Financing long-term care for the elderly in the Netherlands and Japan

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1 Introduction

In many developed countries, expenditure on long-term care for the elderly is a matter of great concern due to the ageing of the population. The Netherlands was the first country that introduced a universal mandatory social health insurance scheme (AWBZ) for covering a broad range of long-term care (LTC) services. The Dutch population is relatively young, but expenditure on LTC is high due to relatively comprehensive coverage of LTC in the Netherlands.

The growth of public spending on health and long-term care in the Netherlands has been quite successfully limited until 2000 through cost containment policies. These policies acted essentially through the rationing of supply, wage moderation, price controls and postponement of investment in long-term care facilities (Schut and van den Berg, 2012). In view of rising consumer expectations about the quality and quantity of LTC services, such reform attempt has been taken to increase incentives for efficiency and consumer direction in the LTC system in the Netherlands.

Public LTC Insurance has been implemented since 2000 in Japan, following the German model. The main beneficiaries of the Japanese LTC Insurance are the elderly aged 65 or over, and LTC expenditure has increased quite rapidly. Ageing of the population in Japan will be most serious among developed countries, and how to control the total expenditures of health (medical) and LTC for the elderly is a formidable challenge for Japan.

The main aims of this paper are (1) to describe the basic features of the long-term care for the elderly in both countries (Section 2), (2) to compare both countries using OECD Health Data as well as to describe actual situations in Japan using Japanese data on health and LTC (Section 3), and (3) to discuss which system is more effective and efficient (Section 4). We are quite interested in such questions as high expenditure on long-term care for the elderly in the Netherlands is effective, what factors are contributing towards efficiency of the system, and the system is sustainable in view of the ageing of the population and the expected increase in demand for LTC services.

In this paper, we focus on the long-term care for the elderly, although a more comprehensive definition is used in the Dutch AWBZ system, including also care for the mentally and physically handicapped and care for chronic psychiatric patients.

2 Basic features of the long-term care systems in the Netherlands and Japan

(1) The Netherlands (Note 1)

Public long-term care insurance called the Exceptional Medical Expenses Act (AWBZ)

was introduced in 1968 in the Netherlands. Initially, the AWBZ covered primarily nursing home care, institutionalized care for the mentally handicapped, and hospital admissions lasting more than a year. In due course, however, coverage was expanded. Every citizen older than 15 years of age with a taxable income has to pay an income-related contribution to the AWBZ. In addition, for most long-term care services covered by the AWBZ income-related co-payments are required. The Netherlands is divided into 32 care regions, and in each region a single health insurer (known as a "regional care office") carries out the AWBZ on behalf of all health insurers for all residents living in that region. Regional care offices receive a fixed budget for the administrative tasks. Neither regional care offices nor individual health insurers are at risk for long term expenses covered by the AWBZ scheme. Since 2005, the Centre for Needs Assessment (CIZ) is responsible for the needs assessment, to make needs assessment more objective and uniform.

The percentage of GDP spent on long-term services covered by AWBZ increased from 0.8 percent in 1968 to 2.0 percent in 1980 and further to 4.0 percent in 2005. Part of this increase, however, is due to an expansion of AWBZ coverage. Taking into account the expansion of AWBZ coverage, the expenditure on long-term care services as a percentage of GDP has been quite constant over a considerable period of time. The main reason for the limited growth of public spending on long-term care has been the implementation of cost-containment policies such as supply regulation and budgetary restrictions. In 2005, the government reinstated budgetary controls by imposing regional budgets for each of the 32 regions. Regional care offices were made responsible for the allocation of these budgets and had to negotiate with regional providers about prices and maximum output levels.

In 2003, the definition of entitlements was radically changed into seven broad functional care categories. In 2007, one of these categories – domiciliary care – was excluded from coverage and transferred to the responsibility of the municipalities under a new Social Support Act (WMO). In 2009, two functional categories – supportive and activating guidance – were combined into a single category, "guidance." At the same time, guidance that is aimed at social participation was excluded from coverage and brought under the scope of the WMO.

Except for the functional category, "accommodation," clients who are entitled to care have a choice of receiving care "in kind" or in the form of a *personal care budget* (or a combination of both). Personal care budgets were introduced in 1995 as a small scale experiment to provide consumers with the option to buy and organize their own home health services instead of using "in kind" services contracted by the regional care offices. Since 1995, the personal care budget scheme has been significantly expanded both in scope and expenditure. The rapid expansion of personal care budgets was an effective way to encourage the provision of informal care. The personal care budget is set at about 75 percent of the average cost of care provided "in kind" because the personal care budget can

be spent on informal care which is expected to be less expensive than professional formal care.

