Promising Policy Innovations to Make Aging in the Community Affordable for All:

Lessons from the Netherlands

By Benjamin W. Veghte MPA, Ph.D.

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Executive Summary

Countries across the world are struggling to support ever growing numbers of older adults to age with dignity and independence amid fiscal and workforce constraints. The Netherlands was the first country in the world to introduce universal public long-term care insurance in 1968. Its system covers a comprehensive range of home- and facility-based long-term services and supports (LTSS) for all its residents. In the early 21st century, Dutch policymakers began to realize that demographic shifts with financing and workforce implications would threaten the sustainability of its long-term care system. By 2040 long-term care expenditure was projected to reach between 7% and 9% of GDP, depending on the degree of efficiency gains in the system. And to meet the projected increase in the volume of formal care needs at today's staffing levels, by 2060 more than one in three (36.5%) Dutch workers would need to work in the health and long-term care sectors. Over the past two decades, the Netherlands has undertaken a series of significant structural reforms to render the system more efficient and fiscally sustainable while also strengthening the health, autonomy, and quality of life of older adults and people with disabilities.

In the U.S., Washington State enacted the nation's first universal LTSS program in 2019; several other states are on course to enact similar programs in the coming years. At the same time, twenty-four states are in various stages of developing or implementing Multisector Plans for Aging, and the federal government has developed a Strategic Framework for a National Plan on Aging**.** As the U.S. explores strategies to support its aging population amid fiscal and workforce constraints, much can be learned from the Dutch experience. This paper begins with an overview of the Dutch system, situated in its cultural and institutional context; then explores promising Dutch policy and delivery-system innovations to future proof its system for the age wave. The paper then examines the pivotal role of the Netherlands' historically rooted, vibrant social housing sector in making aging in the community affordable for all. It concludes with a consideration of remaining challenges to the Dutch system as well as seven lessons for long-term care policy in the United States.

Promising Policy Innovations to Make Aging in the Community Affordable for All: Lessons from the Netherlands

By Benjamin W. Veghte*

For U.S. policymakers, supporting families to be more prepared for their current and future long-term care needs is a daunting task. Already today, the families of those who need services and supports to live independently are under great strain financially, emotionally, and logistically as they endeavor to balance work, paying bills, caring for the person needing long-term care, and other family care needs. They face difficult choices between formal home care (which only 14 percent of single households age 75 or older can afford), even more expensive institutional care, or informal care by loved ones, which can have significant health and economic costs for those who provide it.[1] Medicare does not cover long-term care.[2] While Medicaid is a critical resource and the primary public payer of long-term care nationwide,[3] it serves only those with very low income and assets, and requires beneficiaries to surrender their financial independence. In Washington State only, a universal public long-term care insurance program is available, the WA Cares Fund, which covers workers of all income levels who meet the contribution requirements and need long-term care; several other states are considering implementing similar programs.[4] With the population 85 or older projected to nearly double (compared to 2016) by 2035 and triple by 2060, and the population of prime caregiving age (45-64) remaining fairly stagnant,[5] in the coming years many more families in the United States will be affected by long-term care needs and in a more intense way than today. Families, as well as state and federal budgets, will struggle to keep pace. In short, a demographic challenge is approaching. While many foundations, non-profits, and academics are ringing alarm bells and developing potential solutions, policymakers are not doing enough to render families or public budgets more resilient in the face of growing long-term care needs. Substantial innovation in the financing, administration, and delivery of long-term care will be essential.

One of the most innovative long-term care systems in the world can be found in the Netherlands. It is a global leader in terms of its macro-design (universal coverage, comprehensive benefits) but also its delivery system. This paper investigates what U.S. policymakers, providers, and advocates can learn from the structure, financing, and administration of the Dutch long-term care system, as well as from the social housing system that undergirds the affordability of aging in a home or community based setting. It is part of a broader study that yielded a tandem publication on lessons for the U.S. from recent Dutch delivery-system innovations supporting person-centered aging.[6] To research the policy design, financing, and administrative innovations explored in this paper, I reviewed relevant primary and secondary sources, conducted site visits, and interviewed four different groups of actors in the Dutch long-term care system: government officials, academic and think tank experts, care workers and providers, and residents of age-friendly housing communities and nursing homes. The paper begins by identifying the political-cultural and institutional foundations of the Dutch long-term care system. It then explores promising policy innovations intended to manage the fiscal and workforce challenges to its system from an aging society, and contextualizes the reformed Dutch system by comparing it to universal long-term care programs in Germany and – on a far more modest scale – the U.S. (the WA Cares Fund). The paper then examines the pivotal role of the historically rooted, vibrant social (non-profit) housing sector in making aging in place affordable for all. It concludes with a consideration of the systemic challenges that remain and potential insights from the Dutch experience for the United States.

*Benjamin W. Veghte, MA, Ph.D., is Director of the WA Cares Fund, Department of Social and Health Services, Washington State and an MIT Co-Lab Mel King Community Fellow.

Origins of the Dutch Long-Term Care System

Before examining the Dutch long-term care system more closely, a caveat is in order regarding cross-national learnings. Learning from other countries' experiences begins with an understanding of context. Institutional pillars shape what is possible in the short and medium term and these, in turn, are informed by historically rooted political-cultural dynamics. Much like a tree cannot be transplanted successfully without the right environmental conditions to sustain it, policies themselves can seldom be "imported" modularly without a rich understanding of the system that gave rise to them and allowed them to succeed. An understanding of these foundations can pave the way for more nuanced learning and potential adoption of best practices.

Political-Cultural Foundations

Cross-national differences in long-term care systems are heavily driven by cultural norms.[7] Dutch political culture is historically grounded in the country's experience of fighting for survival against the forces of nature. Roughly half of the Netherlands is below sea level and the coastal regions have been battling wind and erosion for two millennia. The Dutch built their country by reclaiming land from the sea, both on the coast and from interior marshland. Since the 12th century, farmers have had to work together to reclaim arable land ("polder") by using windmills to pump the water out of swamps and marshland and into rivers and canals. They built dikes to protect polder from the higher-lying water in the canals around them and engaged in extensive coastal landfill. These are just some of the techniques the Dutch have developed over the centuries to reclaim and protect land for agriculture and settlement. These were expensive investments that required discussion, compromise, and cost sharing. Furthermore, different groups have an interest in different levels of groundwater: the agricultural, manufacturing, construction, and recreation sectors have different preferences in this regard, as do environmentalists. Over the course of history, Dutch civil society has had to develop tools and techniques to jointly balance these different, often conflicting values and interests.

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Just as U.S. history has been characterized by entrepreneurial dynamism and reinvention, the Dutch creation of a country out of marshland has been a Herculean feat requiring enduring innovation, not only technologically but also socially. Cooperation has been pivotal. Through the present day, Dutch farmland and residential communities are spared from flooding only by virtue of a collaboratively run, complex water management system governed by democratically elected bodies. While the American West was conquered and settled through force and self-reliance, Dutch society could only survive, remain safe, and thrive if individual farmers – and later, villages, towns, and cities – cooperated, planned, and jointly administered water management boards to protect the integrity of polders.

The governance model that emerged from this enduring challenge has been known since the late 20th century in the Netherlands as the "polder model" (*poldermodel*).[8] It has been formalized as a tool used in economic and social policymaking to cope with complex challenges that involve multiple actors with competing interests. Typically employers, unions, and the government mediate their differences through this model, but the tool is flexible and applied widely. At its heart is a drive toward compromise and consensus,

grounded in two fundamental beliefs: first, when much is at stake, failure is not an option; second, more can be achieved collaboratively than by the narrow pursuit of selfish interests. As one interview partner noted: "[T]he Dutch have a long tradition of having collective negotiations for the public benefit. And also for your own benefit, which is in fact kind of the same thing."

In addition to the polder model of collaborative consensus, broadly shared cultural values and norms shape the long-term care system. A leading Dutch social psychologist, Geert Hofstede, conducted one of the most comprehensive cross-national studies of how values in the workplace are shaped by culture. He compared and contrasted countries along six dimensions and found the Netherlands to be, in his terminological system, a highly individualistic and "feminine" society.[9] Dutch long-term care experts have used Hofstede's paradigm to describe how the Dutch long-term care system differs from others: "Feminine countries are inclusive and people value equality, solidarity and quality in their working lives. In feminine societies caring for others and solidarity are dominant values, but the family structure is more flexible than the more traditional family structure in masculine countries. Hence, although the demand for care for frail people is felt in society, it could be less automatic that provision of this care is carried out within the family. The combination of individualism and social solidarity in the Netherlands may well explain the strong social support for extensive welfare state arrangements and the early adoption and subsequent expansion of a universal public long-term care insurance scheme. Interestingly, a similar culture of individualism and femininity is observed in Sweden, which is characterized by equally comprehensive publicly financed long-term care arrangements."[10]

> *The combination of individualism and social solidarity in the Netherlands may well explain the early adoption and expansion of a universal public long-term care insurance scheme.*

One interview partner echoed this interpretation: "That's also why we have a long-term care system, already set up in 1968, which we all pay for so that when people get old, they get decent treatment. But we don't want to do it ourselves. In Southern Europe, if you are a child, then you have to care for your parents if they're old. We [in the Netherlands] want to have a kind of collective arrangement. Someone else, some professional can do it. We take care that it will be done in a proper way, but not by ourselves … not as an individual responsibility, but as a social responsibility – and also to enable people to do their own things, have their own lives and not have these obligations on an individual basis. So that's the difference in Germany, which is much more family-based, I think." In other words, in the Dutch long-term care system, having robust, publicly financed benefits frees individuals to pursue their careers and dreams, care for their children, etc. That individual freedom for family members is part of what the premiums in the long-term care system are paying for. In the 2007 Eurobarometer Health and Long-Term Care survey (the most recent wave), when asked "Imagine an elderly father or mother who lives alone and can no longer manage to live without regular help because of her or his physical or mental health condition? In your opinion, what would be the best option for people in this situation? Firstly?," 52% of Dutch chose "Public or private service providers should visit their home and provide them with appropriate help and care" (more than twice the EU27 average of 27%), 18% chose "They should move to a nursing home" (EU27 average: 10%), 20% chose

> *We take care that [long-term care] will be done in a proper way, but not by ourselves, not as an individual responsibility, but as a social responsibility.*

"One of their children should regularly visit their home, in order to provide them with the necessary care" (EU average: 24%), and only 4% chose "They should live with one of their children" (EU average: 30%).[11]

In sum, values of individualism, solidarity, equality, and universality (inclusion) at a high-quality level undergird the Dutch long-term care system. Universal, comprehensive benefits are characteristic of what international social policy scholarship refers to as the "social-democratic welfare states" found in the Netherlands and Nordic countries.[12] The security that universal, comprehensive coverage provides supports individual freedom and entrepreneurship. As one interview partner stated, "Everyone thinks it's common logic that you have universal health insurance, or other universal collective arrangements. And then you have the freedom to do what you want."

While there have been ebbs and flows in how social solidarity has manifested in the Netherlands over historical time, since the Second World War solidarity has strengthened in institutional terms at the national level. In the aforementioned Eurobarometer survey, when presented with the proposition: "Every individual should be obliged to contribute to an insurance scheme that will finance care if and when it is needed," 83% agreed.[13] Multiple interview partners suggested that in the realm of long-term care, there is strong consensus around the principles of risk and income solidarity. Income solidarity refers to everyone's care being financed to a significant extent collectively through income-related premiums; risk solidarity means that the insurance conditions (premium rate, coverage, etc.) are equal for people with different health or long-term care risks.[14] One interview partner noted the collective financing of the long-term care system through a combination of social insurance and general revenues makes it possible to not only support people once they are disabled, but also engage in prevention; less affluent individuals might not otherwise be able to afford such upstream interventions. Indeed, one interview partner noted that the greatest strengths of the Dutch long-term care system are its "extensiveness, the coverage, the access: equal access."

The collective financing of the long-term care system makes it possible to engage in prevention; less affluent individuals might not otherwise be able to afford such upstream interventions.

Entrepreneurialism, efficiency, and innovation are other foundational values that came up repeatedly in expert interviews. The Netherlands has a strong history of entrepreneurialism and innovation that continues through the present day.[15] The engineering feats associated with reclaiming land from the sea are evidence of this, as is the invention of the stock exchange in Amsterdam in 1602. These values manifest in the field of long-term care as well, both in the Netherlands being the first country in the world to introduce a universal long-term care social insurance program in 1968 and in a range of delivery system innovations since.

Another cultural driver of the Dutch system mentioned by several interview partners was that the Dutch tend to be realistic about the fact that they will get older over time and that society as a whole is aging. There is broad consensus across the political spectrum that the country needs to prepare for this to protect both those who will need care and family caregivers.

