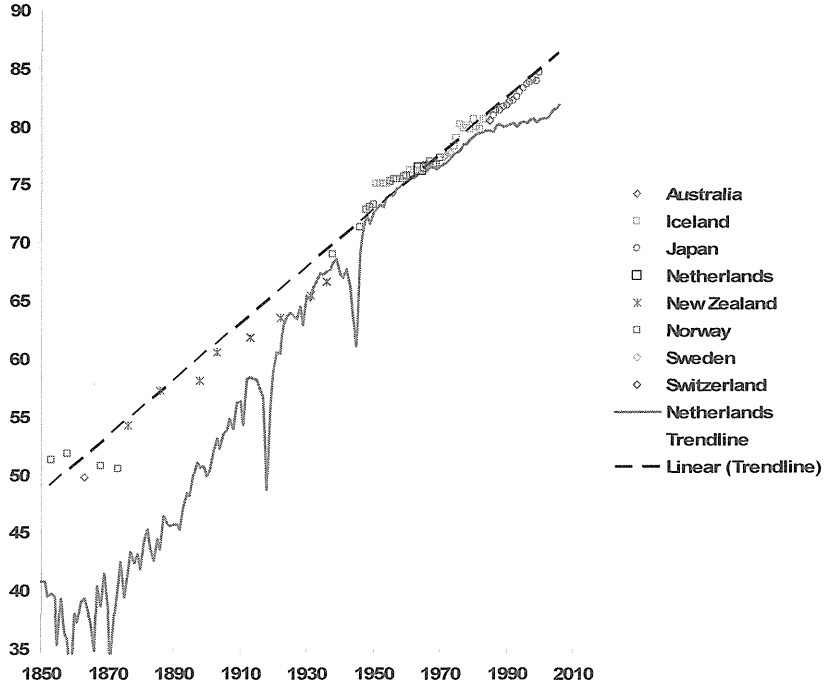
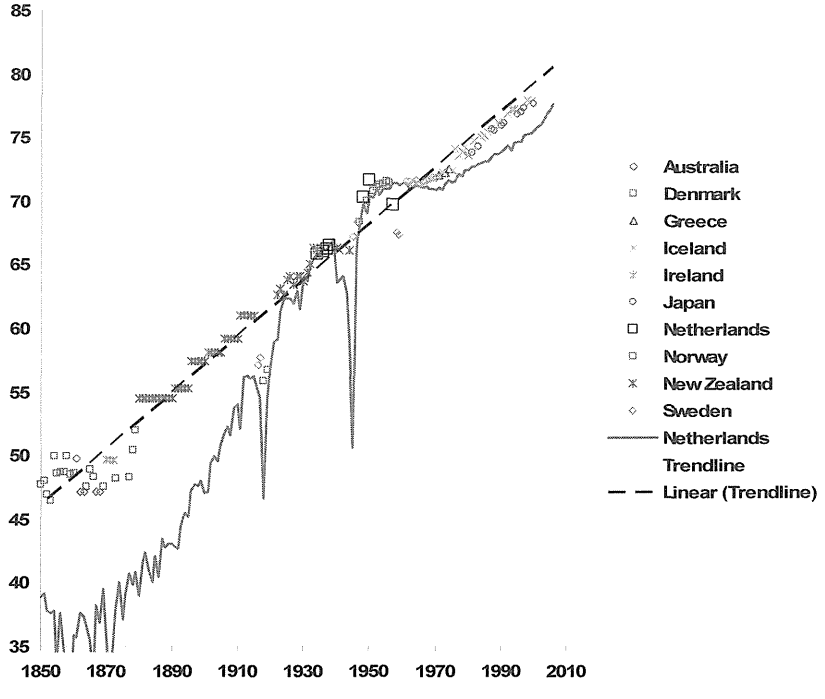
Figure 6: Life expectancies at birth, men and women, from 1850 to 2010. Country with the best performance versus the Netherlands.