Informal care is a crucial part of long-term care all over the world. In the Netherlands, informal care plays a relatively minor role, partly due to the relatively generous coverage of professional formal LTC services. However, the majority of home care is provided by informal caregivers also in the Netherlands. The role of informal care was increased by restricting the possibilities to substitute professional for informal care. Since 2003, strict protocols were developed regarding needs assessments taking into account the potential amount of informal care the care recipient's social network could provide.

In 2008 "care-severity packages" (ZZPs) had been developed for inpatient care (Note 2), which was phased in to determine the budgets for inpatient care long-term care facilities (i.e. nursing homes, elderly homes, institutions for mentally and physically handicapped and mental care institutions).

(2) Japan

Elderly care services had been provided primarily through the tax-based social welfare system, which is targeted to the low-income elderly or those without families in Japan. Even if eligible for this public support, many individuals were reluctant to rely on this program. Therefore, the burden of care giving fell on the informal sector, primarily on females such as daughters-in-laws and elderly wives. There had also been frequent use of hospitals instead of long-term care facilities because the accessibility to the latter is limited, and the medically oriented services are readily accessible to the elderly in Japan. Those elderly who stayed in hospitals much longer than medically appropriate were called "social hospitalization," an induced stay in hospitals caused by social reasons.

Rapid ageing of the population caused by a significant decrease in fertility rate has been increasing the demand for formal long-term care services. Financial and psychological burdens of family members who care for the elderly within the household had become unbearably large. In the mid-1990s, long-term care for the frail elderly became one of the highest priority issues in Japan. Various approaches including a tax-based approach and a public insurance approach were examined (Note 3), and newly implemented public care insurance in Germany in 1995 had a strong influence on the discussions in Japan. The Long-term Care Insurance Act was finally passed in the Diet in November 1997, and implemented in April 2000. The principles underlying this new program are the universality of coverage (although benefits are available mainly for the elderly), financing through social insurance (although the public fund finances 45 percent of the cost), freedom of choice by service users, and reliance on a service market. The main purposes of the program are to divide the burden of caring for the elderly among all members of the society and to lessen the burden upon family caregivers.

Table 1 shows a summary of the Japanese Long-term Care (LTC) Insurance in comparison with the German system. The insured are divided into two categories: persons aged 65 or older (Category 1), and persons aged 40 to 64 years old who are subscribers of health insurance (Category 2). Benefits are available after care need assessment for all in Category 1, but only those who suffer from age-induced illness for Category 2.

Table 1 Long-term Care Insurance in Japan and Germany

	Japan (since April 2000)	Germany (since 1996)
Insurer	Municipality	Care Funds
Insured	Persons aged 65 or older (Category 1), and perons aged 40 to 64 years old and subsribers of health insurance (Category 2)	All subscribers of health insurance
Contribution (rate)	Category 1: about 5,000 yen per month on average Category 2 Health Insurance Association: 1.55%	1.95% (+ 0.25 % if childless)
Financial source	User charge: 10% Government subsidy: 50% of LTC benefits Contribution: 50% of LTC benefits (21% by Category 1)	Contribution: 100%
Beneficiaries	All Category 1 after care assessment + those Category 2 who suffer from age-induced illness (exceptional), both after care assessment.	All insured and their family who need long-term care of middle or above level.
Care assessment	Municipal committee	MDK (Medizinische Dienst der Krankenversicherung)
Care (Case) management	since April 2000	since July 2008
Insurance benefits	Benefit in kind only. Home care services: Frail 1 2 Level 1 2 3 4 5 Facility-based services: Skilled nursing facilities Health service facilities for the elderly Skilled nursing wings of geriatric hospitals	Benefit in kind or in cash or in conbination. Home care services: Level I II III Facility-based services: Level I II III
Expenditure	Expenditure: 1.6 % of GDP in 2010	Expenditure: 0.8 % of GDP in 2009
Responsible authority	Municipality	Provincial Government

Care need assessment is done by each municipal committee, and beneficiaries are classified into one of seven levels of care needs according to their physical and mental functioning. The income and family situation of the elderly are not considered in determining the level of care needs. Home care services include personal care, home aid services, respite care for caregivers, day care services, visiting nurse care, rehabilitation at home or a day care center, and group homes for people with dementia. A care management

approach has been adopted and a care service plan is to be prepared for each beneficiary. Facility-based services are provided at skilled nursing facilities, health service facilities for the elderly (primarily for rehabilitation), and skilled nursing wings of geriatric hospitals. So-called "hotel costs" (eating and accommodation) were eliminated from the benefit catalogue of the LTC Insurance in 2005.

