International Journal of Multidisciplinary Research and Growth Evaluation.

Comparative Analysis of Long-Term Care Systems in the Netherlands and United States

Pavani Kottapalli
Independent Researcher, USA

* Corresponding Author: **Pavani Kottapalli**

Article Info
ISSN (online): 2582-7138
Volume: 05
Issue: 01
January-February 2024
Received: 20-12-2023
Accepted: 17-01-2024
Page No: 1614-1616

Abstract
The Netherlands and the United States are high-income countries with different healthcare systems and distinct approaches to long-term care. Although the United States health care system is a leader in science and technology advancement, it remains far away in terms of the quality and infrastructure of organizations compared to other countries that are members of the Economic Cooperation and Development (OECD). Additionally, the United States spent more than any country on health care in 2021. The United States' expenditure on health care was three times more than other OECD countries and is expected to rise from 5.7% of GDP to 9.4% by 2051. However, the united States spend 1.0% of its GDP on Long-term care as of 2021, much less than other high-income OECD countries. Consequently, the United States has the lowest number of primary care physicians per capita, which highlights that the United States focuses on acute care over primary, preventive, and long-term care. Therefore, the author would like to compare the U.S LTC with the Netherlands LTC and its operation systems to gain insights into the strengths and limitations of both countries' LTCs and the necessity of changes that need to take place in the American LTC system
Aim: This paper aims to understand the reasons for health inequalities and improve accessibility for older adults.
Purpose: Comparing the Long-Term care systems enables administrators, policymakers, and regulatory agencies to understand the opportunities for potential policy reforms and adapt best practices to improve the quality and accessibility, reducing the disparities.

DOI: https://doi.org/10.54660/.IJMRGE.2024.5.1.1614-1616

Keywords: Aging population, Long-term care (LTC), Health policy, Healthcare financing, Access to care

Introduction

The aging population is growing exponentially around the globe, and long-term care services are necessary to meet demand. The number of people who are 60 and older in 2020 around the globe was 1.05 billion, which is 13.46% of the world's total population. It is projected to increase by 16% by 2030 and is expected to surpass 21% by 2050. Due to the lack of resources and coverage to meet this age group's needs, aging is a public health concern. In the same way, aging is highly concerning in developed countries, such as the United States aging population, which accounts for 22.88% (Xia *et al*., 2022) [6].

Therefore, the United States and worldwide governments increasingly recognize the need to create policies to address the aging population. The swift growth of the aging population has put pressure on healthcare systems, Long-Term care, housing, and social services due to a decline in physical, mental, and cognitive abilities, often leading to a lack of quality life, injuries, and vulnerability to other morbidities and mortalities.

Furthermore, although significant studies show longevity as a key health metric, the associated quality of life is not explained well enough to understand the needs of aging and its impact on societal stability (Chang *et al*., 2019) [3]. Therefore, understanding the structural gaps, prioritizing the needs of aging, and taking a holistic approach to aging can be a key strategy to address the issue.

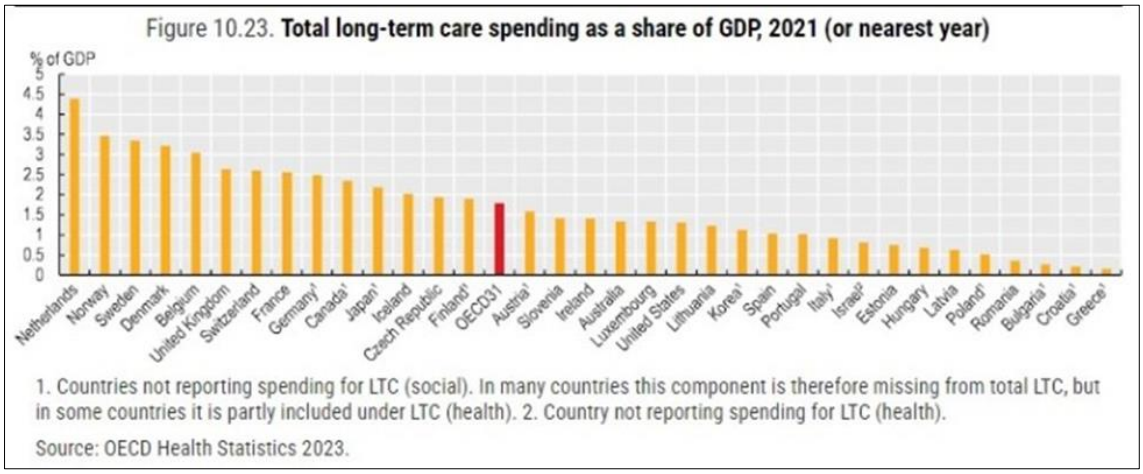

Fig 1: Total long-term care spending as a share of GDP, 2021(or nearest year)

