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Date 1 juni 2011
Re programme letter concerning long-term care

Dear chairman,

I have pleasure in sending you hereby the programme letter concerning long-term care, in which I describe my vision of long-term care as well as providing an elaboration of the measures from the Coalition and Tolerance Agreement.

Yours faithfully,

The State Secretary for Health,
Welfare and Sport,

Ms M.L.L.E. Veldhuijzen van Zanten-Hyllner

Introduction

Day in day out, large numbers of care providers, voluntary workers and carers dedicate themselves to the care of the most vulnerable people in our society. This deserves recognition. Through their input and involvement, the people in need of help are given the care and support which they require. These needy people must also be able to continue to rely on this support.

In my letter 'Trust in the care sector' of 27 January 2011[1], I described the outlines of where my ambitions lie for the coming years. Trust in the care sector is my motto. The offer and supply of care and support is patently human. The basis for good care is formed through the trust between care providers, voluntary workers, carers and the client. Trust also plays a role in other areas in the care sector. Care providers need to know that that the government makes fair and well-reasoned choices. The government in turn also needs to trust that care providers provide responsible and good care through their professionalism, which also suits the needs and wishes of the client and the support by voluntary workers and carers. In this letter, I shall explicitly address the reinforcement of the care staff, both in their position and well as in their quantity, which will lead to an improvement in the quality of the care for the client. The future of the healthcare system lies in the combination of clients and their network, care providers, municipal authorities, voluntary workers, carers and organisations who offer care and support. The background role played by central government involves the final responsibility for the quality, accessibility and affordability of care for everyone with a need for such.

As announced in the above-mentioned letter, the cabinet also informed the House of Representatives about the implementation of measures from the Coalition and Tolerance Agreement. I also promised to provide the House of Representatives with this letter during the 2011 budget debate, the planning discussions with the House of Representatives on 2 February this year and the General Meeting concerning the Exceptional Medical Expenses Act (*Algemene wet bijzondere ziektekosten* or *AWBZ*) on 23 March this year.

Current long-term care

The Exceptional Medical Expenses Act provides for care and support in cases of long-term ill health, handicap or old age. This may entail home help, but can also concern nursing, care, treatment and supervision in care homes, nursing homes, institutions for the handicapped and chronic psychiatric patients. Care in hospitals and rehabilitation centres also falls under the Exceptional Medical Expenses Act, if the stay lasts longer than 365 days. In 2010 over 600,000 people in our society made use of long-term care. More than half of this number of Exceptional Medical Expenses Act clients (around 340,000) receives this care in their own home, whether in kind or by means of a Personal Budget (*persoonsgebonden budget* or *pgb*) whereby the client buys in their own care. The remaining clients (around 260,000) receive the care within an institution. There are around 150,000 voluntary workers active in long-term care. In 2010 the total costs of this form of care amounted to more than EUR 23 billion.

Since its inception in 1968, the Exceptional Medical Expenses Act has been expanded and improved. However, long-term care has also changed in its nature and extent through a whole range of supplementary regulations. This has led to an increased demand for care, rising costs and a sizeable bureaucracy. Moreover, it has led to a system that is aimed too much at the provision of care (by institutions) and which is based too little on the client. In some cases, the appeal for Exceptional Medical Expenses Act care has increased needlessly. This neither

benefits our society, nor the clients themselves. There is also the threat of a shortage of care workers. In 2010 there were 1.3 million employees in the care and welfare sector. According to prognoses from the National Institute of Public Health and Environmental Protection (*Rijksinstituut voor Volksgezondheid en Mileuhygiëne* or *RIVM*), over the coming 15 to 20 years at least 400,000 extra care providers will be needed in the care sector alone, if the policy remains unchanged. At the same time, the working population will decline during the coming decades.

During the last few years there have been several reports published in which the conclusion is put forward that measures are needed in order to allow the Exceptional Medical Expenses Act to take future developments into account. These include the report 'Wide-ranging review of long-term care' (2010), the 'Long-term care insured' (2008) report from the Social and Economic Council (*Sociaal-Economische Raad* or *SER*) and the 'Better without the Exceptional Medical Expenses Act?' (2007) report from the Council for Public Health and Care (*Raad voor de Volksgezondheid en Zorg* or *RVZ*). The Dutch Healthcare Authority (*Nederlandse Zorgautoriteit* or *NZa*), the Healthcare Insurance Board (*College voor Zorgverzekeringen* or *CVZ*) and the Netherlands Bureau for Economic Policy Analysis (*Centraal Planbureau* or *CPB*) have also published their advice about the future of the Exceptional Medical Expenses Act. Besides these reports, analyses have also been compiled within the care sector itself by organisations such as ActiZ (organisation for care providers in the Netherlands) as well as a collaboration of client organisations, which show that the Exceptional Medical Expenses Act does not make sufficient use of the strengths of the people involved and those around them.

The future of long-term care: better and affordable
The final perspective that I have in mind is an Exceptional Medical Expenses Act of high quality for the most vulnerable people needing long-term care in our society. The client's need for care should be take a more central position than is the case at the moment. The basic principle is that clients should receive the care they need, either in an institution, if the need for care demands this, or at home if possible.

In order to be able to continue to guarantee good care for those people who are dependent on such, the Coalition and Tolerance Agreement accommodates a balanced package of measures, which provides for a change in long-term care. Special attention is given thereby to care for the elderly, particularly bearing in mind the considerable increase in the number of elderly people and those with dementia due to the ageing population. The cabinet is succeeding, even in this time of cutbacks, to reserve means for an annual growth in long-term care of 2.5%, but also to provide EUR 852 million structurally on top of that to invest heavily in extra personnel and training in order to improve the quality of care (of the elderly). The care will also be arranged differently and better. Steps are being taken in the direction of a system that is aimed more at the client instead of what is on offer. The regulations will also be simplified or scrapped where possible and clients in institutions will gain a stronger position via the framework Care Institutions Act (*Beginselenwet zorginstellingen*). In order to further strengthen the position of the client, I would like to take steps in the direction whereby funding follows the client to a greater extent. During the coming period and in collaboration with the so-called 'Own Control' coalition (the combined client organisations, BTN [sector interest group for home care in the Netherlands], ActiZ and MEE Nederland [organisation providing support to those people with physical or mental limitations and their helpers]), I shall be looking into how funding that follows the client can best be formulated, bearing in mind the budgetary boundaries. The supervision provided by the Healthcare Inspectorate (IGZ) will be organised differently in order to monitor the quality of the care better. Parts of the

Exceptional Medical Expenses Act will be decentralised to the municipal authorities. This will mean that the support on offer can be better made-to-measure, coming from closer by the client and more in tune with their needs and what can be provided locally. This decentralisation will bring with it an advantage in efficiency terms, which will contribute to more appropriate spending of the collective means and management of the growth in expenditure. The care offices will be closed and the implementation of the Exceptional Medical Expenses Act will be placed in the hands of the insurers. In this way the connection between long-term care and curative care will be better secured. Finally, the cabinet will take irreversible steps in separating living accommodation and care.

Dynamic and responsible
It is of great importance that the measures to be taken by the cabinet are carried out after thorough consultation and in collaboration with the different parties in the field. Care providers, umbrella organisations, patient and client organisations, representatives of carers and voluntary workers in the care sector and municipal authorities, who will be shaping the reforms in long-term care, will all be closely involved in the development of the reform agenda.

I shall make sure that the group of people who experience the effects of the measures will be informed thoroughly and timely about such. I shall also provide adequate support to the municipal authorities in their implementation of the different measures.

The measures in the whole area of care and support are connected with those in other areas of the cabinet's policy, such as social security, youth care and education. The cabinet keeps a very close eye on the implementation of these measures. Special attention will be given hereby to the effects these measures will have, and specifically how they work together, on vulnerable groups who will be affected by multiple measures. In the recently agreed Administrative Agreement 2011-2015, central government and the municipal authorities agreed that, if an unforeseen accumulation of measures disproportionally and inadvertently affects a specific group, the governmental departments involved will consult together accordingly and take appropriate action.
By means of a motion put forward by the members of the House of Representatives Ms Venrooy-van Ark and Mr Azmani[1] the request was made to come up with a policy vision prior to the letter in hand about independent client support. Given the purpose of the motion, this vision will be broadened to include the target groups of the Exceptional Medical Expenses Act, the Invalidity Insurance (Young Disabled Persons) Act (*Wet arbeidsongeschiktheids-voorziening jonggehandicapten* or *Wajong*), the Sheltered Employment Act (*Wet sociale werkvoorziening* or *Wsw*) and the Social Support Act (*Wet maatschappelijke ondersteuning* or *Social Support Act*) and presented this month separately to the House of Representatives.

Layout
This letter is set out as follows. The measures which the cabinet is taking in order to improve the quality of long-term care are described in chapter 1. The choices to be made by the cabinet with a view to bringing order to long-term care are set out in chapter 2. In chapter 3, I shall discuss the Personal Budget in greater depth. The planning of the measures is set out in chapter 4.

[1] House of Representatives, session year 2010-2011, 30597 no. 172

1. Valuing better quality and good care

Measures for the improvement of quality in long-term care were announced in the Coalition and Tolerance Agreement.
The cabinet is providing an extra EUR 852 million structurally per annum for greater numbers of care personnel and training in long-term care. This extra money is on top of the means made available by the cabinet for the normally expected growth. However, the improvement in quality holds more than this. An Institute for Quality will be set up, the supervision carried out by the Healthcare Inspectorate will be improved and the rights of clients will be strengthened. At the same time, the pressure from overheads and regulations will be decreased, the scale of institutions will be optimised and measures will be taken against the mistreatment of the elderly. Furthermore, the current method in the Exceptional Medical Expenses Act of financing per treatment will change to financing based on result. I shall describe these measures in further detail in this chapter.

1.1 Extra personnel and training

Good care comes about through the relationship between client and care provider. In order to provide good care it is essential that there are sufficient numbers of well-trained personnel available. In order to effect this, as from 2012 an extra EUR 852 million will be made available structurally. This will provide institutions with greater financial scope and an extra 12,000 employees can be taken on and trained.