The program is financed through a combination of contributions, government subsidies, and user charges. Service users must pay 10 percent of expenses, although there is an upper ceiling for this user charge. Apart from user charges, a half of the benefits are financed by insurance contributions and the other half by the public tax revenues. For Category 1, the level of contribution is determined by each municipality, and thus differs depending on facilities and services available and the take-up rate of insured persons within the municipality. However, it is income-related, and there are some measures to reduce the contribution for low-income persons. The average monthly contribution is 5,000 yen for Category 1. For institutional care, the beneficiary also pays for meals based on the average amount consumed by the elderly at home (23 thousand yen per month). The total long-term care expenditure was 7.4 trillion yen in 2010 (1.6 percent of GDP), and 97 percent of them were spent for Category 1 insured (namely aged 65 or older).

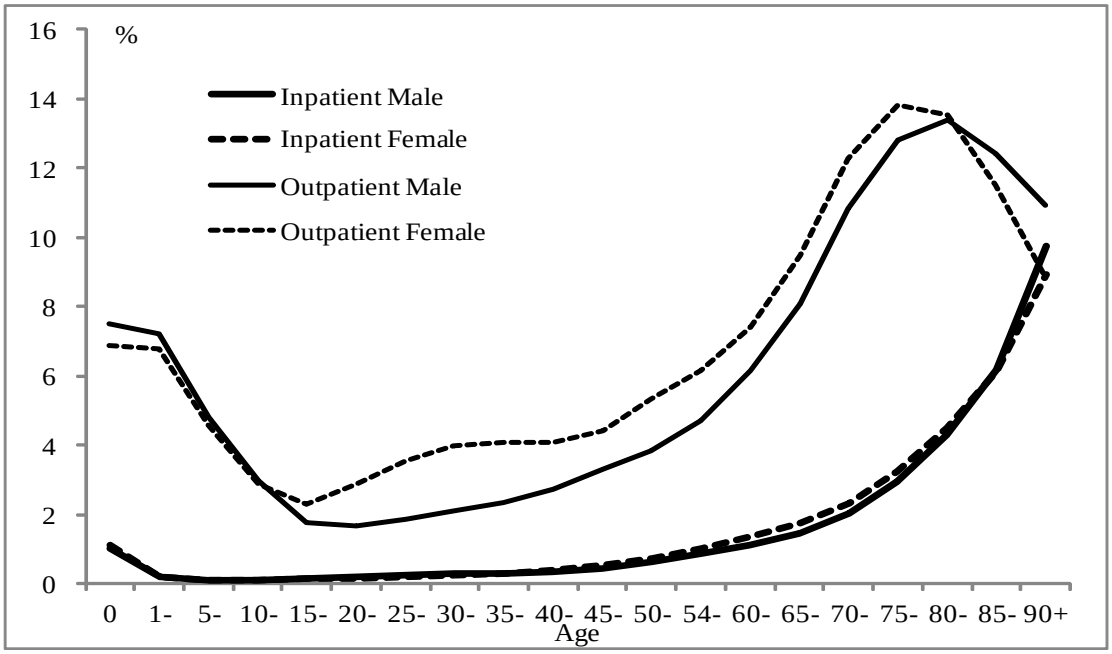
The Japanese system was influenced strongly by the German system, and there are many similarities between the two systems. However, there are several important differences between the two: a) Main beneficiaries in the Japanese system are those aged 65 and over; b) Cash options are not available in the Japanese system; c) Low care need level is also included in the benefit catalogue in Japan; and d) Regional differences are allowed to leave the management of the system to each municipality's discretion.

3 Comparison of health and Elderly LTC expenditures in Japan and the Netherlands

(1) Actual situations in Japan using national data

Fig.1 shows the patient rate for inpatient services as well as outpatient services by age group and sex in 2011. Patient rate for outpatient services decreases after age 75 or 80, but patient rate for inpatient services increases remarkably after around these ages, and for age group 90+, both patient rates are around 10 percent.

