



THE PERSONAL BUDGET (PGB) IN THE NETHERLANDS

January 2010

Elke Decruynaere

Expertise Centre Independent Living

GENERAL

The Netherlands have 16.5 million inhabitants of which 3.2 million have a disability or a chronic disease or who need help because of old age.

The Netherlands obliges all its inhabitants to take a health insurance. In this way a collective system of health care insurance is created in which every Dutch citizen of 18 years and above pays a contribution for medical care in case of illness. This compulsory insurance is a basic package which is legally defined by the government and which comprises medicines, hospitalization, maternity care, patient transport services, ... The basic package does not cover all expenses, which is why it is recommended to take an additional insurance. This additional insurance covers e.g. physiotherapy, extensive dental care, and alternative medicine. The content, costs and conditions for the additional insurances differ depending on the insurance company and are not legally defined. You pay a monthly contribution for the care insurance depending on your income and the care insurance that you are with. In Flanders this care insurance would constitute an integral part of the health care system and be managed by the mutualities. It is a federal government competence in Belgium.

Next to the health care insurance there also exist:

- The AWBZ or *Algemene Wet Bijzondere Ziektekosten* (1986) which insures¹ the special expenses of the treatment, nursing and care of people with a long term disability.
- The WMO or *Wet Maatschappelijke Ondersteuning* (2007), which serves the purpose of giving people the opportunity for independent living for as long as possible as well as the opportunity to take part in society.
- Extra expenses caused by a chronic disability are taken care of via the Wtcg or *Wet tegemoetkoming chronisch zieken en gehandicapten*. It comes down to a financial compensation and a possible reduction of the personal contribution to AWBZ and WMO
- Compensation in case of inability to work.
- *Valys*, which takes care of transportation outside one's own region.
- Compensation for the support costs for disabled children living at home.
- *Bijzondere Bijstand*, a one-shot allowance which one can receive when there are essential expenses for which one cannot pay.
- *Jonggehandicaptenkorting* or a tax reduction for young people who benefit a Wajong-allowance (allowance for young disabled people).
- Raising of the work disability allowance.
- Tax deduction for special care expenses.

¹ The legal texts with regard to the AWBZ can be consulted online: <http://www.st-ab.nl/wetawbz.htm> and (2009). *Beleidsregels indicatiestelling AWBZ 2009 – algemeen*. <http://ikregeer.nl/document/BLG18364>.

According to the *Miljoenennota 2008* (a government policy document), the total amount of care expenses in the Netherlands is at 51,3 billion Euro

This amount is used for the treatment, nursing and care-taking of people who need those services. Just like it is the case with the social security the contributions account for the largest part of the care sector's revenues².

In this policy document we focus on the AWBZ because it deals with the care for people with a chronic disease, symptoms of old age or an intellectual or physical disability. Initially it dealt with intramural care but it evolved towards ambulant, short-term and extramural (home) care.

Facts and figures about the AWBZ³:

- On a yearly basis the AWBZ accounts for approximately 21 billion Euro, i.e. about 40% of all the health care expenses in the Netherlands.
- Every working person pays a monthly contribution to the ABWZ which equals 12% of the first 30.000 of his or her income. This comes down to an average of 320 Euro per month.
- In January 2008, 588.000 people (elderly, adults and children) made use of the AWBZ; that is 3.6% of the Dutch population. 600,000 people were making use of AWBZ at the beginning of 2009 and of those people about 260,000 stayed in a AWBZ facility and about 250,000 people received home care. At that moment there were 107,000 people who benefited from a PGB. 20% of the latter people combines this with care in kind.

² Ministerie van financiën (9 juni 2008.) *Cijfers en feiten collectieve sector 2008*. Consulted on 26 January 2010, <http://www.minfin.nl/dsresource?objectid=38909&type=pdf>

³ Ministerie van volksgezondheid, welzijn en gezin (n.d.) *AWBZ Feiten en cijfers*. Consulted on 26 January 2010, <http://www.minvws.nl/dossiers/awbz/feiten-en-cijfers/>

Defining the context of the PGB

There exist different kinds of personal budgets (PGB) in the Netherlands: a PGB from the AWBZ, a PGB from the WMO (household support) for which the municipalities are competent and a PGB WSW⁴. *Per Saldo*, a Dutch budget holders association and the *CG Raad*, the federation of client associations, demand for an integrated participation budget which would make uniform all the different existing 'types' of personal budgets. They also plead for one central referral service. The reason for this plea is the fragmentation of the current PGB as well as that of the existing regulations and compensations.

The PGB AWBZ is the most important one with 111,813⁵ people using the PGB in June 2009 and a maximum budget of 2,280.8 million Euro⁶. 10% of all care users in the Netherlands uses PGB. 20% of the budget for intramural care is spent through a PGB⁷.

Since 2005 there has been an increase of the number of budget holders by 2,100 per month. In 2009 this increase has slowed down (probably due to the reforms) so today it is assumed that there will be an increase of 1,500 budget holders per month. In June 2009 the total number of budget holders according to the CVZ is at 111,813. In 2008 the average budget per care demander is 14,800 Euro⁸.

Compared to care in kind the PGB only accounts for a small part of the budget from AWBZ. After all 91% of the persons who make use of the AWBZ opt for care in kind. The growth of the PGB does not keep pace with the growth of the AWBZ. Between 2002 and 2007 the total expenditure for PGB has increased by 25.9% whilst the total number of people entitled to AWBZ has increased by 12.6%.

The growth of the PGB is mainly attributable to the clients already known to have made this choice, rather than new clients⁹. The potential for the AWBZ (people who could apply for it, but who don't) is estimated at another 20%. Extrapolating from these figures, in 2020 there will most probably be 350,000 budget holders¹⁰.

⁴ The WSW or *Wet Sociale Werkvoorziening* (2008) is aimed at people who, because of physical, psychological and/ or intellectual disability, cannot find a 'regular job'. Thanks to the WSW the work is adapted to the person's possibilities so that he or she may have colleagues and earn a living. This bill people also allows people to follow courses or do trainings.

⁵ Swarte, V.P.P., Krijswijk J.H. (2009). *De toekomst van persoonsgebonden financiering voor langdurige zorggebruikers*. Leiden: Jansen STG / Health Management Forum, 103.

⁶ Ministerie van Volksgezondheid, Welzijn en Sport (n.d.). *Persoonsgebonden budget (PGB). Feiten en cijfers*. Consulted on 26 January 2010, at http://www.minvws.nl/dossiers/persoonsgebonden_budget_PGB/feiten-en-cijfers-PGB/.

⁷ Cijfers van de Nederlandse Zorg Autoriteit, NZA, (2008).

⁸ Swarte, V.P.P., Krijswijk J.H. (2009). *De toekomst van persoonsgebonden financiering voor langdurige zorggebruikers*. Leiden: Jansen STG / Health Management Forum, 103.

⁹ CIZ (2008). *PGB in ontwikkeling*. Kamerstuk, Ministerie van Volksgezondheid, Welzijn en Sport. Consulted on 26 January 2010, at <http://www.minvws.nl/kamerstukken/lz/2008/onderzoeksrapporten-PGB-groei.asp>.

