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# Long-term care policy: What the United States can learn from Denmark, Sweden, and the Netherlands

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# **LONG-TERM CARE POLICY: WHAT THE UNITED STATES CAN LEARN FROM DENMARK, SWEDEN, AND THE NETHERLANDS**

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# LONG-TERM CARE POLICY: WHAT THE UNITED STATES CAN LEARN FROM DENMARK, SWEDEN, AND THE NETHERLANDS

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## ABSTRACT

*Paying for long-term care consumes a substantial, and growing, part of the spending on healthcare in the U.S. We examine the components and payment systems for long-term care systems in Denmark, Sweden and the Netherlands to determine what policy makers in the U.S. can learn from these countries about how to improve how long-term care provision and financing in the U.S.*

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## INTRODUCTION

The Organization for Economic Cooperation and Development (OECD) defines Long Term Care (LTC) as a variety of services needed for individuals who require help with basic Activities of Daily Living (ADL) over an extended period of time. ADLs include activities such as bathing, dressing, caring for incontinence, toilet use, and eating (DHHS, 2015). As of the year 2000, there were about 10 million American citizens who required some form of LTC, and of those, about 63% were over age 65 (Rogers and Komisar, 2003). As soon as a U.S. citizen becomes 65 years old, he/she will have a 70% chance of requiring some type of LTC services and supports in their remaining years (Genworth, 2015). This figure is quite alarming, in terms of the future burden on society, considering that in 2010, only about 13% of the U.S. population were over the age of 65, but by 2030, the population aged 65 and over will be 20% of the total population, or one in every five individuals (Colby and Ortman, 2014). This is because people generally, and the Baby Boomers in particular, are living longer: as of 2007, the U.S. citizens age 85 or older represented about four million people, but by 2050, this population is expected to reach 19 million (National Institute on Aging, 2007).

In 2012, the financial cost of LTC in U.S. represented about 10% of the nation's health care spending (O'Shaughnessy, 2014). LTC is provided in a number of ways including (in order of least to most costly): by an unpaid family member or caregiver, by a visiting nurse aide, by an adult daycare, or by personnel in a nursing/assisting living facility (Genworth, 2015).

The Medicare program was never intended nor has it ever paid for the majority of LTC services provided in the U.S.; instead, the vast majority of LTC has been paid for by private individuals unless they qualify for Medicaid or have LTC private insurance (Sultz and Young, 2014). In general, Medicaid recipients will only be entitled for LTC care in a nursing home facility with a low-level of privacy compared to privately paying individuals who often will be provided with an apartment home setting (Spillman, Liu and McGilliard, 2008). The Genworth 2015 Cost of Care Survey estimated the median annual cost of nursing home care (semi-private room) at \$80,300 nationally, and the median cost of assisted living for a one-bedroom apartment was estimated at \$43,200, although these costs vary greatly by state (Genworth, 2015). In order to qualify for Medicaid for LTC in a nursing facility, individuals must be at poverty level and have exhausted all of their personal assets and ability to pay for their care privately (Medicaid.gov, 2015). LTC insurance has been another option to pay for LTC; however, only about 13.8% of U.S. citizens age 60 or older in 2008 had private LTC insurance (Brown and Finkelstein, 2011).

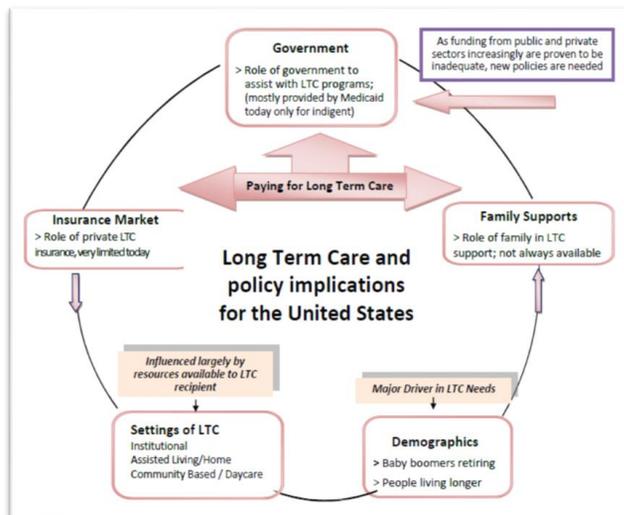
In contrast to the U.S., in many European countries LTC services were more generously covered by public government funded programs. In Sweden and the Netherlands, their governments spent over 3.6% of their Gross Domestic Product (GDP) in 2011 on LTC versus less than 1% of the GDP spent by the U.S during the same year (OECD, 2013a). Denmark, Sweden, and the Netherlands provide LTC coverage, whereby all citizens have the right