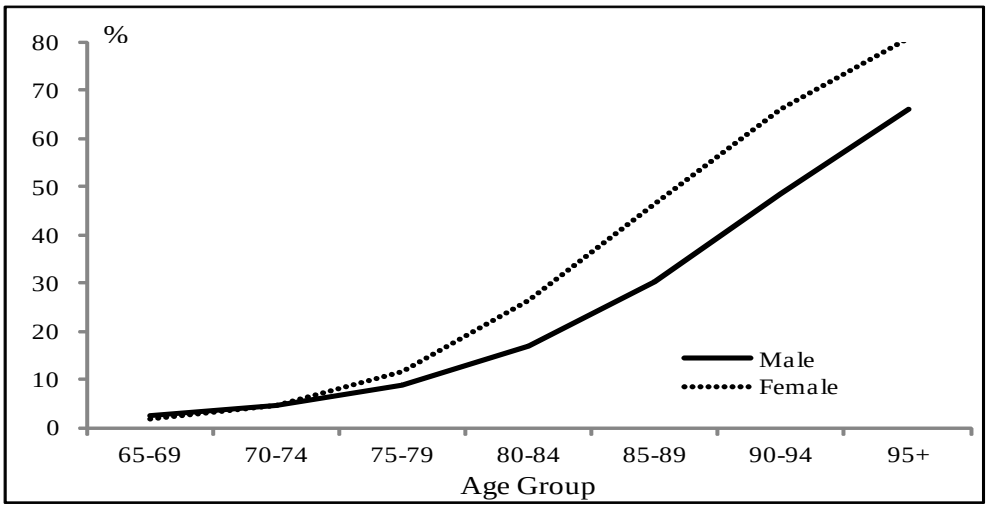
Fig 1 Patient rate by age group and sex: 2011



Source:Ministry of Health, Laboue and Welfare, Patient survey 2011.

Quite contrary to medical services, the percentage of LTC beneficiaries among the elderly population shows a much steeper increase according to age increase. More than half of those elderly aged 90 or over for males and aged 85 or over for females received LTC services in Japan in 2011 (Fig.2).

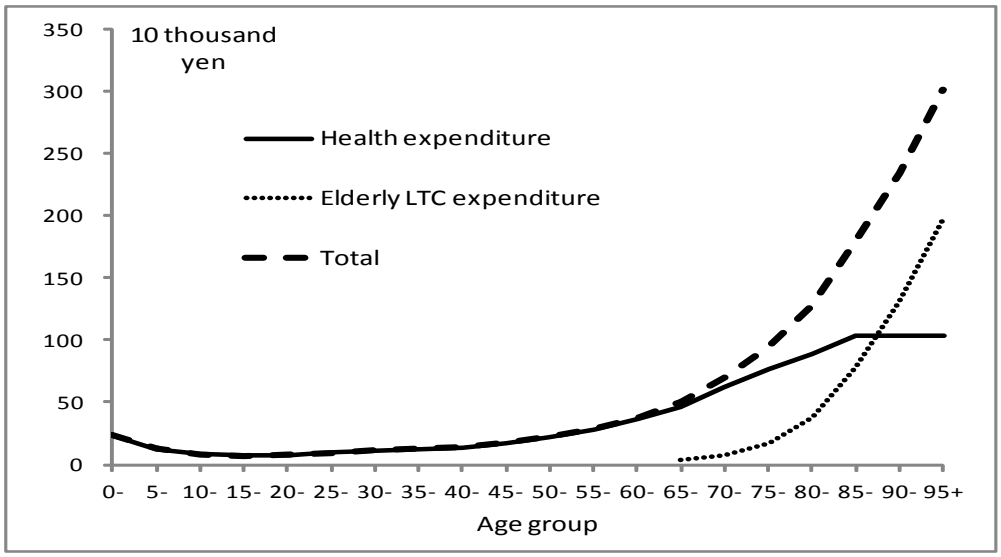
Fig.2 Percentage of LTC beneficiaries among elderly populaion by age group and sex in Japan: 2011



Source: Ministry of Health, Labour and Welfare, LTC Benefit Survey FY2011.