¹⁰ Swarte, V.P.P., Krijswijk J.H. (2009). *De toekomst van persoonsgebonden financiering voor*

Also in the Netherlands the PGB went through an evolution. It has started out in 1991 with an experimental group of 300 budget holders¹¹. Since 1995 the PGB is subsidized. In December 2004 51,432 people were using PGB. In 2007 there was a slight decrease in the growth of the PGB. That was when household support was made possible through WMO, which accounted for the fact that particularly elderly people using a PGB disappeared from the AWBZ's statistics. So in June 2009 already 111,183 persons were using the PGB.

We have observed that the intended focus group is much bigger than the focus group as defined by the *Vlaams Agentschap voor personen met een Handicap*¹². For example: also elderly people and patients from mental health care are admitted. The last 2 years there has been a considerable influx of children and young people with psychological difficulties. The reaction to this growth has been that 'activating treatment' was dropped out of the PGB. All persons in the *Centra voor Geestelijke Gezondheidszorg* (Centres for Mental Health Care) also need to be reassessed. These measures have been met with great resistance but nevertheless have been executed in the meantime.

langdurige zorggebruikers. Leiden: Jansen STG / Health Management Forum, 44.

¹¹ Ramakers, C. (1998). *Clïëntgebonden budget. Een experimenteel onderzoek*. Nijmegen: ITS.

¹² Abbreviated as VAPH, website can be consulted at <http://www.vaph.be> This agency is legally (by decree) put in charge of the implementation of the government policy with regard to the social integration of disabled people in Flanders. Initially it was created as a Flemish Fund in 1990 and reformed into an agency in 2006.

1. THE NEEDS ASSESSMENT

The AWBZ is a collective insurance. It is carried out by care liaison offices. All health care insurers in the Netherlands have delegated the execution of the AWBZ to a care liaison office (there is a current debate about whether the execution of the AWBZ should be handed over to the individual health care insurers). There are 32 regional care liaison offices in the Netherlands, which can be compared to the 'mutualities' in Flanders¹³. The needs assessment procedure is carried out by an independent assessment body, independent of one's own choice. The needs assessment itself (=the assessment whether someone falls under the AWBZ and investigation of which part of the person's care demand is insured under the terms of AWBZ) and the final decision about the needs assessment is carried out by the *Centraal Indicatieorgaan Zorg* or CIZ¹⁴. The needs assessment decree (*zorgindicatiebesluit*¹⁵) stipulates how and by whom the needs assessments should be carried out.

The needs assessment decision of the CIZ is then communicated to the care liaison office. The person insured by the AWBZ can then indicate to the care liaison office for every type of care whether he or she needs a PGB or care in kind. If someone is entitled to long-term residence, then the CIZ expresses this care need into a *Zorgzwaartepakket* (support need package)¹⁶. If the insured person wants to organize this care himself then he or she may receive a PGB to this end.

After the needs assessment you have the following options:

- You may opt for care in kind. A care liaison office organizes your care.
- You may opt for a PGB. You organize your own care and a budget is deposited on your bank account. You have to account to the care liaison office for the expenditure of your budget. After all it is the care liaison office which assigns the budgets and

¹³ Jos Huys (2004). *Het Nederlandse Persoonsgebonden Budget: een bron van inspiratie voor de hervorming van de Vlaamse gehandicaptenzorg*. Consulted on 5 November 2009, at <http://www.gripvzw.be/pdfs/Het%20Nederlandse%20PGB.pdf>

¹⁴ The website of the CIZ can be consulted at <http://www.ciz.nl>

¹⁵ Sorgdrager, W. (1997). *Besluit van 2 oktober 1997, houdende regels met betrekking tot het werkteerrein, de samenstelling en werkwijze van indicatieorganen (Zorgindicatiebesluit)*. Consulted on 26 januari 2010, at <http://www.st-ab.nl/wetawbzorzib.htm>.

¹⁶ As from 2009 the amount of the grant received by a facility depends on the support need of the clients living in a facility. The amount also depends on the client's specificities and the amount of support required by a client. In this more achievement-oriented system of support need financing the care need is expressed into a support need package (ZP) which defines the extent of the required assistance with living, daily activities and treatment. A total of 52 ZPs have been developed. User's manuals have been developed specifically for clients with a AWBZ long-term residence assessment. These manuals describe in a clear and understandable way how much help or care one can receive with a given ZP: ZP nursing and care, ZP physical disability, ZP intellectual disability, ZP mental health care and ZP young people with a minor intellectual disability. This reform may probably be compared to *zorggradatie* (gradation of care) in Flanders.

controls its expenditure by government order (the Ministry of Health Care, Well-being and Sports).

- You may opt for a PGB and continue to receive care in kind, and thus choosing to combine both.

Who carries out the needs assessment?

The needs assessment for the PGB ABWZ is carried out by regional offices of the *Centraal Indicatieorgaan Zorg*, or CIZ¹⁷. This body checks whether a person is eligible for ABWZ care. The policy guidelines which serve as the basis for their actions have been issued by ministerial decree¹⁸.

Many municipalities also make an appeal to the CIZ for the needs assessment for the PGB WMO¹⁹. Children and minors with psychiatric difficulties and who are not intellectually disabled are assessed by the *Bureau Jeugdzorg* (Youth care office).

The PGB WSW requires a needs assessment carried out by the *UWV WERKbedrijf*.

We shall now focus on the needs assessment carried out by the CIZ because it concerns the greatest number of PGB's. Consequently the text here below in the first place concentrates on PGB through ABWZ

Who is eligible?

This is stipulated in the *Besluit Zorg Aanspraken AWBZ* (Bza) (Decree on Eligibility to Care, or Bza)²⁰. There have to be one or more so-called 'motivations': an ailment or disability as a result of which the insured person requires one or more types of care. For example: a somatic, psycho-geriatric or psychiatric ailment or disability or an intellectual, physical or sensory disability.

¹⁷ In 2004 the former Regionale Indicatie Organen (Regional Assessment Bodies) have been centralized in the CIZ.

¹⁸ Sorgdrager, W. (1997). *Besluit van 2 oktober 1997, houdende regels met betrekking tot het werkterrein, de samenstelling en werkwijze van indicatieorganen (Zorgindicatiebesluit)*. Consulted on 26 January 2010, at <http://www.st-ab.nl/wetawbzorrib.htm>.

¹⁹ CIZ (2009). *Indicatiewijzer*. Consulted on 26 January 2010, at <http://www.ciz.nl/sf.cgi?5562>.

²⁰ Ross-van Dorp, C. I. J. M. (2002). *Besluit van 25 oktober 2002, houdende hernieuwde vaststelling van de aard, inhoud en omvang van de zorg waarop aanspraak bestaat ingevolge de Algemene Wet Bijzondere Ziektekosten en wijziging van andere besluiten in verband daarmee (Besluit zorgaanspraken AWBZ)*. Consulted on 25 January 2010., at www.ggzbeleid.nl/pdfwetgeving/awbz_bza.rtf. tekst valid as from 1st January 2009.

The assessment tool

The CIZ establishes an interleaved set which is used for the assessment inquiry and the registration of research data and the assessment. This set is based on:

- DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, version 4);
- ICD-10 (International Statistical Classification of Diseases and Related Health Problems, version 10) for the assessment of diseases and ailments;
- ICF (International Classification of Functioning, Disability and Health) for the assessment of disorders, disabilities and participation problems.²¹

The maximum period of validity of an assessment is 5 years. This period is determined on the basis of several criteria:

- The variability (prognosis) of the insured person's disability. This is based on the diagnosis by a competent person.
- The variability of the living conditions and the insured person's household composition.
- Approaching a certain age limit which may affect the eligibility

Within six weeks after the date of submittal of the care demand, the CIZ carries out an assessment. A health care insurer may in certain situations decide that an insured person is entitled to care without further delay, without submission of a needs assessment. This is only possible for a duration of two weeks. In the occurrence of this event the CIZ shall make a decision about the demand for care before the two weeks are over.