Figure taken from OECD (2023) [5]. Public and private expenditures on long-term care as a percentage of GDP. Health at a Glance 2023: OECD Indicators. OECD Publishing. https://doi.org/10.1787/7a7afb35-en

Therefore, the author would like to examine the two different LTC systems, their success strategies, and challenges to understand their approach to the problem of aging. The aging population has increased faster than projected in the literature, and public spending on Long-Term care is estimated to climb from 1.4% of GDP in 2014 to 4.3% by 2060 in Europe, per an economic policy report (Tenand *et al*., 2020) [7].

Netherlands has the second highest spending of its GDP on Long-Term care (4.1% of GDP) among all other OECD countries. It stands as a model for other countries due to its ability to pay against the out-of-pocket cost for older people. It also provides generous public subsidies, where access to care is not limited by individual financial ability. Therefore, the Netherlands LTC system minimizes healthcare inequities (Tenand *et al*., 2020) [7]. The Netherlands started a public LTC insurance program in 1968, providing universal and comprehensive coverage through three complementary public financing schemes. 1. Social Long-Term care insurance pays for institutional care, which means nursing home and hospice care. 2. Social health insurance, which pays for nursing and personal care provided at home. 3. Social Support Act, which makes municipalities responsible for organizing and financing assistance and providing social support for the elderly living in their vicinity (Bakx *et al*., 2023) [2]. The applicant eligibility criteria depend on consistent needs-based assessments and processes (Tenand *et al*., 2020) [7], where individual income and wealth are not considered. However, the number of family members or relatives is considered in the expectation that household members can provide minimal personal care to support their family member or relative. Further, the eligibility decision for Long-term care services depends on the volume of care type and length of the care required. When the individual application gets rejected for LTC, the individual can reapply when the care situation changes. However, rejection rates are usually lower (Tenand *et al*., 2020) [7].

Also, the Netherlands has various beneficiary options, such as being cared for at home or in an institutional setting (Tenand *et al*., 2020) [7]. They can opt for LTC vouchers to pay their healthcare professionals and informal home caregivers. Meanwhile, beneficiaries with more severe conditions and a lack of home support can be admitted to long-term care services (Tenand *et al*., 2020) [7]. Long-term care services in the Netherlands are funded through mandatory social security contributions, income-based payments, and co-payments. This financial system ensures that individuals pay according to their financial means without facing out-of-pocket challenges, economic sustainability, and equal access to care (Tenand *et al*., 2020) [7].

Also, the way the Netherlands LTC system works, it is more favorable for the poor to be eligible for institutionalized settings (nursing homes) than the rich. Most rich get services at home as they prefer their homes and can pay more (Tenand *et al*., 2020) [7]. Therefore, barriers to LTC access are highly restricted compared to other countries' LTC. However, as the Netherlands' aging population grows, the LTC funding models and financial viability must be examined for potential resource depletion. Therefore, the Netherlands and other countries with similar LTC funding models must review and adopt policies to help face the aging population's challenges. The U.S. long-term care system operates differently from the Netherlands and other OECD countries. In contrast, the Netherlands prioritizes universal LTC coverage to ensure access, quality, and cost-effective care (Werner & Konetzka, 2022) [8]. Further, while the Netherlands, like countries that have structured financing models for LTC funding, the United States lacks a cohesive national financing strategy to provide coverage for LTC by depending on the mixed payer system such as Medicaid, private pay, and out-of-pocket funds, which is compromising the accessibility, quality, and affordability of the LTC systems (Werner & Konetzka, 2022) [8]. Therefore, the aging population is left in the community without proper support. Further, the United States relies heavily on informal care from family members, which is also becoming a significant challenge due to the changing demographics and increasing women in the labor market (Werner & Konetzka, 2022) [8]. Formal LTC care services are funded through the fragmented systems in the United States, such as Medicaid, Medicare, Veterans Administration, and other public and local funding programs, private insurance, and out-of-pocket costs of around $420 billion per year. Medicaid pays for more than half of the LTC services for those who need help with daily activities. However,

eligibility for Medicaid requires individuals to spend down their assets, leaving many older adults without any help with LTC coverage and indirectly seeking out-of-pocket expenditures. Similarly, Medicare only covers post-acute/skilled and transition care, not daily or long-term care (Werner & Konetzka, 2022) [8].