Of the total extra means, I am putting EUR 636 million towards raising the self-employed tariffs and EUR 142 million for raising the contracting space. This will create financial space within institutions for taking on and training extra personnel. I believe it is very important that these extra means are spent efficiently so that this will actually lead to more ‘hands on the bed’. In order to ensure this, it is my aim in the near future to reach a managerial covenant that will form the guiding principle for purchasing care. The healthcare insurers, the employers in the care sector and the professional associations will all be involved in this covenant. Agreements will be set out in this covenant about quantitative objectives, the 12,000 extra employees, as well as the desired quality of the training courses and the personnel.

In the labour market letter, which I will be sending to the House of Representatives shortly after the summer recess, I will go into greater detail about this covenant, the interim objectives and the measurement of the results. I had mentioned this already in my letter of 12 April this year,[2] which I sent to the House of Representatives in connection with the Voortman motion.

I am setting aside one specific part of the extra means, to the tune of EUR 74 million, for the benefit of the work practice fund. The work practice fund leads to extra care personnel. Good supervision of trainees is necessary for the overall quality of the training and to promote a good connection between training and practice. The work practice fund, which was started in 2008, has shown itself to make an important contribution in this area.

The input of EUR 852 million will provide a strong impulse to the quality of long-term care.

[2] House of Representatives, session year 2010-2011, 29 282 no. 122

1.2 Strengthening clients' rights

In order to strengthen the position of the client, the Legislative Proposal Care Clients' Rights (*Wetsvoorstel cliëntenrechten zorg* or *Wcz*) was presented in June 2010. This Act, which according to the planning will come into force during the second half of 2012, will strengthen the position of the client in their individual relationship with the care provider. Clients will be afforded the right to information regarding choice, the right to information about incidents and will be able more easily to compel compliance with their rights by means of a better complaints procedure and, if necessary, obtain a binding advice from an independent conciliatory body. Clients' councils will also gain more authority through the Legislative Proposal Care Clients' Rights. The care provider must provide the clients' council with all the means that are necessary within reason in order to be able to carry out their tasks well.

By means of the Care Institutions (Framework) Act (*Beginselenwet zorginstellingen*), the dialogue that should take place between client and care provider will be awarded a legal basis. I provided the House of Representatives with a sketch of the Framework Act in my letter of 17 January this year.[3] In that letter, as well as in the answers to the questions that were put in response to that letter, it was stated that agreements must be made concerning eight points in a care plan. Compliance with these agreements can be forced by the client. An external complaints committee would be useful hereby. The Framework Act has now been put before the Council of State, after which it will be presented to the House of Representatives. This Act offers clients the possibility of reporting serious complaints about personal care and treatment directly to the Healthcare Inspectorate. The Healthcare Inspectorate will act immediately in very serious cases in the area of care and treatment.

I also want to make it possible for the client's voice to be heard better indirectly as well. Clients and care providers form the care together. That is why the perspective of reciprocity between the care provider and the client must be the leading factor. It is important that the care provider has the space to support the client in a professional manner that is most suitable according to the client. Care workers should therefore be afforded as much space as possible to act according to their own insight. They earn the right to be listened to. They are the people who are closest to the care that is provided and from this position, generally speaking, they have the best view of the welfare of the client. It is also my wish that clients and professionals have more influence on important policy decisions in care institutions and that their opinions should be heard directly. An important instrument that contributes to this point is the Nurses and Carers Advice Council (*Verpleegkundige en Verzorgende Adviesraad* or *VAR*), which can give advice within an institution either voluntarily or when requested by the Board of Directors or the Management Board concerning the quality of care.

1.3 Governance

In order to be able to provide good care it is essential that care institutions are run well and that an institution has permanent information available about the quality of that institution. An external complaints committee would be useful hereby. Boards of Directors are responsible for the way in which their institutions function. It is the task of the Supervisory Board to supervise the Board of Directors and the general day-to-day running of a care institution. This means that the Supervisory Board is also responsible for speaking to the Board of Directors if the institution is not functioning well. Care providers are in the process of further

[3] House of Representatives, session year 2010 – 2011, 32 604, no. 1

professionalisation of the governance of long-term care. Good examples of this include the Governance Code for All Care (*Zorgbrede Governancecode*) and the model regulation for whistleblowers within the Sector Organisations Care (*Brancheorganisaties Zorg* or *BoZ*), ActiZ's two-sided terms of supply and the Toolkit Supervision of Care (*Toolkit Toezicht Zorg*) of the national register of supervisory board members and supervisors. Together with their input, I shall be setting out a framework for managerial responsibility within the care sector.

The client council has the possibility of instigating an investigation through the Enterprise Division of Amsterdam Court of Appeal into possible mismanagement within their care institution. The Governance Code for All Care 2010, formulated by the care sector itself, offers care providers with rules for good governance and supervision. On the grounds of the Care Institutions (Accreditation) Act (*Wet toelating zorginstellingen* or *WTZi*) and the Care Institutions (Quality) Act (*Kwaliteitswet zorginstellingen*), together with the Healthcare Inspectorate I have the power to intervene when the quality of care is threatened, for example when the level of supervision is raised.

Prevention is better than cure. For this reason I will also be providing measures through the Legislative Proposal Care Clients' Rights, which will strengthen the management and supervision of an institution. It is set out in the Legislative Proposal Care Clients' Rights, for example, that one director is explicitly responsible as contact person regarding quality. It is also set out in the Legislative Proposal Care Clients' Rights that, if there are serious structural shortcomings in the quality of care or in compliance with the rights of clients to information, permission, the compilation of files and privacy, then there may be a case of a dangerous situation, the ultimate remedy for which can lead to the order to stop providing care.

It is to the advantage of clients when the size of institutions is in keeping with the human scale. An optimal scale of care institution leads to greater efficiency, lower costs, greater integrality, higher levels of client satisfaction and better care. The cabinet would also like to optimise the scale of care institutions and thereby to reduce the existence of care giants, in which the tendency is to lose sight of the human scale of care. To this end and before presenting a merger proposition to the Netherlands Competition Authority (*Nederlandse Mededingingsautoriteit* or *NMa*) as from 2013 the care providers will be required to present the merger proposition for testing by the Dutch Healthcare Authority. Institutions will be required thereby to formulate a merger effect report, which must provide insight into whether the merger plans have been clearly thought through, what the consequences of the merger would have on the quality of the care provided and in which ways the parties that are to be merged have involved the immediately interested parties, such as client councils and the personnel, in formulating the merger plan.

1.4 Different method of supervising inspection

I want the Healthcare Inspectorate to react quickly to reports of abuse. In accordance with the Coalition and Tolerance Agreement, the Healthcare Inspectorate will require less justification on paper and will carry out more inspections on the shop floor, including spot checks whereby 'mystery guests', for example, can be deployed. Increased monitoring, which is also different and more powerful, requires the inspectors to use a combination of technique and alertness (in detecting a 'fishy' smell or not, as the case may be). The Healthcare Inspectorate will be using the extra financial means awarded under the Coalition and Tolerance Agreement to deploy extra inspectors and programme, as well as supervisory employees. They will act quickly and in a targeted manner in case of

incidents or when structural shortcomings are identified in institutions. In its supervisory role, the Healthcare Inspectorate operates under the principle of high trust, high penalty. The inspectorate trusts in the fact that care providers live up to their responsibility towards security and quality, but when irregularities are detected then sanctions will follow. The Healthcare Inspectorate has a whole range of instruments to this end, varying from light through to heavy.

In the area of good management, the Healthcare Inspectorate has recently set out a 'Supervision Framework for Managerial Responsibility concerning Quality and Security'. In this document the Healthcare Inspectorate gives a transparent description as to how this supervision will be carried out. This supervision framework will be sent to the House of Representatives.

In addition to the intended merger test as described in the previous paragraph, the Healthcare Inspectorate will be given the authority to split up care providers for reasons of quality. This authority is explicitly intended as an ultimate remedy, to be applied only if the normal means appear to be insufficient. This means that ordering changes to the business structure will only occur in case of breaches in the quality and security standards, whereby such breaches arise due to the structure of the care provider and whereby it is reasonably likely that continuation or repetition of the breach will occur. Furthermore, such structural measures will only be demanded when there is no other equally effective corrective measure that is less onerous for the care provider. It is my aim to provide the Healthcare Inspectorate with the authority for splitting up care providers during the course of 2013.

1.5 Appreciating good care, standards and good examples

In accordance with the Care Institutions (Quality) Act, the care providers are responsible for providing responsible care. As stated in my letter 'Trust in the care', I believe that good care deserves to be given due attention. I want to support institutions in improving the quality of care and modernisation of care. In order to realise this, various current programmes aimed at stimulating the improvement in quality and increasing work productivity and efficiency will continue to be built upon, programmes such as 'Better Care', 'Transition Programme in Long-term Care', the 'National Programme of Care for the Elderly', 'In for Care' and 'Welfare New Style'.

The programme 'In for Care' was started at the end of 2009. Through this programme innovations coming from professionals in the field are collected together and then circulated. This happens in three ways. First of all, the innovations that have already been developed in the 'Transition programme in Long-term Care' and 'Better Care', for example, are collected together. The innovations that have arisen themselves in the field are added to these and presented in an accessible manner. The second way is for the 'In for Care' professionals to come together by means of meetings, congresses and online. This will facilitate good examples being highlighted and professionals can give each other advice and share their innovations with each other. Many examples of innovations, experiences and other information can all be found on the website www.invoorzorg.nl. The third way is that care providers are supported by the implementation of innovations chosen by themselves. Hereby they are offered more knowledge and hands-on help. There is great interest in this. More than 130 care organisations, particularly in the area of care for the elderly, have indicated that they would like to be helped with the implementation of innovations. More space for the professionals, small scale solutions, less internal bureaucracy and genuinely placing the client at the centre of the question are all objectives that are seen time and time again in the chosen innovations. These objectives fit in well with the key focus areas of this cabinet's policy on quality and the concept of care

in the neighbourhood.

