Long term care in the Netherlands:
The state, the market and the family

Bernard van den Berg
bernard.vandenberg@york.ac.uk

THE UNIVERSITY of York

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International health & long term care reforms

Do long-term care reforms fundamentally differ from health care reforms?

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Dynamics of international health reforms

- Guaranteeing universal access to medical care *(Cutler, 2002)*
  - Public insurance
  - Taxation
  - Target at low incomes
- A price of universal access is increasing costs *(Cutler, 2002)*
  - Moral hazard
  - Lack of supply side incentives for cost containment
  - Technological progress
- Co-payments/deductibles might not be effective in terms of avoiding cost increases because of supplier-induced demand *(Maynard, 1999; Van Dijk et al., 2013)*
- Introduction of various types of competition to incentivise health care provider to control cost/increase quality
- Determining insurance coverage based on incremental cost-effectiveness ratios might accelerate the cost increases *(Gafni & Birch, 2003)*

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Types of competition in health & long term care

- Individual purchasing of care (personal budgets)
  - Freedom of choice & control
  - Better coordinate professional & informal care
- Collective purchasing of care
  - Increase market power
  - Reduce information asymmetry between consumer and provider

- Types of competition
  - Competition in contracting between health care providers and competing purchasers of healthcare (insurers)
  - Competition in contracting between health care providers and non-competing purchasers of healthcare (local governments/GPs)
  - Price and/or quality competition
- Competition based on price and/or quality

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The Dutch LTC *(& health)* insurance system in a nutshell

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Background public LTC insurance

- 1968: Netherlands first country worldwide to introduce universal mandatory LTC insurance *(AWBZ)*
- 1994-1995: Germany introduced public LTC insurance
- 2000: Japan introduced public LTC insurance
- 1965: US Medicare does not cover LTC
- What about tax based systems?

Source: Schut & Van den Berg, 2010

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Dutch public LTC insurance

Increasingly comprehensive LTC coverage

- Initially:
  - Nursing home care
  - Institutionalized care for the mentally handicapped
  - Hospital admissions exceeding one year
- Expansion over time:
  - Home health care (1980)
  - Mental health care (in 1982)
  - Family care (1989)
  - Residential care for the elderly (1997)

Source: Schut & Van den Berg, 2010

Funding of public LTC insurance

Sources of funding	Payments in billion euro	Share of total payments
Income-related contributions	13,1	68%
Co-payments	1,7	9%
State subsidy (from general taxation)	4,6	24%
Total	19,3	100%

Mandatory for entire population (16 million inhabitants)

Income-related contributions
2008: 12.15% of taxable income (income threshold: 31,589 euro per year)

Income-related co-payments
(max 1800 euro per month for institutional care)

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Reasons for universal LTC insurance

- Financing LTC was highly fragmented and could not provide sufficient access to LTC services
- Growing demand for LTC services
- Strong economic growth during the 1960s
- No substantial demand for private LTC insurance

- Expanding social insurance for curative services was no option since it covered only 65% of population
  - No universal access
  - To broaden the funding basis to higher income groups

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Universal coverage & access to LTC

- Legal entitlements defined by 6 “functional categories”
- Administered by “regional care offices”, mandated by health insurers
- Needs assessment by national, independent organization (CIZ)
- For non-institutional care: choice between “service benefits” and “cash benefits” (personal care budgets)

Entitlements: 6 functional categories

1. ***Personal care**:* e.g. help with taking a shower, bed baths, dressing, shaving, skin care, going to the toilet, eating and drinking.
2. ***Nursing:*** e.g. dressing wounds, giving injections, advising on how to cope with illness, showing clients how to self-inject
3. ***Supportive guidance:*** e.g. helping the client organize his/her day and manage his/her life better, as well as day-care or provision of daytime activities
4. ***Activating guidance:*** e.g. talking to the client to help him modify his behavior or learn new forms of behavior in cases where behavioral or psychological problems exist
5. ***Treatment:*** e.g. care in connection with an ailment, such as serious absent mindedness
6. ***Accommodation:*** institutional care

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Main groups of LTC-insurance beneficiaries

Type of long-term care user*	Number	Share of total number	Expenditure (billion euro)	Share of total expenditure
Elderly and chronically ill	360,000	69%	11,4	65%
Mentally handicapped persons	100,000	19%	4,6	26%
Physically handicapped persons	15,000	3%	0,5	3%
Chronic psychiatric patients	50,000	9%	1,1	6%
Total	525,000	100%	17,6	100%

