論　　文

Increasing the Sustainability of Long-term Care in an Ageing Society: Lessons from the Netherlands [*]

By Frederik T. SCHUT[**]

Abstract

The provision and financing of affordable and high-quality long-term care (LTC) to a rapidly ageing population is a major challenge for many countries. This is particularly true for Japan, which is faced with the largest share of elderly people, and the Netherlands, which has the most comprehensive and expensive public LTC insurance scheme. This paper analyzes the challenges for a sustainable provision and financing of LTC in the Netherlands and discusses which strategies are employed to meet these challenges.

JEL Classification Codes: H51, I13, I18

Keywords: Ageing population, Long-term care, Public LTC insurance

[*] This research was conducted as a part of the Economic and Social Research Institute (ESRI) International Collaboration Project 2019-2020. I would like to thank the participants of the online ESRI conference from 20-22 January 2021 for their useful comments on my presentation of this paper.

[**] Erasmus School of Health Policy & Management, Erasmus University Rotterdam, The Netherlands.

1. Introduction

Most countries with advanced economies are faced with rapid ageing populations, which has far-reaching implications for economic growth, labor markets, the provision of care, and the sustainability of public finances (OECD 2019). A challenging question in these countries is how to provide affordable and high-quality long-term care (LTC) to a growing elderly population, given the constraints on labor supply and public financial resources (Costa-Font et al. 2017). This challenge particularly holds for Japan, having the largest share of elderly people now and in the future, and for the Netherlands, having the most comprehensive and expensive public LTC insurance scheme. For Japan the main challenge may be how to guarantee future LTC provision, whereas for the Netherlands the main challenge may be how to finance this. This paper describes how the Dutch public LTC system is organized and financed, and discusses the strategies employed to increase its sustainability.

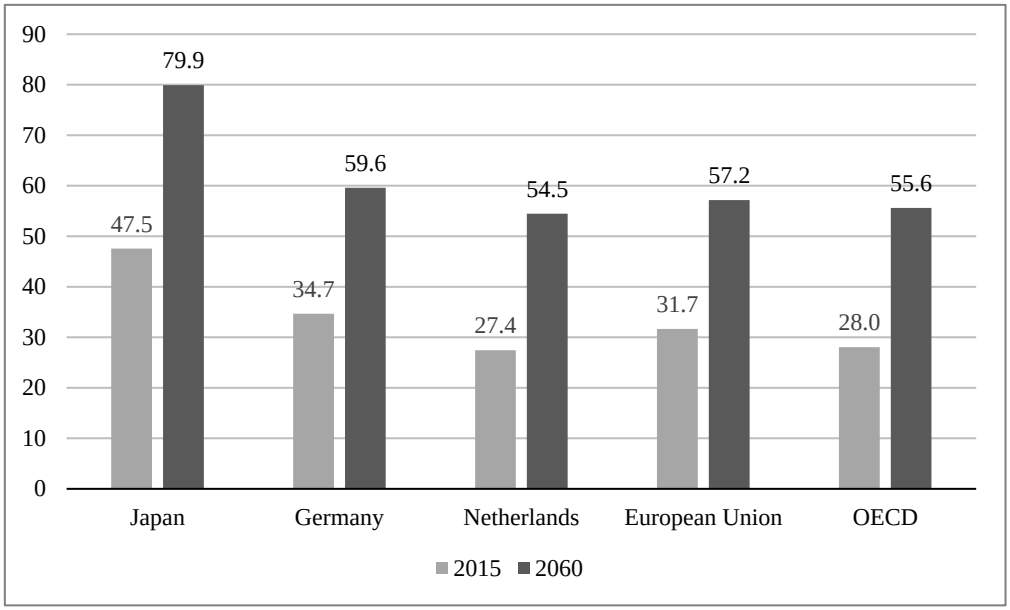
The paper is organized as follows. First, the main challenges for a sustainable provision and financing of LTC are discussed, highlighting why these are particularly relevant for both Japan and the Netherlands. Next, the main features of the Dutch LTC system and its performance are explained. In the following section, the main strategies to cope with the future challenges are discussed. The final section concludes and discusses potential implications for other countries.