to LTC care which is paid for by government-collected tax revenue and/or through a public insurance program (OECD, 2007). The LTC services provided by all three countries include both LTC in a facility-based, at-home, and community-based LTC services (OECD, 2007). In 2012, the percentage of the population aged 65 or older who received LTC in any setting was 19.1% in the Netherlands, 16.7% in Denmark, and 16.3% in Sweden, which was much higher than the OECD 22-country median of 12.2%; and considerably higher than the U.S. which was 6.4% (OECD, 2013b). The purpose of this research study was to examine the LTC policies of select OECD countries which have more developed LTC public programs and to determine if there are tangible lessons for policy makers in the U.S.

## METHODOLOGY

In light of the substantially greater spending on LTC programs in the Netherlands, Sweden, and Denmark the U.S., two important questions are apparent: (1) what types of LTC models in these European countries have been successful, in terms of its citizens having access to LTC services regardless of their ability to pay? and (2) given the expected increase in LTC services needed in the U.S., what lessons can be learned from the experiences of these other countries which have had more universally provided LTC programs? To answer these questions we examined 3 other countries' experience with more extensive public funding of LTC. Denmark, the Netherlands, and Sweden were chosen as comparisons for the following reasons. First, the Netherlands and Sweden spent the most money on LTC programs than any other OECD country, and Denmark's level of public spending on LTC was considerably more than the U.S. but much less than Sweden and the Netherlands. Thus, while all 3 countries provide a higher level of spending on LTC than available in the U.S., taken as a whole they provide a range of LTC spending which was thought to be useful to evaluate the level of effectiveness of the extra spending on LTC.

**Figure 1: Conceptual Research Framework (model adapted from Pocock and Phua, 2011)**



Content adapted from Freundlich (2014)

The methodology for this research was a literature review and an analysis of LTC peer reviewed research as well as a review of data contained in the OECD database. As shown in Figure 1, the study's research conceptual framework provides a basis for which government's leaders make policies to address social LTC issues. The application of this conceptual framework with this study was suitable for several reasons. First, it starts by identifying that there is a growing need for long term care because of the aging of the population and the increase in average life expectancy. Secondly, the model provides a frame of reference for issues relating to LTC funding sources (the government, private insurance companies, and private pay). The conceptual model also highlights the issue that if funding for LTC is not sufficient to meet the country's future demands, some policy changes might be indicated.

The key phrases “long-term care” OR “custodial care” OR “LTC” OR “long-term services and supports” AND “U.S.” OR “OECD Countries” OR “the Netherlands” OR “Sweden” OR “Denmark” AND “policy” OR “programs” OR “public spending” OR “funding” OR “reform” OR “barriers” OR “costs” OR “outcomes” as inclusion criteria to explore scholarly databases for articles. The following databases were used for this research: PubMed, ProQuest, Medline, EBSCO host, Academic Search Premier, Science Direct, Google Scholar and Google. Information from various websites (e.g., the Department of Health and Human Resources, the Center for Diseases Control and Prevention, and OECD) was also included.

Literature was selected for review on the basis of relevance to the study, long-term care and OECD countries’ experience with public policy and use of private sector for meeting the needs. References utilized were limited to those written in English and published between 2002 and 2015 to keep the research current. Only primary and secondary data collected from reports, articles, research studies and reviews were included in this research. References were analyzed and established to have satisfied the inclusion standards if the material yielded accurate knowledge regarding long-term care, with special consideration on other countries’ involvement with policy making around addressing long-term care needs. A total of 65 sources were reviewed. Upon review of the abstracts, only articles determined to be most relevant to the study were categorized and selected. This review resulted in a total of 37 sources used for this study. The literature search was conducted by CS and validated by AC who acted as a second reader and also confirmed that references met the research study inclusion criteria. DP then reviewed, revised and updated the entire manuscript.