There exist more exceptions to the general rule. For example, persons who simply need a prolongation of care but who actually needed to submit a new demand or in case when it takes too long for the CIZ to take a decision, etc.

What is being assessed?

The needs assessment for AWBZ does not concern the support required with regard to work, education, or household support. There is an increasing call for an integral needs assessment. For example: for AWBZ there is a needs assessment for care with regard to education²², but these assessments are not necessarily joined together. In the cities of *Breda* and *Haarlem* there are experiments running with regard to the proposed integral needs assessment.

²¹ CIZ (2009). *Indicatiewijzer*. Consulted on 12 November 2009, at <http://www.ciz.nl/sf.cgi?5562>.

²² This has been described by the Ministry of Public Health Care, Well-being and Sports in the following guideline: "*Afbakening en reikwijdte AWBZ-zorg en onderwijs*" (2004). Also see CIZ (2009). *Indicatiewijzer*. Consulted on 26 January 2010, at <http://www.ciz.nl/sf.cgi?5562>.

The CIZ checks whether an insured person is entitled to AWBZ care. Article 6 of the *Zorgindicatiebesluit* (Care assessment decree) stipulates the following with regard to the needs assessment investigation:

“In so far as necessary in order to make an assessment decision, the following aspects are investigated:

- *The care demander's general state of health.*
- *The limitations on the functioning as experienced by the care demander as a result of a somatic, psycho-geriatric or psychiatric ailment or disability, or an intellectual, physical or sensory disability.*
- *The care demander's residence and living environment.*
- *The care demander's psychological and social functioning.*
- *The care demander's social conditions.*
- *The nature and intensity of the professional and non-professional support and care provided to the care demander and the possibilities for the continuation and extension thereof.*

In this investigation a uniform decision framework is used: the so-called ‘trechtermodel’ (funnel model)”²³.

Needs assessment decision

Before coming to a decision, the CIZ goes through the different steps of the '*trechtermodel*' (funnel model). This '*trechtermodel*' is the decision framework for the CIZ. The care situation of the insured person serves as the basis for defining the *bruto vastgestelde zorg* (AWBZ) *behoefte* (grossly determined care (AWBZ) need). The net-result is obtained by deducting from the latter the self-chosen informal care and the personal contributions. The last step in the '*trechtermodel*' is the option *AWBZ-zorg zonder Verblijf* (care without residence) or *AWBZ-zorg met Verblijf* (care with residence) (for more information about both care types, see here below):

- ❖ *AWBZ-zorg met Verblijf* (AWBZ-care with residence)

The care need is connected to the most fitting client profile within the support need packages. Subsequently this is translated into a claim to AWBZ- care in terms of functions, extent of the functions combined and a support need package.

AWBZ-zorg met Verblijf is assigned to people who need permanent supervision, need

²³ CIZ (2009). *Indicatiewijzer*. Consulted on 26 januari 2010, at <http://www.ciz.nl/sf.cgi?5562>,15.

support at any given moment or who live in a specifically adapted environment. A PGB for *AWBZ-zorg met Verblijf* used to be out of question because PGB was destined only for ambulant or temporary intramural care. This has changed since 1 July 2007.

Since that date the CIZ and Bureau Jeugdzorg assess everyone entitled to a long-term residence a support need package ('*zorgzwaartepaket*'). The goal is to make the facilities focus more on the individual person's needs. On the other hand that does mean that PGB for people with a very high care need is now being calculated in a different way than before. Previously they simply received a PGB according to the PGB-tariffs (see budget calculation).

The extent of the residence is expressed in a number of days per week, also subdivided into classes, with the following subdivision:

- Maximum three days of *AWBZ-zorg met Verblijf* per week: the extent of the care is expressed in classes.
- More than three days of *AWBZ-zorg met Verblijf*: the extent of the care is expressed in terms of a support need package, based on the amount of care for all the care types combined.

One point of criticism with regard to the support need packages is the fact that not every demand for support 'fits into it'. This means that there are people who are assessed too low because they do not fit into a given care profile.

❖ *AWBZ-zorg zonder Verblijf* (AWBZ-care without residence)

The care need is translated into a claim to ABWZ-care in terms of functions and classes. The extent of the care is expressed in a category. The different existing classes are the following:

- Categories based on an average number of hours of care per week, defined as a range of hours (e.g. class 1: 0 – 1.9 hours). These apply to the functions *Persoonlijke Verzorging* (Personal Care), *Verpleging* (Nursing) and *Begeleiding Individueel* (Individual Guidance)..
- Categories based on parts of the day per week. These apply to *Begeleiding in groepsverband* (Guidance in group).
- The *Omvang van Behandeling* (Extent of Treatment) is not expressed in a class.
- The *Omvang van Vervoer* (Extent of Transportation) is not expressed in a class. This extent is connected to the extent of *Begeleiding in groepsverband* (Guidance in group).

The classes range from class 0 up until the highest class, which is 9 (depending on the function). For exceptional cases, where the care need of the insured person exceeds the highest class, the additional care expressed in hours and/ or parts of the day is assessed and duly motivated.

The care functions describe the care that a person can require. We can differentiate six different care functions:

- *Persoonlijke Verzorging* (PV) (Personal Care)
- *Verpleging* (VP) (Nursing)
- *Begeleiding* (BG *ind* en BG *groep*) (Guidance, individual and in group)
- *Behandeling* (BH) (Treatment)
- *Verblijf* (VB) (Residence)
- *Voortgezet verblijf op psychiatrische grondslag* (Continuated residence because of psychiatric reasons)

The motivations which give the right to a budget vary depending on each function.

The PGB can be freely spent on these functions, even when one is not assessed for them. Only *Vervoer* (Transportation) is an exception to this rule.

Delivery terms, form of delivery and activities

The needs assessment decision contains the following points:

- The motivation for- and the period of validity of the care.
- The care functions to which the person is entitled (see further on in the text).
- An advice about activities (*activiteiten*) and delivery terms (*leveringsvoorwaarden*). If possible the insured person's preference with regard to the form of delivery (*leveringsvorm*) (ZIN (*Zorg in Natura*) or PGB) is also reported (see further on in this text).
- The share of informal care as an integral part of the gross AWBZ-claim of the insured person.

The terms of delivery constitute the advice about the care-service as formulated by the CIZ and is destined for the care liaison office. It deals with the possibility or impossibility to plan the care and/ or the proximity of the care provider. The delivery terms are only mentioned for the care functions *Persoonlijke Verzorging*, *Verpleging* and (*Individuele*) *Begeleiding*. The delivery terms can be compared to the extent of permanence, or P-value, as in the PGB experiment in Flanders. This P-value varies from A (available at previously made appointments and moments) to D (24 hours on 24 immediate availability).

The form of delivery constitutes the choice for the type of care received. There exist two possible forms of delivery: the personal budget (*Persoonsgebonden Budget* or PGB) or care in Kind (*Zorg In Natura* or ZIN). The needs assessment is carried out without distinguishing

between these two forms of delivery. It is thus carried out regardless of the person's choice. If the insured person has already notified his or her choice for PGB or ZIN (for each separate function) during the assessment investigation, then this choice will be indicated in the assessment decision.

