Peer Review in Social Protection and Social Inclusion and Assessment in Social Inclusion

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The Netherlands 2009

Long-term care:
How to organise affordable, sustainable long-term care given the constraints of collective versus individual agreements and responsibilities

Short Report

On behalf of the
European Commission
DG Employment, Social Affairs and Equal Opportunities

The Peer Review meeting on long-term care policies, to examine how best to organise affordable, sustainable long-term care given the constraints of collective versus individual arrangements and responsibilities, took place in the Hague, the Netherlands, on 10-11 February 2009. The event was held within the framework of the European Commission's Peer Review programme on Social Protection and Social Inclusion, and hosted by the Dutch Ministry of Health, Welfare and Sport.

Representatives from ten peer countries took part: Austria, Belgium, Estonia, Germany, Hungary, Poland, Romania, Slovenia, Sweden and the United Kingdom, together with the host country participants. European stakeholder groups were represented by AGE – the European Older People's Platform, and the EASPD – the European Association of Service Providers. Also present were representatives from the European Commission Directorate-General for Employment, Social Affairs and Equal Opportunities, and the thematic expert from the University of Bremen in Germany.

1. The policy under review

The Netherlands, like many EU countries, is currently confronting the problem of how to keep the growing burden of long-term care affordable. To remain not only affordable but also sustainable, accessible and of good quality, such care must respond to a number of questions:

1. How can a balance be established between collective and individual arrangements and responsibilities? Individuals can be involved in collective arrangements (through co-payments; or personal budgets) while local authorities can help people cope independently with long-term care.

2. Where can the boundaries be drawn between long-term health care and related facilities like subsidised housing or domestic help, so that people are aware of what services they are entitled to and decisions on provision are made in a fair and transparent way?

3. Availability of qualified staff is as important as funding being available. How can the correct balance be achieved between supply and demand, taking account of demographic and labour market factors?

Since the Netherlands is currently undertaking a public debate about the future of the long-term care system in challenging times, the government considered it important to reflect, compare and exchange views with other EU Member States.

The review focused on the Dutch system of care for people suffering serious long-term illness or disorders, under the 1967 Exceptional Medical Expenses Act (AWBZ). The Netherlands has a population of 17 million, with an average life expectancy of 78 years. Some 3.6% of the Dutch population qualifies for long-term care (588,000 people). The AWBZ is a national insurance scheme. Everyone who meets the criteria spelled out in the legislation is automatically insured and obliged to pay the statutory contribution, irrespective of whether they plan to use the services. The scheme is funded by these premiums, by the state subsidy, and by personal (co-payment) contributions from care recipients.

The insurance pays for institutional care (nursing homes/elderly homes), or home care for frail elderly, disabled people and people with chronic psychiatric disorders. Within the Netherlands' legal care framework there are two other instruments: the Healthcare Insurance Act (ZVW)

covering medical services, and the Social Support Act (WMO), for services run by local authorities.

Since 1968 the cost of the AWBZ, and therefore of premiums, has increased enormously, due in large part to demographic changes and a growing number of older people requiring long-term care: people are living longer, while a falling birth-rate leads to an ageing population. An individual on an average income now pays €320 a month towards the AWBZ. The question of sustainability is a crucial one. Changes now under way aim to redefine the types of care people are entitled to, and make the system more efficient. These measures are expected to save €800 billion by 2010. However, the cost of the Exceptional Medical Expenses Act will still increase by 3%. Expenditure is likely to rise from €21 billion in 2008 to €23 billion in 2012.

2. The key issues

The discussion focused on three sub themes:

1. Finding a balance between collective and individual arrangements;
2. Setting boundaries between the long-term care system and other services;
3. Securing sustainability and sufficient and well-qualified care personnel.

A number of key questions relating to long-term care provision were identified:

- The sustainability of long-term care – how can the growing demand for services be funded?
- Financial constraints and pressures, especially in light of the current financial crisis.
- Assuring a 'crystal clear insurance' policy whereby people know exactly what their entitlements are; offering reliable, trustworthy care.
- How to ensure an adequate supply of care professionals, and a well-trained labour force, improving efficiency and making maximum use of innovations such as information and communication technology.
- How to measure and guarantee the quality of care, including transparency of entitlement, quality indicators, benchmarking, etc.
- Developing client-centred services, relating to health care systems, client-based payment schemes and personal budgets.
- There is no clear and universal definition of long-term care.

3. Lessons, conclusions and recommendations

Labour force

In the Netherlands, projections for the number of care workers required up to the year 2040 varies from 14% of the workforce, to a worst case scenario of 21% of the workforce, influenced by variables such as productivity and working hours. In other countries the time frame differs – not all Member States have problems yet. However, demographic change will lead to increased demand for workers, leading to widespread problems.

It is possible to influence both demand and supply:

- Demand – through prevention, better healthcare, special measures such as the 'reablement' scheme in the UK which helps people to be more self-sufficient in their own homes. Informal care and the voluntary sector also have an important role. Some countries rely heavily on family members doing the care, but family patterns are changing, suggesting challenges in future.
- Supply – raising productivity, getting more people into services and keeping them there. It was generally agreed that care work suffers from an 'image problem' and steps are needed to make it more attractive, especially to young people, through boosting social recognition, career opportunities and pay, and lessening pressure on workers.

A 'brain drain' effect means that care workers trained in some countries (e.g. Romania) often leave to take up better-paid jobs in 'receiving' countries (e.g. Austria), thereby exacerbating shortages in the 'sending' state. New measures could be introduced to encourage people to stay, such as student loans that could be written off once the individual completes a specified period of work in the training country.

Economic crisis

As an additional round in the discussions the question about how the present financial and economic crisis will influence long-term care was debated. There was much diversity of opinion, but most representatives did not have optimistic views. Care has to be paid and when tax- or premium payments decrease, effects will be felt in long-term care as well. Maybe long-term care will encounter these effects later than the commercial sectors of economy. It was noted, however, that the current economic crisis might have a beneficial effect as well on care work by attracting people who are no longer employed in other sectors.

Public/private financing

It was agreed that there is no one-size-fits-all solution. However, there was consensus in favour of universal coverage and equal access, opposition to two-tier arrangements, and in the direction of forms of social insurance. Another option is tax-financing. However social insurance gives greater protection against service cuts, for example during periods of recession.

The meeting took the overall view that private insurance cannot be the backbone of the system: if it is risk-related it excludes universal care provision, and if it is compulsory it thereby becomes a form of social insurance.

Means-testing is adopted in some countries but rejected in others.

Setting boundaries

On this topic, debate focused less on how to control budgets in specific areas (healthcare, social care etc.) and more on how to erode boundaries that obstruct integrated care. Participants also warned of the danger of health care taking precedence over and attracting funds away from long-term care if the care services were integrated.

There was a lot of interest in the Dutch scheme of 'personal budgets' (PBs), whereby individuals receive a specific allowance (independently assessed) and can use it on the services they choose. Practices vary in different countries. For example in the Netherlands, family members can be paid for services, in some other countries this was forbidden.

A considerable number of participants believed PBs offer a way forward in controlling costs while at the same time giving clients more autonomy. However, important questions remain: who can receive payments? Should payments be restricted to trained carers? How does society control the system? And most of all, how can quality of service be measured and guaranteed?

Informal network

On the suggestion of the host country it was agreed that those who attended this Peer Review would form an informal network to inform one another about major effects of the economic crisis for long-term care in their own countries.