## RESULTS

A literature search provided a background on the public and private LTC programs for the three comparative OECD countries of Denmark, Sweden, and the Netherlands.

### Long-Term Care in Denmark

Denmark is a small but relatively prosperous country, with a strong welfare state tradition (CESEP, 2007). It is widely recognized as a leader in care for its elderly population and is often cited as a model by European experts (Stuart and Weinrich, 2001). From a population perspective, personal care is seen primarily as the task of the state, which funds health care services mainly via taxation, however, rent has been charged to citizens using an inpatient service, if they had the ability to pay (WHO, 2003). Important values in the Danish health care system include equity and solidarity (Anell, 2005).

Denmark is by far the leader of all OECD countries in terms of its level of spending on home LTC, with 1.2% of the country’s GDP in 2008 spent on home-based LTC, which was more than half of its overall spending on LTC services (Francesca et al. 2011). The time spent providing long term care assistance in the home, however, was relatively low: as of 2007, around 50% of the over-65 population in Denmark received assistance of only 2 hours per week or less, and only about 13% had received more than 20 hours or more of home care assistance per week (Schulz, 2010).

In the 1980s the Danish government took notice of demographic trends similar to those in the United States currently: the numbers of older people were increasing while the workforce was declining. At the time, the Danes relied mostly on an institutional system of care, primarily nursing homes (Stuart and Weinrich, 2001), as informal care provided by family is uncommon in Denmark (Schultz, 2010), despite the fact that informal caregivers in Denmark can claim compensation for lost wages if approved by local authorities (OECD, 2011).

In the mid-1990s Denmark began the adoption of what they called the “integrated care system,” with extensive systems of home- and community-based LTC facilities located throughout the country. The staffing and organization of this new system were, in particular, “integrated”: previously nursing homes and home care organizations had been staffed separately, but in the integrated care system a single one organization cared for elderly and disabled people within in a district (Hansen, 2000). Home-based LTC, rather than residential LTC is, however, a policy priority in Denmark, where relatively fewer older individuals live in LTC institutions than in any other EU country. No new nursing homes have been constructed since 1987, and instead a wide range of dwellings constructed explicitly for older individuals have been built (Schultz, 2010). In fact, the number of nursing home patients fell from approximately 51,000 in 1987 to 31,500 in 2003 (Statistics Denmark, 2005). This decline in the number of nursing

homes has been associated with an increase in the number of home nurses and others carrying out home help services. Many such home care services are provided 24 hours a day (Strandberg-Lawson et al., 2007).

The overall objective for LTC policy in Denmark is for services to be based on the wants and needs of the older person (Government of Denmark, 2003). The goal is to try, insofar as is possible, to maintain continuity in older persons' lives throughout their lifetimes, even if they should become ill and/or infirm; "to move away from aging as a process that inevitable leads to weakness and toward a more positive view of retirement as a phase in life when people finally have time to follow their own inclinations" (Wagner, 1997, p. 150). Personal assistance and care are offered to the elderly, from the viewpoint that recipients may use this assistance to help themselves; i.e., supplementary assistance is available for tasks the recipient is unable to perform and that this is designed to help recipients to remain active and able to perform for themselves as many tasks as possible (Government of Denmark, 2006) while remaining independently in their own homes. Services provided include, but are not limited to, personal hygiene, shopping, and meal preparation (Strandberg-Lawson et al., 2008). These health benefits are available to any legal resident of Denmark, regardless of age, income or wealth (Schultz, 2010).

### **Long-Term Care in Sweden**

Sweden, a country of about 9.5 million people based on the 2011 census, with 18.8% over the age of 65 (EuroStat, 2015), is widely known as a model for comprehensive LTC, providing generous coverage, little cost-sharing, and encouragement for its elderly population to remain in their homes for as long as possible. Sweden's LTC program has historically mostly been a social welfare system that relied heavily on the government to provide home-based and institutional care for the elderly with little or no regard to the person's support system (Sundström, Johansson and Hassing, 2002). Pavolini and Ranci (2008) referred to Sweden's LTC system as a services-led model, meaning that the services that were provided were designed to at least partially take the place of families.