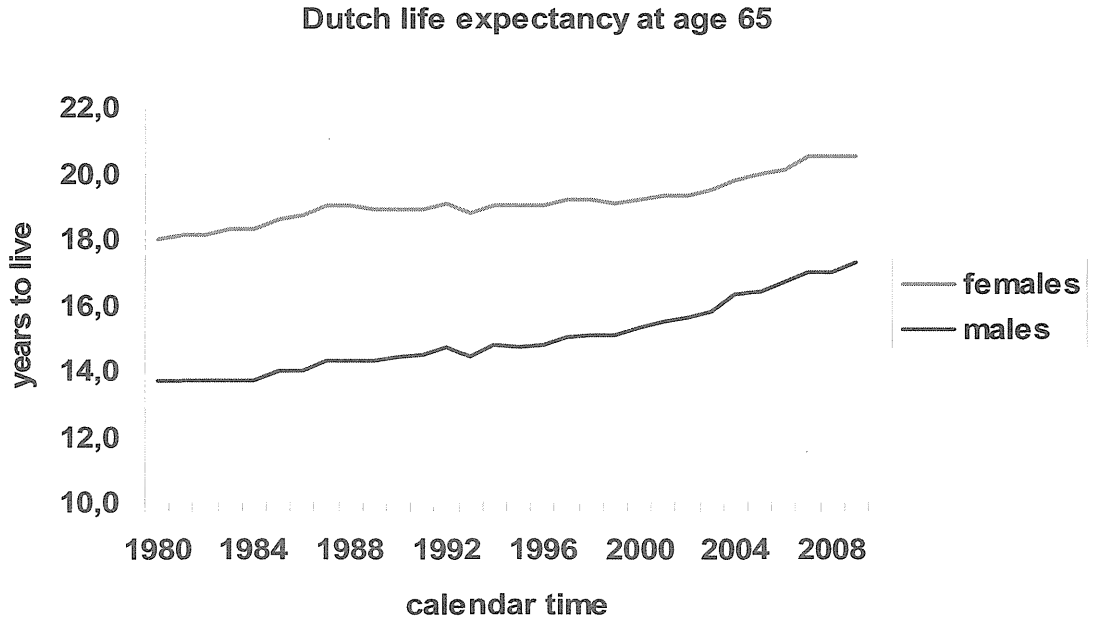


Women



Men

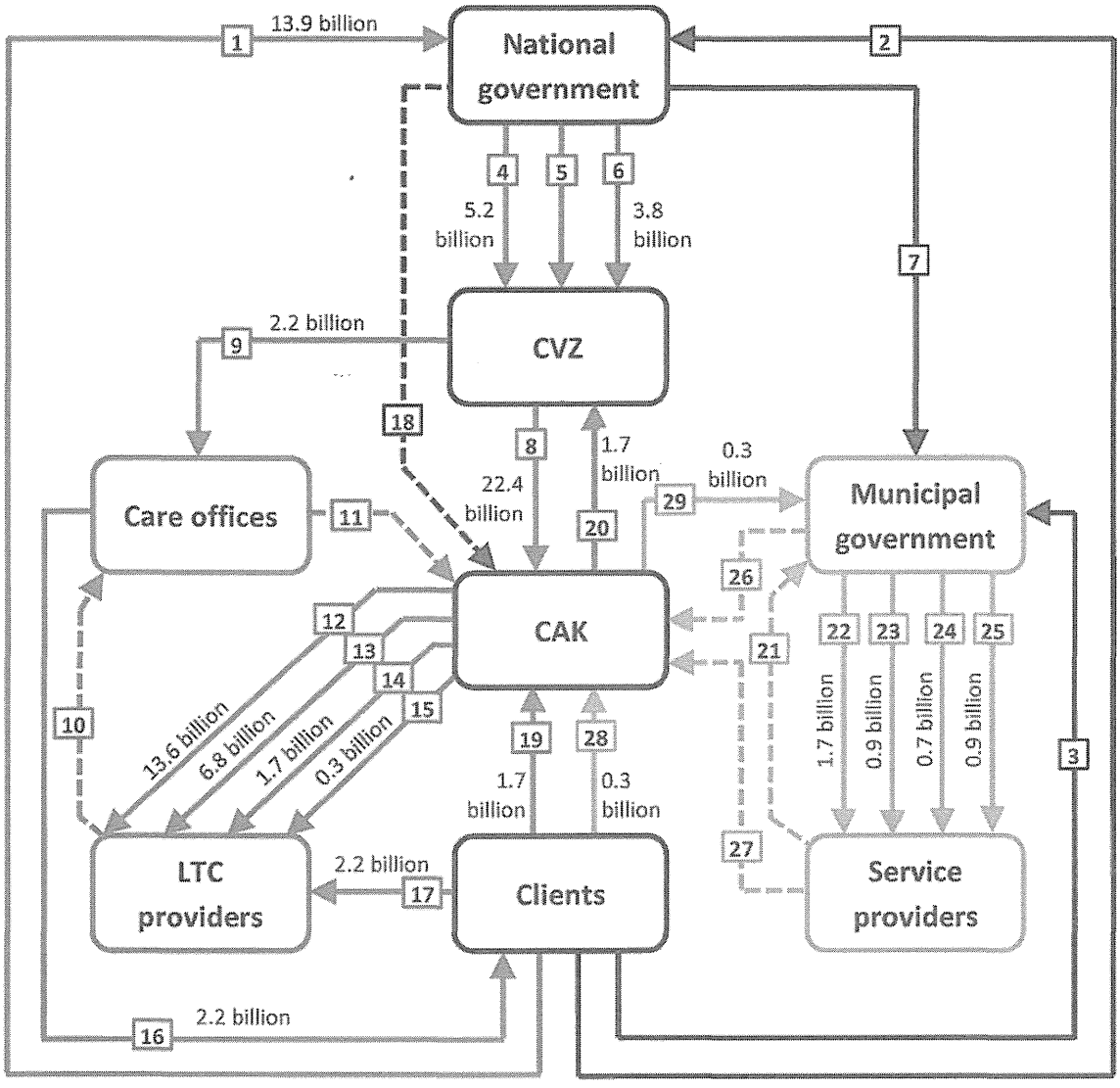
Figure 7: Dutch life expectancy for males and females at birth and at age of 65 from 1980 to 2008 (source: CBS).



4.2.2 Macro-level: Health care expenditure

Information on health care expenditure on the macro-level can be found in tables A1.1 and A1.2 in the appendix. Figure 9 shows the monetary flows in the long-term care and social support sector on a national scale. Expenditure in the social support sector is estimated on the basis of data from the SGBO from 123 municipalities in the Netherlands in 2011.

Figure 8: Monetary flows in the AWBZ and WMO, 2011 (Source: Leyden Academy)[5]



[5] Data of the levels of AWBZ expenditure are from the CVZ. Data on the levels of WMO expenditure are estimated from the data in a report by the SGBO ("Benchmark WMO 2012: Results of the Year 2011"). Data on personal budgets for instrumental aids and home adjustments (WMO) were unavailable. Therefore, flows of expenditure through PGBs are not reported for the WMO, and instead subsumed under flows 22, 23, 24, and 25.

Explanation of flows in figure 8:

1. All Dutch citizens with an income pay a fee of 12.15% of a first part of their income.
2. All Dutch citizens with an income pay different kinds of taxes to the national government.
3. All Dutch citizens with an income pay different kinds of taxes to their municipal government.
4. The national government adds a monetary amount to the AWBZ fund (the BIKK).
5. The national government lets the CVZ administer the funds received from AWBZ fees.
6. Shortages in the AWBZ fund are compensated by the national government.
7. The national government transfers a part of the national taxes to the municipal governments through the municipal fund.
8. The CVZ transfers the part of the AWBZ fund that is destined for long-term care in kind to the CAK.
9. The CVZ transfers the part of the AWBZ fund that is destined for personal budgets to the care offices.
10. Long-term care providers report the start, end and changes in provided care to clients to the care offices.
11. Care offices calculate the compensations long-term care providers are entitled to, and orders the CAK to pay the bills of the long-term care providers.
12. The CAK pays out the providers of nursing care, personal care and counselling.
13. The CAK pays out the providers of care for the handicapped.
14. The CAK pays out the providers of long-term mental health care.
15. The CAK pays out the providers of other forms of AWBZ care.
16. The care offices pay out the personal budgets to the clients.
17. Clients use their personal budgets to pay long-term care providers for their services.
18. The CAK receives information on the financial situations of all the clients (AWBZ and WMO) from the national government through the tax department.
19. The CAK calculates the client contributions of the AWBZ on the basis of the information from (11) and (18), and charges the clients.
20. The client contributions of the AWBZ go back to the AWBZ fund, administered by the CVZ.
21. When service providers deliver WMO support to clients, they charge or inform municipal governments for these services.
22. The municipal governments pay out the providers of domiciliary care.
23. The municipal governments pay out the providers of instrumental aids and other assistance to the handicapped.
24. The municipal governments pay out the providers of social counselling and advice.
25. The municipal governments pay out the providers of social and cultural work (0.7 billion), and other social support services (0.2 billion).
26. The municipal governments deliver the utilization figures of social support services by their clients to the CAK.
27. Domiciliary care providers deliver the utilization figures of their clients to the CAK.
28. The CAK calculates the client contributions of the WMO on the basis of the information from (18), (26), and (27), and charges the clients.
29. The client contributions of the WMO go back to the municipal governments.

