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RETHINKING LONG-TERM CARE IN CANADA

Lessons on Public-Private Collaboration from Four Countries with Universal Health Care

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Contents

Executive Summary / i

Introduction / 1

The Many Challenges Faced by the Canadian Long-Term Care Sector / 3

Lessons from Germany / 12

Lessons from Japan / 19

Lessons from the Netherlands / 26

Lessons from Sweden / 33

Discussion and conclusion / 43

References / 47

About the Author / 71

Acknowledgments / 72

Publishing Information / 73

Purpose, Funding, and Independence / 74

Supporting the Fraser Institute / 74

About the Fraser Institute / 75

Editorial Advisory Board / 76

Executive Summary

The long-term care sector in Canada has received a lot of media attention since the beginning of the COVID-19 pandemic. This is not surprising, given the tragic consequences that have affected the residents of public and private nursing homes and their families. However, the difficulties in meeting the care needs of the elderly in nursing homes or at home precede the arrival of the pandemic in the country.

For some time now, calls for the integration of long-term care into the public health systems in Canada have multiplied. Various lobby groups are calling for a substantial increase in public spending and a major overhaul of the system. Some opinion leaders have even suggested eliminating private for-profit providers, accusing them of being at the root of the many failings observed in the sector. These calls are based on the reality of an aging population, coupled with misconceptions of how other universal health-care systems include such care as part of their system.

This study has examined how four countries—Germany, Japan, the Netherlands, and Sweden—have either universalized or meaningfully reformed their universal long-term care system over time to make it financially sustainable and resilient and more adequately meet the needs of elderly. These countries with older populations are managing to integrate long-term care into their universal health-care system, while devoting a share of their GDP to health comparable to, or less than, that of Canada. They have responded to the growing concerns about the aging of their population and the financial sustainability of their public health-care system mostly by adopting a decentralized approach that efficiently leverages collaboration between the public and private sectors. There are many important policy lessons to draw from their experience.

In all four countries, patients have universal access to the long-term care and services they need regardless of their income and pre-existing health conditions. In each country, universality refers to eligibility and access to long-term care, and does not mean that care needs of elderly citizens are fully financed by governments. Indeed, patients must contribute to the financing of a non-negligible part of the costs of care through cost sharing. Costs of accommodations and meals are generally not covered by public insurance schemes. Only some patients—those with incomes below a certain threshold—receive full public funding. Cost-sharing is an integral part of these foreign health systems, and does not lead to inequitable or reduced access to needed care. Importantly, the co-payments give patients incentives to use long-term care services in a more cost-efficient manner.

These four countries have implemented reforms over time in order to leave more room for patients to choose a provider and organize their own long-term care

as they see fit. At the same time, private for-profit entrepreneurs have been increasingly called upon to play a larger role in the provision of long-term care services, and have shown they could respond effectively to changes in customers' needs and preferences. Choice and competition among care providers have been encouraged by policy makers, and have helped improve the quality of services and the efficiency with which they are delivered. Unlike the practice in Canada, care providers in these four countries are not guaranteed they will operate at full capacity, and good quality is rewarded through user choice.

In Canada, in contrast, the vast majority of long-term care is still provided in institutions. It is a well-known fact that most seniors in Canada consider institutional care a last resort and would prefer to receive care services at home if these were accessible to them. The four countries analyzed in this report have made a major shift towards home care in the last few decades. Access to institutional care in nursing homes is now reserved to people in need of permanent supervision or intensive care and treatments. These aging-in-place policies not only coincided with population preferences but also contributed to softening the impact of the population's aging on long-term care expenditures in these countries.

In Germany and the Netherlands, in particular, a system of cash benefits has been set up to give more options to patients and to promote care delivered at home or in the community. Seniors can even hire family members or relatives and pay for the domestic help or home care with the personal allowance they receive. These cash-for-care schemes have proven to be more cost-efficient than traditional government-directed programs. Most importantly, these schemes have brought benefits to users in the form of increased autonomy and care solutions more suited to their needs and preferences.

In recent years, several Canadian provinces have adopted governance reforms, merging regional health authorities, which were meant to be autonomous intermediary bodies responsible for liaising between service providers and the population. By removing governance and decision-making power from regional health authorities and health institutions—from hospitals to nursing homes—, these reforms have led to greater centralization. This centralized approach goes against the trend observed in the four high-performing countries examined here, that have decentralized the decision-making powers to local authorities. This policy orientation is based on the notion that local managers and other actors in the field are better able to understand the specific needs and preferences of patients and the best means to address them. Canadian policy makers should consider the benefits of such decentralized approaches when attempting to reform the long-term care sector and coordinate the actions of millions of people with varying preferences and knowledge in increasingly complex health-care systems.

Introduction

The COVID-19 pandemic that spread globally in 2020 had tragic consequences that particularly affected seniors (Kain, McCreight, Mazzulli, Gubbay, Rea, and Johnstone, 2021). The pandemic has once again shed light on the poor care conditions in several public and private nursing homes, the magnitude of the needs of elderly people in Canada, and the inability of our current public health-care systems to adequately address them. Given the accelerated aging of the population and the increasing prevalence of chronic diseases, the provincial health systems will have to cope with even greater home- and long-term care needs in the future (Nuernberger, Atkinson, and MacDonald, 2018).

Of course, some efforts have been made to improve the situation of elders in most Canadian provinces in recent years. Provincial governments have notably initiated various strategies aimed at allowing seniors to live healthier lives and remain in their own homes as long as possible (MSSS, 2012; Peckham, Rudoler, Li, and d'Souza, 2018). The federal government also recently increased and targeted its transfers to the provinces in order to address some of the shortcomings observed in home and community care. The new Health Accord, ratified in August 2017, was accompanied by a commitment from Ottawa to transfer an additional $11 billion over the following 10 years (Roberts, Bartram, Kalenteridis, and Quesnel-Vallée, 2021). As a result, Canada was in the top third of countries that spend the most on long-term care as a percentage of GDP in 2018 (Hughes Tuohy, 2021).

These efforts seem no longer sufficient, however, and there are many voices calling for a major overhaul of the system, the establishment of national standards for long-term care across the country, and the injection of additional public funds to improve the delivery of elder care (Roman, 2021). Notably, there have been increasing calls to integrate long-term care into Canada's public health-care system (Marchildon and Tuohy, 2021; McGregor, 2020). Some even suggest that we should rely solely on public or non-profit organizations for the provision of long-term care to seniors (Patel, 2020; Reynolds and Loriggio, 2021). These calls are based on the reality of an aging population, coupled with misconceptions of how other universal health-care systems include such care as part of their system.

This study examines how four countries—Germany, Japan, the Netherlands and Sweden—have either universalized or meaningfully reformed their universal long-term care system over time. These systems have all at one time or another been praised as models to emulate by opinion leaders and pundits in Canada (Blomqvist and Busby, 2016; Szehehely, 2016; Peng, 2020; Flood, DeJean, Doetter, Quesnel-Vallée,

and Schut, 2021). Canada has a lot to learn from the experience of these countries. They all provide universal access to long-term care to their citizens and give them many more options about where and how to get the care and services they need. Their approach contrasts with those of the Canadian provinces, where most patients have very little control over the basket of services offered to them.

This study is organized as follows. The first section presents a brief description of the long-term care system in Canada and the main challenges to be overcome. The following sections examine how Germany, Japan, the Netherlands, and Sweden integrate long-term care into their health systems, and look particularly at the public-private partnerships that have emerged over time to respond to the challenges posed by the aging of the population and the increasing needs of senior citizens. The report concludes with a discussion of key findings from foreign practice and policy lessons for Canada.

The Many Challenges Faced by the Canadian Long-Term Care Sector

Long-term care (LTC) refers to the health-care services generally provided to people with a reduced degree of functional capacity requiring comprehensive accommodation and supports in nursing homes or residential care facilities, and to people with limitations on the activities of daily living in their own home (Marchildon, Allin, and Merkur, 2020: 119). While the Canada Health Act specifies the set of criteria under which physician and hospital services deemed medically necessary must be covered by the provincial health-insurance programs, it excludes long-term care. Rather, LTC in Canada is considered an extended health-care service that can be provided at the discretion of provinces and territories (Norris, 2020). [1]

Nonetheless, each province provides services to its elderly population under programs that cover part of the costs of institutional care and home care. There are variations in the generosity of these programs, although the models are similar from province to province. Care in nursing homes is generally publicly funded or subsidized, while the financing of accommodation services is the responsibility of residents and may vary according to income (Norris, 2020). With regard to home care, public programs cover the care portion of the services in most provinces (up to a maximum) but, in general, other services for less acute personal needs must be borne financially by the users themselves (Zhang, Sun, and l'Heureux, forthcoming). Home-care services (nursing care, rehabilitation therapy, nutritional counselling, and so on) are needs-based and provided by regulated health professionals such as nurses and physiotherapists, while home assistance services (meal preparation, eating, toileting, and so on) are delivered mostly by personal support workers and informal caregivers (Mery, Wodchis, and Laporte, 2016).