Treatment (*Behandeling*) is only provided in the form of care in Kind.

The activities are one or more care-activities or day programs which further specify the assessed functions.

2. THE CARE PROVIDERS

CARE IN KIND VERSUS PGB

There is a great difference between providing care with regard to PGB or with regard to care in kind. Care providers are however allowed to offer both.

Providing care in kind requires a permit. In order to obtain such a permit, you need to meet certain legally defined quality standards. Providing care for an insured person implies that you comply with the *Wet Toelating Zorginstellingen* (or WTZ; Bill regulating the admission standards for care facilities)²⁴. This law defines the rules with regard to a transparent company structure and orderly business management. The Health care inspection services monitor the application of this law.

The pricing for care in kind (en PGB-AWBZ met verblijf) is carried out on the basis of the support need packages.

The only laws which apply to the provision of care with regard to a PGB, is the general Dutch legislation concerning terms of employment, fire protection, hygiene, ... There is no other legislation with regard to the matter.

If you work with a PGB you may choose where to purchase your care. On the condition however that the living expenses are on one's own account and that the care costs are paid by the AWBZ. The pricing of services is free and is determined by the care provider.

PGB budget holders also purchase their care at regular care providers who also provide care in kind. This does not seem to make sense because it actually would be easier to just opt for care in kind, but the budget holders argue that they use the PGB in order to have their say in these facilities. The PGB is used as a lever for change in the care sector²⁵.

DEVELOPMENT OF A CARE MARKET

In the Netherlands, the opening of the care sector to the free market has become reality and is no longer taboo. The government aims at the introduction of market forces in the care.

²⁴ Ministerie van Volksgezondheid, Welzijn en Sport (n.d.) *Wet toelating zorginstellingen (WTZi)*. Consulted on 16 November 2009, at <http://www.minvws.nl/dossiers/wtzi/default.asp>.
Sluijs, E., Keijser, A. & Wagner, C. (2007). *Kwaliteitssystemen in zorginstellingen, de stand van zaken in 2005*. NIVEL. Consulted on 26 January 2010, at <http://www.nivel.nl/pdf/Kwaliteitssystemen-in-zorginstellingen-stand-van-zaken-2005.pdf>.

²⁵ This has been discussed at *de dag van het PGB* which had been organized by among others *Per Saldo* and the *Centrum voor Publieke Doelmatigheid* on 4 November 2009.

This manifests itself in free prices, services, profits but also loss and expansion based on the potentialities of each individual organization. Through market forces the government wants to stimulate competition in order to increase efficiency and encourage innovation²⁶. Not only have we witnessed the introduction of the PGB, next to the already existing care in kind. The nature of the financing of care in kind itself is subject to change due to the recently introduced support need packages. The underlying idea is that the 'financial urgency' for demand steering is lacking when dealing with the financing of facilities as a whole. Financing based on support need and a personal budget on the other hand does emphasize the urgency for demand steering²⁷.

Yet the care market is no free market. The fixed maximum budget acts as a regulating principle by curtailing growth and there are conditions and recognitions which the facilities have to take into account. All that restricts market forces. It is exactly the profit margin and the potential growth which can cover for the enterprise risks. But because of the fact that there is not much financial leeway for the increasing care demands, these are very limited.

Monopolization is prohibited and controlled. The *Nederlandse Zorg autoriteit* (or NZa; Dutch care authority) is an independent watchdog which monitors the activities of all care providers and care insurers on the curative- and long-term care market and makes sure those abide by the law. The NZa determines the rules, the budgets and the tariffs for those aspects of the care which are regulated and also determines the conditions for market forces, which can be liberalized completely or partially²⁸.

There also exists an inequality with regard to the requirements with which the care providers need to comply and which disturbs the market²⁹. Personnel working for a recognized care facility has to comply with the conditions as prescribed by the applicable law. Working with a PGB on the other hand, implies that you are free. It is the budget holder who carries responsibility.

The government's role is mainly to guarantee the access to the care. At present the government introduces market forces and at the same time determines the quality standards. The government wants to increase cost-efficiency by encouraging innovation in order to eventually realize an increase in productivity. It is remarkable how the notions of efficiency and effectiveness of the care and personal budgets are much more of a topic in the Netherlands than they are in Belgium.

²⁶ Swarte, V.P.P., Krijswijk J.H. (2009). De toekomst van persoonsgebonden financiering voor langdurige zorggebruikers. Leiden: Jansen STG / Health Management Forum, 53.

²⁷ Swarte, V.P.P., Krijswijk J.H. (2009). De toekomst van persoonsgebonden financiering voor langdurige zorggebruikers. Leiden: Jansen STG / Health Management Forum, p. 62.

²⁸ Website of the NZa: <http://www.nza.nl>

²⁹ Swarte, V.P.P., Krijswijk J.H. (2009). De toekomst van persoonsgebonden financiering voor langdurige zorggebruikers. Leiden: Jansen STG / Health Management Forum, 59.

For example: the budget holders association *Per Saldo* ordered *Zorgconsult* to investigate the difference in price between the PGB and care in kind. It was concluded that budget holders on average cost 12% less than care providers who provide mainly care in kind. In other words, with an equal budget amount the budget holders manage to receive more support. There are two explanations for this: 1) budget holders can ask for more custom-tailored or personalized care and 2) they can also have a better view on how their illness may evolve, which means they can foresee when they will need more or less support, and this without having to be reassessed each time.

It is also remarkable to see that for children with a multiple disability the PGB seems to be a better instrument than care in kind because the PGB allows to anticipate more easily onto the need for extensive individual support than is the case in the organized (institutionalized) offer. Also the price- quality ratio has been investigated and turned out to be positive. Two other plus points: the relationship with the care providers was better and the PGB allows a person to influence the context of his or her own care and makes the person independent from the care facility's context³⁰. The flexibility with regard to the extent and timing and the fact that the PGB actually reversed the roles were explicitly mentioned as great assets³¹.

THE IMPACT OF THE PGB ON THE CARE OFFER

The PGB's impact on the care offer is being recognized. The PGB plays a catalytic role in changing the care. The budget holders are perceived as innovators who have opened up new ways in the care and who at the same time have pointed out certain difficulties³². Among the many examples of the new initiatives are the care farms, independent living initiatives sustained by a PGB and the so-called *Thomashuizen*. Specialized child care facilities for seriously ill small children have also been made possible because parents have started using a PGB for financing day and night care provided by these facilities. The guidance offer is diverse, not only for guidance at home but also for day care and guidance which constitutes an integral part of the holiday-offers and recreational activities.

Websites like <http://www.zoekpgbzorg.nl> provide a forum where those who search for a specific offer and those who can provide it, can meet. There exists a whole variety of people who want to provide care to budget holders. Some are private persons, people who freelance or have started a small business of their own. For example: <http://www.buurtzorgnederland.nl>, <http://www.stichtingeigenwijs.nl> and <http://www.thomashuizen.nl>.

³⁰ Damen, S. (2009). Zorg met PGB is goedkoper dan zorg in natura. *Eigenwijs*, (issue 3), 36 en 37.

http://www.pgb.nl/per_saldo/up1/ZohuwsdIG_Zorg_mt_pgb_is_goedkoper_dan_zorg_in_natura.pdf

³¹ Kaaij, R., Huijsman, R. (2009). PGB als strategische pijler van zorgaanbieders, *ZMMagazine*, (issue 4), 4-9.