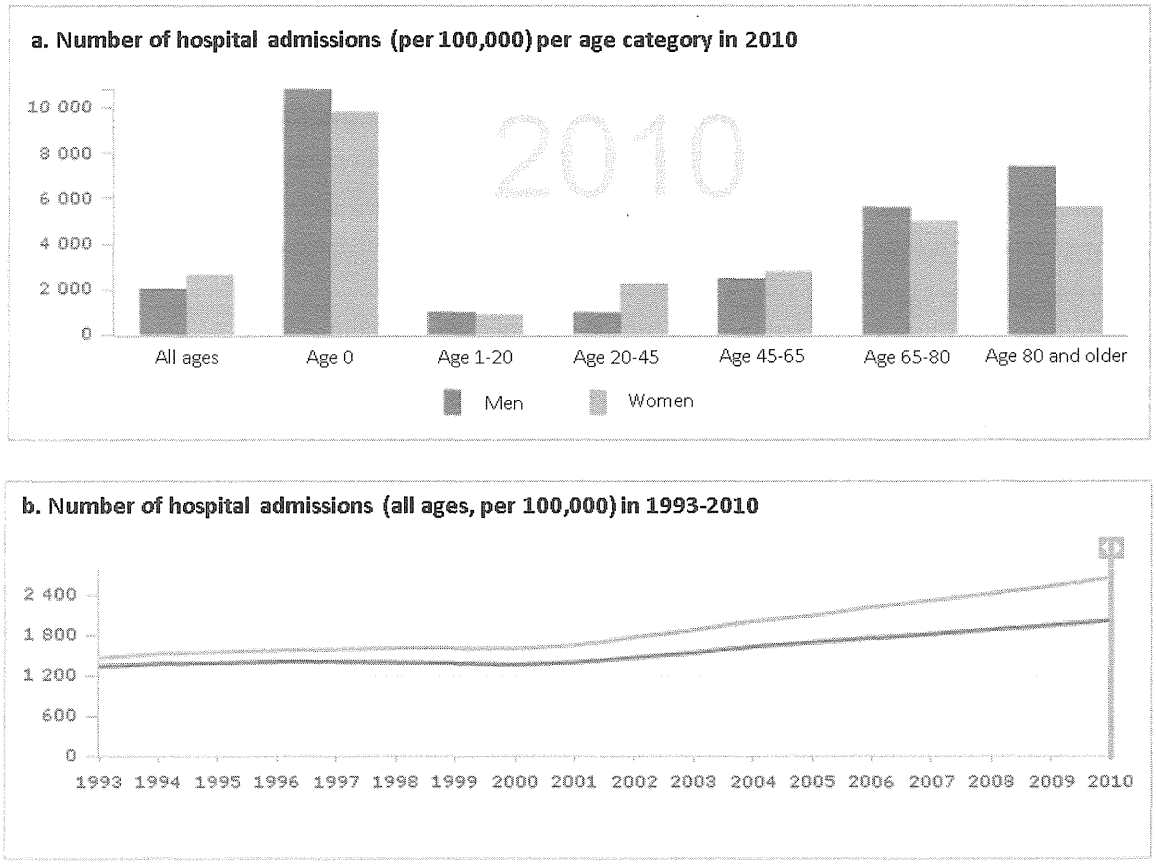
4.2.3 Institutional level: hospitals

In the Netherlands, the number of hospital admissions increased throughout the last two decades, but the average number of hospital beds and days spent in hospital decreased. In the period 1976-2006, the number of beds in both general and university hospitals decreased with 30%. From 1993 to 2010, the number of hospital admissions increased with almost 50%. This can be seen in the lower panel (b) of figure 9. In the upper panel (a), it is visible that both

newborns and people over 65 are admitted most often. Like the number of beds, the number of days spent in hospital also decreased. This can be seen in figure 10.

Compared to surrounding countries (Austria, Belgium, Denmark, France, Germany, Spain, Switzerland, United Kingdom), the admission rate and length of stay in the Netherlands was a little below average in 2009.[6]

Figure 9: Trends in hospital admission in the Netherlands (Source: CBS)