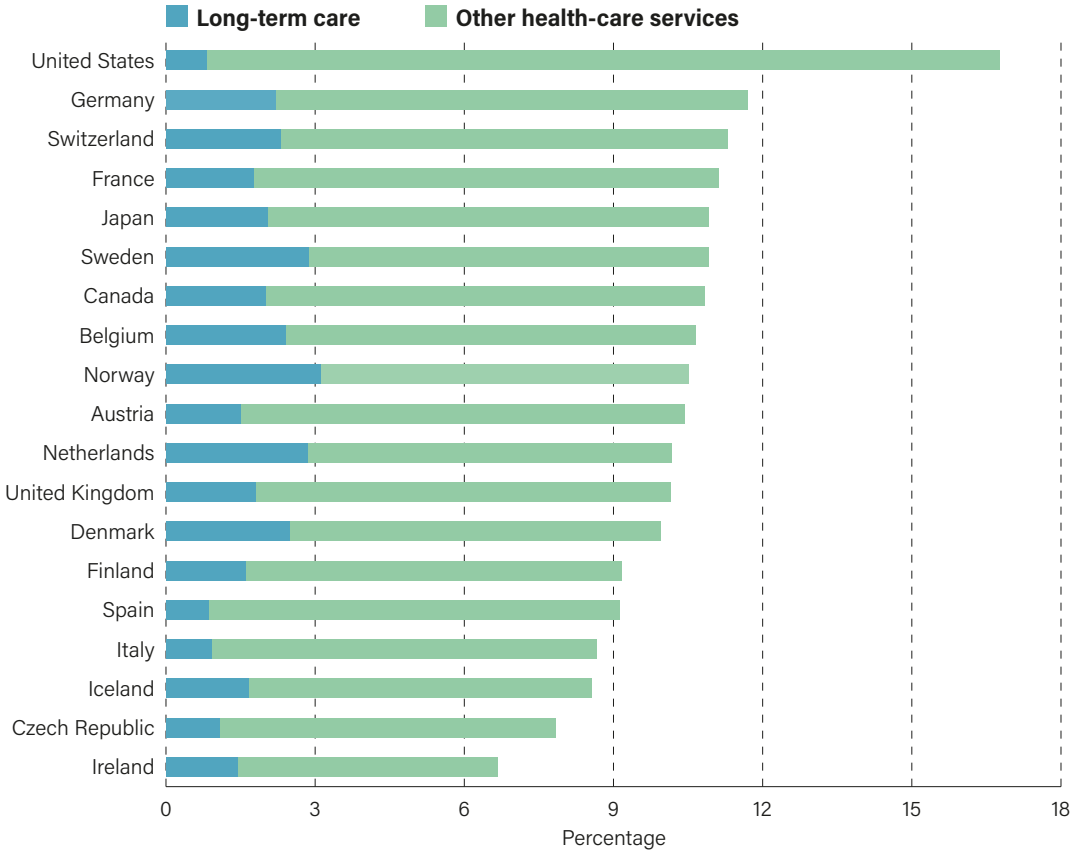
In recent years, several provinces have adopted governance reforms, merging regional health authorities (RHA), which were meant to be autonomous intermediary bodies responsible for liaising between service providers and the population. By removing governance and decision-making power from RHAs and health institutions (from hospitals to nursing homes), these reforms have in a way led to greater

[1] The Canada Health Act (CHA) defines insured health services, under a set of criteria, as those deemed medically necessary, especially physician and hospital services. Care in nursing homes care and home care are mentioned in the CHA as "extended care services"; they are not insured health services but can be provided at the discretion of provinces and territories (Government of Canada, 1984: S.13).

centralization (Picard, 2017; Labrie, 2017; Ragupathi, 2020). In Quebec, this increased centralization was recently identified as a factor that has contributed to reducing the accountability of managers, undermining the organization of long-term care and weakening its ability to cope with the COVID-19 pandemic (CSBE, 2021).

Overall, Canada devotes 2% of its GDP to long-term care, which includes institutional and home care (**figure 1**). About 78.4% of funding for long-term care comes from governments, 3.3% from private insurers, and 18.3% from out-of-pocket spending by individuals (OECD, 2021). Among the main reasons for the low uptake of private long-term care insurance (LTCI) in Canada are a limited awareness of the LTCI products (Boyer, de Donder, Fluet, Leroux, and Michaud, 2020) and the perception that governments will somehow meet the long-term care needs of the population (so-called "crowding-out effect of government programs") (Boyer, de Donder, Fluet, Leroux, and Michaud, 2019).

Figure 1: Expenditures for long-term care and other health-care services as a percentage of GDP, selected OECD countries, 2019

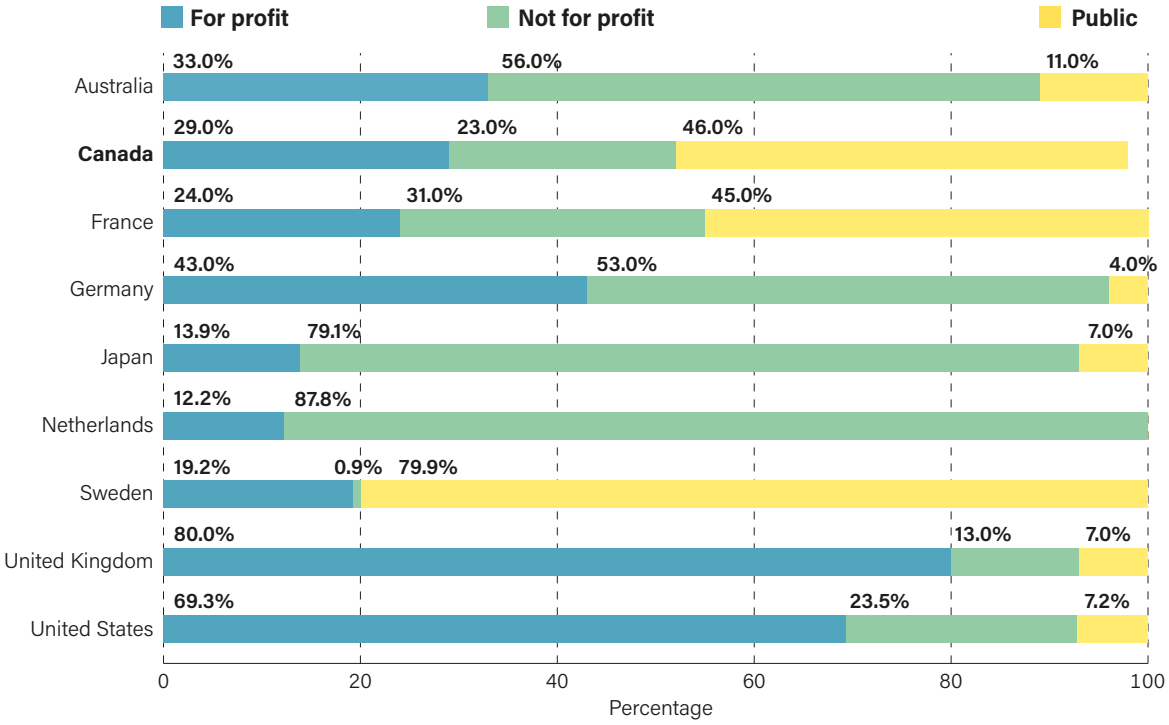


Note: data for Japan pertain to the year 2018.
Source: OECD, 2021.

A diversity of nursing home-care providers, but no real competition

In terms of service delivery, there is a diversity of institutional care providers of different types in each province. According to data compiled by the Canadian Institute for Health Information (CIHI), there were 2,076 nursing homes in Canada in 2021, 46% of which are publicly owned, 29% are private for-profit, and 23% are private not-for-profit. [2] However, private for-profit participation varies significantly from province to province, being higher in Ontario (57%) and Prince Edward Island (47%), lower in Quebec (12%) and almost non-existent in Newfoundland & Labrador (2%) (CIHI, 2021a). In general, the participation of the private sector (for-profit or not-for-profit) in the provision of nursing home care in Canada is lower than in many OECD countries (**figure 2**).

Figure 2: Provision of nursing-home care, by ownership type, selected OECD countries, 2021 or most recent year



Note: For Canada, the breakdown between private for-profit and not-for-profit was not available for 2% of the facilities.
Sources: Australia (2018/19): ACFA, 2020; Canada (2021): CIHI, 2021b; France (2020): Delanglade, 2021; Germany (2019): German Federal Health Monitoring, 2021g; Japan (2017): MHWL, 2019; Netherlands (2019): Bos, Kruse, and Jeurissen, 2020; Sweden (2020): NBHW, 2021; United Kingdom (2016): Pujol, Hancock, Hviid, Morciano, and Pudney, 2021; United States (2016): CDCP, 2019..

[2] The breakdown between private for-profit and not-for-profit was not available for 2% of the facilities (CIHI, 2021b).

