# Three aspects of the Dutch experience with financing aged care

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The report of the Royal Commission into Aged Care Quality and Safety on how to finance aged care in Australia highlights a comprehensive list of options. As the Commission points out, some of these options have been implemented and pretty much all of them have been discussed in other countries as well. The discussion about the financing and organization of aged care in the Netherlands has been ongoing and in the meantime several reforms have been enacted. In this submission, I highlight three aspects of the Dutch experience with aged care financing that may help to better understand some of the features of the options discussed in the Royal Commission's report.

## Predicting aged care expenditures far ahead is difficult

The report mentions several options that involve a form pre-funding, either through explicit pre-funding or setting a premium that is stable over time and thus not only pays for current spending but also generates earmarked savings to pay for future spending increases. Both options require predicting aged care expenditures far into the future. This prediction is difficult, not only for an individual but also for a birth cohort. Section two emphasizes that population ageing will cause an increase in the demand for aged care and while population ageing is indeed a major driver of aged care spending, it is by far not the only one, as also pointed out in the Commission's Background Paper 2: "Medium- and long-term pressures on the system: the changing demographics and dynamics of aged care".

While demographic trends may be predicted with a fair amount of certainty, the other factors are much more unpredictable and have a large impact. For example, institutional care use decreased in the period 2000-2008 in the Netherlands, while a forecast for this period that was based solely on demographic and health characteristics would have predicted a large increase in admissions.[1] On the contrary, in recent years aged expenditures have increased considerably faster than would have been predicted based on demographic changes alone.[2] The same is true for longer periods: much of the growth of health care expenditures in the past 40 years in the Netherlands is not a direct consequence of demographic changes but instead caused by other factors.[3]

This uncertainty means that the amount saved may be much larger or smaller than the amount that is needed. Hence, for any form of pre-funding a major question that needs to be answered is: who bears the remaining risk; the government, individuals or another party?

## The value of insurance

Insurance of aged care expenditures creates value. It enables individuals to use care that they might need but that they could not afford without insurance: aged care is expensive and up to 90% of the Dutch elderly would be in relative income poverty after paying for aged care without public insurance.[4,5] In addition, insurance generates value as it creates financial certainty about one's future. It reduces the need for large precautionary savings and means that people may spend this money on other things during their life.

Public insurance is comprehensive in the Netherlands. Yet, there remains some financial risk as people need to pay co-payments when they move to a nursing home. Even as these financial risks are limited, research shows that changes in the co-payments would have consequences for the welfare that are equivalent to giving up a considerable share of income, especially for the poor.[6] This finding supports the idea that insurance generates value as it creates financial certainty.

Moreover, comprehensive insurance reduces the demand for informal care and thus limits the risk for relatives of an older person have that they may have to reduce their work hours to free up time to provide informal care. Indeed, in the Netherlands children of older persons may combine caregiving and a paid job after a hospitalization and this is likely at least in part a consequence of comprehensive public insurance.[7]

These benefits have implications for the appropriate design of aged care financing. They mean that co-payments – and other types of incomplete insurance coverage – lower the value of the program because of by the financial uncertainty they create, not just for current users but also for anyone who may be a prospective user. This value needs to be taken into account when considering different financing options and deciding about how comprehensive the insurance coverage is. And when deciding about the design of the co-payments or the implementation of a means test: this matters a great deal for the value that is generated by reducing the uncertainty for subgroups in the population.

**Managed competition among private insurers requires adequate risk equalization**

Medical care, which also covers nursing and personal care provided at home, is organized and financed through the universal public health insurance scheme in the Netherlands. The financing and contracting of care are entrusted to competing private insurers under a system called managed competition. People have an annual free choice of health plans. Enrolment in a health insurance plan is mandatory and health insurers must charge the same premium to all enrollees. Furthermore, health insurers are required to accept all applicants.

Health insurers compete through their premium and through the quality of their service and the providers that they contract. They are at risk for the expenditures of their enrollees. Health insurers are private entities (publicly owned companies or mutual insurance company) that currently are not allowed to pay out dividends. If managed competition works well, the incentives that it generates for insurers and providers may help to improve health care. However, insurers and providers may also engage in wasteful activities such as risk selection, underprovision of care and quality skimping if the incentives are not set right. Whether the potential benefits outweigh the potential costs depends on the context: the types of health care expenditures that are insured, the information that is available for individuals, insurers and providers and how well the incentives may be managed by the national government.[8]

One of the questions is how to set the insurance premiums. To ensure that insurers have proper incentives to ensure high-quality aged care for their enrollees, a system of risk equalization payments must compensate for the higher expected expenditures of enrollees who may need aged care: if these enrollees cause a predictable loss, insurers may try to discourage this group from enrolling by contracting a limited amount – or low-quality – aged care. In the Netherlands, these risk equalization payments come from a national health insurance fund that is financed by income-related contributions. Currently, these risk equalization payments are based on spending on home care in the prior 3 years. While this reduces the expected loss for health insurers, it also limits their incentives for purchasing high-quality home care for a low price because high expenditures are compensated in the next calendar year. To repair this, the risk

adjustment should be based on characteristics that cannot be influenced by insurers rather than on expenditures in the past. However, currently there are no individual-level characteristics that can accurately predict home care expenditures and for which data are available for the full population.

In addition, insurers will only have incentives to organize efficient aged care if potential enrollees have information about quality differences and are willing to shop around. Most of the younger enrollees will not be very interested in getting good coverage for aged care. Hence, having a sufficient share of the oldest old who may switch insurers if they believe that another offers a better deal on aged care insurance is important for encouraging insurers to make an effort.

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[1] De Meijer C et al. 2015. Explaining declining rates of institutional LTC use in the Netherlands: a decomposition approach. Health Economics 24(S1): 18–31.

[2] Statistics Netherlands. 2020. Zorguitgaven stegen in 2019 met 5,2 procent. Link

[3] CPB Netherlands Bureau for Economic Policy Analysis. 2016. Financiering van de zorg op lange termijn. CPB Policy Brief 2016\10

[4] Nyman J. 1999. The value of health insurance: the access motive. Journal of Health Economics 18(2): 141–152.

[5] OECD. 2020. The effectiveness of social protection for long-term care in old age. OECD Health Working Paper 117

[6] Wouterse B et al. 2019. The welfare effects of co-payments in long term care. CPB Discussion Paper 394

[7] Rellstab S. 2020. The kids are alright. Labour market effects of unexpected parental hospitalisations in the Netherlands. Journal of Health Economics

[8] See for a more comprehensive overview e.g. Van de Ven et al. 2013. Preconditions for efficiency and affordability in competitive healthcare markets: Are they fulfilled in Belgium, Germany, Israel, the Netherlands and Switzerland? Health Policy 109(3): 226-245