



Developments in home-care use. Policy and changing community-based care use by independent community-dwelling adults in the Netherlands



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ABSTRACT

Reforms have recently been introduced in the Dutch care system in order to constrain the rising expenditure on long-term care. In this study we examined changes in community-based care use between 2004 and 2011 and changes in the explanatory effects of its determinants (health, personal and facilitating factors) that may result from these reforms.

The study drew on care use registration data linked to data from national health surveys and income data from the tax authorities. Changes in community-based care use determined by health, personal and facilitating factors between 2004 and 2011 were studied. Changes in determinants were investigated by incorporating time-interaction terms of each determinant in logistic regression models.

The main findings show among other things that the use of community-based care did not increase between 2004 and 2011 if allowances made for the increase in the number of (elderly) older people. The role of income and household composition has changed the most (and to a lesser extent the role of age and physical impairments). Care use decreased among individuals with high incomes and increased among single persons.

The changes in community-based care use and in the role of income and household composition could be due to changes in eligibility for care, in which the applicant's personal situation is given a more prominent role alongside health considerations.

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1. Introduction

Public expenditure on long-term care in the Netherlands is among the highest in Europe. In 2004, 4.1% of Dutch GDP was spent on long-term care for the chronically ill, older persons and people with disabilities [1]. Only Scandinavian countries show a comparable level of spending. However, population ageing means that the

costs will rise much faster in the Netherlands than in those countries in the future if policy remains unchanged [2]. The most common form of long-term care provided to people with impairments living independently in the Netherlands is community-based care, comprising household help, personal care and nursing care. Much of the responsibility for providing care to those who need it lies with the government in the Netherlands, whereas in the majority of European countries most of this responsibility lies with the care recipient's family, who either pay for this help or provide it themselves [3,4]. As elsewhere in Europe, the Dutch government has taken drastic measures in recent years to curtail spending on long-term care [5]. The policy changes introduced in the Netherlands are aimed

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at limiting the accessibility of home-care, with greater emphasis being placed over the last ten years on the responsibility of citizens to organise their own help and care [6]. Financial co-payments for community-based care have been raised, especially for the higher income groups. The rules governing access to care have been made stricter and harmonised nationally. The introduction of the 'usual care protocol' in 2005 made the referral system less generous; help that fellow-household members could clearly provide to each other was henceforth deducted from the number of hours of professional home-care allocated [7,8]. The responsibility for providing household help was transferred from central to local government in 2007. The underlying idea was that this would bring the organisation of care closer to the recipients and make it easier to find tailor-made solutions. The government employs a variety of incentives in a bid to bring about a change in behaviour and encourage citizens to take more responsibility for organising the help they need [9]. The Netherlands is thus now pursuing policy that is comparable with several European countries where decentralised local authorities are responsible for the provision of long-term care (e.g. Denmark, Sweden and France) and wide use is made of informal care (e.g. Germany and Southern Europe). The purpose of this study is to find an answer to the question whether changes in Dutch policy formalized in this range of measures are related to changes in the use of home-care over recent year..

1.1. Model for home-care use

Use of care is determined by a person's health, but their personal situation and the accessibility of care also play a role. The widely used Behavioural Model of Health Services Use for determinants of care use identifies three groups of determinants: societal determinants (such as cultural values, economic developments) and health service-systems determinants at the macro-level, both influencing individual determinants (micro-level). This third group can in turn be subdivided into three categories: in addition to illness level and the care need that derives from it, they are predisposing factors and enabling factors [10–12]. Predisposing factors such as age, gender and ethnicity are fixed and influence the use of care regardless of the person's health status. For example, advanced age can be a reason for making use of community-based care, and it is known that women make more use of health care than men [13,14]. Predisposing factors may also be associated with the onset of health problems, and are to some extent therefore also indirectly related to care use [15]. Enabling factors mainly determine the accessibility of care. They may be factors relating to the applicant for care, such as their financial situation and the presence of other people in the household. We also consider education level as an enabling factor, because people with a high education level may be more able to find and organise the support they need than people with a low education level. Also the degree of urbanization may determine whether health care is available and accessible.

These determinants are also used in models to forecast care use in the Netherlands [16]. Although there are several refinements of the Behavioural Model of Health Services

Use published [11], we use the original model as a robust framework to underline the types of determinants that are used in our study. Changes in policy governing the access criteria to care can lead to changes in the degree to which the three groups of individual determinants (illness level, predisposing factors and enabling factors) influence the use of care.

The central question addressed in this study is whether the degree in which determinants attribute to home-care use changed recently; and whether the changed care use is in line with changes in policy (such as higher co-payments for those on higher incomes and stricter rules applying for a 'usual care') over this period. If the latter proves to be the case, this would have led to changes in the relative importance of determinants for access to home care, with the effect of enabling factors, such as income, becoming stronger. In this study we were able to link survey data from population studies on health to integrated data on care use and income obtained from the Central Administration Office (CAK) and the Dutch tax authorities for the period 2004–2011. That makes this study unique.

2. Method

2.1. Data sources

For this study we used data published by the Central Administration Office (CAK) which were linked to survey data from annual cross-sectional population studies on health and care and data on income provided by the Dutch tax authorities. The CAK, which implements the financial aspects of the care system such as collecting co-payments, has data available starting from the year 2004. The most recent population survey to which we had access dated from 2011. The introduction of the Wmo in 2005, bringing in major reforms in long-term community-based care, thus falls in the middle of this period. That makes our data highly suited to studying developments in care use before, during and after this change. The CAK data only contain care data for people aged 18 years and older, and we therefore limited our study to adults. Table 1 summarises the available data sources that were linked and the number of respondents in the population survey.

2.2. Care use

In this study, we take care use to mean use of community-based care in the form of nursing, personal care and household help, provided in kind by a home-care organisation to the independent community-dwelling population. Whether or not someone uses care was determined on the basis of the CAK data.

2.3. Predisposing factors

The personal characteristics studied as determinants of care use were age, sex, origin and education. As we were also interested in measuring changes in subgroups, we divided age into six categories: 18–29 years; 30–69 years; 70–74 years; 75–79 years; 80–84 years; and 85 years and older. As care use is much higher among those aged

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