In 2000, Sweden's public spending for home care was reported as the highest of all the OECD countries with 0.78% of the Sweden's GDP in 2000 spent on home-based LTC (OECD, 2004). This system became too costly, and the Swedish government was forced to make some reforms to its LTC system (Pavolini and Ranci, 2008): in 1992 Swedish municipalities were given the option to assume responsibility for social care of the elderly, including the provision of care services, the management of care staff (not including physicians), and the responsibility for assistance living at nursing or other facilities targeted to individuals with dementia or other high levels of care (Sundström, Johansson and Hassing, 2002). This likely contributed to a 19% decline in Sweden's institutional-based LTC that occurred from 1998 to 2008 (Francesca et al., 2011), while home-based LTC dramatically increased from the year 2000, when 55.5% of the elderly population received LTC at home to 2011, when 69.9% of the elderly population received home-based long term care (OECD & EC, 2013).

More than 50% of the municipalities in Sweden have taken over from county councils the responsibility for home health cares, including home nursing care. As a consequence of the assumption of responsibility for LTC by Swedish municipalities, most LTC services are financed through local municipal taxes collected by the 290 municipalities, which collect local taxes and decide the extent to which expenditures on elderly people over other groups will be prioritized (Anell, Glengård and Merkur, 2012). In 2010, local municipal taxes paid 85% of total LTC spending, annually negotiated government grants to the municipalities paid 11-12%, and user fees accounted for the remaining 3-4%, one of the lowest levels of private out-of-pocket spending for LTC in the OECD (Colombo et al., 2011). The co-pays paid by the elderly are capped based upon income, after adjusting for housing and basic necessities.

LTC for the Swedish elderly includes varying forms of in-home care, institutional care residential care, specialized homes for those with dementia, and nursing homes (Edebalk, 2010). It includes personal care such as cooking, cleaning and laundry and also provides the elderly in need with transportation, housing adaptations, handicap aids and support for informal caregivers. This is considerably more than what is provided in many other OECD countries. (OECD, 2013b).

The average life expectancy in Sweden is 84.4 and this is expected to rise to 87.0 years by 2050 (NBHW, 2010). In 2013, 19.4% of the Swedish population was over 65 years old, compared to an OECD average of 16%, while 5.2% of Swedes were over 80, compared to an OECD average of 4.2%. While the growth in the over 80 cohort

will be less dramatic than that of other OECD countries, projections indicate that LTC spending in Sweden will more than double by 2050.

In addition to having a proportionally older population than the vast majority of OECD countries, the Swedish elderly population is healthier than the OECD average, and therefore expected to live longer and require LTC care for a longer period of time. Swedes have among the highest healthy life years – years that an individual can expect to live in a healthy condition – at age 65 of any country in the European Union. Swedish 65-year old men and women are expected to live 14 more healthy years compared to an average of 8.6 additional healthy years for men and 9.5 additional years for women in 24 OECD countries (Eurostat, 2013) Swedes between 65 and 74 require fewer ADLs than any other EU country except Norway, and those over 75 require fewer ADLs than any other EU country except Norway and Iceland (Eurostat, 2013).

Swedish spending on LTC exceeds that of most other OECD countries. Sweden's public expenditure on LTC was 3.6% of GDP in 2011, second only to the Netherlands, and more than twice the OECD average of 1.7% (OECD, 2013a). This expenditure is projected to increase over the coming years: The European Commission in 2012 projected that by 2050 public expenditure on LTC will account for 5.7% of GDP. This projection raised questions about longer-term sustainability and raises expectations that additional spending will be necessary to deliver good quality and efficient care (Bergmark et al., 2000; NBHW, 2010).