The sector is tightly regulated and monitored in all provinces. Nursing homes must obtain a licence to operate and new licences granted by provincial governments are generally restricted by number or geography (Roblin, Deber, Kuluski, and Pannor Silver, 2019). In several provinces, it is not possible for licensed private providers to turn a profit from the nursing care delivered to residents. In Ontario and Quebec, for instance, public funds dedicated to nursing and personal care must be used for this sole purpose, and any unused surplus must be returned to governments (Hsu, Rohit Dass, Berta, Coyte, and Laporte, 2017; Déry, 2018). [3] Inspection visits are also frequently carried out in several provinces to ensure that licensed providers meet established standards of care. [4]

Evidence accumulated over time about how the ownership status of nursing homes affects care outcomes in Canada is mixed. For instance, researchers showed that non-profit nursing homes attached to a hospital or a regional health authority have lower adjusted rates of hospitalization relative to for-profit facilities in British Columbia (McGregor, Tate, McGrail, Ronald, Broemeling, and Cohen, 2006). [5] In Ontario, Tanuseputro and colleagues (2015) demonstrated that residents of publicly funded private nursing homes were more likely to be admitted to a hospital and die than residents of not-for-profit homes. These results contrast with those obtained by other groups of researchers using different statistical tools and distinct populations. Wilkinson and colleagues (2019) for instance showed, using nine performance indicators, [6] that private for-profit providers perform as well as private non-profit providers and significantly better than lagging public providers. Their analysis also revealed that the quality of services in the long-term care sector in Ontario improved significantly from 2012 to 2017.

Similarly, other researchers found that the quality of care in private facilities is relatively higher than public ones in Quebec and the gap between them has widened significantly over time. Their analysis showed that a lower share of seniors received

[3] Nursing homes operating in Ontario also have to maintain at least a 97% occupancy rate in order to obtain the totality of their adjusted case-mix per diem funding from the government (Hsu, Rohit Dass, Berta, Coyte, and Laporte, 2017).

[4] In Ontario, for instance, there is the Long-Term Care Home Quality Inspection Program, <https://www.health.gov.on.ca/en/public/programs/ltc/31_pr_inspections.aspx>. In Quebec, ministerial inspection visits are conducted periodically and evaluation reports are published on line, <https://www.msss.gouv.qc.ca/reseau/visites-evaluation/>.

[5] Of particular note, McGregor and colleagues (2006) also showed higher hospitalization rates in unattached not-for-profit nursing homes compared to for-profit homes, after controlling for home size.

[6] These nine indicators, collected by the Canadian Institute for Health Information (CIHI), are: experiencing pain, experiencing worsening pain, falls in the past 30 days, improved physical functioning, potentially inappropriate use of antipsychotics, restraint use, worsened depressive mood, worsened physical functioning, and worsened pressure injuries.

inadequate care in private facilities (7.9%), compared to public institutions (33.2%) (Bravo, Dubois, Demers, Dubuc, Blanchette, Painter, *et al.*, 2014). Another study found that private facilities on publicly funded contracts in Quebec offered greater comfort and privacy as well as a less restrictive environment to residents than public nursing homes. On-site evaluations also showed that all needs were satisfied in a higher proportion of cases for services delivered by private (for-profit and not-for-profit) providers, relative to public institutions (Dubuc, Dubois, Demers, Tourigny, Tousignant, Desrosiers, *et al.*, 2014). Quality assessment visits by the Quebec Ministry of Health and Social Services also demonstrated that private for-profit facilities integrated into the public health system are proportionally more likely (64.4% of them) to have living environments deemed entirely adequate than public nursing homes (17.6%) (Déry, 2019).

For-profit provision of long-term care has nonetheless been criticized recently in the context of the COVID-19 pandemic for allegedly reporting worse outcomes, at least in Ontario (Tubb, Wallace, and Kennedy, 2021). However, several independent researchers, notably from CIHI and Statistics Canada, have contested this conclusion and raised doubts about the existence of a direct link between the ownership status of nursing homes and the risk of outbreak or death from the coronavirus (Bell and Wodchis, 2021; Clarke, 2021; Damanio and Turcotte, 2021; Fisman, Bogoch, Lapointe-Shaw, McCready, and Tuite, 2020). The older design standards and the number of shared rooms in certain facilities (Damanio and Turcotte, 2021; Stall, Jones, Brown, Rocha, and Costa, 2020), as well as the absence of real competition (Pue, Westlake, and Jansen, forthcoming) would be much more important factors to explain the observed differences in outcomes.

Lack of choice and competition hamper access in the public nursing-home sector

Excess capacity being virtually nil in most provinces, dissatisfied users are not able to turn to some other provider with available places. In Ontario, for instance, the overall occupancy rate is around 99% and just 40% of residents awaiting placement in publicly funded nursing homes in 2020 were granted their first choice of residence, after several weeks of waiting (MHLTC, 2020). Thus, there is no real competition between providers and user choice mostly exists in theory. Admissions to LTC institutions are controlled by governments, which determine who is eligible for publicly funded services. Most providers operate at full capacity and their revenues do not depend on the quality of service provided nor on their effectiveness in attracting clients.

As in many other aspects of the health systems, provinces struggle to provide needed institutional care for the elderly population in a timely fashion. The wait time to obtain a place in a publicly funded nursing home in some provinces can drag on for many months. In Ontario, the wait list to obtain a place in a long-term care facility has almost doubled over the last 10 years to about 38,000 people in 2019/20 (FAO, 2019; OLTCA, 2021). Half of elderly patients had to wait 145 days or more before being

admitted to a nursing home in 2019/20 (HQO, 2021). The situation is even worse in Quebec, where seniors in need of a place in a public nursing facility (CHSLD) had to wait 300 days on average during this same year (MSSS, 2021). Despite increased government funding, there has been no sign of improvement in this regard over the last decade in either of these provinces; quite the opposite (FAO, 2019; CSBE, 2017).

Some of these patients are occupying beds in hospitals during the time they wait for a place in a nursing home. These so-called "bed blockers" occupy beds and mobilize staff time and other medical resources, which make them not only more expensive to care for relative to the cost of caring for them in a long-term care home, but also prevent other patients with greater need from gaining access to required hospital treatment in a more timely manner. Some years ago, Canadian researchers estimated that these patients consumed the equivalent of 2.4 million hospital days annually (Sutherland and Trafford Crump, 2013).

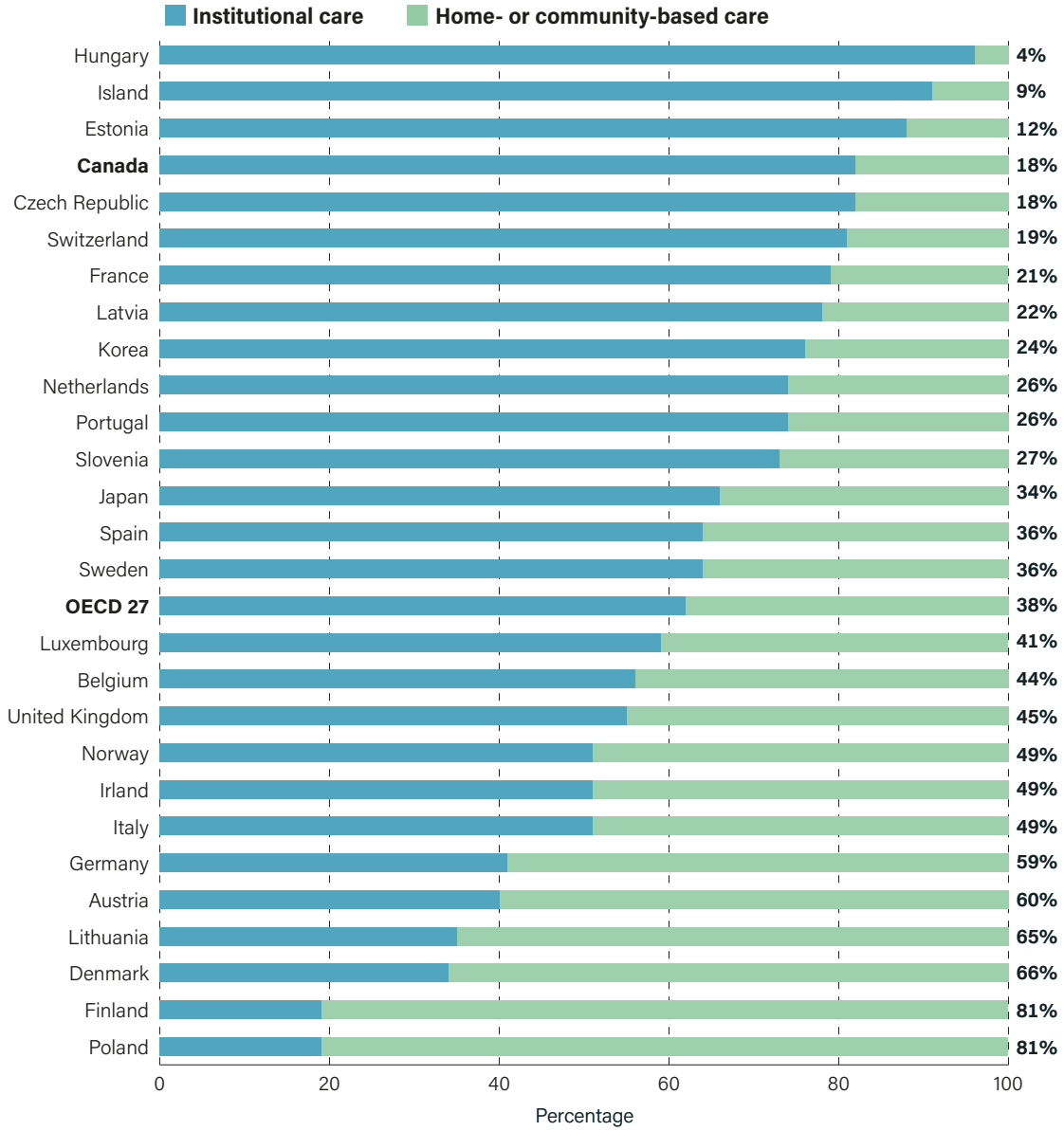
Difficult access to publicly funded home-care services