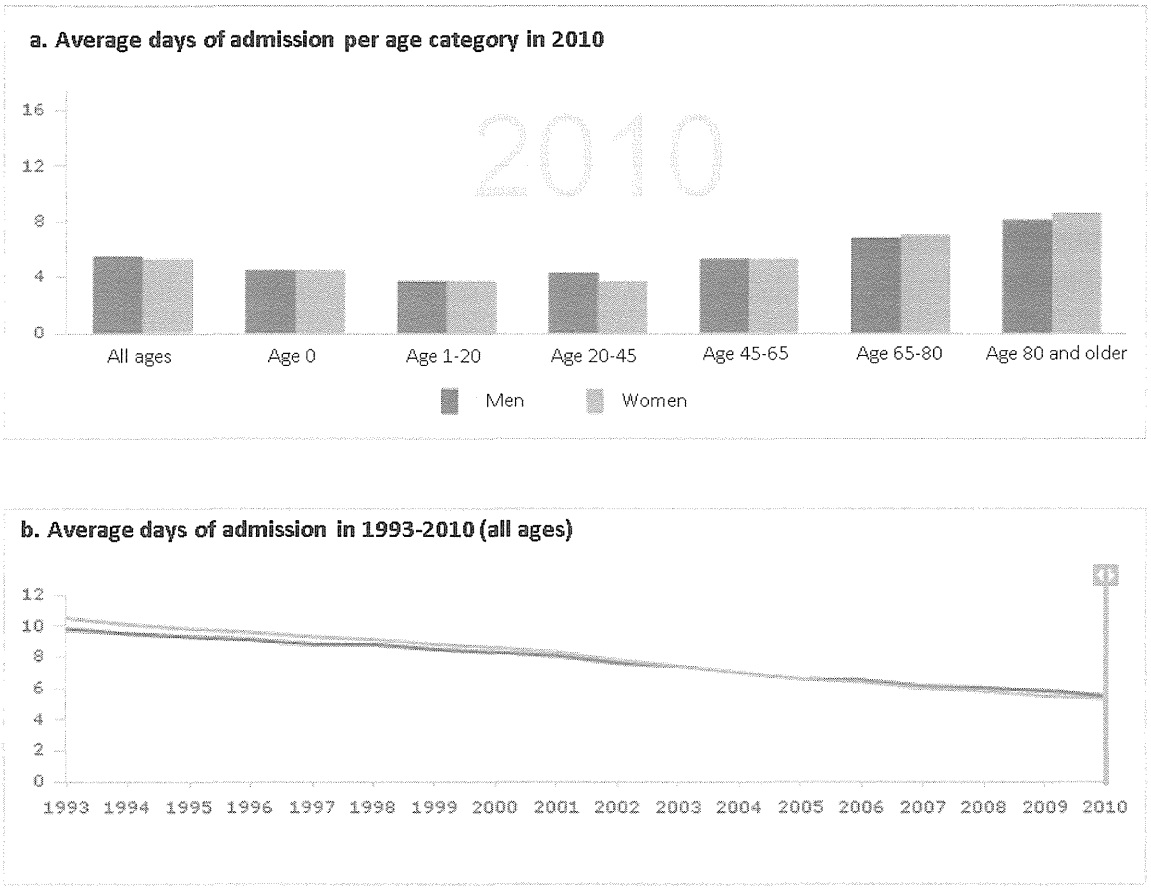


The number of hospital beds is low in the Netherlands (2.8 per 1,000 inhabitants, compared to an average of 3.7), and the number of doctors is even the lowest of the eight selected countries (1.6 per 1,000 inhabitants, compared to an average of 2.4). The number of surgical procedures is lower in the Netherlands than the average of other seven countries (except for tonsil removals and cataract surgeries), and the 5-year survival rate after surgery is higher.

It is perhaps not surprising then, that the Netherlands spends the lowest share of its GDP on general practices and hospitals of these countries (3.7% , adjusted for gender and age differences). Also, according to the Euro Health Consumer Index 2012, the Netherlands scores the highest on hospital performance. This score is based on five categories: patient rights and information, accessibility, outcome measures, prevention, and pharmacy. From these scores, one can conclude that the Netherlands has a highly efficient medical care system.

[6] Based on *Health at a Glance,* 2011: OECD.

Figure 10: Trends in admission days in the Netherlands (Source: CBS)



On the other hand, other expenses in health care (other than general practices and hospitals) is the highest in the Netherlands, compared to the other seven European countries. The costs of long-term care provision, social support, mental health care, overhead costs, and of other health care providers add up to 7.4% of GDP (adjusted for gender and age differences). All in all, to deal with the rising health care costs effectively, policy-makers in the Netherlands need to focus on health care sectors, other than general practice and hospitals.

4.2.4 Institutional level: long-term care

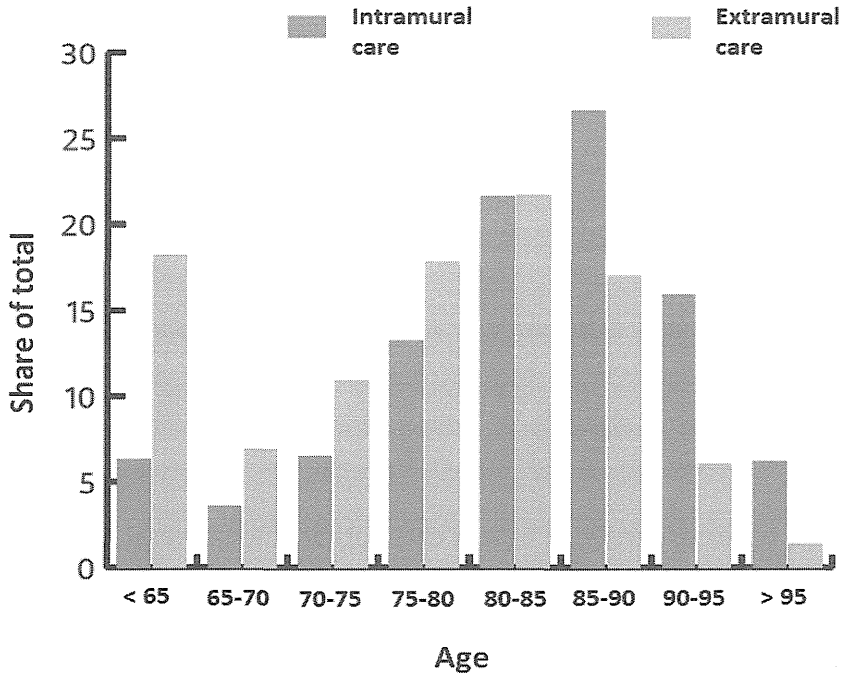
From 2006 to 2010, the number of extramural care providers has been increasing from ±700 to over 1200. The number of intramural care providers has been decreasing. Especially the number of care homes has decreased (from ±500 to ±400). The number of nursing homes has remained stable. These trends have two reasons: (1) mergers in the care home sectors has decreased the total number of care homes; (2) more long-term care is provided extramural rather than intramural. The second reason relates to an increase in efficiency in the long-term care sector, since intramural care is more expensive than extramural care.

Not only has the number of care homes decreased between 2006 and 2010, the days spent in care or nursing homes per client have also decreased. If a long-term care institution has a capacity of 100 clients, the average number of clients that were admitted to this institution in 2006 were 152. This number increased to 160 in 2009, meaning that the average period of admittance decreased with 5% between 2006 and 2009. While the relative use of intramural long-term care has decreased over the last years, the total number of informal

care-givers has increased.[7] This could be a direct effect of population ageing, but it is also possible that long-term care becomes less institutionalized in the Netherlands. This runs parallel with the broad aim of the Dutch government to expect more effort from informal care-givers, the social network and the community, rather than the formal long-term care system. Figure 11 shows what shares different age categories of clients had in long-term care utilization in 2009.

As stated below figure 11, extramural care includes domiciliary care through the WMO, but no other WMO-services. The effectiveness (quality) and costs of the WMO are discussed in the next paragraph.

Figure 11: What share do clients have in long-term care utilization by age, 2009?[8]



The monetary flows in long-term care and social support (AWBZ and WMO) are given in figure 10. This figure shows that expenditure levels in the AWBZ are much higher than the estimated levels in the WMO: 24.6 billion versus 4.2 billion. Care in the AWBZ is much more intensive than WMO support (including Care Weight Packages with full-time residence and 24 hours supervision, and nursing and personal care). However, policy-makers are planning to move substantial parts of the AWBZ to the WMO, because it is assumed less intensive long-term care activities are much more efficiently arranges through local governments with restricted budgets than through a large national system (see also paragraph 4.3 and 4.4).

