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Improving the work – life balance through long-term care systems, the example of the Netherlands

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Worldwide, the number of older people requiring care and support is increasing rapidly. At the same time, the proportion of younger people who might be able to provide this care is falling. Women, the traditional caregivers within many families, are filling other social and economic roles. As a result, families alone cannot meet the needs of older people and other dependents with significant losses of capacity.

WHO states in the recently published World report on ageing and health that in the 21st century every country needs a comprehensive long-term care system. This system must ensure that older people receive this care and support, whether it be in their homes, their communities, or within institutions. The form this system takes will vary among countries. Informal care givers will always form an integral part of this long-term care system.

In my presentation, I will elaborate on this interaction between formal long-term care and informal care givers. I will do so by using the Dutch context. The Netherlands is interesting to study as it has one of the largest public long-term care systems in the world. At the same time we still have millions of people providing informal care to elderly people and people with a handicap. Informal care givers include family members, but also many volunteers. There are some interesting questions I would like to

raise.

1. Does a large formal long-term care system lead to a lower need for informal care?
2. How to best integrate and support informal care givers in a large public long-term care system?
3. What are the implications for the work-life balance of people?

Before trying to answer these questions, I first would like to introduce our long-term care system, the recent reforms and the characteristics of informal care in the Netherlands.

1. Long-term care

The Netherlands is the highest spender on long-term care in the OECD-countries with 4,3% of gdp according to OECD health data 2015. Long-term care in the Netherlands includes a broad range of health and social-care services for various clients including persons with handicaps, persons with long-term mental health problems and older persons. In 2014, nearly 5% of the population received long-term care with a 45–55 split between residential care and non-residential care. The biggest category (56%) consisted of older persons. In total, 16% of the population aged 65 and older receives either residential or non-residential long-term care.

Long-term care is largely publicly funded. In 2012, private financing (mainly income-related copayments) accounted for only 8% of total expenditures. Public financing is combined with private delivery by mainly not-for-profit provider organizations. A marginal stand-alone private sector for the wealthy co-exists with the public long-term care scheme.

2. Reforms

This rather extensive public long-term care system became very expensive and also made people rely too much on government interventions. It was also too heavily supply oriented and not client oriented.

The reforms of 2015 consisted of three interrelated pillars: a shift from residential to non-residential care, decentralization of non-residential care and a normative reorientation. These were accompanied by some expenditure cuts (although limited).

The first pillar of the reforms aims at a substantial shift of clients from a residential to a non-residential setting. I will not elaborate on that, but the shift is based upon the assumption that persons with mild problems may better be cared for in their home-setting and that ever more people prefer 'ageing in their own homes'. The reform therefore includes the introduction of a new Long-term care act for mainly residential care.

The second pillar is that provision of all non-residential care, that was before included in the old long-term care act, has been devolved to either insurers or municipalities. Health insurers are now made responsible for contracting community nursing (e.g., diabetes care and administration of medicines) and 'body-related' personal care (e.g., support in washing, dressing). All other non-residential care including, among others, social services for older persons, persons with a handicap and addicts, have been decentralized to municipalities.

The last pillar, the normative reorientation, is most relevant for our discussion. In the government's view, the broad coverage of long-term care and its high level of public funding had created a supply-driven and 'over-medicalized' system with clients in a mainly dependent role. The view is that universal access and

solidarity in financing can only be upheld, if people, where possible, take on more individual and social responsibility. The underlying policy assumption is that various social care services may also be provided by family members and local community networks. Hence, when we have to determine how much care is needed, we will now first look at what people and their family members and social network can do themselves. There is no longer a fixed right so that for example you are entitled to so many hours of cleaning services when you have this or that condition. First it will be discussed with the client what are his or her needs and who can assist in his or her social network.

3. Informal care

Especially the last pillar, the normative reorientation and its underlying assumptions, are disputed. An important line of criticism is not only that informal care is already provided at a large scale, but also that the potential of 'unexplored' informal care is overestimated. Furthermore, the costs for caregivers who deliver intense informal care are underestimated.

On the other hand, it can be argued that informal care has always been there. In 1961 it was still regulated by law that children had to take care of their parents. Informal care was widely prevalent. But after abolishing this law and the building up of the welfare state (including state pensions and the long-term care system) opinions has changed and society also became more individualistic. 2 out of 3 people consider the care for their parents as mainly or a bit more the task of the government. Just 50% is prepared to take care of their parents when needed for just a couple of months.