### **Long-Term Care in the Netherlands**

According to the 2011 census, the Netherlands had an overall population of 16.6 million with approximately 15.6% of the total population aged 65 and older (EuroStat, 2015). Public expenses for LTC were 3.1% of GDP in 2005, and remained steady at 3.7-3.8% of GDP between 2005 and 2012 (OECD, 2012). This Dutch spending on LTC is more than twice the OECD average, reflecting the “comprehensiveness and generosity” of the Dutch LTC system, which covers many more services and has a substantially higher reliance on institutional care than do other OECD countries (OECD, 2012, p. 117). In fact, Danes are the most likely of Europeans to believe (76%) that their LTC will be financed by the government and are the least likely (22%) to believe that they would not be able to obtain LTC due to financial reasons (Eurobarometer, 2007).

In the Netherlands, regardless of income level, LTC services are paid under the Exceptional Medical Expenses Act, which is a mandatory insurance policy that began including coverage for LTC in nursing homes and homes in 1997 (Gleckman, 2010). According to the authors, the Exceptional Medical Expenses coverage was paid primarily by employers or income tax. Co-payments, which averaged about eight percent of the insurance premiums, were the responsibility of the recipients, depending on their income level (Francesca et al., 2011). With a recession in the 1990s, the Netherlands LTC system experienced significant financial distress and as a consequence access to LTC services was severely limited, with many people placed on long waiting lists (Da Roitman and Le Bahin 2010; Schut and Van Den Berg, 2010). Urged by the courts and under pressure from citizens, the government lifted budget controls on LTC in 2000 and by 2003 the waiting lists for home-based care dropped by over 60% and the waiting lists for home-based LTC dropped by nearly 40% (Van Gameren 2005). With spending and costs rising, the Netherlands policy makers were ready to implement some key reforms to help in reducing expenses, including decentralization of home help to local municipalities and allowing citizens to purchase their own home health providers, known as the “personal care budgets” program (OECD, 2012). Although institutionally based LTC was widespread in the Netherlands, the Danes have attempted to move away from this system and toward a more free-market based one. A cash-for-care approach now encourages free choice and the development of free markets in the LTC sector, as also represents an attempt to bring more family-based care into the LTC system. However, even this more free market-based approach in the Netherlands is “known for its regulation, generosity, and inclusiveness” (Da Roit and Le Bahin, 2010, p. 305). Substitution of home-based care for institutionally-based care has not solved the financial problems of the Netherlands’ comprehensive LTC programs and policies, especially their universality and individual rights-based nature, and consequently for over 2 decades, containment of costs associated with LTC have remained central to governmental policies in the Netherlands (Da Roit, 2012).

### **Level of Effectiveness and Quality of Long-Term Care**

Researchers interested in evaluating LTC patterns in Europe have analyzed OECD Health Statistics and reviewed a number of variables, such as disability rates, demographics, elderly needs, and each country's LTC

expenditures, and they concluded that the LTC needs of the elderly seemed to be properly met in Denmark, the Netherlands, and Sweden (Damiani et al., 2011). According to the authors, the reasons that these countries were successful with meeting LTC needs had to do with the countries' strong sense of state responsibility and their high level of formalized LTC; although, the researchers also specifically recognized the Personal Budget for Care in the Netherlands and the Care Leave Program in Sweden as good examples of LTC informal care and cash-for-care reforms that contributed towards their success. More recently, the Netherlands established a Quality Institute to review and to spread LTC best practices and to review and assess LTC providers, both home-based and institutional (OECD, 2012). The Quality Institute was expected to provide useful information for Dutch citizens and designed to protect them when choosing LTC providers under the country's Personal Budget Program (OECD, 2012).