2. Challenges for sustainable LTC provision and finance

While the ageing population is the most important threat for a sustainable provision and financing of future LTC (Eggink et al. 2017), this threat is accompanied with several other challenges (Colombo et al. 2011, Costa-Font et al. 2017). First, due to the success of treating acute health problems, the prevalence of chronic diseases (e.g. dementia) is increasing. For instance, in the Netherlands, this is projected to account for about 10% of the annual growth of LTC use over the period 2014-2030 (Eggink et al. 2017). Second, due to increasing welfare, future elderly people are likely to have higher preferences and expectations about the quality of LTC, which is likely to boost demand for LTC even further. Third, for several reasons the supply of informal care is declining. Families get smaller and are becoming more dispersed geographically, while family ties are loosening. In addition, female labor market participation is increasing, and the age cohort of 45-65 years, being most involved in informal caregiving, is shrinking. As illustrated in Figure 1, the old-age dependency ratio is almost doubling in many countries and is becoming particularly high in Japan.

In sum, while the demand for LTC is increasing, the supply from traditional informal caregivers is likely to decrease. This will may result in higher prices and LTC expenses and may jeopardize access to adequate LTC.

Figure 1 Projected changes in old-age dependency ratios
(people over 65 as percentage share of people 20-64 years) from 2015 to 2060



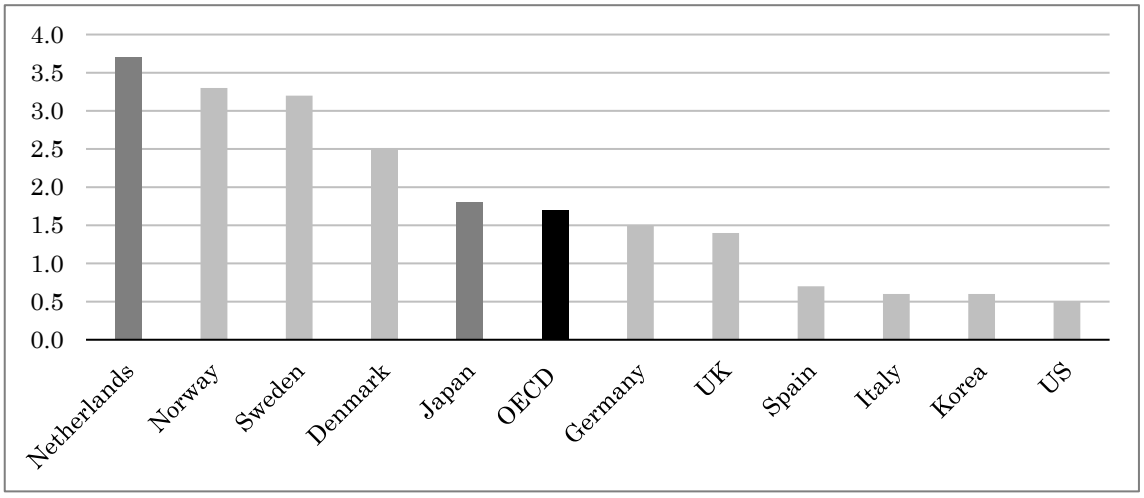
Sources: OECD (2019) http://www.oecd.org/economy/ageing-inclusive-growth/; Statistics Netherlands (2020), https://opendata.cbs.nl/statline/#/CBS/nl/dataset/84872NED/table?ts=1613473267709, World Bank (2019), https://data.worldbank.org/indicator/SP.POP.DPND.OL?locations=NL

Finally, since the productivity growth in LTC provision typically is far below overall productivity growth, the share of GDP spent on LTC is likely to increase as a result of Baumol's cost disease (Baumol 1993). As pointed out by Baumol, service sectors like healthcare and education tend to become relatively more expensive over time, because productivity growth in these sectors lags behind average productivity growth in the economy. If wages in these sectors are raising at the same rate as in the entire economy and demand is price inelastic, the share of GDP spent on these services will increase. This observation particularly holds for LTC, as the scope for productivity growth is limited because this is a very labor-intensive sector in which the quality is largely determined by the amount of personal care and attention. For instance, in the Netherlands the average annual productivity growth over the period 1972-2010 was about 1.8% for the entire economy, whereas this growth rate was only 0.2% in LTC (Wouterse and Smid 2017). The implication of Baumol's cost disease is that an increasing share of welfare growth in societies will be consumed by a increasing LTC expenditures. As the demand for LTC will substantially grow due to an rapidly ageing population, the impact of Baumol's cost disease is likely to increase too.

