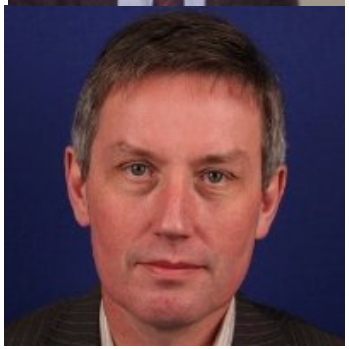
Policy changes in Dutch long term care: what does this mean for healthcare infrastructure?

Fred Bisschop
Leo Mimpen
Theo Staats

Who we are



- 35 years of experience in healthcare building design and construction
- Backgrounds in economics and construction
- Reviewed numerous healthcare projects and businesscases
- We support large insurance companies and health care providers
- We make publications of general interest, including guidelines and standards
- We do our work independent
- Therefore our valuation of healthcare projects is important for attracting loans from banks

The age of social security from the 60's till 2000

- The Netherlands strongly believed in social security:
  - Health insurance
  - Unemployment insurance
  - Basic pension for the entire population
  - Insurance for long term health problems that can only be insured by law

Large natural gas resources discovered in the 70's helped to carry out this policy

Exceptional Medical Expenses Act 1968- 2015

- Law intended to create an insurance system to cover for health care costs that cannot be insured otherwise
- EMEA was originally intended for financing the nursing homes, the mentally handicapped and the long term psychiatric care.
- Premiums were paid by employees and employers through the tax system.
- From the 70’s on a lot of nursing homes were built.
- The coverage of the insurance has been extended several times with consequences for the total costs.

Exceptional Medical Expenses Act

- Total costs € 23,5 bln
- Important additions over time:
  - Home care including household help
  - Homes for the elderly: originally built to for old people without health problems but now housing mainly very old with health problems
  - Personalised budget
  - Capacity enlargements: In the 90's politicians thought that in relation to the insurance principle waiting lists were not acceptable

Supply of long term care

Spending on long-term care as a percentage of GDP in 2010, subdivided into residential and non-residential care (% GDP)

country	Residential care provisions	Ambulant (home) care provisions	Total
Netherlands	2.6	2.2	4.8
Austria	0.9	2.5	3.4
Belgium	1.3	3.3	4.6
Czech Republic	0.1	1.9	2.0
Denmark	1.4	3.0	4.5
Estonia	0.2	1.4	1.6
France	0.7	3.2	3.8
Germany	0.9	3.4	4.3
Hungary	0.3	1.6	1.9
Italy	-	-	-
Poland	0.1	1.9	2.0
Portugal	0.1	3.3	3.5
Slovenia	0.5	2.1	2.6
Spain	0.7	2.4	3.1
Sweden	-	2.0	-
Switzerland	2.0	3.6	5.6
average	0.8	2.5	3.4

Policy changes 2013-2015

- Long term care act
- People with the lowest levels of care no longer entitled to insured care
- Municipalities now responsable for people receiving care at home
- The money transferred to municipalities is 75% of the money spent on the same people through the former medical expenses act

Institutions delivering long term care (beds)

	2015	forecast
Nursing homes / Homes for the elderly	150.000	100.000
Institutions for mentally handicapped	78.000	63.000
Mental healthcare	30.000	20.000

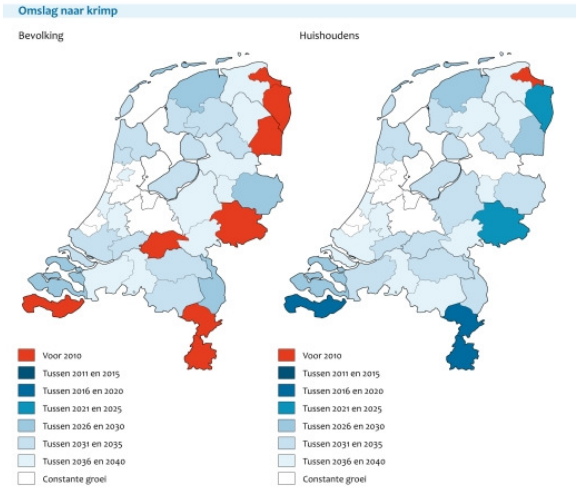
What do these developments mean for healthcare infrastructure ?

- All sectors:
  - Need for capacity decreases
  - Financial burden for excess capacity remains a burden for institutions. Only a problem outside the “Randstad”, the densely populated region in the Netherlands.
  - From 2009 instutions are within their budget responsible for their building acitivies
  - Care consumers have more power to chose according to their preferences
  - New capacity is built like normal appartments. The new buildings are not care-specific. Only a few exceptions.
  - Quality improvements of the buildings have taken place before 2009
  - New investments are difficult to finance

One region is not the other!

Healthcare housing is changing from specific to current real estate

Less developed regions



Other solutions ?

What do these developments mean for Care for the elderly?

- The homes for the elderly disappear or are transformed to nursing homes or are transferred to normal housing.
- Reimbursment for capital costs is sufficient for downgrading assets, at least in the centre of the Netherlands.
- Economies of scale forces institutions to increase the size of groups.
- Most institutions are financially sound.

What do these developments mean for Care mentally handicapped ?

- Government advocated in the past decentralisation and small groups.
- Economies of scale forces institutions to move clients back to the campus and increase the size of groups.
- Most institutions are financially sound.
- Reimbursment for capital costs is sufficient for downgrading assets.

What do these developments mean for mental healthcare ?

- Healthcare providers are under pressure to reorganise and streamline their organisation
- Institutions are forced to close down locations and move clients back to the campus.
- In the Randstad region institutions are being redeveloped into zones for care purposes and zones that can be sold off for normal housing.
- Elsewhere there are vacancies in the assets on the campus

Effects for the people

- Care demands are shifting towards family, neighbours etc.
- Coordination problems between the communities, the home care and the institutions.
- Workload increases for the family doctor and the district nursing
- Transitional problems in financing the care.

Lessons learned

- Organise long term care as much as possible as home care
- As far as housing is needed buildings should realised as current real estate(with the exception of a few very specific groups)
- In delivering long term care: find a proper balance between small scale provisions and efficieny
- In a competetive health care market financing investments through banks has to be supported by guarentees

Thank you for your attention