In the area of home-care services, there are marked variations in the approaches used by the provinces. Ontario favoured for some time, in the early 2000s, a model of competitive procurement processes involving private providers, with some success in terms of quality of service (Doran, Pickard, Harris, Coyte, McRaw, Laschinger, *et al.*, 2007). Almost half (45.7%) of home-care providers in Canada are now located in this province, proportionally more than its demographic weight in the country (Koronios, 2020). However, the approach based on competition among providers for publicly funded service contracts was suspended in 2008 (OAGO, 2017), so that the expected positive effects from competition no longer exist (Wojtak and Stark, 2017). In Quebec, too, there is no real competition, since government-administered services facilities (CLSCs) remain both the principal providers and the single entry point for people seeking care at home (Firbank, 2011).

Most of the long-term care budget in Canada is spent on institutional care, unlike the situation generally prevailing in other OECD countries (**figure 3**). It is a well-known fact that most seniors in Canada consider institutional care a last resort and would prefer to receive care services at home if these were accessible to them (Home Care Ontario, 2020). One in 10 Canadians wait more than 35 days before obtaining needed home-care services, according to the latest figures published by CIHI. The wait times for home-care services are especially long in Alberta and British Columbia (CIHI, 2021a). In Quebec, there were over 40,000 people waiting for home-care services in the Spring of 2020 at the dawn of the COVID-19 pandemic (MSSS, 2021: 41).

As a result, many seniors fail to get the care they need in their own homes and have to be admitted to long-term care facilities prematurely. In 2018/19, about one in nine (11%) newly admitted residents in a long-term care institution had low or moderate health conditions and could have been better cared for at home (CIHI, 2020).

Figure 3: Distribution (%) of public or mandatory long-term care spending by mode of provision (institutional versus home- or community-based care), OECD countries, 2017



Source: OECD, 2019: 239.

A report released by Statistics Canada a few years ago estimated that the home-care needs of over one third of Canadians aged 65 and older were not met. This represented an estimated 167,100 seniors with unmet home-care needs throughout the country (Gilmour, 2018). In recent years, private organizations have shown imagination and innovate in order to alleviate staff shortages and improve access and the range of services offered at home in several provinces (Jamieson, Reed, Amaral, and Cameron, 2021; CEPSEM, 2018). Local public-private partnerships have also emerged (Gamble, 2019), but there is still a long way to go to meet the growing needs.

An aging population with increasing needs

As in other industrialized societies, the population of Canada is aging at a rapid pace. At the beginning of the millennium, 12.6% of Canadians were aged 65 years and older (Statistics Canada, 2021). In 2020, there were 6.8 million seniors in Canada, representing 18% of the overall population. This proportion is expected to rise to one fourth by 2040. The number of people aged 80 and over is also expected to steadily keep increasing in the coming decades. According to the most likely scenario established by Statistics Canada, the number of people aged 80 and over will almost triple between 2018 and 2045, from 1.6 million to 4.4 million people (Statistics Canada, 2019).

It is also estimated that the prevalence of problems associated with chronic diseases will increase in the coming years as the population ages. According to the most recent data, nearly three quarters of Canadian seniors suffer from at least one of the 10 most common chronic diseases (PHAC, 2020a). Data from the latest Canadian Community Health Survey also indicate that about half of those aged 85 years and older report multimorbidity (PHAC, 2020b). These health problems limit the activities of a growing proportion of the elderly population, thereby contributing to an increase in costs associated with the use of health-care services and the provision of long-term care (Lehnert, Heider, Leicht, Heinrich, Corrieri, Luppa, *et al.*, 2011; Globerman, 2021). Data from CIHI show that health-care spending by Canadians 65 and over accounts for almost half of total spending nationwide, more than double their demographic weight (CIHI, 2021c).

Researchers recently estimated that neurocognitive disorders associated with aging should affect a growing share of the population in the coming decades. In 2015/16, 87% of long-term care patients in Canada had some form of cognitive impairments, such as dementia, and this rate has been rising steadily since 2010 (CIHI, 2018). The number of people living with dementia in Canada is expected to more than double between 2011 and 2031. By then, (informal) caregiving is projected to reach two billion hours annually (Manuel, Garner, Finès, Bancej, Flanagan, Tu, *et al.*, 2016).

These demographic shifts and the growing prevalence of chronic conditions among the elderly raise concerns about the future needs for care in institutions and at home (Boissonneault, Décarie, and Légaré, 2017; MacDonald, Wolfson, and Hirdes, 2019). According to the 2016 Census, 6.8% of Canadians aged 65 years and older and 30% of those aged 85 years and older were living in a nursing home or a residence for seniors (Garner, Tanuseputro, Manuel, and Sanmartin, 2018). A recent report by Deloitte commissioned by the Canadian Medical Association (CMA) estimates that the number of seniors requiring a long-term care home will increase by 60% by 2031. In addition, the same report reveals that the number of people in need of home care is expected to increase by a third during the next decade (Deloitte, 2021). According to the CMA, Canada is not prepared to face the challenges associated with these demographic changes and the growing needs that will be associated with them in the years to come.

Canada's challenges from an international perspective

The aging of the population is a global issue that is affecting or will soon affect almost every country in the world (Joshua, 2017). The current pandemic crisis has also heightened concerns about financing the aging populations' growing needs for health and long-term care services in most countries. The following sections examine how four countries—Germany, Japan, the Netherlands, and Sweden—have remodelled their long-term care systems to make it financially sustainable and resilient in order to meet the needs of the elderly more adequately, now and in the future. Like Canada, these countries fully adhere to the principle of universality in health care. They all aim to provide high-quality care to their citizens on the basis of needs rather than ability to pay. These countries with older populations are managing to integrate long-term care into their universal health-care system, while devoting to health care a share of their GDP comparable to, or less than, that allocated by Canada.

It is not to say that these four countries are immune to the challenges posed by an aging population or that they can eliminate them. But, they have responded to the growing concerns about the aging of their population and the financial sustainability of their public health-care system mostly by adopting a decentralized approach that efficiently leverages collaboration between the public and private sectors. This has benefited elderly patients as much in a country with a tax-financed health system, such as Sweden, as in countries where compulsory health insurance schemes predominate, such as Germany, Japan, and the Netherlands.

Lessons from Germany

General overview of the German health-care system

Germany was one of the first countries to establish a universal and government-regulated health-care system in the world—during the reign of Chancellor Otto van Bismarck in 1883. Universality is achieved through statutory enrollment with either competing sickness funds in the social-insurance scheme or substitutive health insurance companies in the private insurance scheme. In this highly decentralized health system, the federal government determines the legal and political structure of the health system, while the states (*Länder*) take charge of hospital planning (Esmail, 2014a). There is little central control over regional delivery of health-care services. The decentralization of the health system gives it the needed flexibility and ability to adapt when unexpected challenges arise, such as during the COVID-19 pandemic (Kirchhof, 2020).

Germany has always encouraged the participation of a diversity of providers within its universal health system. In 2019, the private for-profit sector accounted for the lion's share of the supply of hospital care in the country, with 37.8% of all facilities. The public sector comprised 28.5% of hospitals, while non-profit facilities (*freigemeinnützig*) represented the remaining third (German Federal Health Monitoring, 2021b). Patients are free to choose to be treated in any hospital that operates in the statutory health-care system, whether public or private (de Cruppé and Geraedts, 2017). Hospitals compete on quality to attract patients and operate mainly through an activity-based funding model (Wübkner and Wuckel, 2019). [7] In 2019, Germany spent 11.7% of its gross domestic product on health care (OECD, 2021).