3. The Dutch LTC system and its recent reform

In 1968, the Netherlands was the first country in the world to introduce a universal mandatory LTC insurance scheme (abbreviated as AWBZ). Initially, this public insurance scheme covered primarily institutional care, but in due course coverage was expanded by including home health care, ambulatory mental health care and residential care for the elderly (Alders and Schut 2020). Contributions and co-payments were earmarked and income-related and collected in a national insurance fund, from which providers were paid. In 1995 cash benefits were introduced that can be substituted for service benefits. In 2015 a major reform of the Dutch LTC system was implemented, by which the coverage of the public LTCi scheme was restricted to institutionalized care and intensive, round-the-clock home health care (Maarse and Jeurissen 2016, Alders and Schut 2019a). Coverage of personal care at home was transferred to the social health insurance scheme, while municipalities became responsible for providing social LTC services (social assistance and support with activities of daily living). Despite this major reform, a large share of LTC services are still paid from public resources (Maarse and Jeurissen 2016), and the Netherlands remains top of the league in terms of the share of GDP spent on publicly financed LTC (see Figure 2).

Figure 2 Public long-term care expenditure (health and social components), as a percentage share of GDP, 2017 (or nearest year)*



*OECD: average of 17 OECD countries
Source: OECD Health Statistics 2020

Together with the Scandinavian countries (Norway, Sweden, Denmark), the public coverage of LTC services in the Netherlands is the most universal and comprehensive worldwide. In these countries the provision of LTC is perceived as a public responsibility and the emphasis is on providing

formal care, while there are only weak legal obligations for the family and relatives to provide informal care (Colombo et al. 2011, Alders and Schut 2020). In countries with less comprehensive and more targeted universal schemes, like Japan and Germany, the responsibility for taking care of the elderly is shared between the state and the family (Colombo et al. 2011, Ikegami 2019). In contrast to the Dutch and Scandinavian countries, Mediterranean countries, like Italy and Spain, but also the UK and the US primarily rely on informal care and private financing of LTC.

The high public expenditures on LTC in the Netherlands has resulted in good and equal access to formal LTC irrespective of income (Bakx et al. 2015, Duell et al. 2017) and even in a pro poor concentration of nursing home use (Tenand et al. 2020). Furthermore, relative to most other countries the Dutch LTC system is typified by a high use of formal and institutional care, limited waiting times and limited variation in service and quality of care (Alders et al. 2015; Bakx et al. 2015; Alders and Schut 2019b). Due the relatively strong reliance on formal and institutional care, a negative impact of informal caregiving on the labor market and tax revenues, which is observed in other countries (Geyer et al. 2017), seems to be largely absent in the Netherlands (Rellstab et al. 2020). Nevertheless, the projected increase in LTC demand as result of the ageing population is expected to result in growing labor market tensions and waiting times for institutional care in the decades to come (Alders and Schut 2019b).

4. Strategies to increase the sustainability of LTC in the Netherlands

The high public LTC expenditures and the rapidly ageing population made Dutch policymakers increasingly worried about the fiscal sustainability of the generous public LTCi scheme. The call for cost containment became stronger, especially since the severe economic recession (2008-2012), resulting in an intensifying societal debate on shifting the public responsibility for the provision of LTC partly to the citizens and their families and social network. Eventually, in 2015 this resulted in a major LTC reform and a transfer of home health care and social LTC (social support and assistance) from the public LTC insurance scheme to health insurers and municipalities (Maarse and Jeurissen 2016, Alders and Schut 2019a).

Several strategies are being employed to strengthen the sustainability of the reformed LTC system. A first strategy is to encourage home care arrangements (or ageing-in place) by: (i) abolishing co-payments for home healthcare (i.e. personal care offered by district nurses); (ii) raising the eligibility threshold for institutional care (since 2013 restricted to people with high “care severity levels”); and (iii) investing in home adaptations, assisted living facilities, and in innovative semi-independent residential care facilities (Diepstraten et al. 2020, Commissie Toekomst zorg thuiswonende ouderen 2020). Although encouraging home healthcare arrangements seems a straightforward strategy to reduce future LTC expenses, recent empirical evidence shows that this may not always be true, partic-

ularly for frail people who are at risk to encounter health problems when staying at home (Bakx et al. 2020a). For these people institutional care may prevent hospitalizations and therefore may be at least as cost-effective as home healthcare.