Institutional Origins

The Netherlands introduced the world's first universal public long-term care insurance program in 1968, the Exceptional Medical Expenses Act (*Algemene Wet Bijzondere*

Ziektekosten, henceforth: EMEA). At launch, it covered only nursing home care, hospital admissions lasting longer than a year, inpatient mental health care, and intensive home health care. Over time, it became the vehicle for addressing a number of additional care-related needs: home health care (1980), ambulatory mental health care (1982), ancillary long-term services and supports (household help) (1989), and residential care for the elderly (assisted living) (1997).[16] It manifests the nation's broadly shared values of individualism, solidarity, equality, and universality. In the comparative social policy literature, as well, the Netherlands has been highly regarded not only for being a pioneer, but also for its universal coverage, comprehensive benefits, and high quality. An in-depth comparison of the Dutch, German, Spanish, and Polish long-term care systems in 2012 found that the Dutch system produced the highest quality of life among recipients of long-term care, the highest quality of care, and the most equitable coverage and benefits overall.[17]

Core Challenges at the Turn of the Century

By the early 21st century, Dutch policymakers began to perceive that the EMEA had become to some extent overloaded, and – in the face of the approaching age wave – fiscally unsustainable.[18] Over the course of its half-century of existence, it had expanded to address a broad range of long-term care needs. Ultimately, this led to a system that was widely perceived to be too large, centralized, inefficient, and difficult to reform. For example, the national government budgeted funding for regional procurement offices (typically run by the health insurer with the largest market share), which in turn negotiated contracts with providers. But the regional procurement offices bore no financial risk for long-term care expenses incurred, and hence had no incentives to find efficiencies.[19] And because the EMEA was siloed off from the health insurance system, it missed some opportunities for synergies and other efficiency gains that could have been achieved by integrating home health care with other health care. As the government worked to reform the EMEA before the age wave arrived, it was cognizant of the need to cope with three core, interrelated challenges: overreliance on institutional care (and to a lesser extent, formal care more broadly), fiscal sustainability, and the impending shortage of care workers and family caregivers.

Overreliance on Institutional/Formal Care

In the postwar decades, the tremendous shortage of housing for working families in the Netherlands had led to a policy focus on moving older adults – even ones with no functional or cognitive limitations – into "elderly homes" (a cross between independent living and assisted living) or nursing homes. This policy approach had enduring normative effects. "The 60 years during which many older adults in need of care moved out of the community may have created a social norm with respect to the appropriate setting for care of older adults with disabilities and the assignment of responsibility for financing that care (government or family). … Moreover, there might be a dynamic effect: at the moment that people with relatively fewer ADLs and fewer cognitive impairments are in the nursing home, a nursing home is relatively more appealing to other people."[20] The Dutch had come to expect that when they became old and frail, the government would take care of them. Adult children knew that their parents were being well taken care of by the comprehensive benefits of the EMEA, allowing them to raise families and pursue careers without worrying whether mom and dad would be alright.

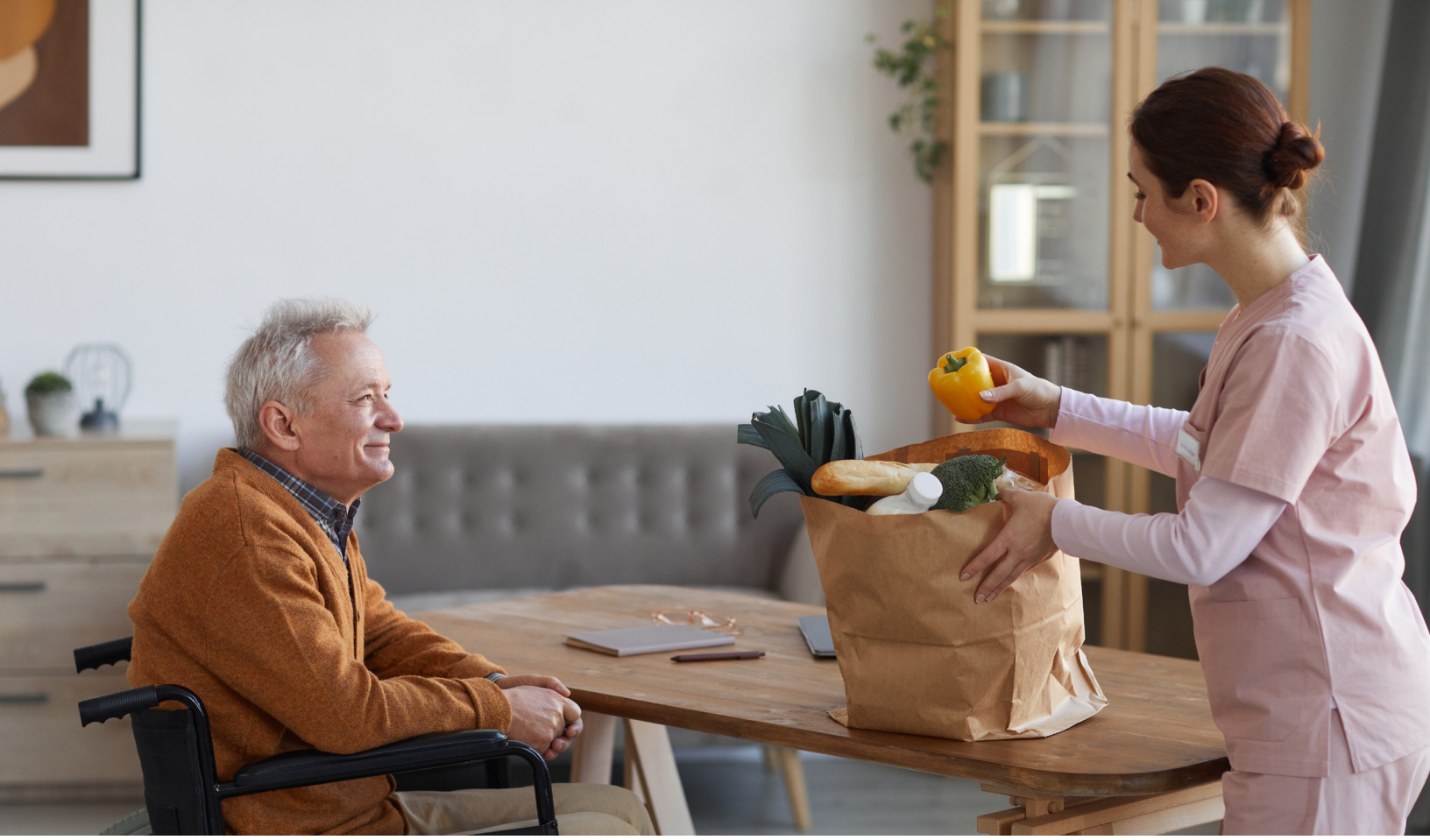
In the early 21st century, the EMEA exhibited a strong institutional (residential) care bias.[21] (In the Dutch context and for the purposes of this paper, assisted living [Dutch "elderly homes"] was considered an institutional setting, because the EMEA paid for housing costs in this setting, which Medicaid generally does not do in the U.S., and which the Dutch system no longer does today.) More broadly, the EMEA embodied a "statist" bureaucratic orientation. It was arguably a textbook case of a 1970s-style social-democratic solution that provided equal, one-size-fits-all benefits to every eligible beneficiary, rather than care tailored to individual needs. This meant that many older adults received residential long-term care they did not need, at taxpayer expense. Similarly, many seniors with strong informal support networks ended up getting more home care than they required.[22] While this had seemed affordable during the late 20th century when the economy was experiencing robust growth and the ratio of workers to retirees was favorable, the slower economic growth of the first decade of the 21st century, culminating in the Great Recession of 2008/9, as well as the impending age wave, led to a consensus that reforms were needed.

Age Wave and Fiscal Sustainability

Together with the Nordic countries, the Netherlands was one of the first countries in the world to offer universal access to quality long-term care. As a result, it has always been near the top of the OECD in terms of spending on long-term care. In 2005, the country already spent 3.4% of GDP on long-term care, reaching 3.9% by 2018.[23] Even after its reforms over the past two decades aimed at achieving greater efficiency, the Netherlands still spends more on long-term care as a percentage of GDP than any other country in the world: 4.4% of GDP, compared to an OECD average of 1.8%, and more than three times what the United States spends (1.3%).[24] It's important to keep in mind that the Dutch figures are comparatively inflated for two reasons: in the Netherlands, medical care in nursing homes is financed by the LTCA, whereas in most other countries it is billed as a health care expense; and the Dutch figures include the country's (very generous) social care benefits (which amounted to 1.3% of GDP in 2021), which many other countries' long-term care spending figures do not.[25] While actual Dutch spending on long-term care may thus not be quite as much of an outlier as the OECD data make it appear, it remains true that the Netherlands provides long-term care at a level of universality and comprehensiveness close to that in the Nordic countries. Despite this fact, in a 2023 Eurobarometer survey, when presented with the statement "Thinking about the taxes and social security contributions you might have to pay, would you like to see the Dutch government spend less, spend the same, or spend more on long-term care (nursing care assistance for older persons at home or in nursing homes)?," 62% of Dutch responded with "more," 32% with "keep at current level," and only 4% with "less." There are few signs that public expectations with regard to universal access, comprehensive benefits, and quality care are diminishing.

> *Without reforms, by 2040 long-term care spending would equal between 7% and 9% of GDP.*

In the early 2000s, with the share of the Dutch population aged 80 or older projected to grow from 3.9% in 2010 to 10.2% in 2050,[26] policymakers were clear-eyed about the projected increase in long-term care costs. A government analysis in 2010 projected that without reforms, by 2040 long-term care spending would equal between 7% and 9% of GDP, depending on the degree of efficiency gains in the system.[27] This realization put tremendous pressure on policymakers and stakeholders to innovate in the realms of administration and service delivery. Innovation and efficiency will be essential to the system being able to continue to provide the high-quality, comprehensive benefits the Dutch have come to expect.[28]



Shortage of Care Workers and Informal Caregivers

Another core challenge facing the Dutch long-term care system since the early 2000s is the care worker shortage, i.e., the imbalance between the demand for long-term care and the supply of care workers.[29] Much like in the U.S., the main driver of this dynamic is that the population most likely to need care is expected to grow rapidly while the labor force is stagnating. The population aged 85 or older is projected to more than double between 2013 and 2043, whereas the population aged 20-64 is projected to modestly *decrease* during this period.[30] A second driver, according to Long-Term Care Minister Conny Helder, is that many young people do not see long-term care as an attractive career.[31] Third, the Dutch long-term care delivery system has been heavily weighted toward institutional care, which tends to require more workers per beneficiary than would an efficient home care system.[32] Finally, the Dutch care workforce is characterized by the second highest degree of part-time work in the OECD, with 77% working part-time.[33] Hence the system is underutilizing the workers engaged in the sector: the average full-time equivalent (FTE) per care worker today is 0.63 in nursing homes and 0.55 in home care. As a result of these trends, institutional and home care providers are already experiencing a worker shortage today. While there were 11.1 long-term care workers per 100 people aged 65 and over in 2011, that ratio declined to 8.2 by 2021.[34]

Policymakers are now beginning to see growing care needs together with the shortage of care workers as a threat not only to future access to long-term care, but also to the national economy. Normally a shortage of workers in one economic sector could be mitigated by raising wages in that sector. In most countries in the world, care work is low paid compared to work requiring similar qualifications. In the Netherlands, however, personal care workers in both residential and home care are more equitably compensated

(relative to the economy-wide average wage) than in any other country in the OECD.[35] In 2019, roughly one in six (16.0%) Dutch workers was employed in the health and long-term care sectors. To meet the projected increase in the volume of formal care needs at today's staffing levels, the Scientific Council for Government Policy projects that this ratio would have to increase to roughly one in five (19.8%) by 2030, one in four (25.3%) by 2040, nearly one in three (30.5%) by 2050, and more than one in three (36.5%) by 2060. In other words, by 2060, more than one third of workers in the entire national economy would need to be employed in the care sector.[36] The Long-Term Care Minister has called this dynamic unsustainable.[37]

To meet projected demand, by 2060, more than one third of workers in the entire economy would need to be employed in the health and long-term care sector.

For similar demographic reasons, a shortage of informal caregivers is manifesting as well. The ratio of potential informal caregivers to those likely to need care has been steadily declining for decades and is projected to continue to drop. In 1975, there were 30 people aged 50-75 for every person 85 or older. By 2021 the ratio had declined to 14 to 1 and by 2040 is expected to drop to 6 to 1. With a growing shortage of both care workers and informal caregivers, new solutions will be needed to ensure that those needing care continue to receive the quality of support that the Dutch have come to expect. In one small step toward addressing this problem, Long-Term Care Minister Helder has invested €500 million to improve job satisfaction and employee retention in the sector.[38]

Promising Strategies to Support Aging in the Community Amid Fiscal and Workforce Challenges

Since the early 2000s, the Dutch have undertaken reforms driven by both fiscal sustainability concerns and a cultural shift toward more person-centered care, i.e., care that prioritizes the autonomy of the person receiving care. (A similar shift has been underway in the United States.) The government has implemented policy changes that serve both goals by supporting healthy, socially connected aging in a home or community setting. The country's historically rooted, vibrant social housing sector has made it much easier to achieve this shift toward aging in the community. At the same time, the housing and care sectors, as well as civil-societal initiatives like resident care cooperatives, green care farms and intergenerational cohabitation in nursing homes, have worked together to foster caring communities that mitigate the need for formal care. This paper focuses primarily on the public policy innovations, with a separate publication exploring in depth innovations among housing and care providers and caring communities.[39]

Policy Reforms 2007-2015

To address the challenges outlined above, while also supporting person-centered aging, the Dutch government developed a range of initiatives. These efforts were intended to decentralize the long-term care system, render it more responsive to efficiency incentives, reduce demand for formal care overall, and encourage those who need care to prioritize home and community settings.