³² Swarte, V.P.P., Krijswijk J.H. (2009). De toekomst van persoonsgebonden financiering voor langdurige zorggebruikers. Leiden: Jansen STG / Health Management Forum, 21.

According to Frans van der Pas (policy staff member of the budget holders association *Per Saldo*)³³ these are examples of innovations which would not have existed without the PGB. These initiatives can see the light because the initiators know that there exists a group of clients with a great purchasing power. The PGB proves to be an attractive potential source of income for many people. The budget holders - through their care needs and their purchasing behavior - decide which initiatives are desired and which are not. The initiators also praise the direct and immediate feedback from the users.

There is only a limited impact of the PGB on the regular care services. The impact is most obvious in the care residences which are run by the regular care providers.

There are also some less positive developments however, like e.g. care mediators and care providers which totally take over the budget and by doing so ignore the basic principle of the user's control over demand and payments. Or regular facilities which force people to take a PGB in case there is a waiting list for regular care in kind. In psychiatric facilities and youth care the PGB often is not a free choice but the only way to be able to organize ambulant care at home. Frans van de Pas also remarks that there exist situations in which care personnel in the regular care talk clients into a PGB because it gives them the opportunity to provide a more flexible guidance.

Researchers have concluded that the PGB – as a strategic part of the care offer - holds a great potential for care providers in the Netherlands, a potential which is still underestimated. They strongly urge the care providers to adapt their service- and pricing strategies in line with the growing PGB segment³⁴.

³³ van der Pas, F. persoonlijke communicatie, 10 January 2010.

³⁴ Kaaij, R., Huijsman, R. (2009). PGB als strategische pijler van zorgaanbieders, *ZMMagazine*, (issue 4), 4-9.

3. THE BUDGET CALCULATION

WITH RESIDENCE

If the applicant for a budget has been assessed for care with Residence, then the budget is calculated and expressed in support need packages (*zorgzwaartepaketten* or ZZP's). The option for a PGB with an assessment for care with Residence has been made available as from July 2007. Before that date the budget holder's options were limited to temporary residence and ambulant care services. A ZZP is a package which consists of intramural care and which fits the client's profile³⁵.

The amount is then calculated taking into account the person's needs as well as the following elements³⁶:

- Average time required by the person, expressed in minutes per week³⁷. Sometimes the possibility of interventions is included in the calculation.
- Potential need for guidance in Group, expressed in parts of the day.
- Potential for care with Residence, expressed in days.

The 'average time' applies to persons without behavioral problems. This average also contains the indirect time spent on care such as: arriving at the care demander's residence or house, saying hello and goodbye, washing-up, (briefly) going through or updating the care file. When the care moment comprises two or more separate actions, then these are qualified as coinciding activities. Less time is assessed for those activities. The underlying idea is that the provision of care is more efficient in that case. The indirect time is calculated per care moment and by consequence is assessed once –only if activities coincide.

For people with a complex care demand the care may be provided by two caretakers if necessary. During the assessment procedure they will first look into the possible use of auxiliary means (patient lifts, sliding sheets, roll slide). Subsequently the remaining care is calculated. If two caretakers are required all care is doubled. In that case it no longer concerns the part of the care which has to be provided by two persons.

The ZZP is translated into tariffs for the budget holder³⁸. A transitional measure applies in 2008, 2009 and 2010. This measure must ensure that the budget holders who have been assessed through a ZZP but who were already working with a PGB, fall behind. They have

³⁵ Policy guideline implementation ZZP <http://www.nza.nl/13755/14769/42765>

³⁶ Ik regeer (2009). *Reageer op dit kamerstuk. Beleidsregels indicatiestelling AWBZ 2009 – algemeen*. <http://ikregeer.nl/document/BLG18364>.

³⁷ The calculation is carried out as follows: minutes per care moment x number of care moments per day per week.

³⁸ Conversion table for conversion of ZZP into PGB tariffs in 2010, consulted on 26 January 2010 on the NaarKeuze website: <http://www.naar-keuze.nl/site.php?id=1279&p=1420&e=e507&>

received a budget warranty. New budget holders fall under the ZZP-tariffs. Sometimes this may come down to a budget which is 30% lower if compared to the PGB-tariffs. There is not only criticism on the tariffs. From the PGB point of view there exists also a problem with the fact that ZZP is based on packages and averages which makes it less likely to provide custom-tailored care³⁹.

WITHOUT RESIDENCE

The amount of the granted PGB is calculated on the basis of the care functions and classes for which one is assessed (see supra). The Ministry of Public Health Care, Well-being and Sports has determined tariffs with regard to those classes. They can be consulted on line. The tables represent the tariff per hour and per class. In case the number of assessed hours or parts of the day is higher than the ceiling value of the highest category, then the tariff of this category is raised by the required number of hours or parts of the day.

If a person is assessed for multiple functions without Residence, then the different amounts are simply added up.

The tariffs apply on a 'yearly basis'. If the PGB is granted for a period shorter than one year, the sum will of course be lower and this in accordance with the period during which the person shall use his or her PGB. An example:

"On 1 October Ms. G is assessed for class 3 personal care. The tariff for this amounts to 8,089 Euro per year. Ms. G. shall receive a PGB for 92 days this year (31 days in October, 30 days in November and 31 days in December): $92/366 \times \text{€ } 8.089 = \text{€ } 2.038,87$. In December Ms. G. shall receive information about the PGB-tariffs for next year. The PGB as calculated here above is also referred to as the 'gross-PGB'. If this Gross-PGB is higher than 300 Euro per day, than the care liaison office may decide to limit the PGB to the admission costs, with a minimum of 300 Euro per day⁴⁰."

❖ Overhead

The PGB does not take into account the budget holder's overhead costs. Costs made by the budget holder can be paid from the budget. For that purpose one and a half percent of the budget can be freely spent, without having to account for it, with a minimum of 250 Euro and a maximum of 1,250 Euro.

³⁹ Van der Pas,F., persoonlijke communicatie, 12 January 2010.

⁴⁰ CVZ (n.d.) *Toekenning PGB. Het zorgkantoor stelt uw budget vast*. Consulted on 26 January 2010, at <http://www.cvz.nl/zorgpakket/awbz-kompas/pgb/pgb.html>

The basic assumption which underpinned the government's PGB valuation was that the PGB needed to be sufficient to purchase the necessary care. For care in kind there are maximum tariffs. There was a clear-cut choice for not basing the PGB's value on the maximum tariff for care in kind. The reason being that facilities which provide care in kind would no longer be motivated to provide care in kind for less than the maximum tariff. Every year the care liaison office negotiates with the care in kind-facilities about the price the latter will receive.

This is why the amount of a PGB is 25% lower than the budgets for care in kind.

The support received for the organization of the PGB is not recognized as a cost and therefore is not taken into account for the budget calculation. Care mediation offices and home care services have raised objections against this.

The amount of the budget does not depend on what you plan to do with it. This is striking. Research has revealed that 75% of the budget holders purchases care in accordance with the assessment decision. The remaining 25% deviate from this decision.

Once the person's needs have been assessed (indication) and the person has opted for a PGB, the care liaison office will officially determine the actual budget. This is also referred to as 'granting'

4. THE SECTOR'S PERSONNEL

DIFFERENT TYPES OF EMPLOYERSHIP

If you receive a PGB you may personally take on the employership or make an appeal to services who can take care of it for you. You may also establish a foundation. Most of these foundations involve parents who bring their budgets together in order to collectively engage assistants. Consequently it is the foundation which becomes the employer. Foundations are not cooperative but private initiatives. The *Landelijk Steunpunt Wonen*⁴¹ gives advice and support to parents who establish such a private living initiative.