A second strategy implemented to improve the sustainability of the LTC system is to encourage informal caregiving by: (i) legislating that people's social network are primarily responsible for providing social support, so that municipalities are only responsible to offer support if people's own network is not able to provide this; (ii) supporting caregivers by subsidies, respite care, care leave and flexible work hours; and (iii) various cash benefit programs for care recipients who prefer to arrange formal or informal care by themselves.

A third strategy is to put buyers (contractors) of LTC at risk for providing LTC to their customers. Prior to the 2015 LTC reform only the national government was at risk for providing LTC (Alders and Schut 2019a, Bakx et al. 2020b). Regional purchasing offices were responsible for distributing the budget set by the national government by negotiating prices and volumes of care with providers, but these buyers were not at risk and therefore had no financial incentives to contract the most efficient LTC providers. By transferring home healthcare benefits to the health insurance scheme, which is carried out by risk bearing health insurers, and by transferring the responsibility of providing social LTC to municipalities, which receive a fixed general budget from the government, the government aimed to increase the incentives for contracting efficient LTC providers. A caveat of this strategy, however, is that health insurers and municipalities also have incentives to shift risk to the public LTC insurance scheme, by encouraging people who need a lot of home healthcare or social support to apply for institutional care or round-the-clock home healthcare covered by the public LTC insurance (Alders and Schut 2019a). This may counteract the policy aim to encourage ageing-in-place.

A fourth strategy that should increase the sustainability of the LTC system is to provide more financial incentives for prevention, coordination, quality and efficiency by the introduction of integrated outcome-based provider payments (Bakx et al. 2020b).

Instead of paying per hour, several large home healthcare providers and health insurers have concluded monthly prices, which are often accompanied with specific agreements about improving quality and innovation. Health care professionals report that these monthly payments offer more room for providing tailor-made care resulting in higher job satisfaction (Bakx et al. 2020b). The Dutch Healthcare Authority recently published a plan for a gradual transformation of the payment system for home healthcare from payment per hour towards outcome-based payment per period adjusted for patient profiles that has to be gradually implemented from 2022 to 2027 (NZa 2020). The caveat here is that the development of adequate client profiles and reliable and relevant outcome indicators is still in its infancy. For this reason, a five year experimental period (2022-2027) is foreseen for the development and gradual implementation of the new payment system.

Although each of these four strategies makes sense, their implementation is far from straightfor-

ward and may involve risks of being counterproductive if not appropriately implemented. At present, the financial incentives for payers, providers and care recipients are not yet well-aligned (Alders and Schut 2019a, Bakx et al. 2020b). Hence, it is still too early to evaluate whether these strategies can effectively increase the sustainability of the Dutch LTC system.

5. Conclusion and discussion

In view of a rapidly ageing society, many countries face the challenge how provide and finance good quality and affordable long-term care to the growing elderly population. The point of departure in the various countries, however, is strikingly different, as there is wide variation in the extent to which LTC is publicly provided and financed. At one side of the spectrum countries like Norway, Sweden and the Netherlands have a universal and very comprehensive publicly financed LTC system, while at the other side countries like Italy and Spain primarily rely on informal care and private financing. In between these two extremes are countries like Japan and Germany, with universal but less comprehensive and more targeted LTC systems. The way LTC systems are organized and financed may reflect the past and prevailing social norms and cultural values in a country and appears to be path dependent (Alders et a. 2015; Ikegami 2019; Alders and Schut 2020).

Despite the different social norms and cultural values and the related differences in point of departure, however, countries face a common challenge of an ageing society, which may induce a convergence of the various LTC systems (Colombo et al. 2011). In countries with comprehensive universal coverage of LTC concerns about fiscal sustainability may result in restricting the eligibility for publicly financed LTC benefits. For instance, in the Netherlands the eligibility criteria for nursing home admission have been substantially restricted, and co-payments for institutional care have been made partly dependent on people's wealth in addition to income. On the other hand, in countries primarily relying on informal care, concerns about the sustainability of the provision of LTC due to a shrinking labor force and an increasing old-age dependency ratio, may urge policy makers to expand the public coverage of formal LTC. During the past two decades, Germany, Japan and Korea already moved in this direction.

In addition to adapting the eligibility and comprehensiveness of public LTC benefits, countries may adopt many other strategies to increase the sustainability of the provision and financing of future LTC. Given the common challenge of population ageing, the strategies employed in various countries may be useful in different contexts as well. Therefore, careful monitoring and evaluating the success of these strategies may provide useful lessons to all countries faced with an ageing society.

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