In 2007, the Dutch government introduced the Social Support Act (*Wet maatschappelijke ondersteuning*, henceforth: SSA), which, among other things, was designed to support people with disabilities and aging adults to remain in the community and meaningfully participate in society. Institutionally, this entailed the national government spinning off

the household-help and home-modification components of the national EMEA – 5% of its long-term care spending – onto municipalities, with an 11% reduction in funding.[40] These services were still nationally financed, but now out of tax revenues rather than social insurance, with monies block-granted to municipalities. Anyone needing social supports was still legally entitled to them. But with the devolution of administrative responsibility and the reduction in funding, municipalities were now fully at risk for these expenses and had incentives to contain the growth in costs that would come with the age wave.[41]

Another demand-throttling reform took place in 2013. EMEA benefit eligibility was tightened such that residential care providers now no longer received compensation for capital costs for beneficiaries who qualified through the lowest three levels of the eight-level severity index. This meant that, from then on, beneficiaries qualifying at lower levels of acuity would need to receive care at home (or pay their own rent in a residential setting). This was the beginning of a conscious effort by the Ministry to usher in a separation of housing and care, part of a broader policy shift away from residential care. The stricter admission criteria led to overcapacity and closure of a significant number of assisted living facilities, and in turn the conversion of many of these to nursing homes. A survey of providers found that 150-200 residential care facilities with a total capacity of circa 10,000 elderly closed between 2013 and 2016.[42]

Finally, in 2015, the government undertook a radical reform of the long-term care system with the interrelated goals of providing "tailor-made" care at home, leveraging informal support networks, and finding other efficiencies to improve fiscal sustainability.[43] It eliminated the EMEA and assigned its three core functions – care, cure, and support – to three different programs (Table 1):[44]

In 2015, the government undertook a radical reform of the long-term care system. It eliminated the EMEA and assigned its three core functions – care, cure, and support – to three different programs.

- Institutional long-term care and highly intensive home health care are now financed and administered through a new long-term care social insurance program (a truncated version of the EMEA) governed by the Long-Term Care Act (*Wet langdurige zorg*, henceforth: LTCA);

- Nursing and personal care at home are now provided through the existing social health insurance system governed by the Health Insurance Act (*Zorgverzekeringswet*, henceforth: HIA);

- Other long-term services and supports for people living in the community—such as home modifications, cooking, cleaning, transportation, and assistance with social participation—are now provided through the nationally funded, municipally administered social assistance system governed by the Social Support Act (*Wet maatschappelijke ondersteuning*, henceforth: SSA).

In addition to care for older adults, these three pillars of the Dutch long-term care system also cover care for individuals with severe physical or sensory disabilities, as well as those with long-term mental illness.[45] The system as a whole continues to provide universal coverage and comprehensive benefits.

Table 1. Main Features of Dutch Long-Term Care Programs Before and After 2015 Reform

Act	2014	2015	Features of Act 1. Risk bearing entity 2. Procurement 3. Needs assessment
Exceptional Medical Expenses Act (EMEA)	Institutional care Home health care (intensive home health care and community nursing) Social LTC (social assistance)	[Replaced by SSA, HIA, and LTCA]	1. Central government 2. 31 regional procurement offices 3. Independent Needs Assessment Centre
Expenditure (€ billion)	24.5	–	
Social Support Act (SSA)	Household help Home adaptations Social welfare	Household help Home adaptations Social welfare *Social LTC (ancillary services that support aging in place)*	1. 342 municipalities 2. Municipalities and purchasing cooperatives of municipalities 3. Civil servants of municipalities (in most cases)
Expenditure (€ billion)	4.4	8.0	
Health Insurance Act (HIA)	Rehabilitation care	Rehabilitation care *Community nursing (home health care and personal care)*	1. 24 health insurers 2. 5 insurance concerns (representing 20 insurers); 1 purchasing cooperative (of 4 small insurers) 3. Providers
Expenditure (€ billion)	0.8	3.9	
Long-Term Care Act (LTCA)		*Institutional care* *Intensive home health care*	1. Central government 2. 31 regional procurement offices 3. Independent Needs Assessment Centre
Expenditure (€ billion)	–	17.8	

Note: Items in italics are changes in 2015. Reproduced and adapted from Peter Alders and Frederick Schut, "The 2015 Long-Term Care Reform in the Netherlands: Getting the Financial Incentives Right?" Health Policy (Vol. 123, Issue 3)(March 2019): 312-316.

The 2015 reform shifted financial risk for home health care (including personal care) from the national government's public long-term care insurance program (EMEA) to non-profit health insurers (HIA). This decentralization of home health care, together with the decentralization of social care described above, de-standardized the provision of long-term care at home and paved the way for care more tailored to individual needs. It also introduced some cost-saving efficiencies into the long-term care system by leveraging the regulated competition of the non-profit health insurance sector and by relying on municipalities to prioritize necessary home care within a fixed budget constraint. Furthermore, by integrating home health care and personal care into the health insurance system, the 2015 reform aimed to maximize prevention and minimize unnecessary doctor's visits and hospital stays. For example, if a home health nurse is bathing a client and finds wounds on their leg, or another medical issue arises, the nurse can treat them in the home, saving a doctor's or hospital visit. Putting home health and personal care in the health insurance system also solved the converse problem: prior to 2015, hospitals were having difficulty discharging patients when there was no one at home to handle medications, wound dressing, bathing etc. Assigning home health care (including personal care) to health insurers incentivizes and facilitates timely hospital discharge and more cost-effective care.

Structure and Financing of the Reformed System in Comparative Context

An overview of key features of the current Dutch long-term care system is presented in Table 2 below. To put the Dutch system in international context, it is compared to another leading universal LTSS model – Germany's social long-term care insurance program; and to facilitate policy learnings for the U.S., it is also compared to the WA Cares Fund, Washington State's social long-term care insurance program, which is far more modest in scope.

Table 2. Main Features of Dutch Long-Term Care Programs Before and After 2015 Reform

COUNTRY / STATE *(year implemented)*	POPULATION COVERAGE		BENEFITS			FINANCING	INTEGRATION	IMPLEMENTATION/ GOVERNANCE
	Universal	Transition cohort (existing retirees) covered?	Duration	Type and setting	Nursing home room and board covered?			
NETHERLANDS *(1968, reformed 2015)*	Yes	Yes	Unlimited	Long-Term Care Act (LTCA) Institutional and intensive home care Health Insurance Act (HIA) Home health care including personal care Social Support Act (SSA): Ancillary household and social supports[1]	Yes, but with income- and wealth-related cost-sharing	**LTCA** Majority contributory (employee/ pensioner payroll tax of 9.65% on earnings up to €38,098 [$41,746] in 2024);[2] remainder general revenues **HIA** 45% contributory (employer payroll tax of 6.68% on earnings up to €71,628 [$77,725] in 2024);[3] 45% community-rated premiums by employees/ pensioners; remainder general revenues **SSA** National general revenues block-granted to municipalities	Juxtaposition of 3 complementary, un-integrated systems: **LTCA** Standalone institutional LTSS / intensive home care **HIA** Integrated health / home health care, including personal care **SSA** Ancillary LTSS (social care)	**LTCA** National program **HIA** National non-profit health insurers contract with local district nursing and other providers **SSA** National statute, municipal administration[4]
GERMANY *(1995)*	Yes	Yes	Unlimited	Service, cash, or combined; HCBS & Institutional	No, but means-tested social assistance available	Payroll tax of 3.4% on earnings (split evenly between employers and employees) up to €62,100 ($67,388) in 2024;[5] pensioners pay full contribution; childless workers pay 0.6% more; workers with 2+ children pay 0.25% less per child up to 5th child; unemployment insurance pays contributions for unemployed	Standalone social long-term care insurance	National program administered by social long-term care insurance funds (organized within the social health insurance funds)
WASHINGTON STATE *(U.S., 2023)*	Near-universal (contribution requirements)	No	Unlimited (lifetime benefit max of $36,500 in 2024)	Service,[6] HCBS, & Institutional	Yes[7]	Payroll tax of 0.58% on all earned income[8]	Standalone social long-term care insurance	State program

1 Peter Alders and Erik Schut, "The 2015 Long-Term Care Reform in the Netherlands: Getting the Financial Incentives Right?" Health Policy Vol. 123, Nr. 3 (2019): 312-316, https://doi.org/10.1016/j.healthpol.2018.10.010.
2 Belastingsdienst (Tax Office), accessed January 6, 2024, https://www.belastingdienst.nl/wps/wcm/connect/bldcontentnl/belastingdienst/prive/werk_en_inkomen/sociale_verzekeringen/premies_volks_en_werknemersverzekeringen/volksverzekeringen/hoeveel_moet_u_betalen.
3 Belastingsdienst (Tax Office), accessed March 2, 2024, https://www.belastingdienst.nl/wps/wcm/connect/bldcontentnl/belastingdienst/prive/werk_en_inkomen/zorgverzekeringswet/veranderingen-bijdrage-zvw/.
4 Pieter Bakx, Erik Schut, and Bram Wouterse, "Price Setting in Long-Term Care in the Netherlands," Erasmus School of Health Policy and Management, November 2020; Wesley Jongen, The Impact of the Long-Term Care Reform in the Netherlands: An Accompanying Analysis of an 'Ongoing' Reform, Ph.D. Dissertation, Maastricht University, 2017, https://cris.maastrichtuniversity.nl/portal/files/7345428/c5595.pdf.
5 Federal Ministry of Health, "Finanzierung der sozialen Pflegeversicherung," https://www.bundesgesundheitsministerium.de/themen/pflege/online-ratgeber-pflege/die-pflegeversicherung/finanzierung.html; Ibid., "Beiträge und Tarife," accessed March 2, 2024, https://www.bundesgesundheitsministerium.de/beitraege-und-tarife.html.
6 Family members may be paid for approved personal care services.
7 Covered in theory, but most beneficiaries using WA Cares for a nursing home stay would exhaust their lifetime benefit after a few months and then either have to pay out of pocket or rely on supplementary private long-term care insurance or social assistance (Medicaid).
8 Washington State Legislature, "Long-Term Services and Supports Trust Program," Chapter 50B.04 RCW, accessed January 6, 2024, https://app.leg.wa.gov/RCW/default.aspx?cite=50B.04.

In designing social long-term care insurance systems, policymakers in the Netherlands, Germany, and Washington State each grappled with a similar set of challenges. Some of the most important ones, and differences in how policymakers navigated them, are highlighted below:

- ***Population Coverage.*** As Table 2 shows, the Dutch and German systems each effectively provide universal coverage; upon enactment, both even covered the transition cohorts, i.e. those who were already disabled or retired when the programs were introduced. While both are social insurance systems (with the exception of the SSA component of the Dutch system) and hence contributory, the Dutch system has no vesting requirement. The German program achieved near-universal coverage within a few years of implementation primarily by having a low (two-year) vesting requirement, employing an expansive definition of vesting to include contributions by working family members, and leveraging a pay-as-you-go financing approach to cover those who were already retired at the time of enactment. The Washington State program, the WA Cares Fund, makes coverage available to all workers who meet the contribution requirements (10 years over a career, or 3 of the past 6 years at time of application for benefits). When the program is mature, 88% of adults 65 or older are projected to meet its vesting criteria.[46] Those who were already retired when premium collection began in 2023 are not covered unless they work at least part-time in retirement; those who were near retirement at the time premium collection began can earn pro-rated benefits for each year they contribute. In contrast to Medicaid, none of these social insurance programs restrict coverage to those with low income and assets, or require beneficiaries to lose their financial independence. The Netherlands and Germany provide LTSS to people with developmental disabilities through the same system that provides LTSS to older adults. Washington State does as well, provided they meet the contribution requirements, but because its benefits have a lifetime cap of $36,500 (adjusted for inflation), people with developmental disabilities are likely to rely heavily on other programs, such as Medicaid, as well.