The adoption of long-term care insurance

In 1995, Germany established a universal social-insurance scheme to finance long-term care, aiming to "reduce the physical, psychological, and financial burdens that result from frailty and dependency, and secure 'basic' provision for individuals at various levels of assessed need" (Nadash, 2018: 589). Before the reform, German *Länder* had to bear the burden of the costs of long-term care for low-income people in need

[7] German hospitals also receive funds by state governments to cover long-term infrastructure investments. However, the main source of revenues for hospitals comes from sickness funds and private health insurers that pay for operating costs (90% of expenditure) through an activity-based (DRG) funding model (Wübkner and Wuckel, 2019).

through social-assistance programs. The expenditures associated with these programs were growing rapidly at the same time as reunification was increasing the fiscal pressures on taxpayers (Nadash, 2018). Another goal of the long-term care insurance system (LTCI) was to improve the quantity as well as the quality of home-care services. This aim was to be achieved mostly by shifting large shares of the health-care budget towards home care, by mobilizing private entrepreneurs for the delivery of care and by fostering competition among providers (Roth, Wolter, Stolle, and Rothgang, 2014).

The system put in place is mandatory: 89% of the German population are currently covered by the public scheme, whereas the remaining 11% are required to purchase private health insurance (Nadash, 2018). The compulsory contribution (insurance premiums) comes equally from employees and employers, and represents 3.05% of income for parents and 3.3% for people without children. The maximum contribution amounts to 142.97 € per month (BfG, 2021).

Germany is among the few countries in the world with a relatively important private long-term health-insurance market, consisting of 48 competing insurers that operate throughout the country. A little over 9 million people subscribe to a private long-term insurance plan (guaranteed lifetime renewable) and can freely choose a level of coverage in terms of benefits and co-payments. These enrollees are either civil servants, self-employed individuals, or workers whose gross labour incomes exceed a certain threshold (64,350 € as of 2021) who have opted out of the public insurance scheme. When they decide to opt out of the public scheme and join the private one, it is essentially an irreversible decision (Atal, Fang, Karlsson, and Ziebarth, 2020). Premiums are aged-based but cannot be established according to gender, and persons already in need of care cannot be rejected. People can cancel their contracts and switch insurers but insurers cannot drop clients (Neusius, 2021).

The population of Germany is one of the oldest in Europe. In 2020, 18.2 million people were aged 65 years and older, amounting to 21.8% of the total population (OECD, 2021). Of these, about 891,000 seniors were living in nursing homes (27%), and 2.4 million (73%) received some form of home-care services (informal or formal) (German Federal Health Monitoring, 2021c, 2021d).

Admission into a long-term care home is determined upon an eligibility test based on needs conducted by a medical practitioner. Residents receive a monthly payment that varies by care level (Costa-Font and Zigante, 2020). The majority of the population must contribute to the financing of the services through co-payments representing on average 24% of the total costs (OECD, 2021). A means-tested social-welfare program managed at the municipal level (*Help for Care*) assists users when their financial resources are not sufficient to support the required co-payments. About one out of three residents obtain some financial assistance from this program (Karmann and Sugawara, 2021).

Cash-for-care benefits and choice in home care

The German system offers individuals care in kind in the home first but also offers a smaller subsidy in cash if they prefer (Blomqvist and Busby, 2016). Of the 3.3 million elderly recipients of long-term care, 2.4 million received home-care services and about 1.52 million chose cash benefits (with no regulations on how cash can be used) in 2019 (German Federal Health Monitoring, 2021d, 2021f). The cash benefits vary by care levels (**table 1**) and are transferred directly to the users, who spend them with the help of professionals and care coordinators to ensure that the care received meets their needs. Cash benefits can also be used to pay family members who act as informal caregivers at home. These transfers are not considered taxable income (Blomqvist and Busby, 2016).

Table 1: Monthly benefits (€), 2019

Level of care	Home care—benefits in kind (€)	Home care—benefits in cash (€)	Nursing home care (€)
Grade 1	—	—	—
Grade 2	689	316	770
Grade 3	1,298	545	1,262
Grade 4	1,612	728	1,775
Grade 5	1,995	901	2,005

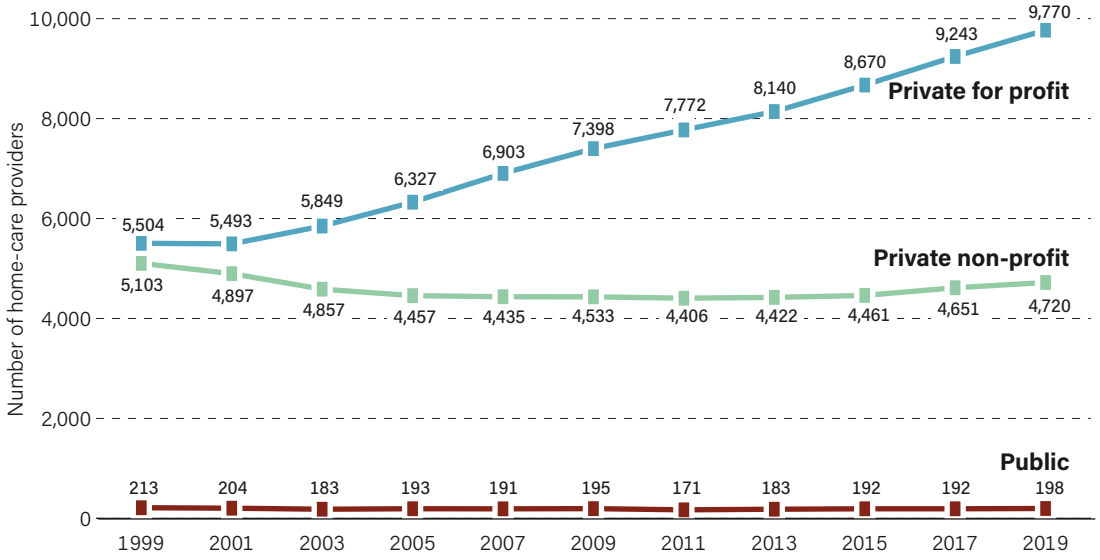
Source: Milstein, Mueller, and Lorenzoni, 2021.

After the implementation of the LTCI system, choice rapidly became an important aspect of long-term care provision. Users gained the ability to choose among a diversity of providers or between integrated care networks (Leichsenring, Rodrigues, Winkelmann, and Falk, 2015). It was expected that user choice would bring benefits like increased autonomy and care solutions more suited to meet individual needs and preferences. Choice was expected to be especially valuable to poor individuals, previously more restricted in their options than well-off individuals (Zigante, 2013). It was also hoped that user choice, along with cash-for-care benefits, would foster competition among care providers (Flood, DeJean, Doetter, Quesnel-Vallée, and Schut, 2021).

In the last two decades, the growth observed in the sector is essentially the result of the entry of new for-profit providers (**figure 4**). At the turn of the millennium, just over half of providers were private, for-profit companies. In 2019, about two thirds of home-care providers were private for-profit, 32% were private not-for-profit and only 1% were public (German Federal Health Monitoring, 2021a).

Researchers have shown that private for-profit providers in Germany have a greater propensity than non-profit providers to adopt resident-assessment tools and

Figure 4: Home-care providers in Germany, by ownership status, 1999–2019



Source: German Federal Health Monitoring, 2021a.

outcome-oriented care-management approaches that can improve the cognitive abilities and the quality of life of patients (Roth, Wolter, Stolle, and Rothgang, 2014; Stolle, Wolter, Roth, and Rothgang, 2012). According to Roth and colleagues (2014), this result contradicts the commonly held belief that profit-oriented providers tend to place economic interests before quality. The fact is that for-profit providers are more often than not newcomers in the market that have to prove themselves *vis-à-vis* long-established non-profit charities (Roth, Wolter, Stolle, and Rothgang, 2014).

Economists have sought to examine the impact of the reform that introduced choice and competition on the well-being of LTC users. A field experiment with random assignment of program participants in a treatment group and a control group has shown the cash-for-care program to be cost-efficient compared to the traditional agency-directed care program. Hence, according to the economists who conducted the study, the cash-benefit scheme and user choice yielded better health outcomes per euro spent than agency-directed care (Arntz and Thomsen, 2011).

In line with the literature on the subject, Zigante (2013) also found strong and statistically significant positive welfare effects following the introduction of the long-term care insurance system in 1994. The analysis also showed that long-term care users gain utility from the autonomy and self-determination involved in cash for care. Perhaps more importantly, according to the economist, "the benefits of choice, in and of itself, are found among individuals in lower income segments to a higher extent than any other income group" (Zigante, 2013: 146). As in other European countries, home-care services in Germany have been shown to be disproportionately concentrated among the poorest seniors (Ilinca, Rodrigues, and Schmidt, 2017).