In order to improve the quality of care institutions, support will be provided in the field by formulating standards and exchanging good examples. This concerns standards that have already been proven to be good through 'Better Care', for example, which will be implemented broadly. The interests and self-determination of the client are placed centrally hereby and there should be a balance between the proven effectiveness of the standard and the wishes of the client. Moreover, I want to stimulate carers and nurses to develop their own quality standards and guidelines because their professional insights are not yet being made sufficiently explicit. In recent times, geriatricians have made important leaps forward in this area, which has strengthened their position with regard to other professionals and administrators. The Quality Institute being set up at the present time will provide a stimulating role in this area. This institute will be afforded a role in the dispersal of knowledge, innovations and good examples that will help to increase the quality, security and efficacy of the care, for example with regard to bedsores and malnourishment. The Minister and I will be informing you soon about the form that this Quality Institute will take.

Specifically with regard to a good example in the area of dementia patient care and for the implementation of the motion of the member of the House of Representatives Ms Agema, I am able to report the following. The European 'Joint Programming Initiative on Neurodegenerative Diseases, especially Alzheimer's Disease' has opened a first round in which shared research proposals concerning Alzheimer's disease can be presented. This first round is aimed at research into (harmonisation of) the use of biomarkers. Biomarkers are 'measurable' changes in the body that can help to give a better diagnosis in cases of dementia.

1.6 The elderly in safe hands

As included in the Coalition and Tolerance Agreement, this cabinet is implementing extra measures for the prevention of the abuse of the elderly. On 30 March 2011[4] I presented the House of Representatives with the action plan 'The elderly in safe hands'. In this action plan I set out ten concrete actions, through which the abuse of the elderly can be combated. My aim is that abuse will be stopped at the earliest possible stage by means of these actions. This aim includes preventing, pointing out, reporting and supporting victims. In collaboration with the Minister of Security and Justice, I am also pursuing a vigorous approach towards perpetrators. The duration of the plan runs from 2011 to the end of 2014 and I am making EUR 10 million structurally available annually.

This action plan starts with breaking the taboo and improving the (general) prevention and early detection. The plan is also aimed at combating the abuse of the elderly by professionals and voluntary workers. Besides this, the plan is aimed at the chain approach to the abuse of the elderly by improving the reporting of abuse of the elderly, boosting the help and support of victims, improving the support in case of care that has gone down the wrong track, as well as a more severe approach towards perpetrators of abuse (action point 10). Through this plan the measures that have been announced in the Coalition and Tolerance Agreement, including an obligatory Declaration of Good Conduct for paid care workers, a guideline regarding abuse of the elderly, an obligation to report abuse of the elderly and continuation of the project 'Stop abuse of the elderly' have been given a solid grounding.

[4] House of Representatives, session year 2010-2011, 29 389, no. 30

1.7 Less overheads and rules

In accordance with the government-wide objective from the Coalition and Tolerance Agreement, the cabinet's aim is to reduce the administrative burden for businesses by 5% annually and to prevent pressure due to new rules arising out of legislation and regulations. This will mean that care providers can spend more time providing care and remove the feeling that they are limited in their dealings through unnecessary regulations. My wish is that care providers are given back their profession without unnecessary administrative burdens. The government-wide objective should also lead to fewer overheads. Moreover, I would like voluntary workers not to be hampered in their work by rules. The member of the House of Representatives Ms Uitslag (CDA) presented a motion[5] during the budget debate 2011 to remove obstructive legislation relating to voluntary workers in care institutions. I am currently working to provide a picture of the hindrances this involves. I shall be informing the House of Representatives sometime this summer about the matter in my policy letter regarding voluntary work and care. In that letter I will also approach the subject of attracting and keeping voluntary workers in the care sector.

In order to reduce the burden of rules in a responsible way, I am firstly introducing an experiment whereby I am calling for the providers of long-term care to report rules to me that stand in the way of improvements in quality or efficiency and which lead to unnecessary bureaucracy in the care sector. According to the results of this, a critical review of these rules will then ensue. This experiment will involve reducing where possible the administrative burden for a period of 2 years, if it appears that the regulations lead to unnecessary bureaucracy. The basic premise hereby is one of high trust, high penalty, i.e. a high level of trust with severe consequences when things go wrong. Prior to the start of the experiment, suitable penalties will be agreed with the participants. Evaluation will take place at the end of the period of the experiment. If on the basis of the experiment it appears that the administrative burden can be reduced and the system of high trust, high penalty works well, then this will be introduced nationwide. The selection of the institutions in question is taking place at the present time. Institutions that provide care financed solely through Personal Budgets will also be included in this experiment.

Besides this, I am deploying 'Help with the Rules' in order to limit the administrative burden. 'Help with the Rules' has been developed in collaboration with the Ministry of Social Affairs and Employment and the implementation organisations. Clients, either independently or together with help from those close to them, can make use of the information provided on the website www.regelhulp.nl. Consultants or those responsible for intakes can also make use of the information provided on this website. Step by step 'Help with the Rules' helps to chart the situation in order to move forward from the need for care through to possible solutions. Information is combined on this website concerning the Exceptional Medical Expenses Act, the Social Support Act, the Invalidity Insurance (Young Disabled Persons) Act and the Sheltered Employment Act, supplemented by information about solutions or services within a client's own environment. The perspective of the client together with guidance towards the right organisation(s) is the leading factor hereby. 'Help with the Rules' will be expanded with information about the Youth Care and other information that is important in order to operate well within our society. This instrument is meant to serve as a guide through the complexity of regulations.

Included in the Coalition and Tolerance Agreement is that healthcare insurers will

[5] House of Representatives, session year 2010 – 2011, 32500 XVI, no. 45

be operating the Exceptional Medical Expenses Act for their own insured persons and that municipal authorities will be responsible for the supervision. An important source of administrative burdens arises from the different formats that care offices and municipal authorities use for similar applications for information from care providers. I will do my best to get the relevant parties to agree to limit the administrative burdens as far as possible.

1.8 Simplifying the indication assessment

The current method of formulating the indication for care under the Exceptional Medical Expenses Act involves too much in the way of administrative work. By simplifying the indication assessment, a good balance can be reached between the provision of care and administration and the professional will be afforded more space. I trust in the judgement of the professional.

The role of the Care Assessment Centre (*Centrum Indicatiestelling Zorg* or *CIZ*) as independent assessor of indications will be maintained. The Care Assessment Centre has achieved a great deal over the last few years in simplifying the process of assessing indications. In relation to this, I refer to the letter to the House of Representatives of 5 November 2009[6] 'Building on Trust'. This includes the fact that the number of standard indications has been expanded [7]. I shall be continuing and furthermore intensifying this simplification. Moreover, starting in 2010 the so-called task mandate has been started. Under this mandate, all care providers can themselves, under certain conditions, give an advice about repeat indications for particular client groups to the Care Assessment Centre. This concerns clients who are already receiving care and for whom a care file already exists. This concerns approximately 80% of the total number of indications given annually. The Care Assessment Centre will test these applications beforehand through sample checks.

Until recently, an indication decision for care under the Exceptional Medical Expenses Act was valid for a maximum term of five years. As from 18 April 2011, a client with a stable need for care can be awarded an indication decision with a maximum term of fifteen years. Should the need arise to change the indication decision for reasons regarding the care involved, for example because at a particular point either different or greater care is required, then the client can report this to the Care Assessment Centre, possibly after consultation with the care provider.

A simplification of the indication assessment will also be achieved through applications for accommodation for people above the age of eighty years, who can no longer live at home due to their need for care and support, only needing to be registered through the Care Assessment Centre. This applies both to the first application for long-term accommodation as well as for the repeat application in case of a change to the level of care. One exception to this concerns the treatment aimed at recovery (Intensity of Care Packages VV 9). In these cases the existing procedures will apply. As from 1 October 2011, the Exceptional Medical Expenses Act care providers will be given the possibility for this category of clients, on the basis of arguments regarding care and in reference to the Exceptional Medical Expenses Act policy rules regarding indication assessment, to determine objectively whether long-term accommodation should be indicated and which care arrangement should be chosen. These details will be presented by the care

[6] House of Representatives, session year 2009 - 2010, 30 597, no. 116

[7] In case of a standard indication, this concerns a situation that leads to the same indication without a full investigation being required. The care provider can quickly submit a request digitally for such a standard indication to the Care Assessment Centre. The care can be started immediately and the formal indication decision supplied by the Care Assessment Centre will then follow within fourteen days. Indications are checked afterwards by the Care Assessment Centre through random sampling.

provider to the Care Assessment Centre via a digital application function. The Care Assessment Centre will automatically set that report in a formal indication decision. The Care Assessment Centre will carry out checks afterwards as required on random samples and will monitor how the development of the indication assessment is working for this group of clients and which care arrangements are indicated. In consultation with the Care Assessment Centre, an enforcement framework is being formulated at the present time for the Care Assessment Centre so that the details can be worked out for the principle of high trust, high penalty.

Also in the sector for those people with sensory disabilities the indication assessment will be simplified. Many of the treatments deployed in this sector have the character of short-term rehabilitation. Providers (or their representatives) have urged that this care should be provided free of indication under the Exceptional Medical Expenses Act. I have met this request by making the treatment free of indication as from 18 April 2011 for authorised providers with acknowledged expertise in the area of care for those people with sensory disabilities.

Steps have been made in recent years (2003 – 2008) to centralise and make uniform the indication assessment with regard to the Exceptional Medical Expenses Act. The investigation carried out in 2010 by Research for Policy 'Policy analysis of indication assessment under the Exceptional Medical Expenses Act' it appears that more indications have been given, the quality of which is better. This has contributed indirectly to the intended use of the Exceptional Medical Expenses Act. The results of the policy analysis support the development, included in the above-mentioned letter 'Building on trust', when this concerns further authorisation and simplification of the indication assessment, reduction in costs, reduction in the administrative burden and a more integral assessment.