It is not possible in the Netherlands to take on the role of employer without carrying administrative and juridical responsibility. You can however make an appeal to the SVB (*Sociale verzekeringsbank*; social insurance bank) or a care mediation office for taking care of administration and the like. SVB offers this service for free to people who use a PGB. If you choose for SVB or a care mediation office you will remain fully responsible for the employership.

The SVB's services are free. The *Sociale Verzekeringsbank* has a separate service for budget holders. The Dutch government grants money to the SVB to give free assistance to budget holders with matters relating to labor legislation with regard to the PGB. The SVB provides free assistance with salary administration, gives personal advice about contracts and offers collective insurances for damage and loss and liability insurances.

It is possible to partly or completely outsource the salary administration to the SVB, which in turn pays the assistant's salaries. The SVB also takes care of the payment of the care provider's salaries during illness

The care mediation offices are commercial offices. They mediate on behalf of the budget holders with assistants or care providers. PGB-offices were created in order to be able to bring supply and demand into balance. But today they often also take care of the assessment application, the management and justification of the budget and at the very same time they also provide the care⁴². And that is exactly where the problem lies, but we will come back to that further below.

⁴¹ The Landelijk Steunpunt Wonen website: <http://www.woonzelf.nl>

⁴² Saers, A. *De gedragscode voor bemiddelingsbureaus*, een publicatie van Per Saldo en de Stichting Ombudsman, Voorwoord. 3-4.
http://www.PGB.nl/per_saldo/up1/ZqpoivDIQ_ZyynlndIW_Gedragscode_PGB-bureaus.doc

PERSONNEL

Within the PGB framework there exist no specific legal stipulations with regard to personnel. The budget holder is held accountable for purchasing good quality care. This goes for individual assistants as well as for PGB-services and care providers working with PGB.

It is worth knowing that 72% of the personnel hired by budget holders has not completed an education in the care⁴³.

This fact gives rise to a debate. The providers of care in kind denounce the fact that they have to comply with a whole range of quality criteria while persons or organizations providing care within the framework of the PGB do not have to fulfill these obligations. Research has revealed that more market forces do not necessarily lead to a diminished quality but that the competition incentive can also have a positive effect.⁴⁴

Recently it has been established that a growing number of care providers are working as self-employed persons. This drew the government's attention. Consequently the *Sociale Verzekeringsbank* has started an investigation and has come to the following conclusions⁴⁵:

- There exist three different groups of supporters for people using a PGB.
 - First of all the 'helpers', most often family or neighbors. These persons have a contract of less than 8 hours per week. 66% of the personnel working for PGB budget holders fall into this category.
 - A second important group are the 'freedom seekers'. These are the 72% freelancers, i.e. the self-employed persons mentioned earlier on in this article. They recruit their clients by mouth-to-mouth advertising and care mediation offices. It often concerns elder women who usually have completed an education in the care. They have two reasons for working in this way: on the one hand it enables them to organize their work better, on the other hand they can give more attention to individual clients.
 - A third category are the 'moonlighters'. They also often have a degree in the care but they are on (early) retirement or still studying. These moonlighters either work as freelancers, i.e. as self-employed persons, or directly for the budget holders.
- Most self-employed care providers are remarkably satisfied about the hourly wage. Even if they know that they are not insured against loss of income due to illness. Often their net income is higher than that of persons who are in the pay of regular facilities, precisely because they are not insured. They also feel that they have more

⁴³ OSA (2009). *Samenvatting ZW44. Zelfstandigen in de Zorg, 2003*, at http://www.uvt.nl/osa/producten/sam_zw44.pdf

⁴⁴ Halbersma, R. (2008), *Kwaliteit van zorg en marktwerking, NZa*, at http://www.nza.nl/binaries/7113/29720/Zorg_en_marktwerking.pdf

⁴⁵ OSA (2009). *Samenvatting ZW44. Zelfstandigen in de Zorg, 2003*, at http://www.uvt.nl/osa/producten/sam_zw44.pdf

time to spend per individual client and they experience less time-pressure.

- Research shows that the regular care facilities do not have to fear the competition of self-employed care providers working with PGB because many of the 'helpers' for example would not be able to work in a regular care facility because they do not have the required training or because they have consciously decided not to work in such a facility (no more). The role played by mediation offices in helping self-employed care providers is often difficult to distinguish from the role played by temporary work agencies.

There is no fixed salary for people who are employed via a PGB. When there is an employment contract however, the minimum wage has to be paid. Yet this is not compulsory when the care provider is older than 65 years or when the work is done within the framework of a care agreement. Such a care agreement can be made with a resident family member, a freelancer, care facility or partner.⁴⁶

⁴⁶ SVB (n.d.) Servicecentrum PGB – Minimumlonen.
http://www.svb.nl/int/nl/ssp/salarisadministratie/salaris_reiskosten_bepalen/minimumlonen/index.jsp.

5. SUPPORTING BUDGET HOLDERS

There are two budget holders associations in the Netherlands. *Per Saldo* is the biggest with 24,000 members in November 2009. They focus on trainings, a help desk, provision of information through publications, support by means of on line tools and collective defense of interests of budget holders. Initially *Per Saldo* wanted to portray itself as an employers' association as well. What does *Per Saldo* not do? Individual mediation and support with taking care of the administration or taking care of the administration altogether.

Individual services (something more than a telephone help desk) such as support with working with a PGB is offered by PGB-offices or mediation offices.

Some offices entirely take over the control that people have over the organization of their care. Others simultaneously provide care, which may lead to a conflict of interests. For the moment a quality label is being created in order to counteract fraud and abuse. *Per Saldo* and *Stichting De Ombudsman*, in collaboration with the government, have already established a code of conduct⁴⁷.

The latter document lays out the different roles played by PGB-offices:

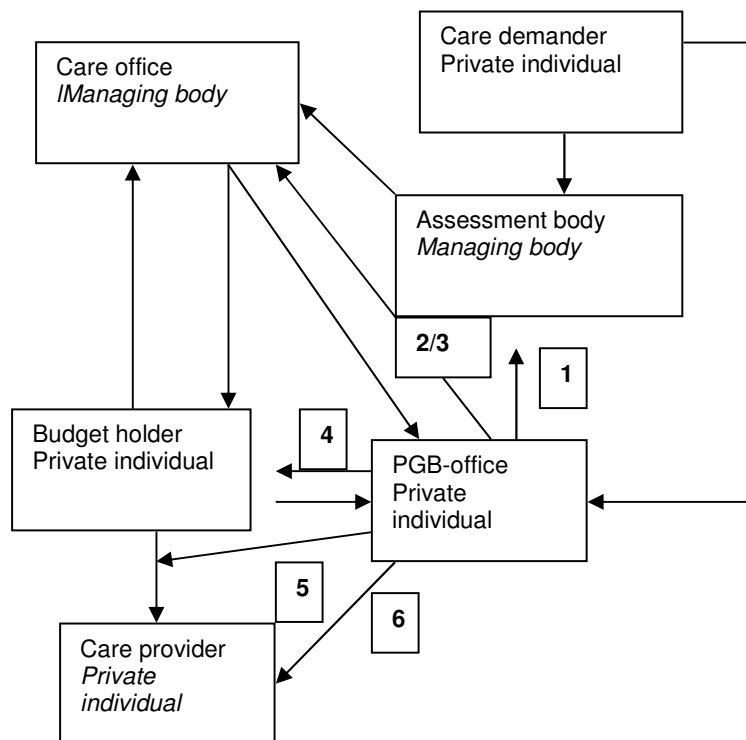


Figure: the chain and the role of PGB-offices, source: *Gedragcode PGB-bureaus (Per Saldo)*