Competition among nursing home providers

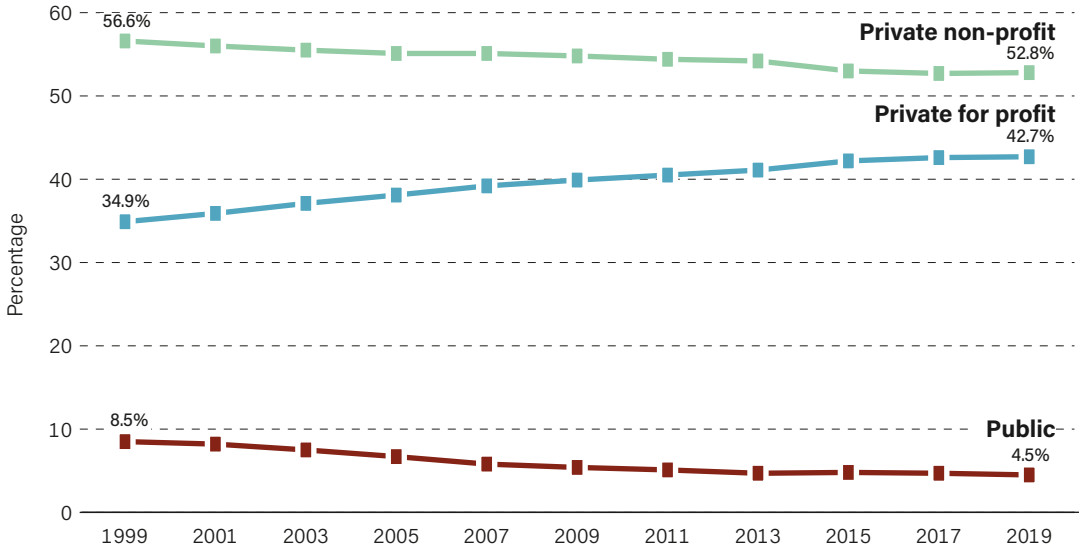
There are no barriers to entry into the nursing home market in Germany. Facilities, be they for profit or not, must comply with certain building regulations and other conditions regarding the threshold of personnel required. As a result, there are fewer constraints on capacity in Germany than in many other countries. Providers are free to enter the market if they meet the established criteria, and seniors can also freely choose which one of them they would like to reside in (Grant, Kesternich, and van Biesebroeck, 2021). Between 1999 and 2019, the number of long-term care facilities in Germany expanded by nearly three quarters, from 8,333 to 14,494 (German Federal Health Monitoring, 2021g), which made it possible to avoid the long waiting lists that plague many countries, Canada included (Grant, Kesternich, and van Biesebroeck, 2021). Around 4.2% of the near 18 million Germans of 65 years and older were living in a nursing home in 2019 (OECD, 2021).

The prices that nursing homes can charge are not regulated in Germany, but are set following a bargaining process between sickness funds and individual institutional care providers (Grant, Kesternich, and van Biesebroeck, 2021). As prices can vary considerably from one nursing home to another, they play a role in the choice of consumers. Within a nursing home, there is no price discrimination among residents, although prices may vary according to the level of care (Herr, Nguyen, and Schmitz, 2016).

The long-term care market was in the past dominated by the presence of not-for-profit nursing homes. In the last 20 years or so, the trend has been reversed as the share of for-profit suppliers has more than doubled: the non-profit and for-profit sectors accounted for 52.8% and 42.9% of all residential care facilities for elderly people in Germany in 2019 (**figure 5**) (German Federal Health Monitoring, 2021g). Governments, on the other hand, have progressively withdrawn their direct involvement in the provision of institutional care over time. The few remaining public nursing homes (about 4.5% of the total) are mostly managed by municipalities and are known to be the most expensive ones. Although they have substantially increased in size over time, for-profit homes are generally smaller in size and less expensive than both public and non-profit homes (Grant, Kesternich, and van Biesebroeck, 2021).

Economists Grant, Kesternich, and van Biesebroeck (2021) recently examined the entry behaviour of private providers in the German long-term care sector and showed that the market environment of the marginal firm has become increasingly competitive over the years. Competition among providers occurs primarily through quality and reputation, and to a lesser extent on price. There does not seem to be large quality differences among German nursing homes, despite the ownership difference (Karmann and Sugawara, 2021). However, researchers have demonstrated that competition (measured by supply per person in need of care) among nursing home providers contributes to lower prices and higher quality (Herr and Hottenrott, 2016).

Figure 5: Distribution (%) of nursing homes in Germany, by ownership status, 1999–2019



Source: German Federal Health Monitoring, 2021f.

Monitoring quality of care

Prior to 2008, the issue of monitoring quality of care in nursing homes was not high on the agenda of policy makers in Germany, and quality issues were dealt with between the insurance company and the nursing home provider on an *ad hoc* basis when required (Herr, Nguyen, and Schmitz, 2016). However, following a series of scandals that arose in some nursing homes in the latter half of the 2000s, health-insurance companies in collaboration with nursing-home owners made it their mission to improve the transparency about the quality of care in the industry (Schmitz and Stroka-Wetsch, 2020). Transparency is indeed an important vector for improving quality, as the empirical literature on the subject has shown (see, for instance, Zhao, 2016).

Nursing facilities are now periodically assessed according to a standardized list of 64 criteria to be met since the "care transparency agreement" came into effect in 2009. A wide range of aspects of care are evaluated, including activities to prevent pressure ulcer, dehydration, and malnutrition, quality of board and lodging, hygiene, and so on (Herr, Nguyen, and Schmitz, 2016). Responsibilities for monitoring quality in nursing homes has been assigned to the Medical Advisory Service of the statutory health insurance (MDK) and its regional operative units (Murakami and Colombo, 2013). [8] Since then, report cards have been published on dedicated websites, [9] where patients can compare the quality of nursing homes managed by

[8] All nursing homes are audited and evaluated once a year by trained experts (BfG, 2021).

[9] For instance, see: <www.pflegenoten.de> or <www.bkk-pflegefinder.de>.

the various providers (Herr, Nguyen, and Schmitz, 2016). According to economists Herr, Nguyen, and Schmitz (2016), who examined the impact of report cards on the quality of care, nursing homes, once they had experienced the unannounced evaluation, responded by providing better-quality services. Their research showed that it was first and foremost nursing homes providing a level of quality of care below the median at the time of the first assessment that tended to improve their performance the most.

Lessons from Japan

General overview of Japan's health-care system

Japan's health-care system is quite different from the Canadian system, although both countries fully adhere to the principle of universality. Japan achieved universal health-care coverage in 1961, with the enactment of the National Health Insurance Act (NIPSSR, 2019). Nowadays, all citizens have health-insurance coverage provided by one of some 3,300 non-profit health insurance funds to which they are affiliated depending on their employment status, place of residence, or age. Mandatory health-insurance plans are funded by premiums (49%), general tax revenues from state and local governments (38%), and co-payments from patients (12%) (MHLW, 2021).

The provision of health services in Japan is based on the principle of free choice for patients. There is no gatekeeping mechanism in the health-care system, and patients are free to visit the medical provider of their choice. Hence, patients can go to a medical clinic or directly to a hospital outpatient department as their first point of entry into the health-care system. The vast majority of care providers in Japan (primary care clinics and hospitals) operate as private not-for-profit corporations (Esmail, 2013).

The latest figures from the OECD show that Japan spends 11.1% of its GDP on health, which is quite low given its relatively older population (OECD, 2021). Japan has succeeded in providing its population with universal and rapid access to a broad range of health-care services (hospital and physician care, dental care, prescription drugs, and so on) at relatively low cost, in a context of unprecedented demographic aging (Esmail, 2013).

The implementation of long-term care insurance

Japan has indeed one of the oldest populations in the world, with 28.9% of its citizens aged 65 years and over (OECD, 2021). Thirty years ago, the country was experiencing a demographic challenge similar to the one Canada is currently facing. In the 1990s, a rapidly aging population was imposing a steadily growing burden on the public health system and it was becoming more and more difficult for caregivers and families to provide appropriate care for older citizens. A system of elderly care existed, but was mostly reserved to individuals who had low incomes, lived alone, or faced disabilities or special requirements. Many seniors were left on the margins of the system, without adequate services to meet their needs, and the burden of caring for them primarily fell on the shoulders of families (Saito, 2014). Faced with these challenges, Japanese policy makers implemented universal long-term care insurance (LTCI) in 2000 with the purpose of "[maintaining] dignity and an independent daily

life routine according to each person's own level of abilities. Other goals included: introduction of competition, consumer choice, and participation of for-profit companies into what had been a bureaucratic system" (Tamiya, Noguchi, Nishi, Reich, Ikegami, Hashimoti, *et al.*, 2011: 1184).

The adoption of the LTCI scheme has been accompanied by major changes. The governance of the system was devolved to local authorities and the responsibility for the provision of care was entrusted mainly to the private sector. Responsibility for funding the system was split among different levels of governments and the citizens. Half of the costs have since been financed by taxes levied at all levels of governments (national, prefectural, municipal); the other half is borne by compulsory insurance premiums paid by citizens aged 40 and over and by co-payments from all users (Suda, 2011).