In paragraph 3.2 concerning the vulnerability of the Personal Budget regulation to fraud, I shall go deeper into the indication assessment carried out by the Care Assessment Centre under the framework of the Personal Budget.

1.9 Plan for extreme need for care

I believe it to be important that within the long-term care that rights are given to the clients' exceptional needs for care, both for clients who choose for care in kind and for those choosing the Personal Budget. A work group is busy at the present time working out the details for the motion from the member of the House of Representatives Ms Wolberts (PvdA) et al[8]. The motion includes the request to come up with a plan that would lead to the extreme need for care or care involving multiple bases being taken into account by the indication assessment of clients who need care together with accommodation.

The work group is made up of the Dutch Healthcare Authority, the Healthcare Insurance Board, the Care Assessment Centre, the Centre for Consultation and Expertise (CCE) and the Ministry of Health, Welfare and Sport. This work group is looking at all the current extra allowances in the funding of the Intensity of Care Packages as to whether these should be set out in the claims and whether the Care Assessment Centre should be required to give an indication for these. I want to increase the accessibility to the support and knowledge within the CCE for clients with an extreme need for care (and their carers) who do not fit into the Intensity of Care Packages. This work group is looking at how this can be realised for both clients who choose for care in kind as well as clients who choose for a Personal Budget. Besides this, the work group will elaborate on the

[8] House of Representatives, session year 2010 -2011, 25 657, no. 48

recommendations from the current evaluations from the policy regulation for extreme need for care from the Dutch Healthcare Authority and the CCE. I shall be informing the House of Representatives this autumn about where I stand with regard to extreme need for care. In addition to this, the Dutch Healthcare Authority annually reviews the maintenance programme of the Intensity of Care Packages whether it is necessary to refine the existing Intensity of Care Packages.

1.10 Financing results

Over the last few years both the care providers as well as the policy makers have made a concerted effort to introduce the individual client-aimed intensity of care financing. Intensity of care financing with Intensity of Care Packages as cost unit only concerns the intramural care under the Exceptional Medical Expenses Act. The Intensity of Care Packages are based on the need for care of comparable patients and therefore an elaboration of the claims in the indication assessment. It is my intention, in line with the budgetary letter[9] that my parliamentary predecessor sent to the House of Representatives, to investigate whether Intensity of Care Packages can also be introduced into extramural care. Since the intended decentralisation of supervision, the limitation of the target group in the Exceptional Medical Expenses Act and the separation of living accommodation and care lead to shifts in the Exceptional Medical Expenses Act claims, this implementation cannot take place before 1 January 2014. The Personal Budget is different from extramural care in the sense that the client with a Personal Budget receives a sum of money with which they themselves can choose from whom and when they purchasing their care. Budget holders justify their responsibility about their expenditure and record this in their administration. In cases of care in kind, as with care provided on the basis of Intensity of Care Packages and extramural care, the care is provided by an institution that has a contract with a care office. The payments and the administration are carried out by the care office and the care institution. As from 2013 the tasks currently being carried out by the care offices will be taken over by the healthcare insurers.

The Intensity of Care Packages are described in the Exceptional Medical Expenses Act functions and (average) number of hours. However, the number of hours care to be provided says nothing about the content of the care process and about the result of the care provided. A logical following step in making the Exceptional Medical Expenses Act more client-aimed is that the financing should be coupled to the results of the care for the client. The current financing system holds too few incentives for innovation because it is the input and not the result that holds the central position. On the other hand, financing results gives providers the incentive to provide tailor-made solutions and offers the space to search out new ways.

I want to maintain a number of principles in the development of the system of financing results. As starting point I want to take into account what people can do instead of what their limitations are. Moreover, the money should follow the client and quality should be coupled to financing. The satisfaction of clients and care workers provides an important indication of quality.

At the present time I am working on a model for financing results on the basis of the above-mentioned starting points. The main challenge hereby is in defining the areas of results that tie in with the actual provision of care. Moreover, financing results should preferably acquire a form that promotes its tying in with the curative care and also with the welfare. It is my intention to provide further information to the House of Representatives during the second half of this year.

[9] House of Representatives, session year 2009-2010, 30597, no. 134

2 Getting the organisation of care in order

A sketch is given in chapter 1 of this letter of the measures that this cabinet is taking to improve the quality of long-term care, to reduce the pressure from regulations and the bureaucracy in the care sector. In this chapter the measures are elaborated on that directly involve how the Exceptional Medical Expenses Act is built up, meaning the claims, the target group, the functions and its implementation. This concerns the decentralisation of the extramural supervision to the municipal authorities, the measure limiting the target group and the transfer of the youth with a light handicap and the youth mental healthcare to a legal framework for the youth. The following task is to separate accommodation from care, leading to an increased possibility for clients to choose their own living accommodation. I shall also be discussing in this chapter the improvement of the implementation of the Exceptional Medical Expenses Act by transferring this from the care offices to the healthcare insurers.

The measures are needed to future-proof the Exceptional Medical Expenses Act and at the same time to maintain good care for those who really need it. Over the last 10 years the expenditure on the Exceptional Medical Expenses Act care has risen by 66%, from just over EUR 14 billion in 2000 to over EUR 23 billion in 2010. Everyone with an income in the Netherlands pays a maximum of EUR 330 per month towards this, which is unrelated to whether or not they make use of Exceptional Medical Expenses Act care. The income from the premiums only covers 70% of the total expenditure arising from the Exceptional Medical Expenses Act. The rest is covered by personal contributions (5%) and government contributions (25%)[10].

2.1 Decentralisation of extramural supervision to municipal authorities

The cabinet has chosen to organise the extramural supervision, which at the moment is included under the Exceptional Medical Expenses Act, closer to the client. This is why the extramural supervision will be placed under the workings of the Social Support Act.

On the grounds of details from the Care Assessment Centre, on the survey date of 1 January 2010 around 180,000 people had an outstanding right to extramural supervision under the Exceptional Medical Expenses Act. This concerns people with a mental, physical or sensory disability, the elderly with somatic or psychogeriatric problems, adults with psychiatric problems and the youth with psychiatric problems in combination with problems in their upbringing or in their growing up.

As from 1 January 2013, people needing supervision for the first time will be able to apply for this under the Social Support Act should they not be able to get by independently. This also applies to children under the age of 18 years who need extramural supervision in 2013 for the first time. A changeover situation will arise thereby in 2013. The right to changeover is important for people who already have an indication for extramural supervision, transport and/or short-term stay. The right to changeover for this group will be arranged in the Decision concerning Care Claims under the Exceptional Medical Expenses Act. As from 2014, everyone needing supervision will need to apply for this under the Social Support Act.

[10] Ministry of Health, Welfare and Sport budget 2011

The supervision for people with an indication for an intramural stay who cannot arrange this themselves, the so-called intramural supervision, will continue to be included under the Exceptional Medical Expenses Act, in accordance with the Coalition and Tolerance Agreement and because of the interwoven nature of the intramural setting. This also applies to people who make use of the Full Home Package.

The decentralisation of extramural supervision fits in with the task that the municipal authorities have under the Social Support Act: the advancement, facilitation and maintenance of the ability to cope independently of the citizen and their participation in our society and the compensation of limitations thereby experienced by the citizen. The municipal authorities are capable of offering tailor-made support that is close at hand, for example within a person's own area or neighbourhood, in cases whereby the citizen cannot participate independently or with help from within their own surroundings. The municipal authority will make the connections thereby between other municipal domains, such as the policy in the area of debt help, adaption of the home, reintegration and support or the accommodation policy.

Including extramural supervision under the Social Support Act also means that the support offered by the municipal authorities, in terms of nature, size and provider, may be different from the supervision to which the client was used to receiving under the Exceptional Medical Expenses Act. Since the municipal authorities know their own citizens and where possible, besides the professional support, are able to deploy voluntary workers and students working in their social work practices for support, the municipal authorities are capable of provide tailor-made solutions. They can also call on their citizens to provide more of their own strengths or networks to contribute to the support.

The Social Support Act contains an obligation to compensation. This means that the municipal authorities must offer support to compensate for the limitations that citizens experience in their participation in our society. It is up to the municipal authorities exactly how they go about this. However, the municipal authorities must provide their citizens with justification of the implementation of their tasks and of the choices that they make. The input from those directly involved is arranged under Sections 11 and 12 of the Social Support Act.

In order to provide clarity and to offer safeguards concerning which results the municipal authorities are responsible for with regard to the individual citizen, I shall be adjusting the obligation to compensation under the Social Support Act. The Association of Netherlands Municipalities is in agreement with this change. In the accompanying appendix you will find the contours set out for the legislative amendment to the Social Support Act, including the adjusted obligation to compensation. An added component to the obligation to compensation (Section 4) is that municipal authorities are obliged to make provisions that make it possible for the citizen to be able to carry out their daily vital functions and to structure their personal lives and thereby to be in charge of what they do. On the grounds of this, support can be offered, for example, with (practical) tasks and activities such as meaningful daytime activities. Examples of this include the lifting and moving of necessary objects in daily use or the management of housekeeping money and housekeeping budget. This section is also aimed at compensating and actively recovering the citizen's limited or non-existent ability for self-regulation. This may concern, for example, organising business in the areas of housing, education, work and income, help with initiating the setting up or adjustment of the daily or weekly plans, providing insight into the (possible) consequences of decisions, as well as help with sticking to rules and agreements. Moreover, it is necessary in such cases as they arise to set up supervision over behaviour, for

example, resulting from a disorder bringing with it the danger of falling, or other complications in connection with an illness.

The concept legislative bill that will change the Social Support Act on these points has already been put before the Council of State. It is my intention to complete the legislative course for changing the Social Support Act around the start of 2012, so that the municipal authorities have sufficient time to prepare and the consequences for the clients and care providers are clarified in good time.

The ‘playing field’ is changing for clients, municipal authorities and care providers. It is up to the care providers and welfare organisations to create a suitable offer of support, which suits the results that the municipal authorities wish to achieve for their citizens on the grounds of the Social Support Act and which fits in with the client’s need for support. Providers will therefore be challenged in their creativity, innovation and efficiency.