*** Excluding about 90,000 LTC-users with a personal care budget (expenditure 1,3 billion euro)**

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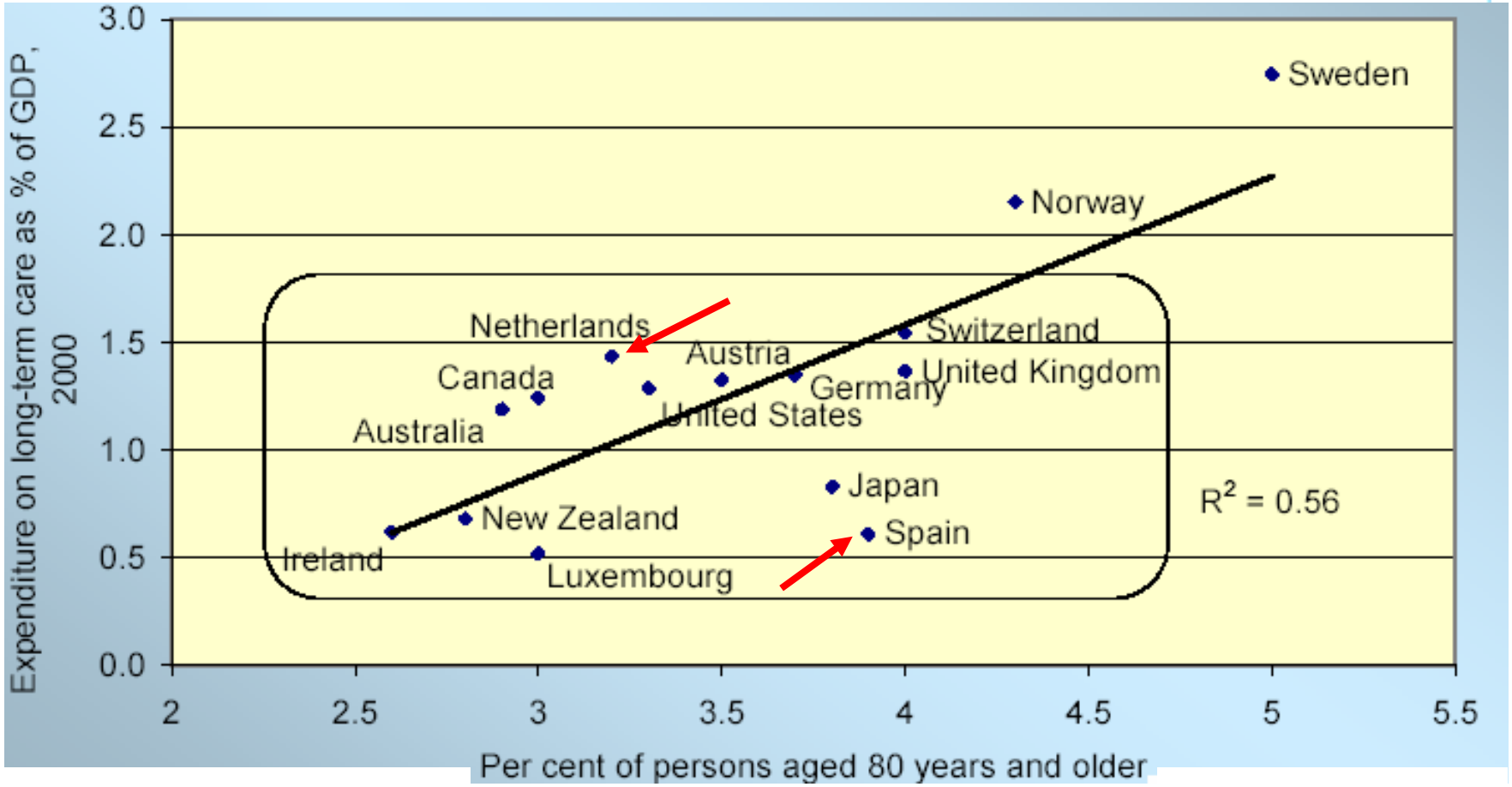
Opportunity costs of comprehensive LTC coverage?

