance, home adaptations and facilities to enable people to stay at home as long as possible. Municipalities also have an instrument to nudge people who are very frail to apply for WLZ-care. When the municipality suspects that someone is eligible for the WLZ, it can demand an assessment for the WLZ. If someone does not cooperate with an assessment, the municipality can deny Wmo-care. Once someone is eligible for WLZ-care, the municipality can reject a demand for support. Although eligibility for WLZ-care is assessed by an independent agency (CIZ), which is rejecting a substantial share (17%) of the applications [23], there is ample room for strategic cost shifting. For instance, people with dementia and high dependency on social support and community nursing who do not apply for WLZ-care by themselves, may be urged to do so.

Although health insurers also are at risk for the cost of community nursing, their incentives for cost-shifting are much weaker than for municipalities. This is because their financial risk is minimized by the system of risk equalization. Due to a lack of data on exogenous risk adjusters for predicting individual expenses on community nursing, the risk equalization is currently based on individuals' prior year cost of community nursing, where people with the highest expenses on nursing are classified in 7 different percentile categories, up to a certain maximum (for adults about 30,000 euro per year). This provides health insurers with incentives for shifting costs to the WLZ-scheme for enrollees with expected costs exceeding 30,000 euros a year (i.e. those needing on average

more than 13 h of community nursing per week), e.g. by urging on advanced care planning and application for admission to WLZ-care.

Hence, municipalities and health insurers financially benefit from nudging independent living people to apply for public LTC insurance (WLZ). These incentives are opposite to the reform goal of financial sustainability because (i) the effect on public LTC expenditure will be negative given that the budget for municipalities is fixed, whereas the expenses of public LTC insurance increase, and (ii) more people than necessary may be institutionalized, which is likely to be more expensive.

Coordination problems

The splitting up of the former AWBZ-scheme also generated new coordination problems between institutional/intensive home healthcare, community nursing and social LTC, because these services are now purchased by different entities serving different populations and having different incentives. Cooperation and coordination between 31 regional procurement offices serving a regional population, 5 health insurance concerns and a purchasing cooperative serving a nationwide population, and 380 municipalities serving a local population is very difficult to organize, especially when incentives for cooperation are not well-aligned. Furthermore, because none of these entities is clearly responsible to take initiative for coordination of medical and social care, and there is no financial reward for coordination tasks with an uncertain outcome and no mechanism for sharing savings in different domains, coordination is often the result of passionate caregivers rather than purchasing entities. The recent evaluation of the reform by the SCP confirmed that coordination of care between different purchasers is indeed perceived as a major problem [10].

Efficiency problems and quality skimping

With the transfer of coverage, the financial risk shifted from the central government (i.e. the single risk bearing entity in the public LTC insurance scheme) to municipalities and private health insurers. As in the former AWBZ-scheme, regional procurement offices are not at risk for LTC expenses and therefore have no financial incentives to encourage an efficient provision of institutional care and intensive home healthcare. By contrast, health insurers and municipalities do have financial incentives for cost-conscious procurement. However, the incentives for health insurers are strongly mitigated by the system of risk equalization, since compensations for insurers are based on prior year costs (until 30,000 euro). Although municipalities have a strong incentive for cost containment, the block grant also provides incentives for quality skimping. However, in the first evaluation of the reform no evidence of quality skimping was found, as the majority of clients of the services on social LTC and community nursing reported to be satisfied about the care provided [10].

While copayments for community nursing were required under the previous AWBZ scheme, after the reform people no longer have to pay out-of-pocket for these services since community nursing is exempted from the mandatory deductible in the health insurance scheme (Zvw). On the one hand, the lack of copayments makes community nursing financially more attractive and may encourage people to age-in-place rather than in institutions. On the other hand, the lack of any incentive for cost-conscious use of community nursing may also result in moral hazard. Relative to the former AWBZ-scheme, incentives for moral hazard with regard to community nursing may also be stronger because the responsibility for needs assessment has been shifted from an independent agency (CIZ) to the providers of care. Furthermore, while the number of hours of care people receive under the WLZ is restricted by

reimbursement limits, such restrictions are absent in the health insurance scheme (Zvw).

Paradoxically, this may result in people getting less hours of home healthcare when becoming eligible for intensive home healthcare under the WLZ scheme. Moreover, these people may have to pay more for less hours of care because they now have to pay an income-related copayment for WLZ-care. Although it is unclear how many people are affected by this, the system is very confusing for professionals and consumers.