Municipal authorities are often confronted by providers who are new to them and with direct responsibility for clients with moderate through to serious limitations. In the Management Agreement it was agreed with the Association of Netherlands Municipalities that before this summer investigations would be carried out together into which client groups would need further measures provided with the Social Support Act, so that the municipal authorities will be able to support them adequately. I am hereby including the short-term stays.

In connection with the decentralisation, from 2013 onwards the responsibility for the transport to and from the external supervision will also be transferred from the Exceptional Medical Expenses Act to the municipal authorities. Running parallel to this, I am carrying out an investigation at the moment into the future of the social recreational supra-regional taxi transport service for people with limited mobility (known as Valys). Decentralisation of this to the municipal authorities is a real option because then the instruments available to the municipal authorities would be supplemented in order to be able to offer citizens integral tailor-made solutions. Besides this, I am also investigating other options, such as a role for the provinces or keeping a national regulation. The intended objective, namely that of promoting the participation in everyday society, is the leading concept in this investigation.

The municipal package of tasks will be widened through the decentralisation of the supervision to the municipal authorities. This widening will lead to additional means for the municipal funds that is commensurate with the expansion of the tasks. You have been informed in the Management Agreement about the agreements concerning the decentralisation of supervision from central government to the municipal authorities.

In order to inform clients, municipal authorities, providers and client and patient organisations in good time and thereby to prepare for the decentralisation of the extramural supervision and also to inspire providers to develop new forms of support and make connections with other domains, I am setting up a careful course of implementation. In doing so, I am working in close collaboration with the Association of Netherlands Municipalities. Employees from my department and employees from the Association of Netherlands Municipalities together form the Transition Bureau (or T bureau). The Transition Bureau supports the municipal authorities, providers and client organisations in the preparation for decentralisation. This is happening in consultation with all the parties involved, such as patient and client organisations, the current Exceptional Medical Expenses Act providers and welfare organisations. The Transition Bureau will provide good examples and will be the source of information for relevant parties in order to give form to their communication with clients. Also, after consultation with the

municipal authorities, client organisations and providers, details will be filled in concerning possible further measures that may be needed by certain client groups. The prevention of unnecessary administrative burdens for clients, providers and municipal authorities is also included amongst the tasks of the Transition Bureau. The Transition Bureau will thereby be using the knowledge and experience arising from the stimulation programme 'Welfare New Style', the project 'The Tilt' and the conclusions from the first evaluation of the Social Support Act[11].

2.2 Limitation of the target group under the Exceptional Medical Expenses Act

Other than is the case in various of our neighbouring countries, in the Netherlands it is not only those mentally handicapped people with an IQ of between 50 and 70 who have the right to Exceptional Medical Expenses Act care (basis of mental handicap), but also those mentally handicapped people with an IQ of between 70 and 85, if besides this disability there is a case of multiple problems. Multiple problems may include the following: serious limitations in social skills and learning and/or behavioural problems as a result of reduced cognitive functioning. This group of mentally subnormal people is a rapidly growing group within the care of the handicapped as a whole.

Included in the Coalition and Tolerance Agreement is that from 2012 the IQ criteria regarding the right to Exceptional Medical Expenses Act care will be equated with the criteria used in many of our neighbouring countries, namely by an IQ of 70 or lower. On the basis of qualitative considerations and for the sake of careful preparation, the cabinet has decided to carry out further research into the way in which this measure can be given the most optimal form and has decided thereby to postpone the implementation of this by one year.

The intended IQ measure concerns people who are vulnerable. The clients with an IQ of between 70 and 85 often have various different problems, which are not only related to their IQ. Many people who fall under this category are lacking in social skills, they are often easily influenced or not capable of satisfying the demands that society places on them. Their problems often present themselves in a number of different areas, such as living accommodation, work, education and personal income. Moreover, these problems are frequently coupled with added behavioural or psychiatric problems. Part of this group of people receives intramural care.

I have asked Healthcare Insurance Board to carry out an implementation assessment of the IQ measure included in the Coalition and Tolerance Agreement. On 21 April this year the Healthcare Insurance Board provided me with the implementation assessment. The Healthcare Insurance Board concluded that the reliability of the IQ tests is limited. Moreover, according to the Healthcare Insurance Board, the assessment of the intellectual capacity says little or nothing about the seriousness of the problems and the level of need for support. According to the Healthcare Insurance Board it is more indicative regarding the question as to whether there is a case of chronic limitations in the areas of social self-reliance, learning problems and/or behavioural problems, together with the level of seriousness of such problems. In the implementation assessment the Healthcare Insurance Board also paid attention to the marked growth in the demand for care from this target group. The conclusions of the Healthcare Insurance Board will be shared with professionals, representatives of client organisations and scientists who took part in two of the expert meetings that were organised with this in mind.

[11] The House of Representatives will be receiving a separate letter concerning the results of the stimulation programme Welfare New Style, as well as the reaction from the cabinet to the first evaluation of the Social Support Act.

The cabinet has decided to carry out further investigations in order to find out how the limitation of the Exceptional Medical Expenses Act target group can be put through in light of the above-mentioned insights. In the further investigations into the elaboration of the measure it will be assumed that the savings, as set out in the Coalition and Tolerance Agreement, will be fully maintained. For the clients who are included in this group, the support must be organised as far as possible from close by with the help of the clients' own social networks. In relation to this, I can see an important role here for the municipal authorities and the youth care departments.

In order to be able to carry out the further investigations, it is necessary to postpone the measure by one year to 1 January 2013. I shall use that time in order to gain insight into how the intramural care can be limited and how an expansion of the intramural capacity for this group can be avoided. The postponement for one year is also important to allow the municipal authorities, both under the framework of the expansion of the Social Support Act with supervision as well as the Sheltered Employment Act, and the youth care department time to be able to prepare well for the demand for support from this group.

During the budget debate the House of Representatives spoke of its worry about people with an IQ of higher than 70 who have multiple problems. The members of the House of Representatives Ms Wolbert (PvdA) and Ms Wiegman-van Meppelen Scheppink (CU) presented a motion[12] in which the government was asked to guarantee supervision for people with an IQ of higher than 70 who have multiple problems. This motion was upheld because it was agreed that a written reaction would be provided concerning the worries of the House of Representatives. With this letter I am providing this written reaction, saying that the measure will after all be postponed for one year. In due course I shall inform the House of Representatives further about the elaboration of the measure as from 2013. At the same time I shall also go further into the content of the above-mentioned motion.

The revenue for 2012, that being EUR 20 million, will be found within the total budgetary framework of the Exceptional Medical Expenses Act, bearing in mind the postponement of one year. The limitation of the Exceptional Medical Expenses Act target group in accordance with the Coalition and Tolerance Agreement will lead to a structural decrease of around EUR 250 million less expenditure under the Exceptional Medical Expenses Act.

2.2 Transfer of care for youths with a light mental handicap and youth mental health care financed under Exceptional Medical Expenses Act

In line with the Coalition and Tolerance Agreement, the cabinet has chosen to settle on one financing system only for the youth care system. The aim of this is to combine all the tasks in the area of youth care under one legal framework, whereby the care for youths and their parents can be fully integrated. All tasks in the area of youth care will be transferred over to the municipal authorities in phases. This concerns the youth mental health care (included under both the Exceptional Medical Expenses Act as well as the Healthcare Insurance Act), the provincial youth care, the secure youth care, youth aftercare, youth protection and care for youths with a light mental handicap. This phased transfer is in line with the advice from the Parliamentary Work Group Investigation into the Future of Youth Care[13]. The legal framework will be phased in from 2014. In accordance

[12] House of Representatives, session year 2010 – 2011, 32 500 XVI, no. 34
[13] 'Youth care closer by', House of Representatives, session year 2009- 2010, 32 296, no. 7

with the governmental agreements with the Association of Netherlands Municipalities, the extramural care for youths with a light mental handicap and the youth mental health care will be transferred out of the Exceptional Medical Expenses Act. The decentralisation of supervision of youths from the Exceptional Medical Expenses Act to the Social Support Act will then be complete. The transfer of the intramural care for youths with a light mental handicap will take place on 1 January 2016 at the latest.
The means that are used at the moment for the tasks in the area of youth care (including the means - EUR 90 million - that the provinces contribute to youth care from their general budget), reduced by a structural efficiency reduction of EUR 300 million, will be transferred, in accordance with the agreements in the Administrative Agreement 2011-2015, to the municipal authorities. By combining the tasks and reassessing the right to care, the municipal authorities will then be able to provide tailor-made solutions and the system of youth care can achieve a more suitable and efficient form.

I shall be informing the House of Representatives before the summer about the approach to decentralisation of youth care.

2.4 Separating living accommodation and care

In accordance with the Coalition and Tolerance Agreement, long-term care accommodation and care will be separated. Residents in institutions will hereby be given greater freedom of choice and care institutions will be better able to aim at clients' accommodation wishes through the ability to offer different varieties of accommodation. People with a need for care who choose to live independently at home can be helped better thereby. The cabinet will be deploying better basic care closer to home in that way. Particularly for the elderly and those people with a more complicated need for care, the need for support close to home is great. This concerns a good balance and collaboration between the district nurse, home help, the GP, carers, the pharmacy, the municipal authority, as well as the hospital and other care providers. The district nurse can form a link between the client, family, carers and the various different professionals. Concerning care in the neighbourhood and the improvement of this, the Minister and I will be sending a letter to the House of Representatives after the summer. After consultation with the Minister of the Interior and Kingdom Relations, I shall be looking into whether the housing associations and municipal authorities will be able to facilitate this movement as far as possible. We shall be looking into whether a follow-up of the programme 'Better at home in the neighbourhood' can contribute to this.