Fig.3 shows per capita health expenditure as well as per capita elderly LTC expenditure by age group in 2010. For ages 65 or over population, LTC expenditure is about one-third of health expenditure. However, for ages 90 or over population, LTC expenditure is greater than health expenditure. Therefore, it is necessary to control LTC expenditure in order to control the total expenditure as shown in Fig.3.

Figure 3 Per capita health expenditure and elderly LTC expenditure by age group in Japan: 2010



Source: Ministry of Health, Laboue and Welfare.

(2) Comparison of health and Elderly LTC expenditures using OECD Health Data

Table 2 shows basic indices related to the LTC services in seven countries. While ageing of the population is common in all six countries, Japan will experience the most serious ageing rate of about 40 percent in 2050 due to its very low fertility rate and its long life expectancy. General government liabilities as well as tax revenue as percent of GDP are key factors to see government ability to support LTC services. With respect to government liabilities, Sweden is the least with less than 50 percent of GDP, and the Netherlands is second lowest with 81 percent, Japan is the largest with more than 200 percent. Regarding annual tax revenue, the order is reversed, with Sweden collecting the most at 46 percent of GDP in tax, and Japan the least at 27 percent. LTC expenditure for the elderly was around 1 percent of GDP in 2005 for five countries, but it was higher in the Netherlands (1.7 percent) and in Sweden (3.3 percent). As LTC expenditure for the elderly is strongly correlated to the ageing of the population, a large increase is expected between now and year 2050 for all countries except for Sweden (Table 2). Therefore, how to finance LTC services for the elderly is a big concern in all seven countries. The relation between health expenditure for the elderly, which is not shown in the table, and LTC expenditure for the elderly is of great concern as well.

Table 2 Comparison of population, health expenditure and long-term care expenditure for the elderly in seven countries

		France	Germany	Japan	NL	Sweden	UK	USA
Total population (million)	2010	62.6	81.9	127.5	16.5	9.4	61.3	309.1
	2050	70.0	74.4	95.2	16.8	10.5	77.0	439.0
Ageing rate (%)	2011	16.8	20.7	23.3	15.6	19.3	16.2	13.1
	2050	24.9	30.9	38.8	26.4	24.6	23.6	21.2
Life expectancy at birth (both sex, year)	2010	81.3	80.5	83.0	80.8	81.5	80.6	78.7
Genaral govern. liabilities (% of GDP)	2012	105.5	88.5	214.1	81.0	48.0	104.2	108.6
Tax revenue (% of GDP)	2010	42.9	36.3	26.9	38.2	45.8	35.0	24.8
Total health expenditure (% of GDP) a	2010	11.6	11.6	9.5	12.0	9.6	9.6	17.6
Elderly LTC expend. (% of GDP) b	2005	1.1	1.0	0.9	1.7	3.3	1.1	0.9
	2050	2.0-2.8	2.2-2.9	2.4-3.1	2.9-3.7	3.4-4.3	2.1-3.0	1.8-2.7

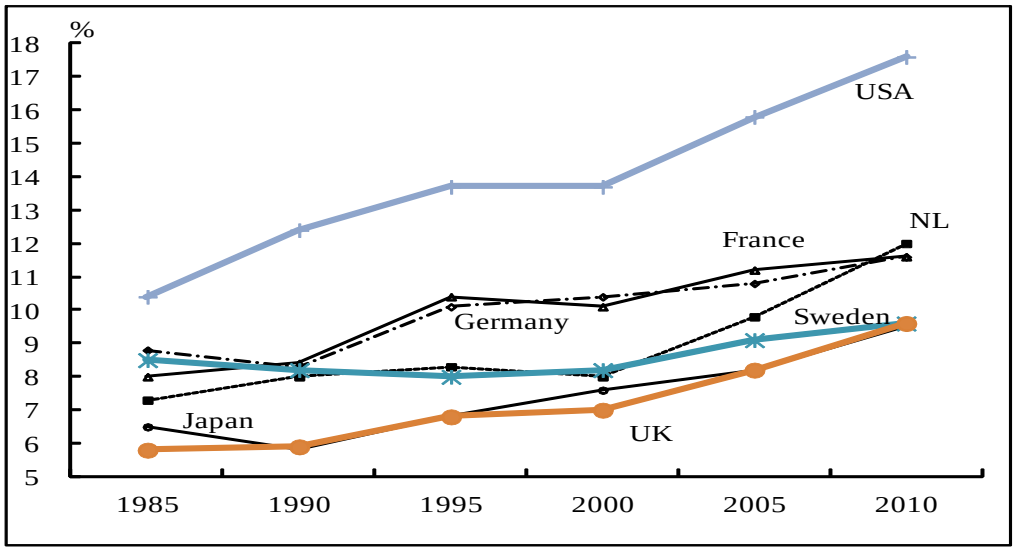
Note a: OECD (2012) OECD Health Data 2012.

b: OECD (2006) Projecting OECD Health and Long-Term Care Expenditures, ECO/WKP(2006).