### Comparison of Long-Term Care Programs in the United States, Denmark, Sweden, and the Netherlands

Table 1 provides an overview and comparison of certain characteristics of the LTC programs in each of these European OECD countries with the LTC programs in the U.S. The first major difference between the U.S. and the other countries was the level of public funding, which was universally provided in Sweden, Denmark, and the Netherlands but only provided publicly by the U.S. to the disabled and indigent population or in a limited way to individuals after a hospital stay (Table 1). The level of public funding is nearly 100% for Denmark, Sweden, and the Netherlands but only 72.9% in the United States (Table 1). As a result, the total U.S. long-term care spending paid out of pocket by patients and/or families in 2011 was \$45.5 billion (Freundlich, 2014). Cash for care programs have been reported to be a part of all three European countries' LTC publicly provided programs, but this was not the case in U.S., which does not yet have a national model for these programs (Table 1). Finally, Table 1 provided noted weaknesses by some researchers regarding LTC in the U.S., Denmark, the Netherlands, and Sweden, which characterized the U.S. LTC system as one that lacked coverage for a large number of citizens compared to the other OECD countries, where the major flaw of their LTC systems was reported to be excessive cost and sustainability.

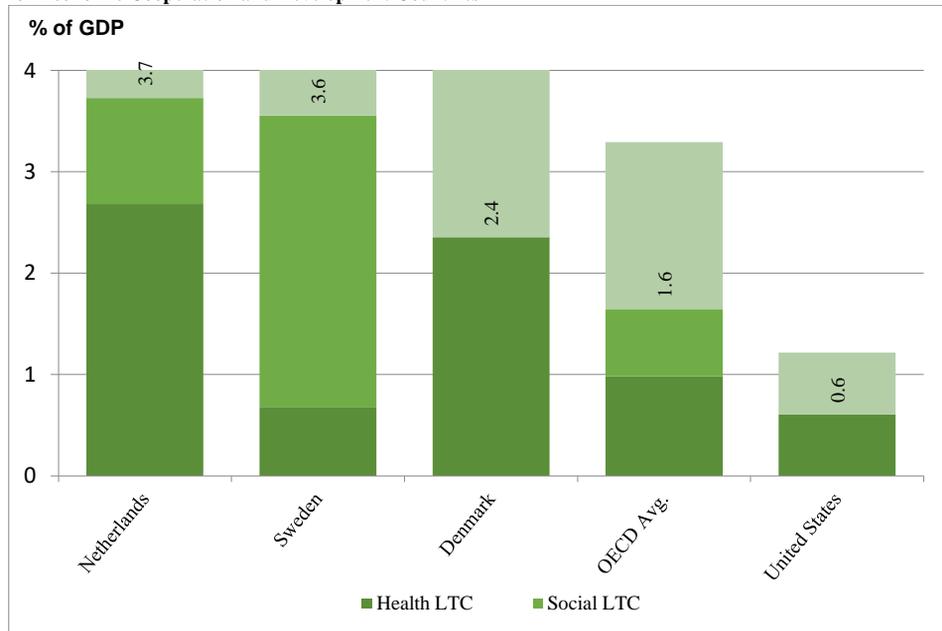
**Table 1: Characteristics of Long Term Care in the United States, Denmark, Sweden, and the Netherlands**

	<b>PUBLIC PROVIDED LTC SERVICES (Source)</b>	<b>LTC FUNDING SOURCES (Source)</b>	<b>USE OF CASH FOR CARE (Source)</b>	<b>LTC PROGRAM WEAKNESSES (Source)</b>
<b>United States</b>	Majority of public funded LTC is paid by Medicaid for the indigent and disabled, or by Medicare for short-term or respite care/post hospitalization  (Colello, Mulvey and Talaga, 2013)	Federal and State Tax Revenue (72.8% in 2011) and privately funded either through private LTC insurance and / or private pay (27.2% in 2011)  (Colello, Mulvey and Talaga, 2013)	No national program as of 2015. The Affordable Care Act established \$4.3 billion for LTC programs. One option has a cash for care model  (Freundlich, 2014)	Complicated system; millions of Americans have limited to no means for LTC unless they qualify for Medicaid.  (Freundlich, 2014)
<b>Denmark</b>	Yes. Every citizen. Established by the Consolidation Act of Social Services  (Schulz, 2010)	Tax revenue. Rent charged to citizens in an inpatient facility with ability to pay  (WHO, 2003)	Yes, availability depended on municipality  (Francesca et al., 2011)	Expensive; Moral hazard exists  (Yoo et al., 2004)