The cabinet has decided to take irreversible steps to separate intramural provisions of care and living accommodation and thereby to start straight away to prepare the necessary changes to the relevant legislation and regulations. The contractual obligations are due to expire as of 1 January 2012. Through this rescinding, the care offices (the healthcare insurers as from 2013) will have the freedom to contract only care providers who, in their opinion, offer accommodation that satisfies the wishes of the client. This cabinet will also be introducing, after years of uncertainty in this area, a system of normative funding of capital costs and the recalculation of capital costs will be freed. These steps are necessary in order to implement the separation of living accommodation and care. I shall go into this further in the following section.

Normative funding of living accommodation
The building regime was abolished in 2009. Care providers were obliged to obtain permission from the government for building and renovation of institutions. This procedure brought with it too much bureaucracy. Approval from the government was tied to a risk-free compensation of all capital costs. At the moment all capital costs are compensated in full on the basis of a recalculation, even if the buildings

are no longer in use.

Through the introduction of normative funding of capital costs by means of a surcharge on het Intensity of Care Packages tariffs, an end will be made to the compensation of such (parts of) empty buildings. This normative funding will be introduced in phases during the period between 2012 and 2017 in order to ensure that care institutions can gradually change over from risk-free to high-risk funding. Under normative funding the compensation of the capital costs will be coupled with the level of occupation. This method of funding is also important in determining the value of individual units of living accommodation and all the other spaces within care institutions. Clients will thereby pay rent for the living accommodation apportioned to the individual client. For the areas coupled to care (such as treatment rooms for physiotherapy) the funding will still come from the Exceptional Medical Expenses Act. Such a split in the funding is not possible within the current system of recalculation.

Implementation of the separation of living accommodation and care
For clients with limitations who are accommodated intramurally, the separation of living accommodation and care will lead to greater freedom of choice as well as an improvement in quality. The cabinet has formulated a number of preconditions by the implementation of the separation of living accommodation and care. This will include, for example, the personal contribution being lowered. Clients will be paying for their own living expenses. Clients should also be considered for rent subsidy if their income makes them eligible for such. Moreover, if the client has a partner living independently, this should not have a negative effect due to the fact that the client must also pay for their own living costs. There must also be sufficient quantities of single person's rooms available.

In order to comply with this precondition, a number of items must be worked out. I shall determine how many of these clients have partners who live independently and what the position is of their income. Accordingly it must then be decided as to whether financial compensation will be necessary. In order to assess the demand for rent subsidy, the rental value of intramural living accommodation in institutions must be charted. Together with the Minister of the Interior and Kingdom Relations it must be worked out whether the rent protection and level of rent regulation, which applies in the rental sector, should be applied in its present form to the living accommodation provided by a care provider. The consequences for clients and care providers in financial terms, but also in terms of the administrative burden, can be charted. In addition to this, I promised the House of Representatives during the General Meeting of 19 May this year that I would find out whether possibilities could be created for clients in an institution to insure themselves against the costs of supplementary services, which are not covered under the Exceptional Medical Expenses Act.

As described above, before the responsible implementation of the separation of living accommodation and care can take place, certain tasks must first be worked out. I shall try to start the separation of living accommodation and care as from 1 January 2014 for the lighter Intensity of Care Packages. My idea hereby is to include, in any case, the Intensity of Care Packages VV 1 and 2. Where possible this separation will also be carried out at the same time for the Intensity of Care Packages VV 3 and 4. During the following years a gradual separation of living accommodation and care will then be carried out through the whole line, including the higher Intensity of Care Packages. The changeover regime of the normative funding of capital costs, whereby institutions maintain their own responsibility for their buildings, will be left intact.

Pilots
During the General Meeting of the Exceptional Medical Expenses Act of 23 March

this year, I indicated that I would also look into the suggestion of setting up pilots in the separation of living accommodation and care, which I shall do herewith. Over the last few years the possibilities for continuing to stay in one's own home have increased. With the help of a Personal Budget or through the conversion of the Intensity of Care Packages into extramural functions or the Full Home Package, many clients even with severe limitations have been able to arrange care at home. The housing market itself has also worked increasingly in favour of the needs of people with limitations to be able to live independently, whether or not within a group situation. You will be further informed about this by the Minister of the Interior and Kingdom Relations in the report 'Monitor investment for the future 2009'. From this report it appears that 26% of the total housing supply is suitable as accommodation for the elderly or those people with limitations (housing without steps and sheltered accommodation). You will also soon be receiving from the Minister of the Interior and Kingdom Relations the Housing Vision, in which the future policy developments are set out. I consider these developments to be pilots and therefore do not see the need to implement further pilot regions or pilot institutions.

Finances
The savings set out in the Coalition and Tolerance Agreement of EUR 100 million in 2015 and EUR 300 million structurally through the separation of living accommodation and care will be realised through the package of phased measures. The introduction of the normative accommodation component on 1 January 2012 will lead to structurally lower outgoings on the capital costs from 2016. The savings of EUR 100 million in 2015 will be included in terms of tasks in the course of implementation of the separation of living accommodation and care. As indicated in the Management Agreement 2011-2015, the government and the Association of Netherlands Municipalities will be charting the consequences of the separation of living accommodation and care for the municipal authorities and will come to an agreement about the manner in which the separation of living accommodation and care can be given concrete form and about the compensation of the municipal authorities for any (financial) consequences. Together with the Ministry of the Interior and Kingdom Relations, the consequences from the call on rent subsidy will also be charted so that agreement can eventually be reached about compensation of the budget of the Ministry of the Interior and Kingdom Relations due to the increase of payments for rent subsidy.

2.5 Implementation of Exceptional Medical Expenses Act for own insured persons

Healthcare insurers are formally responsible for the implementation of the Exceptional Medical Expenses Act for their own insured persons. At the present time they have mandated virtually all of their Exceptional Medical Expenses Act tasks to the regional care offices. The care offices have the authority to work in the region in question on behalf of all healthcare insurers. The care offices have a financial contracting space in the region within which they can purchase care from the care providers.

Included in the Coalition and Tolerance Agreement is that the tasks of the care offices and the risks will be taken over by the healthcare insurers. The Exceptional Medical Expenses Act will be implemented from 1 January 2013 by the healthcare insurers for their own insured persons and this fits in with the change that the cabinet wants to make to more client-oriented care with a good balance between price and quality.

A number of advantages are expected from the implementation of the Exceptional Medical Expenses Act by the healthcare insurers for their own insured persons, such as an increase in the freedom of choice for insured persons and clients, a

higher level of client orientation, improvement in the quality and greater cost efficiency. Rescinding of the contractual obligation as from 1 January 2012 will also contribute to this. The insurer will be the single contact point for the client for the care across the board (both for the Healthcare Insurance Act as well as the Exceptional Medical Expenses Act). The insurer performs a role at client level in the mediation between the need for care and the supply of care. Besides this, clients will gain more influence because insurers are directly approachable and because insured persons have the possibility of switching their insurer annually ('voting with their feet'). It is also expected that healthcare insurers will be able to realise a better relationship in terms of care between the cure (Healthcare Insurance Act) and the care (Exceptional Medical Expenses Act) when purchasing the care. This is of particular importance to clients who need both Healthcare Insurance Act care as well as Exceptional Medical Expenses Act care, such as the elderly and the chronically ill. In case of complex care needs, a good balance and collaboration between care providers is essential in order to safeguard the quality of care. Healthcare insurers can play an important role in balancing the provision of care from different providers, whether these are funded through the Healthcare Insurance Act or the Exceptional Medical Expenses Act.

Bearing in mind the necessary chain of care for clients, good collaboration between healthcare insurers and municipal authorities is important. Based on good examples (chain of care for dementia, supervision, living accommodation areas and stimulation of health), the Netherlands Healthcare Insurers and Association of Netherlands Municipalities have developed a guideline for municipal authorities and insurers (toolkit) that offers levers that can be used in good collaboration.

In order to provide healthcare insurers with the genuine possibility of directing their work in terms of efficiency and quality, the contractual obligation that applies to care offices will be scrapped from the start of 2012. In doing so the care offices (from 2013, the healthcare insurers) will have greater freedom to contract what is, in their opinion, the most desirable quality at the most suitable price. This will contribute to the intended efficient implementation of the Exceptional Medical Expenses Act.

The transfer of tasks to the healthcare insurers as such will change nothing to the claim for Exceptional Medical Expenses Act provisions. Care providers will still be held responsible for providing care. The current (legal) obligation to provide care will continue to apply as well. This also applies to the independent assessment system carried out through Care Assessment Centre, which safeguards the public character of the Exceptional Medical Expenses Act.

The involvement of clients by the implementation of the Exceptional Medical Expenses Act is important. For this reason I want to establish in the legislative proposal, which regulates the implementation of the Exceptional Medical Expenses Act by the healthcare insurers, that the statutes of an Exceptional Medical Expenses Act insurance policy offer safeguards for a reasonable level of influence from the people insured in the policy of the insurers. In this way the healthcare insurers have the intention of working together with client organisations in formulating the purchase of care.

I shall be making concrete agreements with the Netherlands Healthcare Insurers about the preparation and the implementation of the Exceptional Medical Expenses Act for their own insured persons in 2013. Care is people, and this is the basis for the work of care offices and healthcare insurers and which must be the leading factor in the agreements that I reach with them. Therefore the agreements will in any case concern client satisfaction and good employers (leading to employee satisfaction) in the purchase of care. One point of attention hereby is the limitation

of the administrative burden. Criteria are also being developed at the moment so that an assessment can be given concerning the quality of the services on offer.

With the transfer of the implementation of the Exceptional Medical Expenses Act from the care offices to the healthcare insurers as from 2013, the cabinet's starting point is that the healthcare insurers will themselves take over the purchase of care. It is possible that the healthcare insurers will temporarily conduct (parts of) their purchase of Exceptional Medical Expenses Act care, within the frameworks of the competition law, on the basis of the representation model, for example because of a limited target group or due to the complexity of the care. This may include, for example, the care for those people with a sensory handicap, children with serious and multiple handicaps or with Korsakoff's syndrome.