Sources: OECD

Fig. 4 shows historical trends of total health expenditure as percent of GDP in seven countries. Total health expenditure in the Netherlands had been stable in the 1990s, but it increased from 8 percent in 2000 to 12 percent in 2010. Total health expenditure in the UK used to be the lowest, but in 2010 Japanese total health expenditure (9.5 percent) became the lowest according to OECD Health Data.

Fig. 4 Total health expenditure as percent of GDP: 1985-2010



Source : OECD Health Data 2012

Table 3 shows the break down of the total health expenditure by service provider in Japan and the Netherlands (total does not correspond with Table 2). From this table, it is clear that some institutional LTC expenditure is included in the total health expenditure, and the difference in health expenditure between the two countries comes mostly from hospital care and nursing & residential care.

Table 3 Breake down of health expenditure in Japan and the Netherlands

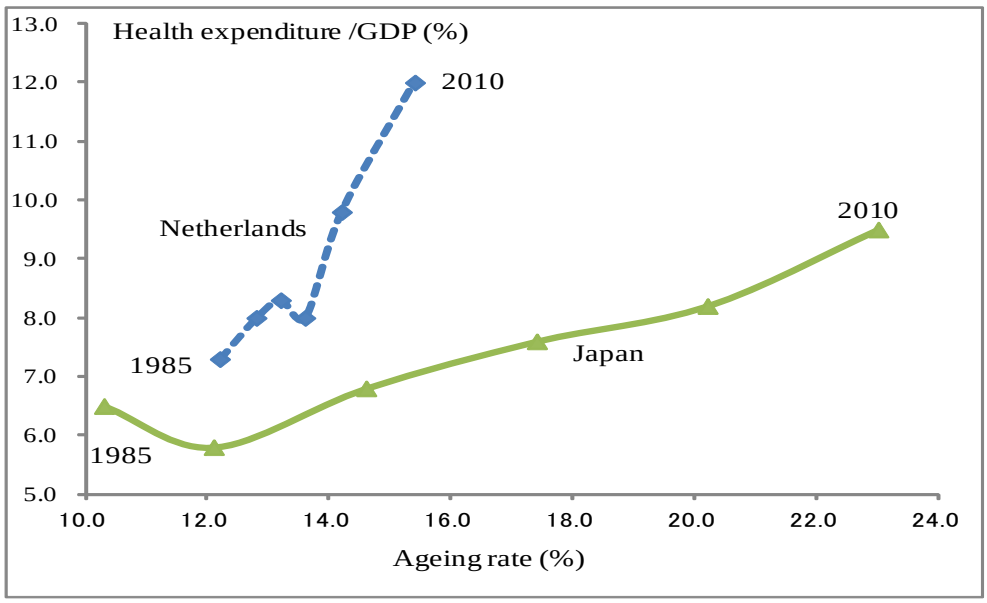
(In % of GDP)

	Japan (2009)	the Netherlands (2010)
Hospital	4.5	3.9
Nursing & residential care	0.3	2.6
Ambulatory care	2.5	2.2
Medical goods	1.6	1.5
Public health	0.2	0.1
Administration	0.2	0.5
Other industries	0.0	0.3
Rest of the world	0.0	0.1
Total	9.3	11.2

Source: OECD (2012) OECD Health Data 2012.

Fig. 5 shows how the ageing rate influenced the total health expenditure in Japan and the Netherlands. The ageing process is quite remarkable in Japan, with a relatively mild increase in health expenditure. Compared to Japan, increase in health expenditure in the Netherlands between 2000 and 2010 is quite remarkable.