Cross-country correlation between ageing and LTC-expenditure*



*** Narrow LTC definition: mainly primarily elderly care**

Source: **OECD 2005**

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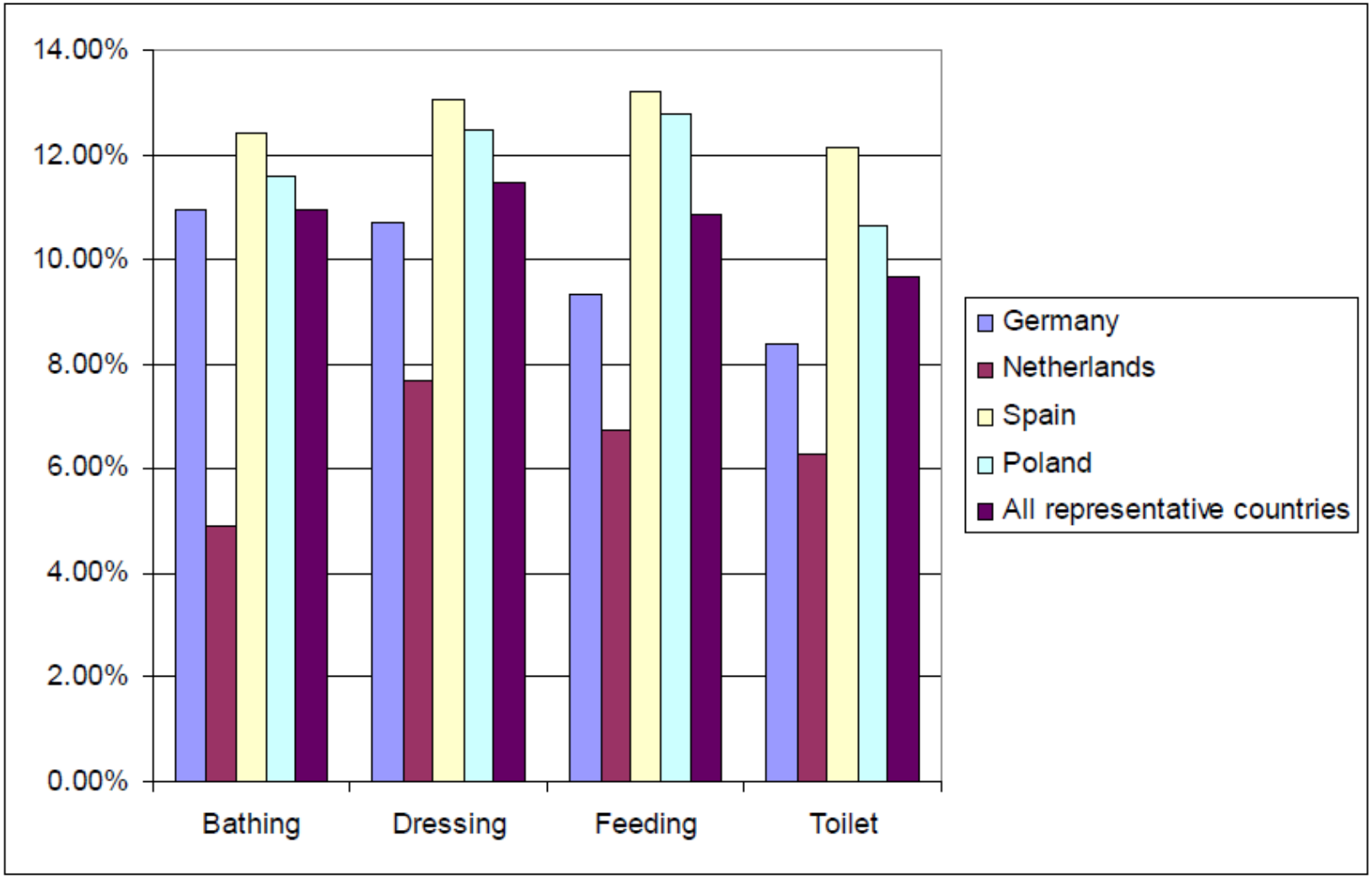
Informal care supply in Europe



Source: Pickard, 2011

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Opportunity costs of comprehensive LTC coverage

- Universal and generous public insurance facilitated strong growth of LTC-services and public LTC-expenditure
- It might have crowded out informal care supply
- Informal care might have been changed from “doing to caring”
- Result: high LTC expenditure relative to the age composition of the population (about OECD average)

Policy response: cost containment

Cost containment policies

- To control the growth of LTC expenditure cost containment policies were introduced in the 1980s
  - Regulation of supply (building license)
  - Tight budgeting of LTC-providers

- As a result, the proportion of GDP spent on LTC remained more or less stable around 3.5% from 1985 – 1995
- Economic growth 1995 less tight budgets

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Opportunity costs of cost containment