[7] Source: Social and Cultural Planning Bureau

[8] Figure from: www.actiz.nl, extramural care includes domiciliary care from the WMO

4.2.5 Institutional level: social support

Table 1 (next page) shows the per capita costs of the WMO in 124 municipalities from 2008 to 2012, also for three performance fields that are specifically important for the elderly. These figures were collected by SGBO, a commercial research institute providing benchmarking services for public organizations. Because data on utilization and expenditure of WMO services are dispersed over 415 municipalities (2012) and every municipality defines a different spectrum of WMO services, coherent information on the expenditure levels in the social support sector is hard to find, and not available through regular means (e.g. from the Ministry of VWS, the CBS, or the SCP). Although the figures from table 1 offer an insight into expenditure levels of the WMO, it remains unclear what share the elderly have in the costs.

Per capita expenditure levels of domiciliary care have risen sharply in 2010, while the number of new applications have decreased between 2009 and 2011. The average expenditure per client receiving domiciliary care has risen from €2,929 to €3,234 from 2009 to 2010 (€3,370 in 2011). It is assumed that the criteria for indication-setting have been made stricter, while the costs of service providers have risen. Also notable from the SGBO reports is that per capita expenditure on WMO is much higher in bigger municipalities than smaller ones: €334.91 versus €237.11. It could be that bigger municipalities offer more WMO services, or that the share of WMO dependent inhabitants is higher in these regions. However, the difference in expenditure levels is almost €100 (29%), and other factors are probably contributing to this difference. Levels of voluntary work, informal support and informal care are higher in smaller communities, substituting for formal care and support.

Table 1: Annual costs and outcomes of the WMO (2008-2011, 124 municipalities)[9]

	2008	2009	2010	2011
Per capita expenditure (€)				
Total	**208.77**	**230.07**	**233.16**	**252.17**
Performance fields 5 & 6	-	**140.71**	**154.73**	**157.25**
Domiciliary care (±)[10]	*78.00*	*77.00*	*91.00*	*96.00*
(% receiving PGB)	-	*(16%)*	*(17%)*	*(18%)*
Adjustments to home	*13.60*	*12.60*	*12.60*	*11.10*
Collective transportation	*11.10*	*10.30*	*11.80*	*11.70*
Wheel chairs	*9.40*	*9.20*	*9.00*	*8.40*
Scooters	-	*7.60*	*8.10*	*8.10*
Individual transportation	-	*6.60*	*4.70*	*4.20*
Overhead costs	*18.89*	*17.41*	*17.53*	*17.75*
(Client contributions)	*(11.24)*	*(11.64)*	*(13.85)*	*(16.93)*
Performance field 4	-	-	**4.71**	**4.45**
Informal care	-	-	*2.05*	*1.95*
Voluntary work	-	-	*2.66*	*2.50*
Other performance fields	-	-	**73.72**	**90.47**
Outcome measures (average scores, 0-10)				
Social quality	-	6.6	6.6	6.7
Environmental deprivation	-	3.9	3.8	3.4
Satisfaction: domiciliary care	7.8	7.8	7.8	7.8
New applications (per 1,000)				
Information and advice: field 3	-	126.0	145.0	108.0
Domiciliary care: field 5/6	-	12.0	10.9	9.2
Other provisions in field 5 & 6	-	23.2	21.9	19.2

4.3 Past measures to deal with rising health care costs

4.3.1 Political environment

Before defining the recent and most important transformations in the Dutch medical and long-term care sector to curtail the rising health care expenditure, the political situation in the Netherlands is sketched. In 2010, national elections were organized after the government resigned. In these elections, the VVD (conservative-liberal party) had received most seats of government by votes (31 of 150 seats), followed by the PvdA (social-democratic or "labour"

[9] Source: SGBO, Benchmark WMO 2012.

[10] Average expenditure levels per client receiving domiciliary care were €2,638 in 2008, €2,929 in 2009, €3,234 in 2010, and €3,370 in 2011.

party) with 30 seats, the PVV (party of Geert Wilders) with 24 seats, and the CDA (Christian-democratic party) with 21. The VVD, PVV and CDA formed a coalition, called Rutte I, in which the PVV offered only cooperation through support. This government resigned again on April 21st 2012, when the PVV withdrew this support. Many decisions were made during the time of Rutte I, which affected the ZVW, AWBZ and WMO. These decisions could not be realized, as the government had lost its acting power.

New elections were held in October 2012 and a new coalition was formed in November 2012. The new coalition, called Rutte II, consists of the VVD and the PvdA. Rutte II was planning to make the health insurance premium income dependent, and to discard the health care allowance completely. This would mean that Dutch citizens with a middle or high income would pay a higher premium to their health insurers, and that the lower income population would pay less. This led to many protests, and the plans to make health insurance premiums income dependent were abolished. Serious cutbacks in the AWBZ were also on the agenda of Rutte II. Although people and health care professionals protested against these cutbacks, they are likely to be followed through. More information on this can be found in paragraph 4.4.2.

4.3.2 Medical care

Medical care costs have increased steeply in the last decade, especially in 2005-2006, when the ZVW was introduced. Measures have been taken from the start of the ZVW in 2006 to contain growing costs in the medical care sector.

- Mainly to curtail the increasing assertiveness and demands of patients, the compulsory deductible has been raised to refrain people from overusing health care facilities.
- To prevent the health insurance premiums from increasing steeply, the government has diminished the coverage of the basic health insurance package. For example, coverage for physiotherapy has been decreased consistently throughout the last few years. The first twenty physiotherapy sessions are no longer covered by the basic package in 2013 (and after twenty physiotherapy sessions, still only some treatments are compensated by basic insurance).
- To counter the effects of a volume increase due to free market incentives, so-called "volume norms" are being researched and issued by the Dutch Health Care Inspectorate (IGZ). Volume norms signify a minimum of complex surgeries or treatments per year a hospital must perform to sustain the right to perform these surgeries or treatments. Examples are pancreatic cancer, rectal carcinoma's or elective surgeries for an aneurysmatic aorta. Scientific committees in health care were asked to give their viewpoint on the number of surgeries or treatments that were required to reach such a norm.
- Volume norms and quality standards have been issued by health insurers. For example, health insurer CZ has stopped compensating breast cancer surgeries in six hospitals in the Netherlands in 2011. These hospitals scored too low on quality indicators – the most important one being survival rates after surgery. Because CZ is one of the biggest players in the Dutch health care sector, these hospitals were forced to increase their quality levels or stop providing these surgeries. Volume norms and quality standards, controlled by the IGZ or health insurers, force hospitals to specialize in certain disciplines.
- Rutte I was planning to charge client contributions for hospitalization (around €7.50 per day) in 2012. Rutte II discarded these plans.
- On November 4 2011, the liberal party (VVD) suggested that clients should also receive health care providers' bills, besides their health insurer. They offered two arguments: (1)

people could then see how expensive health care can be, creating more support for necessary future cutbacks on health care expenditure; (2) people could check whether health care providers are "upcoding", since health insurers cannot check whether a health care provider has booked the right DOT (see 2.5). It is unclear whether these plans will be effectuated in the future.

