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Price setting and contracting help to ensure equitable access in the Netherlands

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Context

The Netherlands has a long tradition of public long-term care provision. The Dutch system provides universal access to a wide range of long-term care (LTC) services, which not only include good quality nursing home care, but also extensive home care and social assistance. The extensive coverage comes at a cost; the Netherlands spends 4% of its Gross Domestic Product (GDP) on LTC – more than any other country based on OECD estimates – and this percentage will grow further in the coming decades.

Care is financed by three public schemes: social long-term care insurance (LTCI), social health insurance (SHI), and the Social Support Act. Social LTCI pays for care in nursing homes, SHI pays for nursing and personal care provided at home, and the Social Support Act makes municipalities responsible for organizing and financing assistance and social support for older people living in their community. Each of these public schemes covers the entire population, and enrolment in the social insurance schemes is mandatory. The two social insurance schemes are primarily funded through earmarked insurance premiums, and the Social Support Act is fully financed through general taxation. Cost sharing is relatively low. Private LTCI is virtually absent.

All LTC providers are private. Nursing homes are not-for-profit organizations, and home care providers may be for-profit organizations. In each system, a different payer is responsible for contracting providers.

Key findings

- LTC in the Netherlands is highly accessible, and the distribution is equitable. Co-payments are low and affordable for all income levels. Eligibility for care is based on needs and strong regulation ensures equal access for all. The pricing and contracting help to ensure access. For instance, specific regulations in the Social Support Act require that prices are set such that providers can at least recover their costs, and thus contribute to ensuring sufficient supply. Payments to providers are not related to the co-payments paid by their clients.
- A key characteristic of the Dutch system is the partial delegation of responsibilities. In the three financing schemes, the procurement of care is delegated by the national government to other parties (e.g. regional purchasing offices, health insurers, and municipalities), while the budget is (ultimately) set at the national level. Each scheme differs in the division of financial risk and responsibilities among the national government, the organization that contracts care providers, and private providers. They also differ in the extent and kind of (price) regulation, and the way in which providers are contracted and prices are set.
- Integrated prices play an increasing role in all schemes. Instead of specifying and pricing the exact hours and types of care that must be provided, one price is set for an integrated, broadly defined package of care that suits the health and social needs of the client.

Best practices

- **Equitable access to care** is supported by separating the price setting and contracting from eligibility decisions and the way in which co-payments are set.
- **Integrated pricing** can reduce the administrative burden for providers and enable them to deliver tailor-made care.

Lessons for other settings

- **Decision-making power, incentives and financial risk should be aligned throughout the system.** If the incentives are to achieve system goals and financial risk and decision-making power are delegated, this is best done in tandem across different types of care and to the same organization(s).
- **Ensure that incentives of all agents are not only aligned within one scheme but also across schemes.** Financing LTC through multiple schemes means coordination problems. Even if incentives of all agents are aligned within one scheme, this may not be the case across schemes.
- **Integrated prices give LTC providers the opportunity to tailor care to the needs of their patients.** However, integrated prices alone are not sufficient. Ensuring appropriate care also requires giving care providers the incentives for patient outcomes.
- **Consistently measured quality information is needed to enable the provision of care that is not only equitable and accessible, but also efficient and of high quality.** In addition, for integrated prices for a bundle of activities, several other preconditions must be met to prevent providers from engaging in risk selection, under-provision of care, and quality skimping. Such pre-conditions include appropriate case-mix correction, registration of activities, and communication to care users.

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The WKC and the OECD have produced a report summarizing key findings from nine country case studies on "Pricing long-term care for older persons". The cases represent a range of health care systems and experiences in organizing and financing long-term care (LTC) for older persons. The report identifies best practices and policy lessons, which demonstrate the benefits of investing in quality LTC in the context of ageing populations. The summary report and case studies can be found here: https://extranet.who.int/kobe_centre/en/project-details/pricesetting2