⁴⁷ Per Saldo en Stichting De Ombudsman (2009). *De gedragcode PGB-bureaus. De opmaat tot een keurmerk.* Consulted on 18 november, at <http://www.minvws.nl/includes/dl/openbestand.asp?File=/images/gedragcode-PGB-tcm19-184948.pdf>.

the following activities of PGB-offices can be discerned:

1. Taking care of the different steps of the needs assessment and the demand of the PGB;
2. Taking care of the budget holder's administration;
3. Taking care of the budget management, be it or not under the authority of the budget holder;
4. Giving advice to the budget holder;
5. Mediating between the budget holder and care providers and social workers;
6. Providing care.

The code of conduct contains rules with regard to the attitudes, acquisition, information services, provision of services, administration and financial transactions.

The *Centrum voor Keurmerk* (Quality Label Centre) investigates whether this code of conduct may lead to a quality label. In practice they focus on the development of a number of criteria which constitute a quality label. These criteria are then to be published on websites so that it would be possible to verify whether you comply with these criteria.

During the development of the quality label special attention is given to the protection of the smaller PGB-offices so that they do not become the victims of a such quality label. The inter-branch organization NBPA⁴⁸ is a federation of PGB-advisors which investigates the practical implications of the introduction of a quality label.

The quest for a quality label had started after a number of mediation offices received some negative publicity in the press. Police investigations had revealed unlawful practices. Not all mediation offices however can be lumped together. The offices which provide care themselves as well as those which completely take over the budget holder's control over the budget, run a greater risk to commit fraud.

A measure to counteract fraud in the future is the obligation to deposit the budget on the budget holder's bank account. Also every accountability form needs to be signed by the budget holder or his or her legal representative.

AN INFORMATION PROBLEM

It is impossible to get a complete, clear and objective overview of all the possibilities of the PGB. There are many sources of information which makes for a difficult appraisal. Nevertheless *MEE Nederland* (association for the support with living with a disability) has been given the task to provide objective and complete information. Still the budget holders often cannot see the wood for the trees due to a surplus of information.

⁴⁸ Nederlandse Branchevereniging voor PGB Adviseurs (2009). *Welkom bij NBPA!* Consulted on 26 January 2010, at <http://www.PGBnbpa.nl/>.

Satisfaction about the information service is rather low among PGB users in comparison with other indicators⁴⁹.

Moreover, the information is not always objective. Providing objective information in order to make a choice is what PGB-offices are supposed to do. But they do not always succeed in this and that explains the code of conduct and the call for a quality label.

Nowadays much work is being done in developing tools and sources of information which should enable users to have a complete overview of the care offer and the quality thereof so that they may make their choice based on those criteria they regard as important.

⁴⁹ Kaaij, R., Huijsman, R., (2008) Dubbele winst, *Zorgvisiemagazine* (issue 11), 40-43.

6. LEGAL ENFORCEABILITY

Article 44 of the AWBZ law stipulates the following:

“A ministerial decree can stipulate that the College zorgverzekeringen, in accordance with the regulations provided in that arrangement,: (...)

b. grant subsidies to enable insured persons to provide themselves with the care that they require instead of asserting a claim based on this law; (...)”⁵⁰

This article mentions the possibility for the minister to decide to let people organize their care themselves. Consequently this arrangement is conditional: the minister may as well decide otherwise.

Furthermore it is worthwhile noticing that the word '*persoonsgebonden budget*' (personal budget) is not mentioned in this arrangement

the PGB is a grant regulation. As a result there exists no legal basis or 'legal claim' which can make the PGB enforceable. There used to be a so-called 'open end financing' and the government budget did not cause any restrictions. In 2003 a so-called 'subsidy ceiling' was introduced. Each time the limit of this ceiling was almost reached, extra money was granted to the PGB. In the last years this has been the case 5 or 6 times. The reaching near the subsidy ceiling has often led to a last-minute debate in the Dutch parliament and stirred up a commotion in the press. In practice there has never been a case where a PGB was denied or delayed due to a budget shortage. If you are assessed you will be guaranteed a PGB.

The same AWBZ law has also provided the possibility for appeal against the assessment decision: *“the assessment decision can be subjected to objection and appeal in conformity with the Algemene wet bestuursrecht (General Law on Administrative law).”⁵¹*

The WMO law mentions the PGB as a possible choice. This is clearly reflected in article 6: *“The college van burgemeesters en wethouders (college of mayors and municipal councilors) offers to persons who are entitled to an individual provision the choice between receiving a provision in kind or receiving a comparable personal budget, except when there exist overriding objectives against this.”⁵²*

This article had been explicitly added to the law because it became clear that maybe not all municipalities would otherwise offer the choice of a PGB. The argument forwarded by the

⁵⁰ Lexius (2009). *Algemene Wet Bijzondere Ziektekosten*. Consulted on 1 December 2009, at <http://lexius.nl/algemene-wet-bijzondere-ziektekosten/artikel44/>.

⁵¹ Zorg voor beter (n.d.) *Beleidsregels indicatiestelling AWBZ 2009. Bijlage 1: algemeen*. Consulted on 2 December, at www.zorgvoorbeter.nl/docs/bijlage_1_algemeen_AWBZ.pdf.

⁵² Stichting AB (2009). *Wet wijziging WMO onder meer inzake inlichtingenverstrekking B & W over aanspraken*. Consulted on 2 december 2009, at <http://www.st-ab.nl/1-09346.htm>.

municipalities was that the invitation to tenders for care had already been issued. In the article one condition is imposed however: if there exists any objection against the fact that a given person is working with the PGB (for example due to debts or incapability) then the freedom of choice of this person can be curtailed.

There exist no waiting lists for the PGB in the Netherlands. They do exist for care in kind however. This makes for the fact that certain budget holders do not make a conscious choice for the PGB but instead choose it because it offers them the possibility to avoid the existing waiting lists⁵³. In other words, the PGB is not their first choice. According to the budget holders association *Per Saldo* this is the reason why a number of things go wrong. According to them people should make a very conscious choice for the PGB (and thus for more control).

Although the PGB is not legally enforceable today, there does exist a broad support to turn the PGB into a legal right. PGB then becomes legally enforceable for every person who is entitled to it.

⁵³ Swarte, V.P.P., Krijswijk J.H. (2009). De toekomst van persoonsgebonden financiering voor langdurige zorggebruikers. Leiden: Jansen STG / Health Management Forum, 33.

7. EVOLUTION AND FUTURE PERSPECTIVES

the following motivations for the choice for a PGB can be distinguished: being able to take of your care independently, being able to choose your own care provider, being able to influence the way in which you are helped and the fact that you have to deal with a smaller number of care providers.

The increasing growth of the total AWBZ budget (PGB included) and the increasing number of users forced the government to take action. It was decided to apply corrections to the whole system of insurance via AWBZ. The number of people who can make an appeal to this law has been limited as well as the possibilities which the PGB offers. These cuts have been carried out in 2009 despite protests of the client associations.