- ***Benefits.*** While there is debate in the United States about whether new LTSS social insurance programs should provide front-end coverage (for one or two years, or up to a lifetime maximum amount) or back-end catastrophic coverage, all existing models abroad—including the Dutch and German systems—provide coverage of unlimited duration. The Dutch system provides comprehensive benefits, covering even room and board in nursing homes, formal home care to individuals with low levels of functional limitation, and ancillary services and supports that support aging in place such as shopping, cooking, and stairlifts.[47] For home health care (through the HIA), there are no copayments; for ancillary LTSS (transportation, meal delivery, family caregiver supports) provided by municipalities (SSA) there is a nominal copayment of €20.60/month ($22.57/month) in 2024.[48] For institutional care or intensive home care (LTCA), there are income- and wealth-related copayments; these are low (between €200 and €1,052 per month) for the first four months, after which they increase up to a maximum of €2,887 per month. If a spouse still

> *While there is debate in the U.S. about front-end vs. back-end coverage, all existing models abroad provide coverage of unlimited duration.*

lives at home or if one is raising children, the beneficiary remains on the lower copayment schedule.[49] The various benefit packages in the Dutch system have daily caps, but these are generous by international standards and designed to cover payment in full. The German system provides capped monthly benefits of unlimited duration; these monthly caps may leave families responsible for paying for care beyond them. Whereas the Dutch social long-term care insurance system provides comprehensive benefits in institutional settings, the German system does not cover room and board, making a backstop social assistance program for long-term care (*Hilfe zur Pflege*) necessary for many families who cannot afford these costs. WA Cares benefits have no copayment or deductible, but for many beneficiaries the capped lifetime benefit ($36,500, adjusted for inflation) will not suffice to pay all of their lifetime care needs. Some beneficiaries will exhaust their WA Cares benefits and then rely on supplemental private long-term care insurance or – either immediately or after paying out of pocket and spending down their assets – on Medicaid.

- ***Financing.*** All three systems (with the exception of the SSA component of the Dutch system) are financed through social insurance. Both workers and their employers contribute to the Dutch and German systems, while the Washington State program is entirely worker funded. Funding sources in the Dutch and German systems have become heterogeneous over time due to financing challenges, equity concerns, and (in the Netherlands) broader tax reform compromises that involved rejiggering employer and employee tax burdens across multiple domains. As Table 2 indicates, the Dutch and German systems now rely on a combination of funding sources that includes worker and employer premiums, general revenues, retiree contributions, and copayments. The Netherlands covers nursing home room and board but charges income- and wealth-related copayments, while Germany does not cover room and board. The Dutch and (to a lesser extent) German systems have comparatively high contribution rates on earnings below a low cap, whereas the Washington State system has a far lower contribution rate on all earnings.[50] In the Dutch and German systems, retirees contribute out of their pension income; in Germany, where premiums are split between workers and employers, retirees pay the full social insurance contribution. In Washington State, premiums cease at retirement (primarily because the state has no income tax and hence no mechanism for universally collecting revenue from retirees).

- ***Integration.*** A major challenge in all three systems is insufficient coordination among the personal care, medical, and social-service components of aging-related care. This fragmentation can lead to uncoordinated health and long-term care and also obliges beneficiaries and their families to navigate multiple administrative processes and funding streams. In 2015, the Netherlands split coverage of long-term care from a single comprehensive program, the EMEA, into the LTCA (institutional care), HIA (home health including personal care), and SSA (social care). While this dis-integrated approach to the funding and administration of long-term care has created some wrong-pocket problems (where the entity that bears the cost does not capture resulting savings, incentivizing inefficiencies which will be discussed further below), it has resulted in much better integration of home health with personal care and other medical care.

- ***Benefit type and setting.*** In all three systems (Netherlands, Germany, and Washington State), benefits can be used for both home and community based and institutional care. In the Netherlands, those seeking home health and personal care turn to their health insurer, which conducts the assessment and provides benefits, and they may seek ancillary social care from their municipality; those seeking institutional or intensive home care turn to the LTCA. The vast majority of Dutch benefits are provided through services by paid providers. In Germany, those seeking care apply to one system and the assessment determines what level of benefits is authorized**.** Beneficiaries can choose whether to receive service benefits, (lower) cash benefits, or a combination of the two. In Washington State, there is one assessment and benefits are provided nearly entirely through services by providers; with minimal training, family members can become paid caregivers as well.

Implementing Tailor-Made Care

A key strategy for achieving more person-centered and cost-effective delivery of long-term care has been the implementation of "tailor-made care" or "tailor-made provision" (*maatwerkvoorziening*). The solidarity principle underlying the Dutch health and long-term care systems was long interpreted to mean that everyone should be treated equally: each person with the same condition should receive the same treatment. Over the past two decades, the concept of tailor-made care has emerged, wherein care is adapted to the totality of a person's physical and social context. This results in each person being treated differently. Tailor-made care was anchored in the disability and youth services space with the creation of the SSA in 2007. In the provision of home care, tailor-made care refers to "a set of services, aids, home adjustments and other measures tailored to the needs, personal characteristics and capabilities of a person." [51] One interview partner noted: "We see it most in the SSA. In fact, within the disability sector, they're much better at tailoring to people, because it's also not really health care. It takes quality of life as a point of departure, and the experience of people is one of the most important outcome measures."

The goals of tailor-made care are twofold. First, by tailoring care to individuals and better leveraging informal and community support networks, care is to be delivered in a more person-centered, targeted, and efficient manner. Second, policymakers hope that by devolving control of care budgets from the national government to municipalities,

giving municipalities flexibility as to what supports they provide and how they deliver them, municipalities will deliver social long-term care in a more person-centered, holistic way, integrated with other social services at the local level like housing and supports for informal caregivers. If effective, all of this should make it easier for frail elderly to age in place for longer, reducing demand for institutional care.

Leveraging Natural Supports in the Family and Neighborhood

One efficiency strategy inherent in tailor-made care is giving municipalities flexibility to work with beneficiaries to leverage their natural support networks to support them in managing their care needs. This should be a more cost-effective way of providing LTSS overall compared to the previous blanket uniform entitlement in the EMEA regardless of circumstance. One of the upsides of transferring domestic help and social long-term care to the SSA is that local governments know not only their residents but also the resources of their neighborhoods and communities much better than the national government does.

In developing a tailor-made service plan, municipalities look at what the client needs in a number of different areas: housing, running a household (shopping, cooking, cleaning), social and personal functioning (social connection and participation), self-care and health (helping to understand, accept, and manage one's condition), daytime activities (engaging in activities the client enjoys, such as coffee in the community center, courses, outings, music lessons, or artistic activities), managing finances, and making sure the client is aware of how to access support on evenings, nights, and weekends. The municipality also considers the intensity of support needed in each of these areas ranging from "base" to "plus" to "intensive," taking into account what the clients can do for themselves and what their informal supports can do for them. The resulting tailor-made plan identifies any public support needed from the SSA in one or more of the areas outlined above.[52]

Tailor-made care was part of the SSA since the Act's implementation in 2007, mainly for people with developmental disabilities. In the 2015 reforms, when the SSA was expanded to include social long-term care, a "kitchen-table conversation" (*keukentafelgesprek*) was added to the intake process to better customize the service plan as well as integrate social long-term care with other municipal services. When a person needing LTSS passes their municipal assessment, the first stage of their care journey is that a social worker comes to their home and sits around the kitchen table with the beneficiary and whatever natural supports – family members, friends, neighbors – the beneficiary brings to the conversation to jointly fashion a "tailor-made plan."[53] The conversation is aimed at determining what the client can do for themselves and how their friends, family, and neighbors can help; whatever remains is then incorporated into the care plan. The municipality is only obligated to provide formal support to the extent that informal supports are unavailable or fall short.

A social worker comes to their home and sits around the kitchen table with the beneficiary and whatever supports – family members, friends, neighbors – they bring, to jointly fashion a "tailor-made plan."

Nationally Funding Municipalities to Provide Home Care Integrated with other Social Services

Devolving responsibility for social long-term care – ancillary services and supports that support aging in place – from the EMEA to municipalities (SSA) in 2015 was intended to both strengthen the person-centeredness of care by better tailoring it to individual needs,

and result in cost savings. Since this reform, municipalities now have the opportunity to support beneficiaries with instrumental activities of daily living (IADLs), i.e. things like shopping, meal-preparation, managing finances, and transportation; supply them with durable medical equipment, like transport scooters; and provide them community services that facilitate aging in place, like adult day care and respite care for family caregivers. Indeed, there are no limitations on the types of services and supports municipalities can offer with SSA funding; flexibility and innovation are explicitly encouraged. They can also integrate these supports with other municipal social services (most of which are also SSA funded) that facilitate social participation.

Moving away from the individual entitlement, one-size-fits-all approach toward providing care only if – and to the extent – it is needed, and not awarding standardized benefits individual by individual, regardless of the availability of informal supports, should result in efficiencies, as should finding synergies by serving the needs of a neighborhood through investments in shared community resources. Hence when these reforms were implemented in 2015, federal funding for social care was reduced by 11%.[54]

Several interview partners noted two factors that have slowed progress in this regard. First, municipal employees lacked expertise and experience in the provision of LTSS. This is a new set of services cities have had to staff up for and experiment with. Second, during the worst years of Covid, social workers could not enter a person's home to assess their environment and tailor supports to it. Few studies have yet been conducted of the success of tailor-made care through the SSA, and the experts interviewed considered it too early to judge how well the potential for integration of home care with other social services is working.

Tailor-made care thus holds great promise not only to support the tasks that make aging in place possible, but also to bring more meaning and connection into the lives of frail seniors to combat social isolation.

The legislative mandate of the SSA is to promote independent living, aging in place, social participation, and social cohesion.[55] Tailor-made care through the SSA thus holds great promise not only to support the IADL tasks that make aging in place possible, but also to bring more meaning and connection into the lives of frail seniors to combat social isolation. A critical difference vis-à-vis the U.S. context is that this Dutch social long-term care assistance is not means-tested; its universality opens the door to investments that make the community as a whole more supportive of people with disabilities. This can include things like improving the accessibility of buildings, neighborhoods, and transportation, and providing digital – and brick and mortar – information hubs on the range of available home and community based services and supports (like Aging and Disability Resource Centers in the U.S.).

Municipalities are already using the significant level of SSA funding block-granted to them by the national government to make neighborhoods and communities more age- and disability-friendly. As one interview partner noted: "So I think the idea was to give these municipalities some freedom. And also they're no longer entitlements, so they have some more discretionary power to spend that money the way they want to … to be efficient, but also to maybe spend on different things. So not only looking at the care part, but maybe the prevention or the broader social assistance or increasing the wellbeing in the neighborhood, etc. That was the idea." One of the advantages of the decentralization brought by the 2007 and 2015 reforms is that the country's 342 municipalities are now laboratories for experimentation in the delivery of tailor-made care. In the coming years, municipal civil servants will gain experience and expertise, some cities will do it better than others, learning will occur, and best practices will emerge.

Housing, Support, and Care for the Elderly Initiative (WOZO)

To prepare for an aging society and impending care worker shortage, in 2022 the Ministry of Health, Welfare, and Sport (henceforth: the Long-Term Care Ministry) – which governs health and long-term care – launched the Housing, Support, and Care for the Elderly (*Wonen Ondersteuning en Zorg voor Ouderen*, or WOZO) initiative. The program seeks to foster health, well-being, and resilience by supporting seniors to age in place either in their own home or by moving to a clustered senior housing community. While the government is investing EUR 770 million in WOZO over five years,[56] this is only a small share of the investments required. Rather than bear the full costs of the initiative directly, the government achieves its goals primarily through partnership with stakeholders via the aforementioned polder model. As noted earlier in the discussion of the political-cultural foundations of the Dutch system, the polder model is a decision-making approach based on consensual, decentralized collaboration among parties with a shared stake in an outcome, where each party compromises in the interest of the larger objective.[57] This approach is often used by the government to achieve results in collaboration with the non-profit sector and, sometimes, private investors as well.

Through its WOZO initiative, the Long-Term Care Ministry is fostering and marshalling multisector collaboration.

Through its WOZO initiative, the Long-Term Care Ministry is fostering and marshalling multisector collaboration in three ways. First, it is driving enhanced cooperation among stakeholders to streamline and better integrate access to primary care and other preventive and re-abling health and long-term care supports provided at home through various financing streams. The goal is to give self-directing older adults access to community nursing, general practitioners, and ancillary supports close to home, i.e. to make neighborhoods conducive to aging in place. The hope is that seniors will leverage these supports to stay fit longer and (re) learn skills that support living independently. Two significant initiatives have resulted from this multisector collaboration: the Integrated Care Agreement (*Integraal Zorgakkoord*, or IZA), which the Ministry concluded with umbrella organizations of hospitals, elderly care providers, and mental health care providers to develop and implement strategies to ensure access to quality, affordable health and long-term care; and the Healthy and Active Living Agreement (*Gezond en Actief Leven Akkoord*, or GALA), which the Ministry concluded with municipal governments, municipal health services, care providers, and non-profit health insurers to develop and implement a set of strategies designed to address social determinants of health, including the development of strong social networks.[58]

Second, both the government and providers are investing heavily in leveraging technology to more efficiently deliver care and support aging in place (age tech). This is a critical component of efforts to get ahead of the impending worker shortage. Examples of such age tech are video calls with a community nurse through an easy-to-use tablet, substituting remote care for some in-home visits; automatic medication dispensers that remind clients verbally when to take medications and then dispense them, forestalling the need for a nurse to be present at every medication point during the day; airbags worn around the waist to prevent hip fractures when a frail individual falls; and fall sensors that alert the nurse when someone has fallen. These are some of the most widely deployed examples of the technological innovations being incorporated into the care delivery system to support aging in place safely with fewer workers at lower cost. This approach has already shown success in Denmark, for example, and is being steadily introduced in the U.S., as well.[59] While more and more providers are using age tech each year, the Long-Term Care

Ministry finds that much more work needs to be done in terms of financing, organization, dissemination, and training in order to integrate proven age-tech applications into the work of care providers and to support clients in using it.