4.3.3 Long-term care

Expenditure in the AWBZ has been growing steadily since 1967. Population ageing has an impact on expenditure in the AWBZ, as the number of clients eligible for long-term care increases. However, the RIVM estimated that only 15% of the total rising health care costs in the Netherlands could be attributed to population ageing between 2001 and 2010. Political decision-making had a more significant impact on rising AWBZ expenses. Through changes in policy, more and more health problems and ailments were covered through the AWBZ between 1967 and 2010. In the last years, policy-makers in the Netherlands have removed some forms of health care provision from the AWBZ and tried to change eligibility criteria for some forms of long-term care. The most important changes in the AWBZ in the last few years are given below.

- Starting from January 1st 2008, domiciliary care is provided through the WMO rather than the AWBZ. In the future, more extramural care is going to be transferred from the AWBZ to the WMO. The aim is to decentralize extramural long-term care, which has several advantages. Municipal offices:
  - are easier to access for care-receivers;
  - are better informed about the costs and quality with regard to local long-term care facilities;
  - are better informed about a client's social environment and network;
  - have tight budgets and are forced to make rigorous cuts in social support and long-term care facilities if that is necessary. Municipalities can realize these cuts by trying to stimulate utilization of a client's social networks rather than formal care facilities;
  - can reach synergy effects with the other social support activities in the WMO.
- In 2009, counselling was no longer indicated for clients with only slight limitations.
- To prevent misuse, the Dutch government has steadily narrowed the eligibility criteria for PGBs. Stories appeared in the media on children of older people who used the PGBs of their parents to go on holiday, rather than to provide their parent(s) with the necessary care. News items were also published on dodgy commercial organizations offering help with requesting, using and administrating PGBs, but using (parts of) their customers' PGBs for other purposes instead. Clients now also have to set up a budget in advance, and accurately report their service utilization.
- To cut costs in AWBZ care for the mentally handicapped, the former coalition of Rutte I of VVD, CDA and PVV were planning to increase the IQ-threshold for eligibility from 85 to 70. These plans were discarded by Rutte II.

4.3.4 Social support

The main change since the start of the WMO in 2007, is the addition of domiciliary care to the responsibility of municipalities in 2008. Other than this, no important changes have taken place in the WMO. This is mainly because the WMO has been in its start-up phase in the last 5 years, and major policy changes in this phase could prove ineffective.

4.4 (Potential) Future measures to deal with rising health care costs

In this chapter, we begin with explaining the broad viewpoints of Dutch policy-makers in health care to improve the quality and efficiency of the system. After this, the specific policy measures for 2013 and after are discussed.

4.4.1 Broad and long-term aims

Two broad and long-term aims of the Dutch government can be distilled that are the basis of the many policy measures that were taken in the last years, and are expected in the feature:

1. A focus on higher responsibility for citizens themselves and their surrounding network of friends, family and neighbours, rather than the formal system;
2. A sharp distinction between individual responsibility, entitlements to health care, and practical solutions.

These two aims are discussed in more detail below. First, many of the future measures of the Dutch government to regulate rising health care costs are related to the concepts of *independence* and *active citizenship*. Independence relates to taking responsibility for oneself, and active citizenship relates to taking responsibility for others in your community. The central aim is to make Dutch citizens less dependent on the formal health care system.

Improving clients' independence could lead to lower levels of health care demand due to higher levels of self-care and self-support, as well as better decision-making by clients. Some policy measures, have the goal to separate health care from residence. One examples is that the former coalition Rutte I was planning to charge client contributions for days spent in the hospital. Another example is that a long-term aim within the AWBZ is to abolish compensation for housing costs (this means that only long-term care is provided through the AWBZ, and not residence). The central motivation is that the availability of good health care is a right, but compensation for housing is not. Instead, paying for residence is (at least partly) the responsibility of the person him-/herself.

Active citizenship relates mainly to the provision of informal care and social support from relatives, friends and neighbours. The main instrument of the government to stimulate such informal care activities, is to downsize the supply of health care. For example, provision of in-hospital recovery from treatment can be reduced, making a speedy and good recovery more dependent on a client's social network. This way, costs are reduced because the average days spent in hospital are decreased. Similarly, eligibility for domiciliary care provision is made more strict to stimulate friends, neigbours and relatives of the client to provide these basic activities.

Second, in many years time the Dutch government wants health care legislation and provision to overlap with current ideas on responsibility and entitlements in health care, and to be arranged in efficient systems of finance and legislation. In short, this implies that a client and his/her social networks have the **first responsibility** to acquire or provide facilities, residence, personal care, forms of social support, and other care and support activities. Care and support activities should only be provided through collective means if a client's financial means, health status and social network does not allow him/her to take this responsibility.

All in all, the current government wants to totally abolish the AWBZ in the very long run (10 years or longer). This long-term aim will pursued in steps. First, personal care, counselling, daytime activities, and other activities currently or formerly provided through the AWBZ should be provided through the WMO. These activities relate more to social support and can potentially be provided through a client's social network, meaning that municipalities might

be better equiped to coordinate and provide these services than the national and bureaucratic system of the AWBZ. This means that clients are no longer **entitled** to receive these forms of care/support, but that these services are seen as **potential practical solutions**. Second, arranging and compensating for short-term or long-term residence and facilities ("hotel costs") are thought to be the client's responsibility, and will no longer be provided through public resources. Third, nursing care should be provided through the ZVW, as this relates more to medical care than long-term care or social support.

4.4.2 Policy measures for 2013

The policy measures in this paragraph relate to changes in government policy in the health care system from 2013 onwards. Policy measures in the short-term are thoroughly worked out by the government. Here, the most important changes in the health care system are defined, after which the changes planned for the long term are described. The following changes in health care policy become effective in 2013:

- From 2013, care office branches of health insurers become responsible for all the clients of the health insurer, regardless in which region they live. Before 2013, health insurers were legally obligated to have a care office branch for all clients in the regions in which they have the highest market share. The year 2013 is a transition year: care offices are still going to cover the regions in which they were active before 2013. Health insurers will then second care office activities to the care office that was responsible for AWBZ services before 2013, until they are ready to perform these activities themselves.
- Clients that were eligible for low-level intramural AWBZ care (ZZP level 1 or 2) in 2012 and before, will now be eligible for extramural care only. This only counts for new indications. Clients with indications from before 2013 for low-level intramural care will not lose them in the near future.
- Rehabilitation in the AWBZ (ZZP 9) will be transferred to the ZVW. Rehabilitative care is found to be short-term by nature, and related more to the curative sector than the care sector.
- The client contribution for AWBZ care is going to be raised.
- More people will become eligible for PGBs in the AWBZ. The government made eligibility criteria more strict in 2011 and 2012, because there were reports of misuse by relatives of clients and commercial long-term care intermediaries.
- The compulsory deductible for medical care is raised with ± 60% (from €220 to €350).
- Walkers, zimmerframes, crutches, and kanes are no longer compensated through the basic health insurance package of the ZVW, the AWBZ or the WMO. Renting instrumental aids through the AWBZ is no longer possible.