Despite these savings the basic principles of the PGB (self-control or being able to take decisions independently) are not under discussion. Marginal phenomena such as the fraud committed by some care mediation offices or the fact that ever more people do not make a conscious choice for PGB, do spark up a debate and lead to corrections (see infra). Whether it comes down to the number of budget holders as well as the fields of application the PGB trend is an upward trend.

To give an example of the growing number of fields of application: an experiment with PGB in the mental health care was launched within the framework of the *Zorgverzekeringswet* (care insurance law). The experiment specifically focused on people who need medical care in order to recover from a psychiatric ailment. Since 1 January 2008 care insurers can no longer deny a PGB to these people. Before 2008 these people could already receive a PGB via AWBZ, but now a budget for *GGZ-zorg* (*Geestelijke Gezondheidszorg*; mental health care) was added on top of that through the *Zorgverzekeringswet*. This experiment had received a negative evaluation from the government. Budget holders association *Per Saldo* puts the blame for this failure on the care insurers. Because their budgets were insufficient the PGB was not considered a fully-fledged choice⁵⁴.

As mentioned earlier the *CG Raad* (federation of client associations) and *Per Saldo* have asked to increase the number of possible applications of the PGB. They also advocate a bundling of all the existing budgets into one 'participation budget' which then could be used for a broad range of purposes.

Furthermore there is a debate about the execution of the PGB. This should no longer be a responsibility of the care offices but should instead be carried out by the care insurers. Until April 2010 this shall be discussed behind closed doors. In April then, the minister should take

⁵⁴ de Vries, A. & Vos de Wael, N. (2008). *Experimenteren met de hakken in het zand. Rapportage regelingen PGB-ggz van de zorgverzekeraars*. Consulted on 26 January 2010, at http://www.PGB.nl/per_saldo/up1/ZyjustdIE_Experimenteren_met_hakken_in_het_zand.pdf.

a decision. There are some questions with regard to this discussion: can the care insurers deal with the idea of users controlling their own care demand? After all, those insurers are used to working in an atmosphere where the doctor knows best, i.e. an atmosphere of medical paternalism. The reason for the existing division of tasks between the care offices and the care insurers is exactly to avoid the latter.

Moreover it is expected that competition between the care insurers would lead to problematic situations. For example, care insurers who would be less strict with regard to the accountability of expenses than their competitors. Competition should not play a role on this level. Competition should focus on providing better service and better management of the PGB.

Frans van der Pas⁵⁵ evaluates the current needs assessment as follows: it is a good thing that the needs assessment is carried out objectively and based on clear criteria which are included in the AWBZ regulations. The individual care demands serve as a starting point and this results in a custom-tailored assessment. The final assessment decision can also be appealed so that you may react in case something goes wrong. Since 2004 however the AWBZ has gradually evolved from an insurance for the compensation of deficiencies of people with a disability into an insurance for care needed in order to help with moderate to serious problems with independent living. The participation objective has been erased from the AWBZ and this has had a clear negative effect. The assessment is less and less focused on taking away obstacles which prevent people from taking part in society and furthermore the assessment is far from complete.

Another relapse is the transfer of the function household support to the WMO which makes it a municipal competence. Also the budget calculation for PGB on the basis of the support need packages is criticized because it is a calculation based on averages instead of an individual calculation.

Finally remains the question whether the PGB is bound to remain a marginal phenomenon in the care. Although the PGB in the Netherlands is much bigger than PAB or PGB in Flanders, it still accounts only for a small part of the AWBZ's means. We have noticed that only a small number of assessed persons who are entitled to a PGB eventually opt for it.

Basing itself on the experience that problems with the PGB mainly occur when people do not make a conscious choice for own control over the organization of their care, *Per Saldo* does not want to recommend the PGB for all people. The association specifically wants to preserve the freedom of choice. Real freedom of choice can only exist when it is possible to choose between equally good options. This assertion was also one of the conclusions drawn from the PGB experiment within the mental health care.

⁵⁵ van der Pas, F. persoonlijke communicatie, 13 januari 2010.

There exist different scenarios concerning the future perspective for the PGB. In 2009 the STG/ Health Management Forum developed 3 possible scenarios based on the 'future explorer' (*toekomstverkenner*)⁵⁶:

❖ Confidence, more than just care

A coalition between the government and the user comes into being. The government aims at accessibility and the care provider aims at professionalism and demand steering. Key to this is the participation budget: 1 budget which is the result of 1 assessment and which can be used for different kinds of purposes. Necessary conditions are decompartmentalization as well as confidence. To implement all of this it is suggested to work with case managers who help people with the management of their budget. The scenario also sees a role for the local government which could make custom-tailored solutions possible.

❖ A feeling of security and an evolution towards less care

This scenario predicts a coalition between the government and the care providers. There is no room in this scenario for a PGB, but for something else: a PVB (*persoonsvolgend budget*; individual-trailing budget). The care insurers play an important role. It is assumed that managing the care is an additional burden which few care users want to be faced with. People want to determine where, when, who and which care is provided and want this care to be guaranteed and of good quality. The problem is that care providers will probably not be very flexible. Formal care will be restricted, translated into protocols and there shall be more standardization. All the specific individual needs of the many care users will need to be taken care of by informal care. Pressure groups will have to watch over the quality of the custom-tailored care, which will prove to be a great challenge. Another problem is the fact that there will be no longer any form of competition.

❖ Fervor and Passion

A third scenario sees a coalition between users and care providers which find each other through market forces. The market is free but still there is a strong emphasis on the individual responsibility of people to pay for their care. This is a strong plea for an insurance system. One problem is the accessibility. In this third scenario pressure groups take on the role of consumer associations.

This recent publication of the Health Management Forum is recommended to all those who not only want to look into the future but also want to have a look into what is going on in the heads of the policy makers, researchers, users associations, insurers, and other services and organizations which are closely involved with the PGB in the Netherlands.

⁵⁶ Swarte, V.P.P., Krijswijk J.H. (2009). *De toekomst van persoonsgebonden financiering voor langdurige zorggebruikers*. Leiden: Jansen STG / Health Management Forum, 83-97.

8. CONCLUSION

The PGB not only exists longer in the Netherlands than in Belgium, it also concerns a much larger scale. Counting more than 111,000 users it is fair to say that it is a well-accepted system which concerns hundreds of thousands of people on a daily basis. Although the PGB is clearly on the rise it is not at par with the care in kind. The number of users as well as the budget amount are causing the PGB to remain the little brother of the care in kind. But this is without a doubt evolving.

The PGB and the Care in Kind are clearly growing towards each other. Already the assessment was the same, and now the way in which the budgets for care in kind are calculated is evolving towards an individual calculation based on support need.

The consequences of the introduction of the PGB in the Netherlands where not limited to the budget holders and the people who are engaged as personal assistants. New initiatives saw the light and an increasing number of people start working in the sector as self-employed persons, existing care facilities offer new services and new initiatives are developed. The PGB as a catalytic agent in the care.

In order to be able to play this role to the full they can make an appeal to well organized budget holders associations, the *Sociale Verzekeringsbank*, and care mediation offices. The latter have appeared in a negative way in the news on a number of occasions. Especially when these care mediation offices also offer care next to their other services, there is a high risk for a conflict of interests. It is remarkable to see that this has lead to the introduction of a code of conduct and a quality label as well as a plea for more freedom of choice. People should always be able to determine to what extent they want to have control over their own lives.