Third, through WOZO, the Ministry is aiming to effect a paradigm shift toward home and community based care. To this end, the government is incentivizing the care and housing sectors to invest in clustered senior housing rather than nursing homes. In 2022 it announced that it is halting all public funding of new nursing home capacity; funding will be limited to replacement demand and maintaining prior investments.[60] This is a continuation of a trend since 2013, when the government gradually began measures that resulted in the closure of a large share of the assisted living and nursing home stock. This move away from institutional settings and toward clustered senior housing is being pursued both because it is more person-centered (and the clear preference of older adults) and because, if the nursing home model of care had continued with the increasing numbers of older adults in the coming decades, the long-term care system would have become unsustainable in terms of both cost and labor-force demands.

> *Through WOZO, the Ministry is incentivizing the care and housing sectors to invest in clustered senior housing rather than nursing homes.*

Since 2022, the Long-Term Care Ministry has been working with municipalities, provincial governments, (mostly social) housing developers, investors, care providers, and seniors to foster the development of 290,000 new housing units for the elderly by 2030.[61] Implementing WOZO is proving challenging, however, because each of these actors faces significant challenges. The municipalities are new to the long-term care space and lack experience and expertise in this area. The housing associations are willing to build housing for older adults, but as one interview partner noted, “If there’s a problem, if they get Alzheimer’s or if they can’t get out of bed, we are not caregivers. So, we have to have the guarantee that there will be someone to take care of our people.” Further, senior housing development is a tough business model, because age-friendly housing costs more to build and most Dutch seniors can only afford to live in social housing, where rent levels are regulated. Finally, health insurers and nursing providers find it hard to break even if they are serving clients who are not geographically concentrated in one building, complex, or neighborhood.

Through WOZO, the Ministry is bringing together key stakeholders from all these sectors to encourage them to listen to one another; develop relationships; become better acquainted with their shared demographic, housing, and care challenges; and map out collaborative solutions. The first step is to identify specific pieces of land that could be developed in the coming years for clustered senior housing communities. Municipalities have to be willing to sell the land to housing associations at below-market prices, something which runs counter to traditional practice. To achieve movement in this regard, elected local officials must sometimes intervene, and there is also the latent threat that the national Ministry could direct the provincial government to zone a desirable parcel for this specific type of functional use. The second step is to reach agreements on the development of clustered senior housing communities. Parties to such plans can include the provincial government, municipal government, housing associations, health insurance companies, and care provider organizations. Provincial-level agreements were completed in the winter of 2023/24. Municipalities are now following up with concrete implementation plans. For each site to be developed, an agreement needs to be in place between the housing developer and care provider that home health care will be available in the new housing community. While today Dutch citizens can choose their home health provider, one interview partner noted that with the age wave, to achieve the efficiencies needed to serve everyone affordably, it may become necessary to have one care provider assigned to each clustered housing community.

The Ministry is bringing together key stakeholders to map out collaborative solutions.

The Long-Term Care Minister, Conny Helder, summed up the care goals of the WOZO initiative as "Do it yourself (if possible), at home (if possible), and digitally (if possible)."[62] Critics of WOZO are concerned that it is risky for seniors with mild physical or cognitive impairments to live in the community without full-time on-site nursing and home-care support. Before the tightening of the LTCA eligibility threshold for institutional/residential care in 2013, such individuals would have qualified for a nursing home or assisted living facility, whereby housing and care would have been fully financed by the EMEA; since this policy shift, low-acuity seniors can choose to remain in their home or move into clustered senior housing (similar to independent living communities in the U.S., but with home health care available to the full extent needed, provided by the HIA), but must pay their own housing costs unless they are low-income and qualify for social housing or rental subsidies. This is a major cost savings for the long-term care system, because it is no longer on the hook for room and board for people with mild impairments (people who in most countries would not have qualified for institutional/residential care in the first place). The risk inherent in the move away from nursing home care is that, while medical care is available immediately in a nursing home, care may not arrive in time if someone has an urgent medical need in these new age-friendly housing communities.[63] Thus, while WOZO gives seniors greater autonomy and independence – aging in place in a way that resembles normal life – it does so with greater risk.

Reformers argue that respecting the "dignity of risk" is essential to supporting person-centered aging.

Interview partners noted that this rebalancing toward home and community based care is not best understood as a government-driven, cost-saving phenomenon, but rather represents a broad-based societal trend in preferences around aging. Reformers argue that respecting the "dignity of risk" is essential to supporting person-centered aging. The fundamental tradeoff is between greater quality of life in one's final years vs. greater safety in an institutional setting.

Caring Communities

As policymakers began to look for innovations to provide care more efficiently, a key component around which they coalesced, beyond the tailor-made care policies discussed above, was a more participatory society with more active citizenship. While there has been little willingness to sacrifice the high-level entitlement to quality comprehensive care, there has been a strong push toward shifting a portion of the responsibility from the government to communities, neighbors, and volunteers. This push is not coming primarily from above; equally robust is a broad social movement supporting aging not in a medicalized, institutionalized way, but in more organic setting that feels like home. In recent years this has manifested in a number of ways, most prominently in resident care cooperatives, green care farms, and reciprocal care communities.

Resident Care Cooperatives

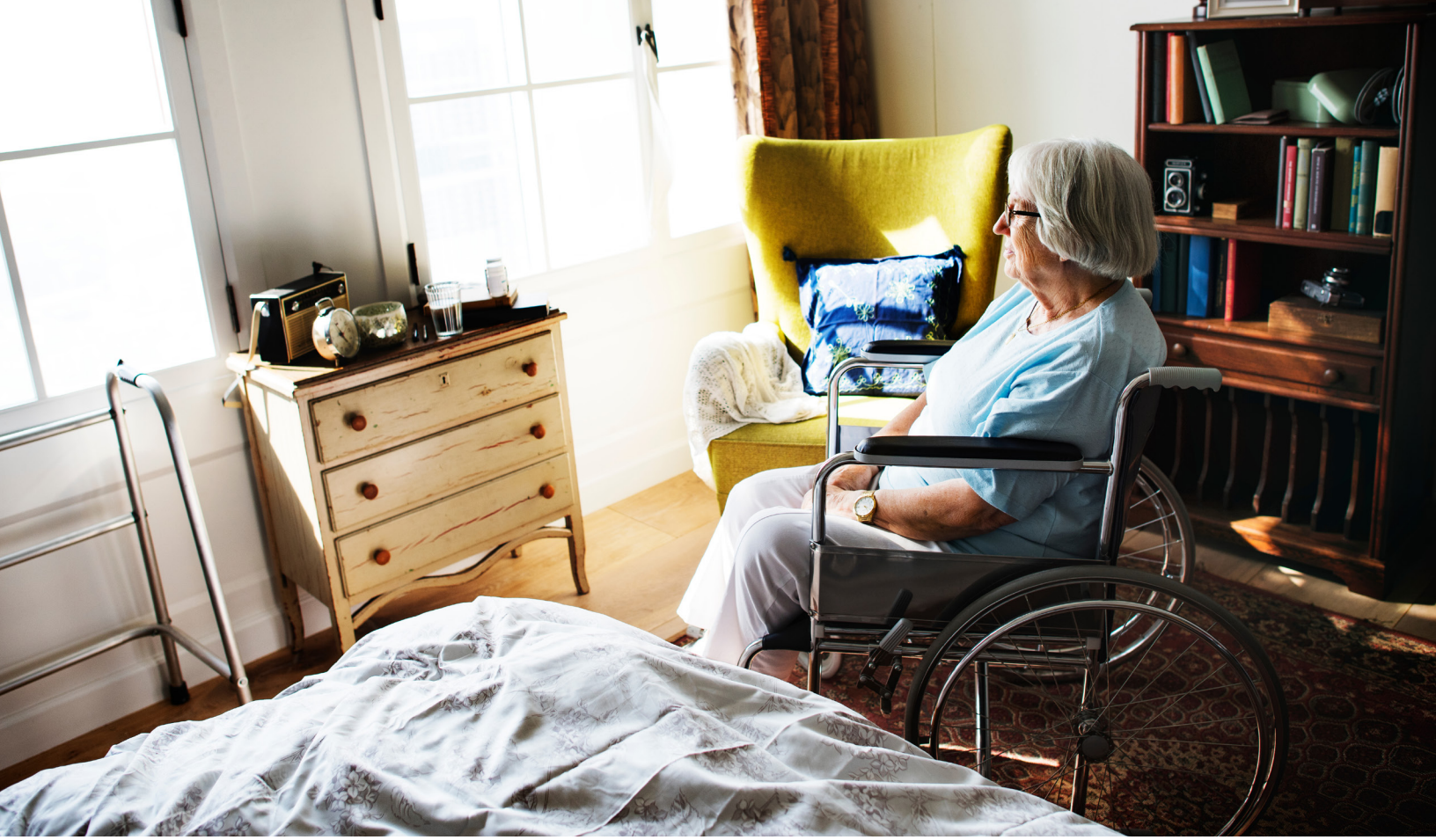
As demand for long-term care has grown with the age wave and is projected to grow much more in the coming decades, and the government has begun to rein in spending on formal care, the Dutch people have been picking up the slack. Care cooperatives (*zorgcoöperaties*) are grass-roots initiatives where residents come together to support one another to age in place, similar to the Village Movement in the U.S.[64] Residents pay low annual dues (typically less than €30) to join and commit to helping their neighbors with things like odd jobs, shopping, going for walks, etc. In turn, when they themselves need such support, they will be able to rely on other members of the care cooperative.

Green Care Farms

The Netherlands has created a regulatory environment that is conducive to innovative dementia care settings outside of a nursing home. The most widespread model is green care farms: small-scale, fully functioning farms that offer either adult day care activities or 24-hour housing with care supports. There are 1,300 care farms in the Netherlands, serving 30,000 clients.[65] About one quarter of these serve people with dementia, while others care for people with psychiatric conditions, addiction, mental disabilities, or children with autism. For people with dementia, care farms provide a safe, home-like environment with ample opportunities for social interaction, fresh air, and purposeful activities like gardening, feeding animals, and other farm chores. Studies of adult-day services at green care farms have found that they offer people with dementia meaningful engagement, social interaction, exercise, and healthy diet, while also providing critical respite to family caregivers.[66] For family farms, offering care to people with dementia is not only a meaningful contribution to society but also brings in an additional revenue source which helps them make ends meet year round and weather economic downturns.

Reciprocal-Care Clustered Housing Communities

Another example of civil-societal actors taking on more responsibility to support aging in place amid fiscal and workforce constraints is reciprocal-care senior housing communities. The institutional reforms of the past two decades have been driving key stakeholders toward the pursuit of clustered senior housing. First, the decentralization of responsibility for social long-term care in 2015 put municipalities on the hook to ensure their elderly could age with dignity and independence. This is a major responsibility because the population has developed high expectations for the universality and comprehensiveness of long-term care, and this responsibility was transferred just as the age wave was about



to fully materialize. Second, the 2013 reform that eliminated housing costs from the long-term care benefits provided to low-acuity EMEA beneficiaries led to the closure of a significant share of assisted living facilities.[67] Third, the coalition agreement of 2021 froze nursing home capacity at existing levels, despite the rapid growth in the population needing care.[68] Together, these measures meant that going forward, housing for most new long-term care beneficiaries would be in the community, where the client pays their own rent and receives any income-based housing subsidies for which they are eligible. Since roughly one third of all housing in the Netherlands is owned by social housing associations, there are more than enough potential suppliers of such housing, if these associations can be motivated to invest in the senior housing sector.

The policy shift from institutional to home and community based care, together with the growing aged population, have put pressure on municipalities to support new models of age-friendly housing. Previously, a municipality could refer mildly frail older adults to the national EMEA and, as one interview partner put it, “they would disappear” into nationally financed residential/institutional care settings. The municipality would no longer have to concern itself with their housing or long-term care. Since access to nursing home care was restricted in 2013, however, municipalities can no longer refer older adults with minor limitations to assisted living facilities or nursing homes. They must find ways to meet their housing and social care needs in the community. As one interview partner noted, municipalities are now asking themselves: “Oh, how does this work? And what do I have to do? And for whom?” And then slowly the notion came, “Oh shoot. If they are all going to live at home, and they can’t get up and down the stairs and we don’t have [enough] nurses in the neighborhoods, then how are we going to do that? So, we have to make new places for them, new spots where they can live independently with a minimum of professional care that supports them.”