4.4.3 (Potential) measures after 2013

Medical care

- In 2014, a client contribution of €50 will be charged when a client reports at the emergency ward in a situation where emergency care is uncalled for. This policy measure aims to reduce redundant medical provision due to client assertiviness.
- The initial plans of Rutte II to make health insurance premiums income dependent were abolished. The current long-term plan is to make the compulsory deductible income dependent, instead of the premiums.

Long-term care

- In the long term, care offices will be abolished. Health insurers will then become responsible for compensating medical as well as long-term care (ZVW and AWBZ) for their clients. This will benefit clients, since they now have one "reception desk" for both ZVW and AWBZ services. Also, health insurers don't have to collect new information on a client, when he or she applies for AWBZ care, since this client is already in the information system of the health insurer. In the new system, long-term care providers will bill health insurers instead of care offices for their provided services.
- As stated in the beginning of this paragraph lower-level intramural care (ZZP 1 and 2) will disappear from 2013. Instead, those who were eligible for lower-level intramural care will now only receive indications for extramural care. In 2014 and 2015, the same will count for ZZP 3 and 4 respectively.
- From 2014, daytime activities (part of counselling) will no longer be compensated through the AWBZ.
- From 2014, indications for personal care for a duration of 6 months or less, will no longer be set.
- In 2015 all extramural personal care and counselling will be the responsibility of the municipality. As was mentioned in in paragraph 4.4.1, all social support activities are going to be detached from the AWBZ, becoming part of the WMO. As municipalities have tighter budgets, it is expected that less clients will be eligible for institutional social support provision, decreasing health care costs. Policy-makers hope to decrease the costs within the AWBZ with 25%, by transferring personal care and counselling to the WMO.
- In 2015 extramural nursing care will be provided and compensated through the ZVW. The underlying argument for this transfer is that nursing care better suits the curative sector (medical care) than the long-term care or social support sector.

Social support

- From 2014 onward, eligibility for domiciliary care will become entirely income-dependent. Municipalities will only provide such services for those with a relatively low income, other clients will have to find their own means to acquire help with housecleaning, grocery shopping etc. These cutbacks will only count for those applying for domiciliary care in 2014. However, in 2015 these changes will also count for all those already receiving domiciliary care.

Appendix

1. Figures of health care expenditure

Given below are three tables with global figures of health care expenditure in the Netherlands. These tables form an update to table 5-7 of the first report.

Table A1.1a: Source and domains of health care expenditure, millions of euro's (source: CBS)

	2006	2007	2008	2009	2010	2011
Source of finance						
Government	8,206	10,724	11,328	12,390	12,739	13,147
ZVW	26,727	27,693	32,325	34,143	35,625	36,394
AWBZ	23,177	23,007	22,169	23,201	24,409	25,128
Other	12,612	13,220	13,933	14,150	14,506	15,043
Domains						
Expenses for cure	40,688	43,306	46,553	48,688	50,741	51,926
Expenses for care	27,026	28,262	30,175	32,195	33,521	34,628
Policy & overhead	3,007	3,074	3,026	3,001	3,016	3,158
Total	70,722	74,643	79,755	83,884	87,279	89,712

Table A1.1b: Source and domains of per capita health care expenditure, millions of euro's (source: CBS)

	2006	2007	2008	2009	2010	2011
Source of finance						
Government	502	655	689	750	767	788
ZVW	1,635	1,690	1,965	2,066	2,144	2,180
AWBZ	1,418	1,404	1,348	1,404	1,469	1,506
Other	772	807	847	856	873	901
Domains						
Expenses for cure	2,489	2,643	2,830	2,946	3,054	3,111
Expenses for care	1,654	1,725	1,835	1,948	2,018	2,075
Policy & overhead	184	188	184	182	182	189
Total	4,327	4,556	4,849	5,075	5,253	5,375

Table 1.1c: Source and domains of health care expenditure as the share (%) of gross domestic product (source: CBS)

	2006	2007	2008	2009	2010	2011
Source of finance						
Government	1.5	1.9	1.9	2.2	2.2	2.2
ZVW	5.0	4.9	5.4	5.9	6.0	6.1
AWBZ	4.3	4.0	3.7	4.0	4.2	4.2
Other[11]	2.3	2.3	2.3	2.5	2.5	2.5
Domains						
Medical care	7.5	7.6	7.8	8.5	8.6	8.7
Long-term care	5.0	5.0	5.1	5.6	5.7	5.8
Policy & overhead	0.6	0.5	0.5	0.5	0.5	0.5
Total	13.1	13.1	13.4	14.6	14.8	15.0

[11] Other sources of finance encompass: compulsory and voluntary deductibles in the ZVW, client contributions in the ZVW and AWBZ, and financing from institutions and companies.

*Table A1.2: Health care expenditure by type of provider, 2009-2011 (source: CBS)**

Provider	2009		2010		2011	
	Total in million €	*% of GDP*	*Total in million €*	*% of GDP*	*Total in million €*	*% of GDP*
Hospitals & specialist practices[1]	21,436	3.73	22,702	3.85	22,811	3.81
Mental health care[1,2]	5,273	0.92	5,401	0.92	5,665	0.95
General practices[1]	2,470	0.43	2,494	0.42	2,697	0.45
Dental practices[1]	2,558	0.45	2,637	0.45	2,743	0.46
Paramedical practices[1]	1,720	0.30	1,807	0.31	1,940	0.32
Municipal health service (GGD)[3]	707	0.12	752	0.13	772	0.13
Health at work[4] & reintegration[5]	1,260	0.22	1,279	0.22	1,266	0.21
Pharmaceutics[1,2]	6,204	1.08	6,340	1.08	6,418	1.07
Therapeutic instruments[1,2]	2,670	0.46	2,727	0.46	2,867	0.48
Supporting services	1,769	0.31	1,878	0.32	1,903	0.32
Other	2,620	0.46	2,725	0.46	2,845	0.48
Total medical care expenditure	48,688	8.47	50,741	8.60	51,926	8.68
Providers of elderly care[2]	15,211	2.65	15,807	2.68	16,386	2.74
Providers of care for the disabled[2]	7,802	1.36	8,088	1.37	8,293	1.39
Providers of youth care[2,6]	1,819	0.32	1,960	0.33	2,077	0.35
Social and cultural work[3]	1,168	0.20	1,221	0.21	1,277	0.21
Day care centers[7]	3,943	0.69	4,138	0.70	4,336	0.72
Boarding schools[6]	576	0.10	549	0.09	481	0.08
Other	1,677	0.29	1,758	0.30	1,778	0.30
Total long-term care and social support expenditure	32,195	5.60	33,521	5.68	34,628	5.79
Policy and management organizations	3,001	0.52	3,016	0.51	3,158	0.53
Total health care expenditure	83,884	14.59	87,279	14.79	89,712	14.99