The LTCI system finances institutional care services, community- and home-based care services as well as some daily-living assistance for senior citizens. Insured individuals wishing to take advantage of these services must undergo an eligibility test held by their municipality. Once deemed eligible, they are assigned a level of care (1 to 6) according to the severity of their physical and mental conditions. Individuals are eligible for more services if their health conditions require extended care. Nursing-home providers receive fee-for-service payments from insurance funds based on a uniform price structure across the country that reflect the level of care needed by users (Karmann and Sugawara, 2021). Japan has also introduced different pay-for-performance programs for LTC services in order to reward providers that successfully improve users' outcome of care. In these programs, providers obtain a bonus payment when they introduce prevention initiatives, recruit staff with particular expertise, or when a certain percentage of their residents experience improved physical functions (OECD, 2013b; Norton, 2018).

Insured individuals may contract with the service providers of their choice for either institutional or home care, although the emphasis is put on the latter. Users have to pay a co-payment of up to 20% depending on their income level (Soga, Murata, Maeda, and Fukuda, 2020). The public insurance covers the cost of a basic package of care services but not the room and board. It is possible for insured individuals wishing to obtain more hours of care or services not covered by the long-term care insurance to get them through direct contract with the care provider. At this time, they must bear the entire cost of these additional services. Only beneficiaries of public welfare assistance program (around 18% of LTC claims) are fully covered for eligible LTCI services with no cost-sharing obligation from them (Fu and Noguchi, 2019). [10]

[10] Users with the lowest incomes (with 0% co-payments) have been shown to have higher LTC expenditures than general users (10% co-payments) and high-income users (20% co-payments) (Jin, Mori, Sato, Watanabe, Noguchi, and Tamiya, 2020).

Responsibility for regulating the industry, establishing norms and quality standards to be met, and granting operating licences to health-care providers, rests with the national government, through the Ministry of Health, Labor and Welfare (MHLW). The MHLW also imposes a set of requirements for the provision of care, such as the minimum staff-to-resident ratio, the qualifications of the care workers, and the levels of accommodation for residents (Estévez-Abe and Ide, forthcoming). Since 2006, when the Care Information Disclosure System was launched, all licensed providers are subject to periodic audits and evaluations by public authorities to ensure that established quality standards are met. The results of these evaluations as well as basic information (for example, the provider's location and the number of staff) are published on line (Lepore, Edvardsson, Meyer, and Igarashi, 2021). "Providers are licensed and supervised by local government, but the main mechanism for quality control is consumer choice, since providers can easily be changed" (Tamiya, Noguchi, Nishi, Reich, Ikegami, Hashimoti, *et al.*, 2011: 1190).

Since 2000, spending on long-term care has grown by 6.2% annually, surpassing the pace of the economic growth (MHLW, 2021) and now takes up 2% of GDP (OECD, 2021). Cost-sharing has been raised over time for higher income earners in order to contain soaring LTCI expenditures (Fu and Noguchi, 2019).

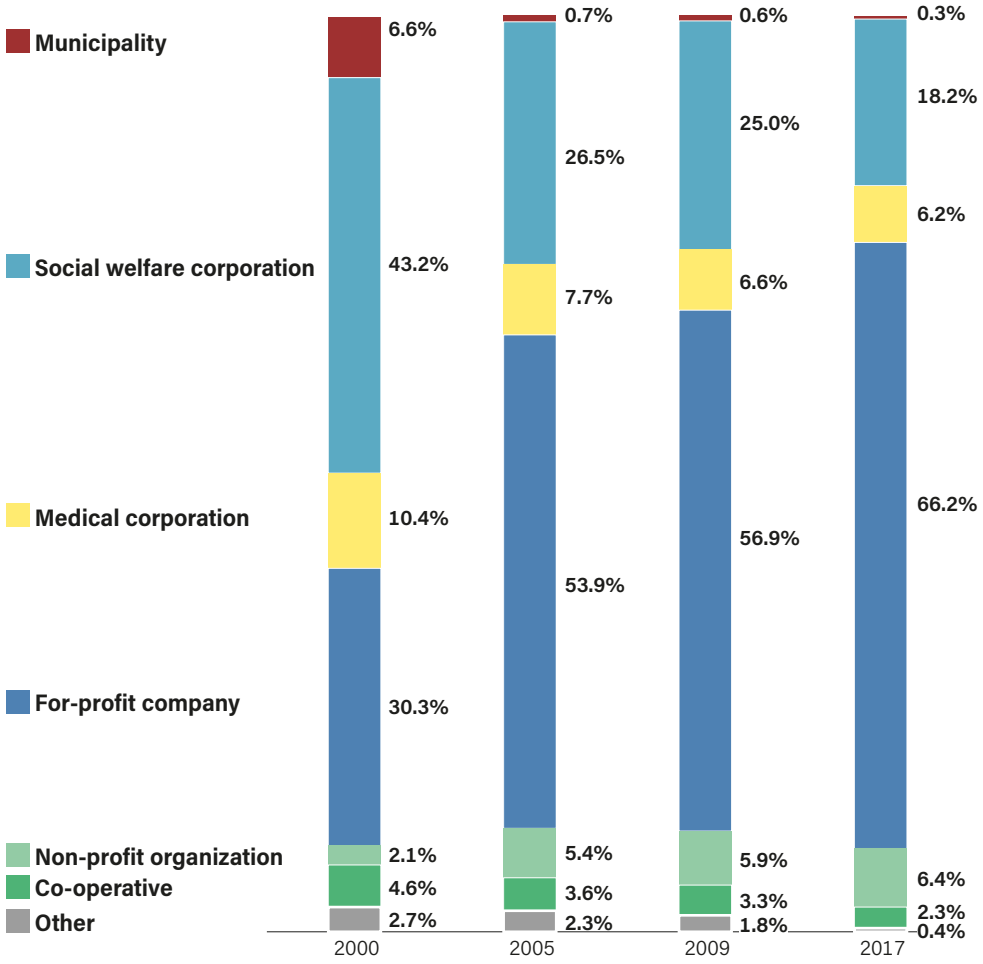
Entrepreneurship in community- and home-based care services

With the introduction of LTCI, as a rapid surge in demand was expected, the government decided to open the market to the private sector for the delivery of home-care services. It was also hoped that, by fostering market participation from a variety of providers, be they for-profit or not-for-profit, the supply would grow faster and the market would become more competitive as a result. Users would reap the benefits by obtaining a wider set of choices of home-care providers, greater efficiency, and better-quality services (Tokunaga and Hashimoto, 2013).

The number of long-term care users has increased sharply since the new system took effect, especially for home-care services. When the new insurance program was introduced in 2000, less than 1.5 million elders used long-term care services, while this figure has risen to 5.6 million people in 2019 (MHLW, 2021). In the new insurance system, users are now free to contract care services with any provider of their choice, in contrast to the previous system, where they had no choice but to resort to local public or non-profit providers for the services they needed (Shimizutani and Suzuki, 2007). Care managers determine the type and number of services needed and coordinate between users and care providers.

In this context, there has been a rapid increase in the number of for-profit providers in Japan over the last two decades. The share of for-profit organizations in home-care services went from 30.3% in 2000 to 66.2% in 2017 (**figure 6**). These figures, however, hide significant differences in this regard among municipalities.

Figure 6: Home-care providers in Japan, according to ownership status, 2000–2017



Sources: for 2000, 2005, 2009: Saito, 2014; for 2017: MHLW, 2019.

Indeed, there are municipalities where the vast majority of service providers are for-profit corporations, whereas others rely overwhelmingly on non-profit organizations and cooperatives for the delivery of such services (Saito, 2014).

Researchers Satoshi Shimizutani and Wataru Suzuki have examined the impact of the arrival of new private providers in the home care-sector on the quality of services and the efficiency with which they are delivered. In their study, for-profit entrepreneurs managed to provide better quality services in several aspects of care, even if the staff qualifications and experience were not necessarily on par with those of non-profit providers. In addition, it was shown that new providers brought more efficient management processes, after controlling for quality of services, than existing providers. According to them, "the competition mechanism works effectively in the home help long-term care market, and that free-market policy contributes significantly toward improving the quality and the efficiency of the home help long-term care market in Japan" (Shimizutani and Suzuki, 2007: 298)

Yoshihiko Kodoya (2010) also analyzed the quality performance of home-care providers and found no significant difference in the quality of service between for-profit and non-profit providers. However, his analysis showed that the service of providers was of significantly better quality in competitive markets than that of those in non-competitive markets. New providers tended to improve the service quality more upon their entry into the market, mostly by bringing new managerial processes, compared to incumbents (Kodoya, 2010). There is also an emulation effect in the industry, as non-profit companies increasingly tend to adopt the same management tools as for-profit companies in order to improve their performance (Shirinasihama, 2019).