As a result, municipalities now not only need age-friendly housing, they also need housing that fosters reciprocal care. As one interview partner noted, the challenge is "who's going to take care of you? Because in the last 40, 50 years, we've professionalized all that. So, once you had your indication [eligibility approval from the long-term care insurance program], then you were taken care of. Your meals were cooked, your bed was cleaned and you were cleaned, yourself and everything, everything, everything. And we made a society where our buildings and our public spaces are... They don't invite you to meet each other. It's all focused on individuality. So, if you want people to take more care of each other, then you have to create ways for them to meet. Because if I don't know you, I'm not going to take care of you. And if I don't meet you, I'm not getting to know you." Supporting clustered senior housing is a strategy to develop a built environment that fosters reciprocal care.

If you want people to take care of each other, then you have to create ways for them to meet. Because if I don't know you, I'm not going to take care of you.

Other strategies to reduce long-term care costs, like relying more on formal home and community based care, have proven effective but by themselves are insufficient to the scope of the age-wave challenge. By reducing the need for formal care altogether, reciprocal-care clustered housing helps address both the financing and care worker challenges. Reciprocal care is the newest arrow in the country's aging policy quiver and arguably the one with the most energy today. The government understands that reciprocal care is much more likely to materialize if the senior housing stock is conducive to it. Hence, the national government is actively supporting the construction of such housing through the Housing, Support, and Care for the Elderly (WOZO) initiative discussed above.[69]

Other strategies to reduce long-term care costs, like relying more on home and community based care, have proven effective but by themselves are insufficient to the scope of the age-wave challenge.

At the same time, now that municipal governments bear risk for social long-term care costs and can no longer refer residents with mild functional impairments to residential care settings (due to the aforementioned tightening of eligibility), they tend to be keenly interested in supporting the development of reciprocal care communities. They have a robust set of tools to encourage such developments. They can zone parcels for social housing and increase the allowable density for such housing. And they steer housing associations toward reciprocal senior housing development through the biannual Performance Agreements which social housing associations are required to conclude with the municipal government (and the national renters' association). This is another example of the polder model at work: These Performance Agreements are not legally binding, but are carried out based on the mutual trust and interdependence that exists between municipal governments and social housing associations, as well as broad alignment around social goals. As one interview partner noted: "Social housing associations build for problems, not profit," and a main problem on which municipal governments are now focused is building enough affordable, reciprocal-care senior housing to meet the needs of an aging population.[70] For in-depth analysis of exemplary reciprocal care communities and their recipes for success, see a tandem publication that is part of this larger research project.[71]

Vibrant Social Housing Sector

Social housing is a key component of the social policy infrastructure that renders home and community based aging affordable in the Netherlands. It has deep historical roots and merits closer examination.

Like Germany, Austria, and many other European countries, the Netherlands has a large and vibrant social housing sector, dating from the late 19th century when European societies grappled with the need to house large numbers of workers moving to rapidly industrializing cities. During that era, social reformers formed cooperatives, known as housing associations, that sold shares to benevolent investors who were willing to receive sub-market returns in order to support worker housing construction. Access to capital on favorable terms allowed the housing associations to achieve operating surpluses, which they reinvested into more housing construction, creating a revolving construction fund. The Dutch refer to this 19th century innovation that led to the creation of the first affordable housing of the modern era as "philanthropic capitalism."[72]

Social housing is a pillar of the social policy system that renders home and community based aging affordable in the Netherlands.

In the early twentieth century, the state began to see a strong public interest in affordable housing. The Housing Act of 1901 provided long-term low-interest government loans, which national and municipal governments financed by issuing bonds, to increase the construction capacity of the housing associations. The Act also required that housing associations be non-profit, and introduced public oversight. The government required further that these associations reinvest all profit achieved from rental income into the maintenance and expansion of their social housing stock. It also regulated rent levels and provided targeted subsidies. During the first half of the 20th century, social housing associations were able to significantly expand housing construction for low- and middle-income individuals of all ages and to maintain affordable rents. During the housing shortage after the Second World War, the government expanded its subsidies of social housing associations, allowing them to increase construction beyond what their revolving loan funds would have allowed. By 1975, 37% of Dutch households lived in social housing. In the decades since, the government has reduced its direct financial involvement in this sector, ultimately eliminating all direct financial ties in the Balancing Act of 1995. The Act cancelled all outstanding government loans to housing associations, eliminated any subsidies, and allowed the associations to own and rent their housing stock freely as social enterprises.[73]

Historical access initially to private – and later to public – capital investment on below-market terms, as well as government subsidies, allowed Dutch housing associations over a century and a half to build up significant housing portfolios that were debt free. These legacy assets have generated more revenue than has been needed to maintain them, allowing the sector to steadily expand. This is the main reason why affordable housing for older adults is widely available in the Netherlands today. While social housing associations no longer receive direct government construction loans or subsidies, they are still able to borrow with a national government guarantee, which enables borrowing at rates similar to direct bond issuance. This backstop is provided by the Social Housing Guarantee Fund (*Waarborgfonds Sociale Woningbouw*, henceforth: WSW), a non-profit entity created in 1983 that guarantees interest and repayment obligations on loans provided to Dutch social housing associations by private investors. The WSW is funded by its members, who represent 98% of the social housing system. If the WSW's internal capital proves

insufficient to fulfill its guarantee function, it can call on the capital of its members; if that proves insufficient, the WSW has contractual backstop agreements with the national government and municipalities. This multi-tiered guarantee system limits risk for private investors, ensuring that social housing associations have access to capital markets under optimal conditions.[74]

> *The Social Housing Guarantee Fund's multi-tiered guarantee system limits risk for private investors, ensuring that social housing associations have access to capital markets under optimal conditions.*

Social housing associations also retain the ability to buy or lease land from the government at a heavily discounted "social" rate. This amounts to a collective €400 million subsidy compared to private developers annually.[75] Access to supply-side subsidies in the form of below-market capital and land has enabled Dutch social housing associations to continue to construct new affordable housing well into the 21st century and to offer far more affordable rents than in most of the private housing market, while breaking even or making a social profit that can be reinvested. Today, the country's 284 social housing associations own two-thirds of all rental units in the Netherlands and house 29% of Dutch households.[76] In addition, the national government offers a demand-side subsidy in the form of the rental allowance (*huurtoeslag*), provided through the tax system, which helps people with low income and assets pay their rent in affordable housing.[77]

The Netherlands' vibrant social housing sector anchors the affordability of reciprocal-care clustered senior housing, and of aging in place generally, on both the supply and demand side. On the supply side, the social housing associations have created – and continue to build – a vast supply of affordable senior housing, whose monthly rents are capped at €879.66 in 2024.[78] Over one third (35%) of Dutch seniors live in social rental housing (55% own their home and 10% rent privately), while over three-quarters (77%) of Dutch *renters* 65 or older live in social housing.[79] The average rent paid by a household 75 or older living in social housing is €608 in 2024, including utilities (compared to €869 in private-market housing).[80] Seniors who cannot afford even such modest rent are eligible for the aforementioned rental allowance (also available to renters of privately-owned affordable housing); one quarter of Dutch households aged 75-85 receive it.[81] Since the vast majority of reciprocal-care senior housing is social housing, this means that seniors living in such communities have affordable housing; between the low rents and the rental allowance, virtually all seniors can afford to live there.

Remaining Challenges

Due to the groundbreaking Dutch innovations and reforms of the past two decades, resting on the foundation of the historically evolved social housing sector, tremendous progress has been made toward addressing the three core challenges discussed at the outset of this paper: an overreliance on institutional/formal care, the fiscal unsustainability of the long-term care system vis-à-vis the age wave, and the shortage of care workers and informal caregivers. While these challenges have by no means been overcome, the Netherlands is now far better positioned to weather them than it was two decades ago. In the wake of the myriad reforms and innovations described above, however, new policy challenges have emerged in the design and delivery of care.

Sustainability Challenges

The Dutch reforms incentivizing aging in place and the policy and delivery system innovations better leveraging informal and reciprocal care have all served to reduce projected reliance on formal and institutional care vis-à-vis the system's trajectory at the turn of the century. Nonetheless, the implicit sustainability equation remains, and it must be solved for: total care needs of older adults and people with disabilities will need to be met by some combination of upstream intervention (prevention), formal care, informal care, reciprocal care, and age tech. If not, the remainder of this equation – people unable to live independently and yet not receiving the support they need – will suffer harm.

The innovations undertaken in recent years portend significant progress toward solving for this equation in a human-centered way. The Housing, Support, and Care for the Elderly (WOZO) initiative is investing in aging in place, reciprocal-care clustered housing, and age tech. It is also advancing preventative care measures among adults on the cusp of potentially needing long-term care and public education of younger generations in an attempt to effect a paradigm shift in expectations about healthy and independent aging. Younger generations are learning that, in the future, it will no longer automatically be the case that the government takes care of all your needs when you are older. Supports will still be there, but they will be less comprehensive and more empowering in nature.

The government is taking an ambitious, transformative, long-term approach to this paradigm shift. In the coming decades, it could well bear fruit. Municipalities will be incentivized to innovate in their provision of social care through age-friendly urban planning, housing development, and integration of social services. Housing associations and nursing care providers will partner on developing clustered senior housing communities that leverage reciprocal care and reduce the need for both nursing home and home care utilization. Such communities hold promise to foster healthier, happier, and less socially isolated aging. Greater investment in assistive devices and other age tech will also likely substitute for some of the formal and informal care provided today.

> *The number of care jobs cannot grow indefinitely, and thus care must be organized differently.*

Despite the many promising innovations of recent years, the scope of the demographic and workforce challenges will likely leave many older adults who need formal care having to rely on informal supports. As in virtually all OECD countries, this greater reliance on informal care will likely pose a threat to the availability of workers in the rest of the economy, and hence to economic growth. As Long-Term Care Minister Helder has underscored repeatedly, the number of care jobs cannot grow indefinitely, and thus care must be organized differently through government-wide strategy shifts in areas such as housing, health care, social support, and transportation.[82] Continued innovation will be needed to forestall a care crisis and broader economic crisis as the age wave materializes.

System Design and Delivery Challenges

Long-term care policy is complex due to the myriad, heterogeneous, overlapping domains that policymakers endeavor to coordinate and influence: different systems of care (health, personal, social), workers (nurses and home care aides), care settings (nursing home, assisted living, clustered senior housing, home-based care), and financing systems (in the Netherlands: LTCA, HIA, SSA). Coordination must also be achieved between the care and housing sectors; national, provincial, and municipal governments; public and private

sectors; and between all of these and consumers. Due to this complexity, aligning financial incentives with desired outcomes is challenging.

Over the past two decades, many OECD countries have set a goal to better coordinate and integrate the delivery of health and long-term care.[83] Most countries have struggled in this endeavor—with the exception of Nordic countries such as Sweden, where institutional, home, and social care are all funded through a single financing stream (general revenues) and managed in an integrated fashion at the regional and (primarily) municipal levels.[84] In the Netherlands, a major success of the 2015 reforms was integrating health care and home-based long-term care. This integration allowed more holistic and tailored home health care.[85] A major downside of these reforms, however, was that the disaggregation and decentralization of long-term care created new coordination and incentive problems. With three unintegrated payers of long-term care (LTCA, HIA, SSA), the system as a whole now lacks incentives to ensure clients are getting the most appropriate type of care in the most appropriate setting.[86]

Wrong-Pocket Problems: Getting the Incentives Right

Each of the three branches of the Dutch long-term care system now has its own statutory framework, administrative regulations, budgetary incentives and constraints, and implementing agencies. Crosscutting incentives among these systems are inevitable, and sometimes lead to inefficiencies. For example, a municipality overwhelmed by the social long-term care costs from the age wave, or experiencing budgetary pressures in general, may seek ways to reduce its expenditures in this area. Such a municipality has an incentive to direct residents to an institutional care setting, where the LTCA picks up the cost of care. Indeed, a 2021 study of municipal responses to the 2015 devolution of social care responsibilities from the national government to municipalities found that municipalities in poor financial condition have a 2.5% higher rate of their residents being admitted to the LTCA. The same study also found that, since national funding for municipally administered social care (WMO) was tightened in 2017, LTCA admission rates increased about 14% in 2018 and 2019 compared to 2015. These findings indicate possible strategic cost shifting by municipalities. The authors suggest this could be mitigated by risk-adjusting national funding for the WMO by inversely relating these allocations to the proportion of frail elderly in the municipality using and/or being admitted to the LTCA. Such strategic cost-shifting could also be reduced by more clearly delineating the boundaries between what is covered by the LTCA and the WMO, such as by restricting LTCA coverage to institutional care (dropping coverage of intensive home care).[87]

Municipalities are also not incentivized to invest resources (home adaptations, a scooter, domestic help) to keep a frail senior in the community because they do not share in any of the resulting system-wide savings from the reduction in potential LTCA or HIA spending.[88] Yet, such supports are critical to enabling someone on the verge of needing nursing home care to age in place. Similarly, health insurers have an incentive to direct a home-health care client whose needs are getting more severe to a more expensive institutional care setting paid for by the LTCA. Furthermore, health insurers are not able to bill the HIA for district nurses performing social care, like taking actions to ensure a client is eating well. Overall, these misaligned incentives are inefficient and often more expensive for the long-term care system as a whole. They also run counter to the goal of person-centered care. Prior to the 2015 reforms, when the EMEA administered all types of long-term care, these silos did not exist.