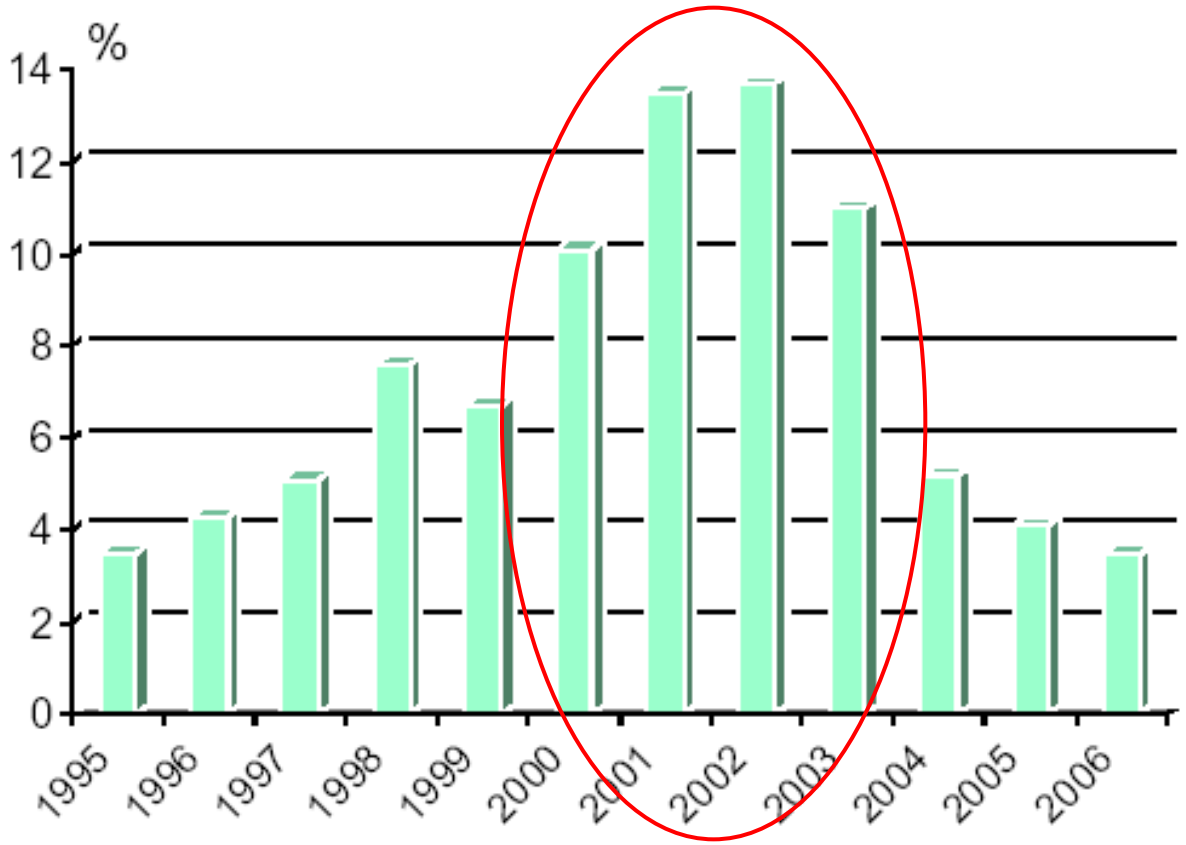
Radical change in LTC policy in 2000

- In 2000 radical policy change from tight budget controls toward retrospective reimbursement
- Reasons:
  - Increasing waiting lists
  - Growing public dissatisfaction about quality and inflexibility of public LTC services
  - Court decisions that waiting lists were in conflict with “right to care” following from the entitlements of public LTC insurance

Effects of radical policy change, 2000-2003

Main effects:

- Waiting lists decrease
- Cost “explosion” 2000-2003



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In 2004: return to cost control policies

Policy measures to control fast increasing public LTC expenditure since 2004:

- Introduction of regional budgets for LTC based on past regional expenditure
- LTC-providers have to negotiate budgets with regional care offices within regional budget constraints
- Increasing co-payments, particularly for home health care

The 2006/2007 reforms of long-term care and medical care in the Netherlands

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Types of competition in health & long term care

- Collective purchasing of care by insurer (health care) or local government (LTC)
  - Increase market power
  - Reduce information asymmetry between consumer and provider
- Introducing various types of competition (incentive based health care reforms)
  - Competition in contracting between health care providers and competing purchasers of healthcare (insurers)
  - Competition in contracting between health care providers and non-competing purchasers of healthcare (local governments/GPs)
  - Price and/or quality competition