<p style="text-align: center;"><b>The Netherlands</b></p>	<p>Yes. Every citizen through a public LTC insurance system</p> <p>(Schut and Van Den Berg, 2010)</p>	<p>Employers and Tax revenue; some co-pays for recipients</p> <p>(Schut and Van Den Berg, 2010)</p>	<p>Yes. Cash for care Through “Personal Care Budgets”</p> <p>(Francesca et al., 2011)</p>	<p>Expensive; Moral hazard exists</p> <p>(Yoo et al., 2004)</p> <p>(Schut and Van Den Berg, 2010)</p>
<p style="text-align: center;"><b>Sweden</b></p>	<p>Yes. Every citizen through a social welfare program</p> <p>(WHO, 2003)</p>	<p>80-85% from local tax revenue and 15-20% from central government; some user fees, if income is sufficient – about 4% of costs from users</p> <p>(Francesca et al., 2011)</p>	<p>Yes. Cash and In-Kind through “Care Leave Program” workers can take paid leave for caring for family home care</p> <p>(Francesca et al., 2011)</p>	<p>Expensive; Moral hazard exists</p> <p>(Yoo et al., 2004)</p>

The average cost of providing LTC as a percentage of GDP for all OECD countries was 1.6% in 2011 (see Figure 2), which was less than half of cost for LTC in the Netherlands and Sweden. Denmark’s cost for providing LTC in 2011 was about 50% higher than the OECD average, while the U.S. costs for LTC the same year was 50% lower than the OECD average (Figure 2).

**Figure 2: Long-Term Care Expenditures as a % of Gross Domestic Product (2011) for Select Organization for Economic Cooperation and Development Countries**



Adapted from OECD Data in [Health at a Glance](#) (OECD, 2013)

One commonality among Sweden, Denmark, the Netherlands and the U.S. was that each country had reported making noteworthy reforms to their LTC programs. In the U.S., after the passage of the Affordable Care Act (ACA) in the U.S. in 2010, there had been some significant legislation that provided six additional LTC programs that states could choose to adopt. The ACA provided expanded Medicaid funding of \$4.3 billion and matching funds for states who participate in these models, and the goal of offering some of these new programs was to provide more incentives for people to receive home-based LTC versus a nursing home care (Figure 3). Significant reforms to the LTC programs in Sweden, the Netherlands and Denmark, were noted by several researchers, primarily aimed at reducing costs and/or waste (Pavolini and Ranci, 2008; Damiani et al., 2011; Schut and van den Berg, 2010).

**Figure 3: Long Term Care Programs Introduced by the Affordable Care Act in the United States (States must choose at least one of the programs listed above to include in their Medicaid Program)**

<p><b>Extension of Money Follows The Person (MFP)</b></p>	<ul style="list-style-type: none"> <li>• Gives individuals LTC benefits so they can move out of an institution. Program was set to expire but ACA continues the program for 5 years. 37 States already participating.</li> </ul>
<p><b>Financial Alignment Demonstrations for Dual Eligible Beneficiaries</b></p>	<ul style="list-style-type: none"> <li>• Integration of LTC and payments for dual eligibles - creation of a CMS Medicare-Medicaid Coordination Office. 5 States have approval and 20 states are pending approval.</li> </ul>
<p><b>Health Home State Plan Option</b></p>	<ul style="list-style-type: none"> <li>• Program only for people with chronic conditions. State run care coordination program in a medical home model.</li> </ul>
<p><b>Community First Option (CFO)</b></p>	<ul style="list-style-type: none"> <li>• Home and community-based care-giver services designed to keep patients out of an institution. States get additional federal funds.</li> </ul>
<p><b>Balancing Incentive Program (BIP)</b></p>	<ul style="list-style-type: none"> <li>• Incentivizes community over institution. No "wrong door" into the LTC system. Use of an assessment tool for determining eligibility. ACA provides \$3 billion in matching funds to states who participate.</li> </ul>
<p><b>Home and Community-Based Services State Plan Option</b></p>	<ul style="list-style-type: none"> <li>• Allows states to create programs for individuals that don't meet full Medicaid benefits but receive state plan benefits. Expands the services that states may cover.</li> </ul>

Adapted from Watts, Musumeci and Reaves (2013) and Peterson (2015)

## DISCUSSION

The purpose of this study was to examine the LTC policies of select OECD countries and to determine what lessons could be learned from them regarding LTC policy in the U.S. The research has suggested that the LTC programs in Sweden, the Netherlands, and Denmark were similar in that all three had been publicly providing LTC to all of its citizens. However, there are several lessons that can be learned by examination of the literature reviewed.