Still, there remain many informal care workers, also in the Netherlands. The informal care association states that 1 in 3

Dutch people already provide informal care (as family member or as volunteer) and that there are 4 million informal care givers. The present official policy is therefore that we start from this huge group, support them as much as possible and that we in addition consider what formal care is still needed.

How does informal care in Netherlands compare to other countries? An interesting cross country study of 27 European countries by Ellen Verbakel et al. using the European quality of life survey shows that in Europe on average 15% of people from 18-65 provide informal care to other family members for on average 12 hours per week. The Netherlands scores a bit lower compared to the average (14% vs 15% of people) and care givers provide less hours (9h vs 12h). The study also shows a significant negative correlation between the number of hours of informal care and the size of the health sector.

That brings me to the first question.
1. Does a large formal long-term care system lead to a lower need for informal care?
The Netherlands has a much larger public long-term care sector than most other countries (often at least 3 times bigger in term of gdp) but our informal care sector is only marginally smaller. According to the study I mentioned before, informal care givers in countries like France, Sweden en Belgium provide less hours than in the Netherlands and the percentage of informal care workers is lower in Germany and also Slovakia.

A recent analysis from our social and cultural planning office based on the EU Share survey on health ageing and retirement shows that increasing expenditures for formal long-term care at home will indeed to some degree lower the use of informal carers.

The overall conclusion is that a large formal long-term care

system wil most probably reduce the need for informal care somewhat, but that apparently there still remains a need for informal care (as also stipulated by WHO). More research is needed to see whether the type of services delivered by informal care workers will differ if more professionals are involved. For example, more quality time can be given to clients because more time remains for other services. Or that less personal care like washing and clothing needs to be done by informal care workers. We need to know more about whether the combination of the two types of care will lead to a better quality of life for the care recipient.

Then the <u>second question</u>:
2. How to best integrate and support informal care givers in a large public long-term care system?
The Netherlands has a wide range of measures and programmes to support informal care givers. Due to limited time I cannot elaborate on that. But the government had subsidized several programmes on informal care and currently stimulates the cooperation and discussion between professional nurses and informal care workers. In my opinion this collaboration, playing together as a team as we call it, is one of the key issues for integrating informal care in a public oriented system. The fact that we stimulate and support informal care for many years now may also be a reason why so many people are engaged and committed to give informal care in our system. And the fact that our system of personal budgets in financing long-term care allows for compensating informal care workers also may be a factor.

Finally the <u>third question</u>,
3. What are the implications for the work-life balance of people?
Typical for the labour market in the Netherlands is that there are many part-time jobs. I believe this is one of the key factors that

make that informal care possible. But it has a drawback as well. Part-time work can also jeopardize the economic independence of women. After all, also in Netherlands, it is often women that will reduce working hours in order to be able to provide informal care. The challenge is to combine and distribute work and care tasks between men and women in a way that both can be economically independent. That requires a change of culture.

Employers also have to allow paid leaves for short term care and unpaid leaves for long-term care. Employees have a legal right to apply for a change of their contractual number of working hours (more of less hours) or to change their working time (work during other hours) or to change their place of work (telework, working at home). This facilitates the combination of work and care. The employers can only refuse it for strong reasons. And more and more, employers understand the importance of flexible arrangements to avoid unnecessary sick leave.

Although due to all these measures many Dutch are able to combine paid work and informal care, this combination can still be difficult. 5 out of 6 informal care givers between 18 and 65 also have paid work, and 1 out of 6 workers provide informal care. Working times and care time may overlap leading to stressful situations. This may explain why informal caregivers have a higher risk to be absent from work due to illness. And that 10% of this group stops working temporarily or will reduce working hours. And that another 10% of informal care givers is overburdened.

For many reasons, it is crucial to prevent illness and burnout among informal caregivers, not in the least for the sake of their own wellbeing. It is also important to determine how the work-life balance and burden of informal care workers in the Netherlands

compare to other countries in Europe. And what role our large long-term care system plays in alleviating this burden. We still do not have the full picture.

Concluding

The example of the Netherlands gives some interesting insights.
1. Spending resources on long-term care is not just a cost but improves the life of older people and gives more room for relatives to engage in productive activities.
2. The formal and informal sector should work together to provide sufficient and even better quality of care.
3. Despite the existence of a large public system it is important to take into account the burden for informal care givers and their work-life balance. Our recent reforms may require even more attention for this issue.
4. More insight is needed with respect to the impact of long-term care systems on the work-life balance.