**The reference numbers in the brackets shows from which act or institution the provider is compensated:*
1 = ZVW.
2 = AWBZ.
3 = Municipal budget (large municipalities have their own Municipal Health Service (GGD), which promotes public health by focusing on prevention, town and country planning to promote health etc.).
4 = Law on Labor Conditions (ARBO), financed by the Ministry of Social Affairs and Employment.
5 = Municipal Budgets and the Ministry of Social Affairs and Employment (mainly by the Law on Working in line with Capabilities (WWNV)).
6 = Government budgets invest in institutes that provide services for youth showing problematic behavior, besides the AWBZ fund.
7 = Dutch citizens may receive subsidies from the tax department for payments made to daycare centers.

Table A1.3: Health care expenditure as budgetted by the government, per sector, in millions of euros, 2010-2011 (Source: BKZ).

Domain	Subdomain	2010	% of total	2011	% of total
Public health		**95**	**0,2%**	**109**	**0,2%**
Medical care	**Total**	**35,417**	**56,6%**	**36,167**	**56,1%**
	Hospital	19,191	30,7%	19,273	29,9%
	Medication	5,215	8,3%	5,460	8,5%
	Mental health care	3,897	6,2%	4,095	6,4%
	General practice	2,219	3,5%	2,310	3,6%
	Instrumental aids	1,394	2,2%	1,475	2,3%
	Dental care	877	1,4%	788	1,2%
	Allied health care	731	1,2%	725	1,1%
	Other	1,893	3,0%	2,041	3,2%
Long-term care	**Total**	**23,983**	**38,3%**	**24,645**	**38,3%**
	Nursing & personal care[12]	7,447	11,9%	7,637	11,9%
	Care for handicapped[12]	4,333	6,9%	4,437	6,9%
	Mental health care[12]	1,246	2,0%	1,281	2,0%
	Extramural care	3,595	5,7%	3,603	5,6%
	Daytime act. & transport.	1,159	1,9%	1,181	1,8%
	Personal budgets	2,157	3,4%	2,279	3,5%
	Capital fees	2,608	4,2%	2,593	4,0%
	Other	1,438	2,3%	1,634	2,5%
Social support	**Total**	**1,721**	**2,8%**	**1,642**	**2,5%**
	Budgetting for WMO	1,541	2,5%	1,456	2,3%
	MEE	180	0,3%	186	0,3%
Other[13]		**1,327**	**2,1%**	**1,850**	**2,9%**
Total		**62,543**	**100%**	**64,413**	**100%**

[12] These long-term care sectors designate intramural care
[13] Other expenses are mainly for education in medicine, and the Wtcg.

2. Benchmark results regarding WMO services of 123 municipalities (Source: SGBO)

*Table A2.1: Information on WMO activities in a study population of 123 municipalities, 2011**

Size of municipal region	Share of study population	Share in the Netherlands
0 – 20,000	18%	37%
20,000 – 50,000	52%	45%
50,000 – 100,000	20%	11%
100,000 and more	10%	6%

Performance field: 1.	"Yes" in share of municipalities:
Promoting liveability (NH = neighbourhood):	
Promoting citizen participation of local activities	98%
Stimulating initiatives from citizens	98%
Promoting citizen platforms	79%
Promoting networks for specific groups	77%
Providing information concerning NHs	93%
Providing mediation for conflicts in NHs	70%
Promoting NHs watchers and coordinators	72%
Promotion of citizens developing behavioral codes in NHs	29%
Promoting activities to improved citizen contact in NHs	90%
Agreements with housing cooperations on:	
Vacancies	59%
Appropriate supply of social housing projects	95%
Illegal renting / residence	58%
Storage and garbage	67%
Maintenance of plants and trees	66%
Investments in play grounds	48%
"Neighbour days"	34%
Providing mediation for conflicts in neighbourhoods	64%
Neighbourhood cleaning projects	54%
Safety issues in the neighbourhood	81%
3.	
Switched to a client-oriented approach**	22%
Switched to a client-oriented approach in a pilot	29%
4.	
Support to informal care-givers:	
Activities to suspend informal-care activities at home	91%
Activities to suspend informal-care activities outside the home	69%
Daycare for children of informal care-givers	15%
Courses	88%
Facilities	21%
Dispensation for obligation to apply for jobs when unemployed	31%

Contact platforms for informal care-givers	96%
Support after death of the informal care-receiver	83%
Counselling	99%
Recreational activities for informal care-givers	88%
Support to voluntary workers:	
Daycare for children of voluntary workers	7%
Promoting professional skills of voluntary workers	88%
Facilities (parking cards, discount cards, etc)	7%
Dispensation for obligation to apply for jobs when unemployed	20%
Insurance	97%
Awards and nominations for voluntary workers	86%
Courses for employees working in voluntary work organizations	84%
Information on legislation	89%
Courses for voluntary workers	70%
Platform with vacancies for voluntary workers	93%
Recruitment campaigns for voluntary workers	78%
Travel allowance	20%
Support for administrative tasks	26%
Financial means for support	38%
Help with organizing	64%

7, 8 & 9.

Agreements with housing cooperations on housing and support for:	
Homeless people	95%
Women from shelters	63%
Patients in long-term mental health care	63%
Addicts	58%
Former prisoners	50%
Activities with regard to:	
Housing rehabilitation	58%
Employment rehabilitation	63%
Education rehabilitation	55%
Social rehabilitation	60%
Financial rehabilitation	57%
Other daytime activities in rehabilitation	54%
Physical recovery	39%
Psychological rehabilitation	48%

* Please note that this is not the complete lists of WMO activities provided by municipalities in the Netherlands, but only those activities for which data was collected.

** Municipalities are switching to a more client-oriented approach (*"De Kanteling"*). This client-oriented approach aims at keeping citizens independent and active by actively approaching and stimulating them. WMO provisions should be a last resort.