The first lesson learned was that providing LTC services universally to each citizen without regard to an individual's need for public assistance is an extremely expensive system which is fraught with the potential for abuse. A citizen might have a good system of family support, but having universal LTC services might have encouraged LTC assistance when it might have not been needed. Additionally, it is possible that such a system could have discouraged the use of informal care. Rather than LTC services being viewed as an absolute right for all citizens, perhaps it should be viewed more as a safety-net program, and only if citizens' do not have family members able to provide informal care, would public assistance be warranted.

The second lesson learned was that giving seniors' money to pay for their LTC allowed them to have more of a choice of providers. The literature reviewed provided a historical perspective of Denmark, Sweden and the Netherlands' LTC policies and showed that LTC policy reforms evolved out of a necessity of the governments to cut costs. The Netherlands LTC policy reforms included changing policies to give the recipients a personal LTC budget for which they could choose their own LTC providers or to pay an informal caregiver, and Sweden's reforms included a measure that granted workers paid leave for care giving for a family member, encouraging the use of informal care givers (Francesca et al. 2011).

The third lesson that was learned was that home-based LTC care is less expensive than nursing home care. This was true whether or not the home-based care was provided by a formal or informal care giver. Denmark's focus on providing home-based LTC versus institutional care was an approach that had been implemented by other OECD countries in Europe. This was in stark contrast to the U.S., where LTC public funding in 2010 was almost exclusively provided in institutions (OECD, 2012), perhaps because (or, conversely, as a result of the fact that) the vast majority of LTC in the U.S. is provided by family and friends (Sultz and Young, 2014).

The fourth lesson is that there was not much available empirical data on the value of LTC services provided by each country. Based on OECD data, in 2005, the U.S. spent about \$1.00 for publicly provided LTC benefits for every \$6.00 spent on government provided medical care; whereas, the Netherlands spent \$1.00 for LTC for every \$3.00 spent on medical care (OECD, 2006). While the Netherlands' approach towards providing LTC was quite extensive, there is insufficient evidence to date to suggest that the amount of money spent on LTC by the Dutch has proven to be of higher value. Obviously effectiveness research is needed to determine from a policy perspective how "best" to allocate LTC spending.

### **Study Limitations**

This research study was limited by the amount of current research on this topic, the search strategy utilized, the number of databases searched along with researchers' and publication bias that may have affected the value and accessibility of research recognized. Another limitation was the lack of information regarding the value of the LTC provided in each country. In order to measure the value of LTC services, researchers will need to measure not only cost of LTC services but also will need to evaluate the quality and overall outcomes of LTC experienced by each country.

### **Practical Implications of Study**

The practical implication of this study was to provide U.S. leaders with a comparative analysis of other countries' experiences with providing LTC programs to help guide them in future policy-making decisions. A review of the LTC policies in Sweden, Denmark, and the Netherlands identified that the U.S. could very well benefit from exploring new LTC policies that would provide a more inclusive delivery system for LTC services based on citizens' level of family support, rather than merely based on income. The LTC policies should provide incentives for receiving informal care, and encourage LTC to be provided in the home, as appropriate. Finally, there should be more research on the value of LTC services provided in OECD countries to evaluate whether the U.S. should invest a similar amount of public funding for LTC services as Sweden, Denmark, and the Netherlands.

## **CONCLUSION**

The U.S. is expected to have a significant increase in LTC needs in the next few decades because of the aging of the population. U.S. policy makers should look at the experiences of Sweden, Denmark and the Netherlands for lessons in developing new LTC policies designed to address the social welfare of its citizens. In order to maximize financial resources, the LTC programs must be carefully crafted to promote the use of home-based care, the use of informal care providers, and the importance of policy adoptions to be based upon research and not hopes or dreams.

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