Two models are conceivable in principle by the transfer of the implementation of the Exceptional Medical Expenses Act from the care offices to the healthcare insurers. The budgetary contractual space, which is divided up over the care offices at the present time, will be divided up over the healthcare insurers as soon as an adequate model for division is available. One part of the contractual space will be reserved for the benefit of the so-called 'bottleneck procedure'[14]. I am hereby considering a larger reserve for the bottleneck procedure than is the case in the current system, in order to build in extra buffers within the budgets. This will help to guarantee the budgetary limits and the risk of exceeding the budget will be limited as far as possible. The cabinet is working out this model and is looking into the extent to which incentives can be introduced in order to make the implementation of the Exceptional Medical Expenses Act run in as efficient a form as possible. The basis of the model that can follow on from this is that healthcare insurers will carry the risk wherever possible for the implementation of the Exceptional Medical Expenses Act. This model will need to be elaborated on in the development of the above-mentioned division model of a risk balancing system[15]. This will require careful preparation. A future cabinet will therefore be required to make the decision about any risk-bearing implementation of the Exceptional Medical Expenses Act by the healthcare insurers.

At the present time I am preparing a legislative proposal in which the above-mentioned bases are being further worked out, including the option of achieving a risk-bearing implementation, and whereby the current contractual space will no longer be apportioned to the care offices, but to the healthcare insurers.

For the implementation of the Exceptional Medical Expenses Act by the care offices, the healthcare insurers were given the assignment for the period 2009-2011 by my parliamentary predecessor. Since the current assignment for the care offices ends in 2011, in the run-up to implementation of the Exceptional Medical Expenses Act for their own insured persons, a changeover course will be set in place. The healthcare insurers will provide each other with a mandate and authority to cover the year 2012. This mandate will lapse in principle on 1 January 2013. The healthcare insurers will need to work very closely with the care offices on the preparations that must be made for the changeover to the implementation of the Exceptional Medical Expenses Act for their own insured persons in 2013.

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[14] Healthcare insurers can start a 'bottleneck procedure' with the Dutch Healthcare Authority if they believe that the budget that has been awarded is not sufficient to cover the demand for care. The Ministry of Health, Welfare and Sport will decide on the basis of advice provided by the Dutch Healthcare Authority whether the budget of the insurer in question will be increased or not.

[15] The intended risk balancing system compensates healthcare insurers beforehand for the differences in costs as a result of differences in levels of health of the insured persons in their portfolios.

3 Towards a solid and legislatively fixed Personal Budget

In this chapter I will set out my vision of the Personal Budget. This will also fulfil the motion presented by the member of the House of Representatives Ms Wolbert (PvdA) et al[16]. I will also elaborate on the measures that are aimed at a solid Personal Budget regulation, the tackling of fraud and the legislative anchoring of the right to a Personal Budget.

3.1 The Personal Budget

At the present time almost 130,000 clients make use of a Personal Budget. The Personal Budget regulation offers the client the possibility of arranging their own say in the purchase of the care they require. The Personal Budget expenditures have risen immensely over the last few years and this growth cannot be sustained. The access to the Personal Budget will therefore by limited in order to make this instrument solid and to be able to maintain its existence for clients with an indication for intramural accommodation and therefore for people with a lifelong need for care that affects every area of their lives. I believe this to be a responsible attitude because there have been modernisations in the extramural care over the last few years that have led to greater freedom of choice for clients, which is one of the objectives of the Personal Budget. This has been less the case with the intramural care sector.
Furthermore, fraudulent claims with regard to the Personal Budget will be prevented and combated and the right to a Personal Budget will be legislatively anchored, in accordance with the Coalition and Tolerance Agreement. This will be the case as from 1 January 2014. This will make the Personal Budget and care in kind equal alternatives and the healthcare insurers and care providers will be given an extra impulse to take the client's need as basis for the provision of care.

The care provided through a Personal Budget, just as is the case with care in kind, must be good care. If this care is efficiently or professionally provided then this must satisfy the legal requirements[17]. For this reason it is not necessary to include criteria for responsible intramural care in the Personal Budget regulation. This was requested in the motion presented by the former member of the House of Representatives Mr De Vries (CDA) et al[18]. I will continue to support initiatives that make the quality of care visible, for example through comparable choice information or quality standards. This will not lead me to interfere further with the privacy of the client, because of the obvious practical objections, with regard to the formulation of the desired supervision and its maintenance. If a budget holder decides to purchase their care from someone who is not working efficiently or professionally in the care sector, then their own choice and responsibility will prevail.

3.2. Solid Personal Budget and tackling fraud

The current practice shows that there is reason to add marginal notes to the Personal Budget. On the basis of the enclosed investigations and figures about the developments in the use of the Personal Budget, I have come to the following conclusions[19]:

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[16] House of Representatives, session year 2010 -2011, 32 500, no. 35
[17] This concerns the Care Institutions (Quality) Act, which will be replaced by the Care Clients' Rights Act, that is currently being handled by the House of Representatives. According to both Acts, it makes no difference whether the care is provided by means of a Personal Budget or care in kind and the supervision of this care is safeguarded through the Healthcare Inspectorate.
[18] House of Representatives, session year 2009 - 2010, 30 597, no. 142
[19] This concerns the following investigations:

1. the regulation is no longer tenable in its current form, partly because of the way it soaks up money and due to the monetisation of informal care;
2. own control is not always the driving force behind choosing for a Personal Budget, which means that responsible care is not always guaranteed;
3. the regulation is sensitive to fraud and leads to dubious Personal Budget expenditure on het basis of the supervision function.

These conclusions are not new. They were already raised in my letter of 30 November 2010[20] and in the answers to questions from the House of Representatives about the Personal Budget[21].

Bearing in mind the above-mentioned problems with the Personal Budget regulation, from 1 January 2012 I shall be implementing the measures set out below, which are aimed at a solid Personal Budget regulation and at tackling fraud. This will fulfil the motion presented by member of the House of Representatives Ms Uitslag (CDA) et al.[22]

A solid Personal Budget regulation

One of the greatest challenges is the affordability of the care provided. Since 2002 the Personal Budget expenditure has risen by 23% annually (from EUR 414 million to EUR 2.2 billion in 2010), whilst the expenditure during the same period on care in kind rose by an average of 4% annually. This growth in the Personal Budget expenditure cannot be maintained in the years to come. Cancelling out the difference between the available Personal Budget means and the necessary Personal Budget means in case of an unchanged policy for the coming years is an important financial task for this cabinet. This difference is estimated to be EUR 864 million in 2015. This is approximately 30% of the available means for Personal Budgets in 2015. No account has been taken thereby of the planned decentralisation of the supervision function to the municipal authorities. I believe that the Personal Budget regulation should also be manageable without this decentralisation and should be brought back to suitable level of growth.

I should point out that the Personal Budget regulation has led to a whole new group of people needing care to turn to the Exceptional Medical Expenses Act, who would not (yet) have done so otherwise. The growth of the Personal Budget has not led to a reduction in the growth of care in kind. This puts the affordability of the long-term care under pressure. Here in the Netherlands we have an accessible Exceptional Medical Expenses Act and an attractive Personal Budget regulation, which encourages carers to finance their care from the collective means. This development is at right angles to my effort to make the long-term care future-proof by addressing people in their own responsibility and to make optimal use of the social environment.

In order to bring the Personal Budget expenditure in line with the growth in the Exceptional Medical Expenses Act, access to the Personal Budget will be limited as from 1 January 2012 to people with an intramural indication. This will lead to structural savings from 2015 of EUR 900 million compared with the results from

- 'Towards a solid Personal Budget' from the ITS, January 2011;
- 'Investigation into the use of Personal Budgets out of necessity due to the reduction in the provision of care under the Healthcare Insurance Act and the Exceptional Medical Expenses Act' from Partners in youth policy, February 2011;
- 'The advance of the Personal Budget' from the SCP, May 2011;
- 'Background and motives for waiting for a Personal Budget' from Research for Policy, December 2010.

[20] House of Representatives, session year 2010 - 2011, 25 756, no. 41
[21] House of Representatives, session year 2010 - 2011, 25 756, no. 42
[22] House of Representatives, session year 2010 - 2011, 25 657, no. 45

an unchanged policy. The Personal Budget offers a valuable alternative for intramural care and stimulates creative solutions. I also want this modernisation to filter through to the care in kind for people with a lifelong need of care that affects every area of their lives, including the separation of living accommodation and care. The Personal Budget Intensity of Care Packages tariffs for all budget holders with an intramural care indication will be increased by 5% from 1 January 2012. As basis for this increase, I am taking the Personal Budget Intensity of Care Packages tariffs from 2010 (minus the general tariff reduction of 3%) and not the Personal Budget Intensity of Care Packages tariffs that were introduced from 1 January 2011 for budget holders with an intramural care indication who stay at home. This will allow more financial means to become available for (future) budget holders with an intramural care indication, just as in the case of care in kind. This will fulfil the motion presented by the member of the House of Representatives Ms Venrooy-van Ark (VVD) et al[23] concerning the future financing of the Personal Budget financed living accommodation initiatives. I am assuming that this will ensure the continuing existence of these living accommodation initiatives.

Limiting access to the Personal Budget only to clients with an intramural care indication as from 1 January 2012 will mean that the choice of a Personal Budget will no longer be available for new clients with an extramural care indication as from that date. At the moment 90% of the total number of budget holders have an extramural indication (around 117,000 people). They will maintain their right to a Personal Budget up to 1 January 2014, even in case of reassessment of their indication. Part of this group will be discharged between now and 2014. Budget holders with an indication for supervision will keep their Personal Budget (even after reassessment of their indication) up to the point of decentralisation to the municipal authorities. It is expected that between 40,000 and 45,000 budget holders with an extramural indication for the functions of personal care and nursing will be directed to care in kind from 1 January 2014. I shall look into whether the MEE can play a role in supporting this group for whom the right to a Personal Budget will lapse.