Figure 5 Ageing rate (X Axis) and total health expenditure/GDP (Y Axis) in Japan and the Netherlands: 1985-2010

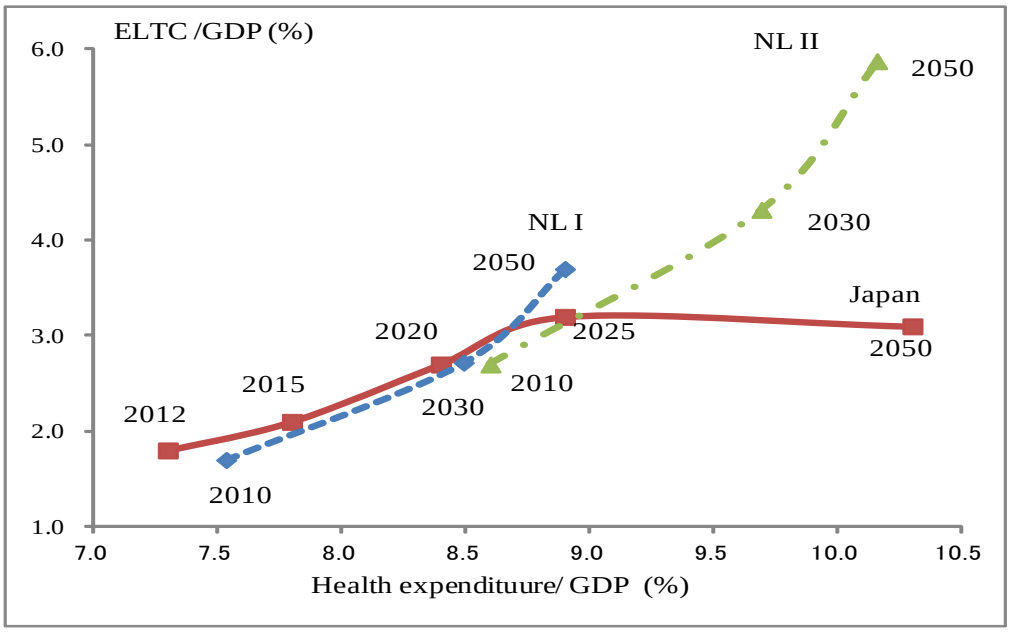


Source: OECD Health Data 2012.

(3) Future health and elderly LTC expenditures in Japan and the Netherlands

Future expenditures on health and long-term care depend on a number of factors. In March 2012, the Japanese Ministry of Health, Labour and Welfare made a projection on future social security benefits as a percentage of GDP for 2015, 2020, 2025 and 2050. The results of health expenditure and elderly LTC expenditure are shown in Fig. 6. Concerning corresponding data for the Netherlands, we quote from Oliveira Martins et al. (2006), which focused on public health and elderly LTC expenditures in 2050 for 30 OECD countries. The middle results for 2010, 2030 and 2050 are shown as NL I in Fig. 6. Based on national data, health expenditure was 8.6 percent of GDP and elderly LTC expenditure was 2.7 percent of GDP in 2010 (Rolden and van der Waal, 2013). Therefore, we add NL II in Fig. 6, adjusting 2010 data of NL I at these levels. Fig. 6 suggests that the Dutch expenditure will continue to be higher than the Japanese despite the lower ageing rate, and that the increase in both health expenditure and elderly LTC expenditure should be controlled in both countries in order to make these systems sustainable for years to come.

Figure 6 Health expenditure (X Axis) and Elderly LTC expenditure (Y Axis) in Japan and the Netherlands: As percent of GDP



Source: MHLW (2012), OECD (2006).

4. Discussions

The main purpose of the introduction of the LTC Insurance in Japan has been to divide the burden of caring for the elderly among all members of the society, but it was also intended to relieve some of the financial pressures on the health expenditure of the elderly, in which long-term stays of the elderly patients in hospitals had been included. Japanese LTC

Insurance is a universal program financed by contribution, public subsidy, and user charge. There is still a significant shortage of institutional and home care services in Japan. There is also a wide variation across municipalities and between urban and rural communities in the amount and quality of service providers in Japan. Besides the concern about the quality of care provided, this kind of regional difference itself may become a big issue in the future. Another contentious issue is whether or not to provide cash benefits for those choosing to care for the elderly by family members.

The Japanese approach is to convert a vertically divided welfare and health care system for the elderly to a coherent system in terms of institutional and domiciliary services and to separate the long-term care from the medical care insurance. This is just the opposite of the Dutch approach. Integrating long-term medical and social cares into a single scheme in the Netherlands would provide incentives and possibilities for a better coordination of care for people with chronic diseases. The transfer of social care benefits from the AWBZ to the WMO would also enhance a better coordination of social care and welfare assistance. The issue here is how to ensure coordination through information sharing and other means.