5. Getting the incentives right?

Based on the analysis of the post-reform incentives, we conclude that although some incentives for coordinating care have been improved, important financial incentives are not well-aligned. In Table 2, we summed the strengths and weaknesses of the reform.

Although it is too early to establish whether and to what extent the observed incentive problems might occur in practice, a better aligning of the financial incentives with the goals of the reform seems desirable. Hence, to support a financially sustainable, accessible and high quality LTC system, we focus on options for restructuring incentives to bring the incentives in the system more in line with the objectives of the reform.

How to counteract or eliminate incentives for cost-shifting?

To counteract the strong incentives for municipalities to shift LTC costs to the WLZ scheme, the Wmo-budget allocated to individual municipalities could be inversely related to the percentage of frail people in the municipal population that uses WLZ-care. Furthermore the current legislation that municipalities can deny Wmo-support when someone does not cooperate to an assessment for the WLZ could be abolished. In addition, to eliminate the overlapping entitlements to home healthcare covered by the three financing regimes, the WLZ scheme should be restricted to covering only institutional care. For health insurers, incentives for cost-shifting could be reduced by including an additional risk class with a higher maximum compensation from the risk equalization fund. However, this would also increase incentives for moral hazard.

How to improve incentives for coordination?

At the moment transaction costs for cooperation between insurance companies and municipalities are high and investments in coordinating social assistance and community nursing may not be attractive if the benefits partly accrue to another third party. Investments in coordination can be encouraged by the government by explicitly rewarding joint initiatives by municipalities, insurance companies and providers for improving cooperation to prevent exacerbations and for interventions to improve the interface between social care, primary and secondary care. For instance, government may reward municipalities and insurers by sharing a percentage of the savings on the costs of people admitted to the WLZ, relative to the projected costs based on a normative or historical admission rate.

How to improve incentives for quality and efficiency?

For more efficient procurement, publicly available quality standards and indicators (e.g. net promoter scores or client satisfaction ratings) should be developed. With these indicators the efficiency of the procurement of the various third party payers can be monitored and clients can make a better informed choice.

To better align the incentives for consumers to choose between home healthcare covered by the public LTC insurance scheme

Table 2
Main strengths and weaknesses of LTC reform.

Goal	Strengths	Weaknesses
Cost containment and efficiency	More incentives for efficient procurement (higher share procurement by risk-bearing entities).	More incentives for cost-shifting, especially to public LTC insurance scheme (WLZ). Municipalities have little financial incentives to prevent frail elderly from being institutionalized, for instance by investing in social assistance, home adaptations and facilities to enable people to stay at home as long as possible. Higher burden on informal caregivers.
Care coordination	Enhanced role and responsibility of people's social network in care provision. Stronger incentives for coordination of LTC provision with social welfare, primary care and hospital care.	Fragmentation of LTC benefits in three different financing regimes with little incentives to coordinate care between the different purchasing entities.
Quality of Care	More possibilities for tailor-made care. More incentives for accommodating people's preferences.	More incentives for quality skimming by purchasers. Different copayments schemes may distort people's choices.

(WLZ) and the health insurance scheme (Zvw), differences in copayments and entitlements should be eliminated. The most straightforward option to realize this, is by restricting the WLZ scheme to covering only institutional care. As explained above, this may also reduce the opportunities for cost shifting.

A major, still unresolved puzzle is how to strengthen insurers' incentives for efficiency without increasing their incentives for risk selection. This is because the prospect of improving the currently inadequate risk adjustment for community nursing is unclear due to a lack of population-wide data on relevant predictors of the expenses of people needing this type of care.

6. Conclusion

Getting the incentives right in the financing and organization of LTC is all but straightforward and a major challenge in many countries. Our analysis of the LTC reform in the Netherlands shows that there is considerable room for improving the post-reform incentive structure. It is important to recognize, however, that improving the incentive structure may involve transaction costs, e.g. the cost of rewarding and monitoring coordination and of developing and measuring reliable quality indicators. These costs have to be weighted against the potential (long-term) benefits of improving incentives.

Since many countries struggle with the question how to create or maintain a sustainable LTC system in view of an ageing population, the Dutch reform experience may offer interesting information about how (not) to organize and finance LTC. An open question is whether the allocation of different LTC benefits to different purchasers (i.e. the state, health insurers and municipalities) can offer appropriate incentives to maintain a sustainable, accessible and high quality LTC system.

Conflict of interest

Peter Alders is also working at the Ministry of Health, Welfare and Sport. The views presented here are those of the authors and should not be attributed to the Ministry of Health, Welfare and Sport.

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