Long-term care in the Netherlands: budget cuts and restrictions

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Public long-term care insurance

Picture: Igna Bonfrer (PhD thesis 2015)
Long-term care expenditures are mostly public
Unemployment rate is up

Source: CBS
GDP declined

GDP in billion euro (2013 prices)

Source: CPB
Public expenditures went down, too

Source: CBS 1,2

Public expenditures
(in billions; 2013 euros)
Public finance deficit

Sustainability gap (CPB 2014):

<table>
<thead>
<tr>
<th>Year</th>
<th>% of GDP</th>
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<tbody>
<tr>
<td>2010</td>
<td>-4.5</td>
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<tr>
<td>2014</td>
<td>0.4</td>
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</table>
Health care spending stabilized

Total health care expenditures per capita in euro (national definition, 2013 price level)

Source: CBS 1, 2
Long-term care spending

Expenditures on long-term care for the elderly
(in billions; 2013 prices)

Source: CBS 1, 2
Public long-term care insurance

• In contrast to other countries, relatively few demand-side restrictions (Bakx et al. 2015 J HSR P);

• Supply-side restrictions proved to be a bad match with the legal entitlement to care.
Reforms 2007-2016

• Limit legal entitlement to care;
• Intensify demand-side measures;

• In addition, ageing in place policies.
Non-medical LTC: end of legal entitlement

• Coverage for domestic care, support and assistance through the Social Support Act
• Municipalities organize care
• Financed through block grants from the national government
• Expenditures decreased on average – but much there is much variation
Medical home care

• Personal care and nursing have been covered through the Health Insurance Act since 2015.

• A shift from incentivizing the patient to incentivizing the insurer
Health Insurance Act

• No centralized eligibility assessment; no co-payments.

• Instead, health insurers compete for enrollees
• Insurers now have incentives to ensure elderly receive the right mix of home care and health care
• But insurers also have incentives to encourage home care users to move a nursing home.
2013: co-payments increased

• Differentially affected the rich and the poor;
• Revenues from co-payments increased by 33% for home care; 11% for institutional care (CBS 2015);
• But no evidence of large behavioral response.
Centralized eligibility assessment was not very restrictive
Ageing in place

Share of elderly aged 80 and over receiving institutional care

Source: CBS
Ageing in place

- Higher co-payments for institutional care (2013);
- Stricter eligibility criteria for institutional care (2014, 2015);
- Incentives for insurers and municipalities to encourage home care users to move to a nursing home.
Conclusion

• LTC expenditures grew until 2012 but growth has been limited thereafter;
• Reforms likely contributed to this;
• Demographic changes may have helped too, but their contribution between 2000 and 2008 was limited (De Meijer et al. 2015 Health Econ).
Conclusion

• No evidence of the impact on
  – the health and well-being of the elderly;
  – on the utility derived from being insured against the risk of high expenditures late in life.
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