Municipalities and health insurers, as well as leading Dutch health economists, realize that these inefficiencies need to be overcome. In some parts of the country, municipalities and health insurers have started to work on ideas for sharing the risk of efficient, quality care through shared payment systems. Others have worked on better communication and coordination. A well-suited vehicle for improved coordination is the kitchen-table conversation introduced through the WMO. If district nurses were invited to these, this would present an opportunity to develop a holistic care plan.

Care Coordination in Home and Community Based Care

To fully deliver on the espoused goal of providing "tailor-made" home and community based care, the Dutch long-term care system needs a case manager function formally embedded somewhere in the system, funded through either the HIA or SSA. But as one interview partner noted: "No one is paid to coordinate care across these two systems." Another interview partner noted: "Sometimes there is [a case manager] and sometimes there isn't, it's a big mess around case management. And in some cases, it's paid from the Health Insurance Act and they find money somewhere, but there's no structural solution to that. And so, in general, there is not enough money or there's not money allocated for coordination. It's purely for [care] delivery." As a result, clients often have to deal with multiple providers. One study found that if all people with dementia had a case manager, it would save the system €1.2 billion annually at 2023 caseloads, and €2.8 billion annually at the caseloads projected for 2050, largely due to reduced hours of work needed by direct care workers. Silos in the long-term care system impede such a reform, however.[89] As one interview partner noted: "The municipalities are responsible for the social part of long-term care and the health insurers for the more personalized home care, more medical type of long-term care. And well, of course there's a gray area in between, but they have completely different financial incentives."

Not only is case management inconsistently funded and available, there is often no way for providers to bill for attending care coordination meetings. The interview partner continued: "If you want, for instance, to have a meeting of a general practitioner with a district nurse and a social worker, they don't have a financial title, as we call it, to fund this. And if they need to talk to each other for one hour that's non-productive time." As a result, home health care and municipally provided ancillary long-term services and supports are not formally coordinated. A client could have a nurse from a health insurer (HIA) come in the morning to help with wound dressing, bathing, and eating; a social worker from the municipal SSA midday to help with mobility and social engagement; and a GP come in the afternoon, and this care is typically not coordinated at all.

The system would do a better job of meeting its goal of providing holistic, person-centered care if these two schemes were coordinated. The largest home health provider, Buurtzorg, has tried to do this to some extent by developing Buurtdiensten, which provides social care funded by the SSA. Those two arms of the broader Buurtzorg organization do coordinate to some extent, but for the system as a whole, this remains perhaps the largest endogenous structural challenge. The expert interviews revealed that there is growing awareness of this problem among administrators and stakeholders, and there are myriad efforts underway to mitigate it. Some municipalities have developed neighborhood teams consisting of a general practitioner, a nurse, and a social worker, for example, to improve care coordination and case management.[90] They try to identify what an older person needs and which provider(s) should be involved, and to bring in the client's health insurer as well.

Such efforts run into wrong-pocket problems, however, where financial incentives may not be sufficiently strong to motivate each of the various participants to invest in the shared costs of coordination and prevention.[91]

Financing and Management of Reciprocal-Care Clustered Senior Housing

The national government is devoting considerable energy to fostering the construction of clustered senior housing communities, particularly those that operate on a reciprocal care model. While such communities should result in significant cost savings for the long-term care system over time, it has been a struggle to find housing associations willing to develop them. This is in part because the savings to the long-term care system resulting from investment in clustered senior housing are not captured by the housing associations that make these investments. This has hindered progress in the financing and development of reciprocal care communities.[92]

> *What may be needed is a system of shared savings across multiple systems, payers, and providers to incentivize investments in clustered senior housing.*

What may be needed is a system of shared savings across multiple systems (housing and long-term care), payers, and providers to incentivize strategic investments in reciprocal-care clustered senior housing. If that existed, it would be easier for a housing organization and a care provider to join forces in financing and developing a new community. This, in turn, would accelerate the implementation of government plans to reduce demand for formal and institutional care.

An additional challenge in regard to reciprocal care communities is that it is not enough to merely build these – they will also likely require some ongoing management to support the vitality, social engagement, and reciprocal care of residents. The history of urban planning is riddled with examples of theoretically ambitious projects that do not work well

in practice. For example, many social housing communities in the postwar decades were supposed to foster dynamic urban public spaces, attract shops, and more. Yet, often times, the architectural vision did not result in community or social engagement, or budgets became exhausted after the built environment was completed and ongoing funding for the social components dried up. Reciprocal care communities in the Netherlands, discussed in depth in a companion publication,[93] are too new to assess definitively whether their social vision of reciprocal care will pan out. Early experience gives cause for optimism, but only time will tell if this initial success endures.

Quality of Care and Equity Risks Stemming from Non-Earmarked Block Grants and Reliance on Informal and Reciprocal Care

Two interrelated goals of the 2015 reforms were to scale back system reliance on formal care and achieve efficiencies through devolution. Block granting funds to municipalities, it was thought, would result in more efficient, better tailored social care, since local officials know their residents better than the national government ever could. Interview partners flagged initial reports that, while some municipalities are doing an excellent job efficiently assuming the social care responsibilities that used to be part of the LTCA, others are not.[94] Because SSA funding is block-granted without earmark, local civil servants have considerable flexibility in how they provide and integrate services. This brings obvious risks for the provision of social care. That said, the SSA obliges municipalities to conduct an individual assessment of all residents who request support under the SSA and they have a legal duty of care obligation. Anyone denied care has recourse to the administrative courts.[95] Hence to achieve budgetary savings, rather than reducing the volume of care provided, many municipalities are reducing the rates they pay to providers. One study of Dutch municipalities found an average provider rate cut of 17% in the wake of the 2015 reforms.[96]

Another risk inherent in devolution of social long-term care to municipalities is their lack of expertise in this area. As one interview partner noted: “The municipalities offered social assistance, and had social assistance workers through the SSA, since 2007 for housekeeping activities. But they got a lot of extra work in 2015 and they were not very knowledgeable [about long-term care], and we have very small municipalities too.” With both the national government and many applied research institutes and other civil-societal organizations working to socialize best practices and train administrators and providers, there is reason to expect that these challenges could be, to a large extent, overcome in due time.[97] One promising trend in this regard is that municipalities are already joining forces to leverage their joint expertise and purchasing power. By 2020, 40% of municipalities (mostly smaller ones) were cooperating to jointly contract with providers; on average these purchasing cooperatives consisted of 3.6 municipalities.[98] One interview partner noted that 20 small municipalities in the northern provinces have begun to engage in collective purchasing. Even with such progress, however, the 2015 decentralization will inevitably result in more horizontal inequity in the system, in that people with like conditions and care needs will be supported differently depending on their zip code.

An additional risk to the quality and equity of care in the Netherlands is the new reliance on reciprocal care (i.e., clustered senior housing communities) and informal care (families and social networks). On the one hand, this shift is an essential part of national strategies to mitigate the twin risks of fiscal unsustainability and the workforce shortage. Nevertheless, it is important to acknowledge that it is also likely to compromise quality and equity. Those untrained in providing care cannot be expected to keep care

recipients as safe as professional caregivers would. With regard to equity, the costs of the comprehensive formal care benefits of the LTCA were broadly shared through the LTCA's social insurance financing. The burden of informal care, by contrast, falls entirely on the subsets of the population who are willing to provide it – disproportionately women.

Lessons for the United States

This paper has explored how the Netherlands is able to continue to support its residents to age with dignity and independence despite severe fiscal and workforce challenges stemming from the age wave. The United States can learn a great deal from the structure and financing of the Dutch system, and from the many promising strategies the Netherlands has pursued to more efficiently support older adults to age safely in place. While some of the tools discussed in this paper could be helpful in bending the cost curve in Medicaid long-term care, a focus on Medicaid alone would miss that it is not merely the poor who cannot afford quality home- or facility-based long-term care. Fewer than half of U.S. seniors with significant LTSS needs receive any paid LTSS, in large part due to affordability barriers.[99] Policy reformers and advocates could draw lessons from the Netherlands on how to prepare society as a whole for the aging challenge, including its fiscal and workforce dimensions.

Lesson 1: Universal coverage results in a far more equitable long-term care system.

The first lesson the U.S. can learn from the Dutch system relates to the equity implications of the presence (or in the case of the U.S., absence) of universal access to formal long-term care. These equity implications manifest in different ways for those needing care, family caregivers, and care workers respectively. First, quality home-based, assisted living, and nursing home care are financially out of reach for most Americans. Nearly 9 in 10 Americans would prefer to age in place,[100] but most cannot afford the home care they would need to do so safely, as home care costs equate to 83% of the income of the typical older, middle-income family.[101] Nursing home costs equate to more than twice median senior household income.[102] Access to long-term care is rationed by income and assets in the U.S., with the wealthy able to afford private long-term care insurance or pay out of pocket, and the poor having access to Medicaid. The Netherlands does not ration access this way; everyone is comprehensively covered by public long-term care insurance. The example of the Netherlands shows that universal access to quality long-term care for as long as one needs it – something that seems unimaginable in the U.S. context – is indeed feasible, even in a country with a lower GDP per capita.[103]

> *The Dutch case shows that universal access to quality long-term care for as long as one needs it is indeed feasible, even in a country with a lower GDP per capita.*

A second equity issue relates to family caregivers and the relative roles of formal versus informal care. In 2015, the Netherlands was at one end of the formal/informal care spectrum while the United States was at the other; that is, the Dutch relied heavily on collectively financed paid care, while the U.S. relied heavily on family caregivers.[104] A universal, comprehensive system is not inexpensive; as noted above, the Netherlands spends 4.4% of GDP on formal long-term care, more than twice the OECD average of 1.8%, and more than three times what the United States spends (1.3%).[105] But informal care is not free; its cost is not captured in these figures, and its distribution is highly inequitable. When the opportunity costs of informal care are taken into account, cross-

national differences in the total cost of long-term care become much smaller (although still, the Netherlands invests much more overall). A political choice is whether the cost of long-term care is collectively borne and distributed based on ability to pay, or borne by a subpopulation willing to sacrifice their own economic security to provide care informally.[106] In the U.S., 7 in 10 informal caregivers aged 50 or older are female.[107] A U.S. sociologist captured this phenomenon with the aphorism: "Other countries have social safety nets. The U.S. has women."[108] While most family caregivers do so willingly out of love, there are significant equity issues inherent in designing a system that relies on a subset of the population making significant health and economic sacrifices on behalf of society as a whole. These equity issues are compounded by the fact that the subpopulations that disproportionately provide informal care may be disadvantaged in other ways.[109] Furthermore, because many workers who leave the workforce, reduce their hours, or turn down promotions due to caregiving responsibilities are in the prime of their careers, their lost productivity also harms their employers and the nation's GDP.

Other countries have social safety nets. The U.S. has women.

A third equity issue relates to care workers. In the absence of a universal, collectively financed, formal long-term care system, most families with loved ones who need care struggle to pay for it. Often they engage a care worker off the books with substandard wages and working conditions. There is a racial- and gender-equity dimension here, as well, because these workers are disproportionately female, persons of color, and undocumented. This structural exploitation of some of the most vulnerable members of society is rare in the Netherlands because the country enables those who need care to hire a care worker at collectively bargained wages.

Lesson 2: Universal coverage makes upstream interventions possible and paves the way for system-wide improvements to the care infrastructure.

In contrast to Medicaid, which catches many people downstream in their health and long-term care journey, the Dutch system provides home health care and social long-term care to anyone who needs these services and supports, as early as they need them, regardless of their income or assets. This helps more people age in place safely, slowing deterioration of their health or functional status. In turn, this results not only in greater quality of life, but almost certainly in lower system-wide health and institutional long-term care costs down the road.

This is plausible in general, but particularly for post-acute care, which may be one of the most wasteful parts of the U.S. health care system.[110] In the U.S., older adults are more likely to be admitted to a nursing home than their counterparts in the Netherlands, even though the share of older adults residing in a nursing home is higher there. One driver of this might be that higher profit margins for post-acute stays billable to Medicare incentivize higher post-acute admissions to nursing homes.[111] Another likely driver of this dynamic is that, in the U.S., most people leaving the hospital lack reliable access to home health care.[112] Given evidence that excessive post-acute skilled nursing facility care may be associated with adverse health outcomes,[113] universal home care coverage could save both short-term nursing home and longer-term health care costs for people released from the hospital.

Universal home care coverage could reduce both short-term nursing home and longer-term health care costs for people released from the hospital.

A universal long-term care financing program would also be a key policy tool to promote widespread access to age tech. Such technology can support aging in place with fewer home visits by nurses or home care aides. This will be increasingly important as the home care workforce shortage becomes more severe in the coming years.