In the Netherlands, the mandatory insurance scheme for curative services was extended to the entire population in 2006. The new health insurance scheme for curative services, based on the model of managed competition, would provide much stronger incentives for efficiency and to meet consumer preferences. A key element of the managed competition model, which makes it possible to guarantee universal access in a competitive health insurance market, is an adequate system of risk adjustment (Van de Ven and Schut 2008). At present, there are no appropriate risk adjusters available for long-term care and it is even unclear whether adequate risk adjustment is feasible for many of these services (Schut and van den Berg, 2012).

Since the dependency on long-term care increases sharply with age, demographic effects contribute to a substantial increase in LTC expenditures. The future expenditure on elderly LTC are very sensitive to the exact growth of the number of elderly, changes in real prices of long-term care, and trends in dependency among the elderly. The effects of ageing on LTC consumption might be mitigated by a "healthy ageing" process if longevity gains are fully or partially translated in additional years in good health. The correlation across countries between LTC spending and ageing is rather weak (OECD, 2005), therefore the way of organizing and financing LTC plays an important role.

In the Netherlands, supply constraints in the form of regional care budgets are currently imposed, which is a mixture of a *"laissez faire"* policy without supply and demand constraints (as in the period 2000-2003) and the stringent top down rationing policy of the 1990s, relying both on supply constraints and arrangements to improve efficiency by increasing consumer direction and choice (Schut and van den Berg, 2012).

It is quite interesting to know to what extent Dutch personal care budgets are successful

in offering better opportunities to meet consumer preferences than care in kind, and inducing an efficient substitution of informal for formal care. Counteracting the substitution of paid for unpaid informal care was another reason for implementing strict needs assessment protocols that explicitly take into account the amount of informal care the care recipient's social network could provide (Schut and van den Berg, 2012). Personal care budgets were increasingly used by home care providers to escape the imposed budget constraints.

As regional care offices do not have an incentive to allocate the regional budget to the most efficient providers, it seems appropriate to abolish the regional care offices and make individual health insurers responsible for the purchasing and contracting LTC-services on behalf of their insured. However, it is questionable whether the model of managed competition is adequate for the provision and financing of long-term care (Van de Ven and Schut 1994).

Whether a reform will lead to a sustainable financing and more consumer-directed provision of long-term care services crucially depends on the ability to develop a clear-cut definition of entitlements, to improve the accuracy of needs assessment, and to develop appropriate "care-severity packages" as a solid basis for client-based budgeting (Schut and van den Berg, 2012). For adequate client-based budgeting (Note 4), it is crucial that the "care-severity packages" are relatively homogenous in terms of predicted costs as substantial variation involves clear incentives for up-coding and risk selection.

In view of the fact that elderly LTC expenditure is and will be higher in the Netherlands than in Japan, it is interesting to do a precise comparison on utilization and outcome of the LTC services in both countries. Separation of the financing of residing and care has already been implemented in the Japanese system. Reduction of coverage by transferring short-term rehabilitation services to the ZVW and the provision of social care to WMO is instructive in reforming the benefit catalogue of the Japanese LTC Insurance. The Dutch approach to increase incentives for efficiency and consumer direction in the LTC system will be quite relevant for reform discussion in Japan.

(Note 1) This section is based on Schut and van den Berg (2012) and Rolden and van der Waal (2013).

(Note 2) The determination of adequate ZZP capitation payments for outpatient LTC may be more complicated because the need for outpatient care crucially depends on the availability of a social network of informal caregivers, which typically varies substantially across individuals.

(Note 3) Some experts argued for a tax-based system such as in Sweden that would be built on the existing social welfare system. However, the tax-based approach was rejected

because of the stigma attached and the fact that such a financing system would be strongly influenced by the general budget. A private insurance approach was also considered and was rejected because it was not suitable to the culture and values of the Japanese people. The majority of the Japanese people supported the idea of public long-term care insurance, although critics of this approach raised serious concerns about a social insurance approach.
(Note 4) Rather than clients following the money in the provider-based budgeting system, the money should follow the client in the client-based budgeting. Clients would have the option to choose a personal care budget (as in the current system) and to arrange all care by themselves, or to choose among providers contracted by the LTC individual insurers.

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