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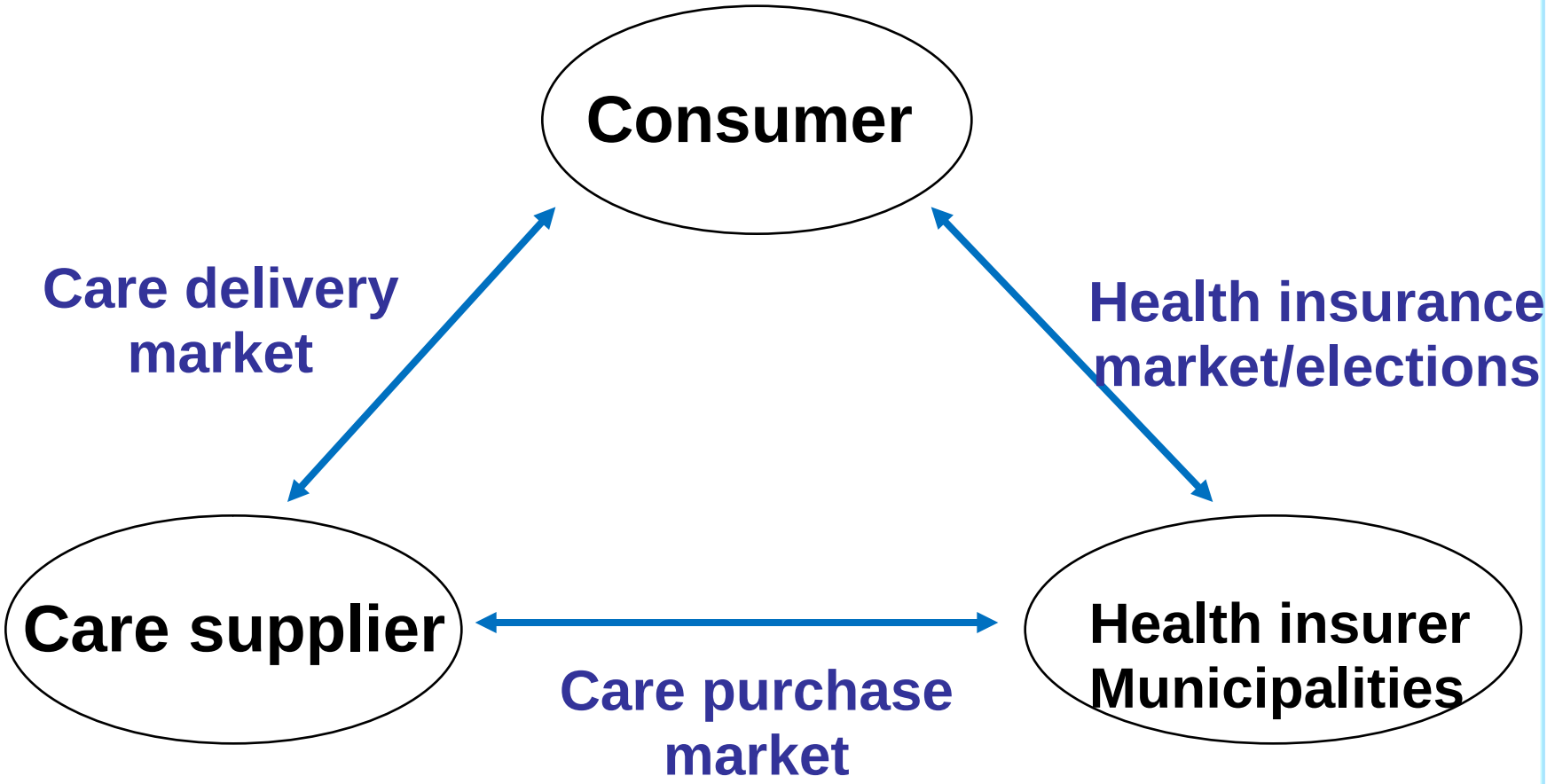
Types of competition



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Long-term care reform proposal of 2013

- Long term care insurance covers only institutional LTC
- Institutional LTC split housing from care
- Savings/home owners selling their house *(please note not big market for second houses in the Netherlands due to strict regulation rental market)*
- Long term home care responsibility of local governments (not insurance based)
- Compulsory informal care

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Conclusions

- Having comprehensive public LTC insurance might crowd out supply of informal care
- Increasing insurance coverage increases costs & challenges sustainability of public LTC insurance
- Fragmented financing might involve incentives to shift costs
- Need assessment & upcoding
- During all stages no supply/demand private LTC insurance
- How to determine what to fund by public LTC insurance?

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Conclusions

- From the Dutch experience can be taken that health economics concepts could be used to inform policy to support them to avoid making the same mistake over and over again
- Fundamentally: which type of competition involves which incentives for providers to contain costs and/or improve quality and fits on which “market”?
- Incentives for labour saving technological innovations in LTC?

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Discussion