Finally, universal long-term care coverage would pave the way politically for urgently needed, system-wide investments in the U.S. care infrastructure, because such investments could lower costs and hence premiums for the universal long-term care system. If all American workers were contributing to a universal long-term care program, this could foster a broad political constituency for significant society-wide investments in the care infrastructure, such as investments in affordable housing that would allow more adults to age in the community, or investments in a more robust system of Aging and Disability Resource Centers, which provide unbiased information and assistance as well as person-centered care planning and coordination to individuals and families.

Lesson 3: Traditional long-term care is only part of the solution.

Compared to the Netherlands, the United States is approaching the age wave from the opposite starting point: a lack of widespread affordable access to quality long-term care (whether at home or in a facility). For the United States, expansion, rather than retrenchment, of access to formal care will be needed in the coming years.

The Dutch case reveals, however, that the U.S. will not be able to fully address the aging-related long-term care challenge through traditional long-term care alone. While ensuring that older adults can age in place as long as possible will require sufficient availability of professional home care, the U.S., like the Netherlands, is experiencing a care worker shortage and fiscal challenges that will significantly worsen in the coming decades. The Dutch experience shows that in order to support aging in place amid these resource constraints, both preventative interventions and substitutes for formal home care are needed.

Hence in the U.S. as well, technology such as video calls, remote care, sensors, and automatic medication dispensers, as well as equipment such as lift systems that reduce the demands on caregivers, must be better leveraged to deliver care more efficiently and support aging in place. Collaboration between public and private entities in the housing, care, transportation and social services fields – as have been pursued through the Dutch Housing, Support, and Care for the Elderly (WOZO) initiative – will be critical to developing sufficient clustered senior housing, which can, in turn, facilitate reciprocal care.

Lesson 4: To achieve radical system transformation, a multisector approach is needed.

In the Netherlands, the national government facilitates close coordination between the different layers (national/provincial/municipal) of government, care providers (both primary care and home health care), care insurance (LTCA, HIA) organizations, housing associations, and resident associations and initiatives. The United States would benefit from such broad-based macro/meso/micro collaboration in preparing for the age wave, but it is more of a challenge in a country that is much larger and divided by federalism, income and wealth inequality, and racial/ethnic and ideological cleavages. The U.S. also lacks the Netherlands' deep historical tradition of collaboration and compromise.

For years now in the U.S., the federal government, foundations, and non-profits have led significant initiatives to better prepare the United States for the long-term care needs of an aging society. Endeavors like the state-based Multisector Plans for Aging and the Strategic Framework for a National Plan on Aging, supported by a range of philanthropic and non-profit actors, are critical building blocks, as are the White House Conference on Aging (once per decade) and state-level Aging Summits.[114] More such cross-sector collaboration, with public and private participation, will be needed to adequately prepare society to support all Americans to age safely in the community.

Lesson 5: The supply of affordable senior housing must be vastly increased to support aging in place.

In addition to the lack of a universal long-term care financing system, the shortage of affordable senior housing is a significant barrier to Americans being able to age in place. Dutch seniors are able to age in the community not only because home-health care is free at point of use (based on contributions to the HIA during one's career), but also because the country's strong social housing sector makes affordable housing available to virtually anyone who needs it. Over one third (35%) of Dutch seniors live in social housing, a majority in multi-dwelling buildings, including a small but rapidly increasing number in reciprocal-care senior housing.[115] Rents paid by adults aged 75 or older living in social housing averaged €608 ($652) in 2024, including utilities,[116] and the one quarter of Dutch households aged 75-85 who could not afford this modest rent received a subsidy.[117] By contrast, one third of senior households in the U.S. are cost-burdened by housing, half of them severely so (spending 30-50%, or more than 50%, respectively, of their income on housing).[118] The median monthly base fee for assisted living in the U.S. is $5,350, not including fees for available personal care services, which depend on the level of care needed. The median monthly cost for independent living is $3,065.[119] At these cost levels, it is unsurprising that only 13% of adults aged 75 or older who live alone can afford the median assisted living facility in their area.[120]

If policymakers do not address the high cost of senior housing, both in independent and assisted living and more broadly, low and middle-income individuals in the U.S. will continue to struggle to afford to age in place in their communities. Despite the lack of an historical tradition of social housing in the U.S., key elements of the Dutch affordability approach are feasible. Dutch social housing is ubiquitous and affordable because of private and public sector investments as well as public subsidies and loan guarantees that have provided access to capital and land on below-market terms. The major programs designed to stimulate the construction of affordable housing in the U.S. are far from sufficient to meet the need. The Section 202 program of the Department of Housing and Urban Development (HUD) is the only federal program expressly dedicated to affordable senior housing. It provides capital advances to finance the development of supportive housing for very low-income seniors (average household income: $15,000) as well as rent subsidies. Its impact is limited, however, by its sporadic and inadequate funding: new construction went unfunded for nearly a decade after 2010 and new awards amounted to only $160 million in 2023, enough to finance only 1,262 new units.[121] The largest program, the Low-Income Housing Tax Credit (LIHTC), allocates roughly $10 billion in budget authority to state and local agencies, which in turn give tax credits to developers of affordable housing. The LIHTC program funds about 90% of all new affordable housing in the U.S, and one third (35%) of the renters of active LIHTC units are households headed by someone aged 62 or older.[122] In both Section 202 and LIHTC projects, however, the affordability requirement expires over

time (after 40 and 30 years, respectively). This contrasts sharply with the historical success of the social housing sector in the Netherlands, which not only funded construction but also ensured it would be affordable for subsequent generations.

Over the past few years, some U.S. housing agencies have sought to achieve greater impact by better leveraging limited public construction subsidies through revolving loan funds. This approach was pioneered in Montgomery County, Maryland, in 2021 and adopted in several other jurisdictions since. Its Housing Production Fund generates affordability by providing financing on highly favorable terms, achieves scale quickly by leveraging limited public funding to partner with non-governmental entities (in this case: private developers), and ensures permanent affordability of a portion of the units developed by using the power of public control.[123] This is just one example of how the public sector could, akin to the Dutch experience, subsidize construction of affordable housing at greater scale with enduring impact. Furthermore, philanthropic capital – as well as more expansive public loan guarantees that attract other investors at below-market terms – could serve as a source for low-cost construction loans.

Lesson 6: To incentivize innovation, savings must be captured by payers that fund them.

Investments by the Dutch national government, in partnership with non-profit health insurers, care providers, and municipal governments, in innovations that foster healthy aging and aging in place, and reduce utilization of formal long-term care, are beginning to bear fruit. The share of Dutch adults 80 and older who receive long-term care in an institution declined by 36% from 2012 to 2020, and spending on community nursing has declined from 2019 through 2023. Both the average costs per client and the number of clients have modestly decreased as well, despite a significant increase in the population of older adults.[124] The universal public long-term care insurance programs, the LTCA and the HIA, are capturing these savings, which will, in turn, lower upward pressure on premiums in these programs as the age wave continues to manifest.

> *The share of Dutch adults 80+ who receive care in an institution has declined by 36%, and spending on community nursing has decreased over the last four years in a row, despite a rapidly aging population.*

A significant impediment to similar innovations in the financing, administration, and delivery of long-term care in the U.S. is the matrix of heterogeneous payers of housing, health care, and long-term care. These diverse funding mechanisms make it hard to get the incentives right. For example, if a state invests in clustered senior housing, social care services, or a 24/7 support line for family caregivers, much of the potential savings from improved senior health status or reduced long-term care expenditures may end up being captured by a for-profit Medicare Advantage plan. Meanwhile, with annual open enrollment, a Medicare Advantage plan may not feel incentivized to invest in measures that could reduce long-term care expenditure for its members a decade hence. These wrong-pocket problems are easier to fix in a system that is predominately public- or quasi-public-sector-driven and in a country with a deep historical tradition of multi-sector collaboration and compromise. Such hurdles are challenging to overcome in the U.S.

Lesson 7: Public outreach about the universal risk is critical.

A major component of the Housing, Support, and Care for the Elderly (WOZO) initiative launched in 2022 is a public education campaign preparing younger generations to plan for a different kind of future characterized by less reliance on extensive formal care, particularly in an institutional setting, and more on reciprocal and informal care. Because the U.S. is approaching the age wave from the other end of the spectrum, with inadequate rather than overly robust access to formal care, public education will be even more important here. Without radical reforms, fiscal and workforce challenges are likely to make formal care even harder to access in the future than it is today, meaning that more Americans will need to find alternative ways to age safely. The WOZO initiative educates younger adults about what aging looks like and encourages them to plan ahead, be better prepared to leverage age tech, and ultimately move to an age-friendly neighborhood early in retirement so they can develop the social network needed to access reciprocal care. In the United States, the state of Minnesota has an excellent initiative and website that helps residents learn about long-term care, plan for their future, and access additional resources.[125] Other U.S. states would do well to learn from these examples. Such outreach will increase the degree to which Americans prepare for their future long-term care needs, including willingness to do so by contributing to a universal public insurance program.

Conclusion

Many of the innovations and reforms that have helped the Netherlands manage the challenges of an aging society more efficiently could prove helpful to the U.S. Universal public long-term care insurance, whether through standalone state programs like the WA Cares Fund or an expansion of Medicare to cover long-term care, with supplemental coverage available through the private market, will be essential to preparing for the challenge of an aging society. In the coming decades, the declining ratio of working-age adults to older adults needing care will overwhelm society's ability to meet the long-term care demand either formally through the tax system or informally through family caregiving. If today's workers pre-fund a portion of their long-term care needs through social insurance, this will reduce the tax and care burdens on their children, who in the future could also be experiencing premium increases to maintain the solvency of Social Security and Medicare, just as they are bearing the costs of raising their own children.

The Dutch case also reveals that public and private investment in innovative, affordable senior housing, regulatory reform to facilitate the development of such housing, and cross-sector collaboration between the housing and care sectors could, taken together, lead to the development of reciprocal care communities. Civil-societal innovation such as green care farms, residential care cooperatives (akin to the U.S. Village Movement), and intergenerational cohabitation would further support seniors to age safely in the community with less need for formal home health, institutional, or social care. Remote care, assistive devices, and other age tech (already gaining prevalence in the U.S.) could also mitigate the growing shortages of long-term care funding, care workers, and family caregivers. Finally, public education could encourage younger adults to prepare for their future long-term care needs not only financially but also by building and maintaining a social network as they age. On their own, each of these strategies could have a modest impact, but taken together, they would significantly better position the United States to make aging with dignity and independence affordable despite growing fiscal and workforce constraints. As the Dutch example reveals, it will require a comprehensive set of innovations to prepare our housing and care systems for the age wave.

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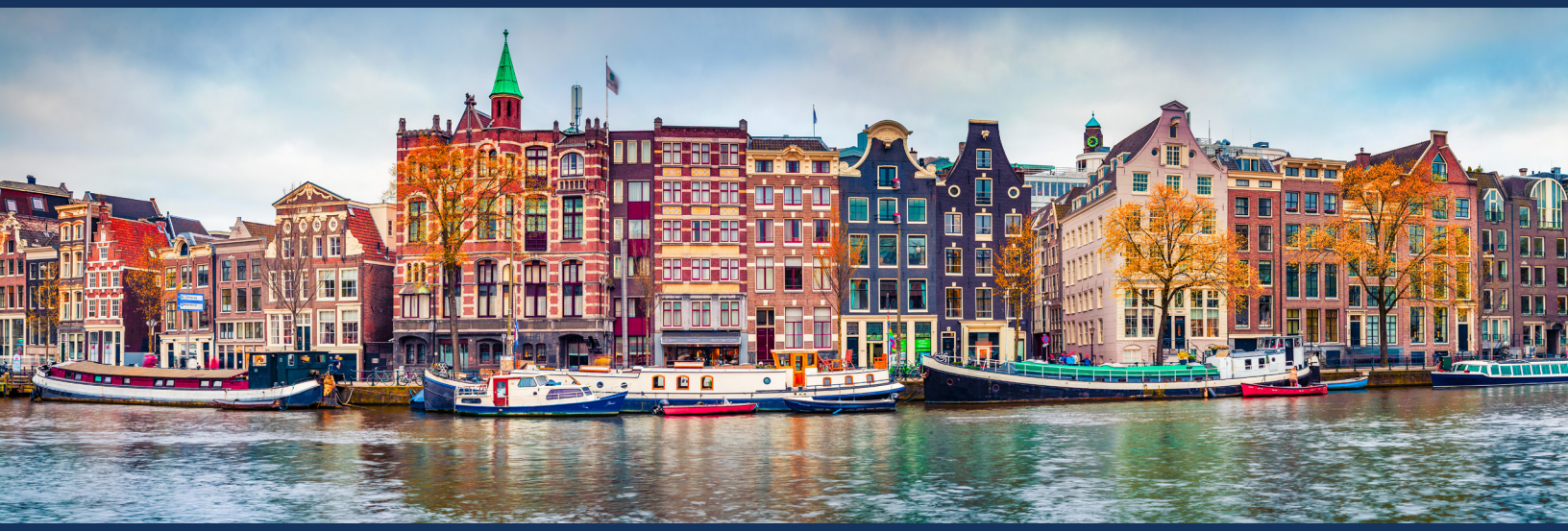

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