Moreover, Medicaid-funded nursing homes are flagged with quality concerns due to low funding, such as staffing shortages, high infection rates, and hospitalizations. Also, there is no available transparency regarding the cost of services in nursing homes compared with Medicaid payments to understand the quality and safety concerns in the nursing home's operations (Werner & Konetzka, 2022) [8].

Additionally, it is predominant that ethnic minorities, economically low and impoverished groups, are admitted to low-quality nursing homes compared to the Caucasian population and financially well (Werner & Konetzka, 2022) [8]. Finally, the fragmented payment system of LTC in the United States increases the administration cost due to the complexity of coordination. As well, inefficiencies in the budget allocation and fragmented system cause adverse effects such as intentional hospitalizations from the LTC setting, besides the availability of solutions in the LTC setting for organizational financial gains (Medicare-post acute incentives) (Werner & Konetzka, 2022) [8].

In conclusion, this analysis suggests that the United States must move toward more unified healthcare funding and centralized operational systems to reduce administrative costs and operational inefficiencies that can lead to misuse of services. The U.S. can better support its aging population by restructuring long-term care (LTC) policies without compromising individual freedoms. Adopting successful strategies from the Netherlands, such as integrated home-based care, social support networks, and proactive aging-in-place initiatives, can enhance LTC accessibility and sustainability. Furthermore, implementing financial models that increase accessibility without requiring individuals to spend down their assets can prevent financial hardship among seniors through financial reforms such as France's income-adjusted universal public program, which allows voluntary private supplementation according to the person's choices. Also, reducing the burden on families by providing time off benefits at work without punitive actions for the family members assisting their older adults at home, who often struggle to balance work and caregiving, can ensure that elderly individuals receive adequate care without placing excessive strain on their loved ones. Further, the United States must create eligibility criteria that depend on health status rather than the individual's income status to overcome the social justice concern. To overcome the political gridlock between financial and social justice aspects, lawmakers must enforce bipartisan congregations to advance the conversations to guide and create policies to improve the accessibility and quality of care.

References

1. Andrews M. Dying broke: Why is long-term care crumbling in America compared to other countries [Internet]. KFF Health News; 2023 [cited 2025 Apr 7]. Available from: https://kffhealthnews.org/news/article/dying-broke-long-term-care-other-countries/
2. Bakx P, van Doorslaer E, Wouterse B. Long-term care in the Netherlands (NBER Working Paper No. 31823). National Bureau of Economic Research; 2023. https://doi.org/10.3386/w31823
3. Chang AY, Skirbekk VF, Tyrovolas S, Kassebaum NJ, Dieleman JL. Measuring population ageing: an analysis of the Global Burden of Disease Study 2017. The Lancet. Public Health. 2019;4(3): e159–67. https://doi.org/10.1016/S2468-2667(19)30019-2
4. Lee S-H, Chon Y, Kim Y-Y. Comparative analysis of long-term care in OECD countries: Focusing on long-term care financing type. Healthcare. 2023;11(2):206. https://doi.org/10.3390/healthcare11020206
5. Organisation for Economic Co-operation and Development (OECD). Public and private expenditures on long-term care as a percentage of GDP. In: Health at a Glance 2023: OECD Indicators [Internet]. OECD Publishing; 2023 [cited 2025 Apr 7]. Available from: https://doi.org/10.1787/7a7afb35-en
6. Xia L, Chai L, Zhang H, Sun Z. Mapping the global landscape of long-term care insurance research: A scientometric analysis. International Journal of Environmental Research and Public Health. 2022;19(12):7425. https://doi.org/10.3390/ijerph19127425
7. Tenand M, Bakx P, van Doorslaer E. Equal long-term care for equal needs with universal and comprehensive coverage? An assessment using Dutch administrative data. Health Economics. 2020;29(4):435–51. https://doi.org/10.1002/hec.3994
8. Werner RM, Konetzka RT. Reimagining financing and payment of long-term care. Journal of the American Medical Directors Association. 2022;23(2):220–4. https://doi.org/10.1016/j.jamda.2021.11.030.