I am aware of the impact these measures will have on clients and providers of care in kind. Over the last few years there have been modernisations realised in the area of extramural care. Good examples of these include Neighbourhood Care in the Netherlands and the innovations under the framework of In for Care. This process has not yet been completed, but is now well enough advanced that I think it is responsible to take these measures. In consultation with the care offices (and from 2013, the healthcare insurers) I shall be stimulating this modernisation process even further. For youths with psychiatric problems with an Exceptional Medical Expenses Act indication for supervision (at the moment 30,000 budget holders) there is insufficient Exceptional Medical Expenses Act care available. I am in the process of having consultations with the care offices in order to develop Exceptional Medical Expenses Act care together with the care providers. This will fulfil the motion presented by the member of the House of Representatives Ms Dijkstra (D66) et al[24]. Clients with an Exceptional Medical Expenses Act indication have at the present time and will keep the right to Exceptional Medical Expenses Act care, for which the care offices have an obligation to provide care. The care offices are obliged to take this new group of clients into account as from 2012 when purchasing their care. A transfer of part of the current Personal Budget means to care in kind is included in this measure.

For the care businesses (such as care farms) and self-employed workers who offer care at the moment that is paid for out of a Personal Budget, I shall be looking into which barriers they experience on their request to admittance to care in kind

[23] House of Representatives, session year 2010 - 2011, 32 500, no. 74
[24] House of Representatives, session year 2010 - 2011, 25 657, no. 49

and in making contractual agreements with a care office. This will fulfil the motion presented by the member of the House of Representatives Ms Leijten (SP) et al.[25] Besides this I shall also look into whether these provisions can be included under the experiment of low regulation institutions so that care in kind can be organised for this group of clients.

Tackling fraud

I am regularly confronted by fraud with Personal Budgets and I also receive signs of possible fraud. This is detrimental to the image of the Personal Budget. It is possible to see from these signs that particularly in the case of budget holders who are not so able at organising their own need for care and thereby their own budget they can become the victim of fraudulent intermediaries. In order to prevent fraud with Personal Budgets a number of measures have been introduced in recent times. By means of these measures I am limiting the demand on Personal Budgets and thereby the possibility of fraud. However, further measures are also required. In the following section I shall describe the supplementary measures that I am planning to take with regard to this. These measures have come about from governmental advice, whereby all parties concerned with the Personal Budget have been consulted.

1. Prevention (of fraud)

Providing thorough information about the rights and obligations that go hand in hand with a Personal Budget and about the care in kind that is on offer within the region which fits in with the client's indication decision is essential. I shall be asking the care offices (from 2013 the healthcare insurers) to formulate this information by actively and personally approaching all the people who make the choice to use a Personal Budget for care in kind, but who at the time of that choice have not yet shown a preference for a particular care provider. This will fulfil the motion presented by the member of the House of Representatives Ms Venrooy-van Ark (VVD) et al[26]. I also want the care offices (from 2013 the healthcare insurers) to actively support new budget holders in their first use of the budget, so that any problems that may arise with the care providers can be brought to light as soon as possible. Moreover I want the client who chooses for a Personal Budget firstly to formulate a care plan, on the basis of which the care office (from 2013 the healthcare insurers) will provide a Personal Budget. By means of these measures I hope to achieve personal control becoming the driving force in a more emphatic way for people who choose for a Personal Budget.

From the analysis of the cases of fraud, it can be seen that there are client groups (for example clients with psychiatric problems) whereby it is not simple for the Care Assessment Centre to make a good diagnosis without direct contact with the client and thereby to determine the nature and level of the limitations. In order to overcome this problem, the work instruction that the Care Assessment Centre applies at that moment to budget holders who make use of an intermediary office for the client groups in question will be broadened. By means of a risk analysis based on the grounds of this instruction, it will be determined whether clients will need to be seen by the Care Assessment Centre.

2. Detecting fraud

In order that the care providers are better able to monitor the spending of the budgets, I am making it obligatory from 1 January 2012 that a separate current account is used for the Personal Budget and payments to care providers can only be made through such bank accounts. Any cash payments will only be possible then from the amount that is without the obligation for justification. I see this

[25] House of Representatives, session year 2010 - 2011, 25 657, no. 53
[26] House of Representatives, session year 2010 -2011, 25 657, no. 44

measure as a possible step on the way to a different structure of implementation. At the point of implementation of the legislative anchoring of the Personal Budget on 1 January 2014, I am considering replacing the direct payment of the Personal Budget with a drawing right. This will mean that budgets will no longer be paid into the budget holder's bank account, but that the budget will be held by the healthcare insurer, for example. This will provide the possibility of checks beforehand and will lead to a reduction in the administrative burden for the budget holder, since the need for justification will then have lapsed. The client will still hold the control over purchasing the care.

3. Detection of intermediaries

The detection of fraud is also aimed at the intermediaries, as requested by the member of the House of Representatives Ms Uitslag (CDA) et al.[27] As from 1 January 2012 it will no longer be possible for new budget holders to use their Personal Budget means for intermediaries. I believe this to be a responsible step to take since there are sufficient instruments that can take over the functions of the intermediaries of which the budget holders can make use. My consideration here is for the electronic management of the Personal Budget and the information regarding choice about care providers. Existing budget holders will keep the possibility to pay for the costs of intermediaries out of their Personal Budget, but then only for intermediary services from bureaus that are certified. A final point in the detection of fraud is that I want the parties involved to share their details better, which will make it easier to trace fraudulent bureaus.

Tackling fraud in care in kind

Measures for tackling Personal Budget fraud form part of a broader programme for the prevention, detection and tackling of fraud in the care sector. Working together under the direction of the Ministry of Health, Welfare and Sport are the healthcare insurers and care offices combined in the Healthcare Insurers Nederland, the Dutch Association of Insurers, the Dutch Healthcare Authority, DNB, the Healthcare Inspectorate, the Public Prosecution Service, the Social Security Information and Investigation Service (*SIOD*), the Fiscal Intelligence and Investigation Service (*FIOD*) and the Ministry of Security and Justice together. In the work programme for 2010-2012 provision is made for formulating a fraud risk analysis for the Exceptional Medical Expenses Act care in kind. As soon as the outcome of the risk analysis is known, I shall inform the House of Representatives about this. This will fulfil the motion presented by the member of the House of Representatives Ms Venrooy-van Ark (VVD) et al[28] to carry out investigations into fraud and improper use of the Exceptional Medical Expenses Act care in kind.

3.3 Legislative anchoring

The Personal Budget is still organised at the present time under a subsidy regulation with a subsidy ceiling. By the legislative anchoring of the Personal Budget on 1 January 2014 the means will form part of the Exceptional Medical Expenses Act contract space. The legislative proposal for the legislative anchoring of the Personal Budget will be prepared in 2011, so that at the start of 2012 it can be put before the Council of State. I shall be putting the legislative proposal before the House of Representatives around halfway through next year. With this legislative proposal I shall fulfil the wish of the House of Representatives to legislatively anchor the Personal Budget, as expressed in the motion of the member of the House of Representatives Ms van Miltenburg (VVD) et al[29] and the motion of the member of the House of Representatives Ms Venrooy-van Ark (VVD)

[27] House of Representatives, session year 2010 - 2011, 25 657, no. 46
[28] House of Representatives, session year 2010- 2011, 25 657, no. 43
[29] House of Representatives, session year 2009 - 2010, 32 123, no. 147

et al.[30]

In consultation with the parties involved, I shall work out how the Personal Budget means will be included in the Exceptional Medical Expenses Act contract space. Together with these parties I shall also look into how the purchasing process by the healthcare insurers can best be organised. The healthcare insurers will purchase care in kind beforehand and reserve budget for the award of Personal Budgets during the course of the year. These activities must be completed by the start of 2013 so that the results can be taken into account in the frameworks for purchasing care for 2014 that will be announced in May 2013.

One important point of interest regarding the legislative anchoring is that it must be excluded that the Personal Budget will be made available unconditionally for all people in need of care who have a Dutch passport and who live abroad. This fits in with the legislative proposal Exceptional Medical Expenses Act care abroad[31]. Announced therein is that the regulation for subsidies under the Exceptional Medical Expenses Act will be adjusted. The Personal Budget will be withdrawn if the stay abroad exceeds the permitted duration.

[30] House of Representatives, session year 2010 - 2011, 32 500, no. 75
[31] House of Representatives, session year 2009 - 2010, 32 154, no. 2

4 The planning

The measures are set out in the preceding chapters that are necessary to bring the Exceptional Medical Expenses Act back to its main core objective and to improve the quality of long-term care. The measures that need to be taken are not independent of each other, but mainly work in conjunction. The various implementation courses for the different measures all have their own turnaround times. The planning of the measures is given in the table below.

Taking effect	**Measure**
From 2011	Start preparations and implementation of plan 'the elderly in safe hands' (2011- 2014)
1 January 2012	Start making Personal Budget solid
	Separating living accommodation and care: introduction of normative funding of capital costs
	Start extra quality impulse: EUR 852 million structurally per annum
	Change to formulation of Healthcare Inspectorate
	Start experiments in low level regulation care institutions
Second half 2012	Care Clients' Rights Act takes effect
1 January 2013	Framework Care Institutions Act takes effect
	Decentralisation supervision of the Exceptional Medical Expenses Act to the Social Support Act for new applicants
	Implementation of Exceptional Medical Expenses Act by healthcare insurers
	Measure to limit claim to Exceptional Medical Expenses Act (IQ measure)
	Transfer of rehabilitation care to Healthcare Insurance Act
	Healthcare Inspectorate has authority to split up institutions
	Quality institute set up
1 January 2014	Full decentralisation of supervision to the Social Support Act
	Legislative anchoring of Personal Budget
	Phased implementation of new youth care Act
	Start of separation of living accommodation and care: clients paying for their own accommodation by care provider
1 January 2016	Transfer of intramural youth care from Exceptional Medical Expenses Act to municipal authorities

Final comment

By means of this letter I have provided the cabinet with further elaboration of the measures included in the Coalition and Tolerance Agreement for better and more affordable care both now and in the future. The cabinet realises that the reform process asks a great deal from all parties involved. However, the cabinet has complete faith in the strength of citizens and the staying power of the institutions, central authorities, municipal authorities, professionals, voluntary workers and carers involved to work together towards a good end.