Innovative approaches to overcome challenges in the nursing-home sector

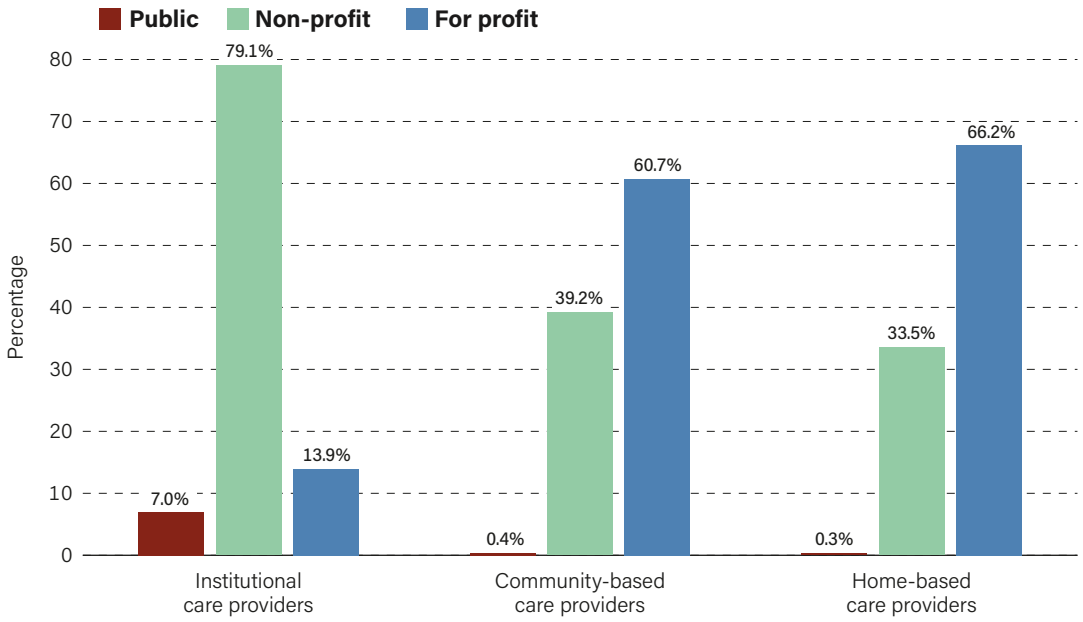
Before the implementation of the LTCI scheme, institutional-care services were also mostly provided by the government. Social welfare corporations, which are non-profit organizations, were the only exception as they were allowed to provide services under governmental contracts (Suda, 2014). Citizen could not freely choose a service provider and government bureaucrats decided how to assign clients to the provider that they deemed most appropriate (Suda, 2011).

In principle, even today, only non-profit organizations are allowed to provide institutional care. In practice, however, an increasing number of for-profit organizations have been licensed by prefectural governments to provide nursing-home care in recent years. Data from the Ministry of Health, Labor and Welfare show that approximately 13.9% of nursing homes in Japan were operated by for-profit organizations in 2017 (MHLW, 2019). These organizations are closely monitored by prefectural governments and the rate of compliance with government regulations remains high (97.1% in 2017) (Estévez-Abe and Ide, forthcoming).

In addition, there are other types of private for-profit facilities and group homes that are categorized as "community-based care" in the classification of the LTCI system in Japan while they operate for all practical purposes as institutional care (Sugawara, 2020). In response to the growing needs to be met in the sector, the number of such facilities has grown rapidly over the last two decades, from less than 500 providers in 2000 to 13,499 in 2017. As shown in **figure 7**, over 60 % of the establishments providing so-called "community-based services" (at the boundary of institutional care) are operated by private entrepreneurs (MHLW, 2019).

Hence, the implementation of long-term care insurance has stimulated the development of innovative approaches from the private sector. The impact was particularly felt in the area of care for people suffering from dementia, who benefited from the emergence of "group homes", small-scale facilities that offered a superior living environment and were better able to adequately meet their needs. The LTCI program "has created a context in which medical professionals in the private sector have

Figure 7: Distribution (%) of long-term care providers in Japan, by type of care and ownership status, 2017



Sources: for home-based and community-based care: MHLW, 2019; for institutional care: Estévez-Abe and Ide (forthcoming); author's calculations.

been able to take risks and develop new programs, many of which are directed at helping those diagnosed with Alzheimer's disease (AD) and their families" (Traphagan and Nagasawa, 2008: 90).

The nursing-home sector is nonetheless facing growing challenges. As previously mentioned, in response to the rapid increase in the financial burden of the social insurance scheme, there was a shift in policy orientation that aimed to replace costly institutional care with community-based and home-based care. Thus, local authorities restricted the construction of new public nursing homes, which had the unintended consequence of lengthening the waiting list for institutional care, especially in non-profit homes (Sugawara, 2017). As a matter of fact, waiting lists in non-profit nursing homes can be quite long, while they are non-existent in for-profit homes (Karmann and Sugawara, 2021). The problem is exacerbated by the fixed and uniform fee schedule for accommodation costs—not adjusted to the local prices and rents—for non-profit providers in Japan. Given the limited supply, access has become more difficult for inhabitants of some regions, especially in more expensive metropolitan areas (Yoshida and Kawara, 2014).

Another worrying issue is the labour shortage in Japan's long-term care sector. The situation is such that many workers in various fields, mostly women, are forced to leave the traditional labour market to come and act as informal caregivers and provide long-term care for elderly relatives (Jones and Seitani, 2019). Faced with major

difficulty in recruiting and retaining qualified employees, care providers have had to rely on pay increases, promotions, and financial incentives. Private enterprises, in partnership with public agencies, have also worked to develop and fund nursing training programs and apprenticeships and began to look to foreign-born workers as a way to alleviate the problem of labour shortage (Milly, forthcoming).

With the growing care needs and difficulties in recruiting workers, some creative inventors and entrepreneurs have been trying to develop care technologies and robots to enable elderly people to continue living independently in their own home and to overcome the lack of qualified staff in care facilities (Kohlbacher and Rabe, 2015). The national government has also been partnering with private entrepreneurs to accelerate the production and adoption of care robots, notably through the Project to Promote the Development and Introduction of Robotic Devices for Nursing Care (2019). Since 2018, prefectural governments have offered subsidies to cover part of the costs of acquiring robotic products (Wright, 2021). Some robotic products have also been added to the coverage of the LTCI, aiming to foster accessibility and availability of care robots in institutional facilities. A recent study showed that robots have contributed to alleviate the problems of labour shortages and staff retention and promote a more flexible work environment (Eggleston, Lee, and Iizuka, 2021).

Lessons from the Netherlands

General overview of the health-care system in the Netherlands

The Dutch health-care system provides universal health-insurance coverage to all citizens through compulsory enrollment with competing private health-insurance companies (profit and non-profit) funded by premiums (Esmail, 2014b). In this system, individuals are mandated to take out an insurance policy and health insurers are encouraged "to increase the efficiency of health care delivery by becoming prudent purchasers of health services on behalf of their clients" (van de Ven and Schut, 2009).

The central government regulates the market so that no citizen is deprived of health insurance because of age, medical history, or inability to pay (Esmail, 2014b). There is a risk equalization system under which insurers whose policyholders are proportionately older or in less good health are compensated by insurers whose policyholders are relatively younger and in good health. Policyholders can supplement their basic package with additional insurance offered on the market. Competition among private health insurers has intensified significantly over time, resulting in lower operating costs and lower premiums to policyholders (Bikker and Bekooij, 2021).

The Ministry of Health defines the priorities, remains responsible for establishing the conditions of access, ensuring the maintenance of the financial viability of the system, but no longer intervenes in the management of health facilities. In the Netherlands, hospitals are private non-profit entities with full autonomy in the management of operations. The providers deliver the services on the basis of the terms negotiated with the insurers. Hospitals (including outpatient services) derive their income from the number of patients treated and from diagnostic-treatment combinations (the Dutch version of diagnostic related groups) (Rechel, Duran, and Saltman, 2018). The government simply ensures that a level playing field is maintained among health providers and supervises the quality of care offered to patients.

The Dutch system is generally less expensive than the Canadian system: 10.3% of GDP is spent on financing health care (OECD, 2021). The Dutch health-care system is considered high performing, with rapid access to needed care for patients and a relatively low level of health disparity (Esmail, 2014b).

The universal long-term care system

Netherlands was one of the first countries to grant universal access to long-term care to its population in 1968. Currently, this universal coverage is obtained through three complementary public funding schemes that serve to cover the costs of specific types of care. Two statutory insurance schemes funded through premiums pay for

care provided in nursing home facilities and at home, while since 2015 municipalities are responsible for domestic help services financed through general taxation (Bakx, Schut, and Wouterse, 2020). [11]

In the Dutch system, users of LTC pay each year a means-tested deductible. Users basically pay all costs out-of-pocket until they reach a maximum amount that varies according to each individual's income and wealth (house excluded). Income up to a certain threshold (different for institutional and home care) is exempted (Wouterse, Hussem, and Wong, forthcoming). [12] In 2019, cost-sharing amounted to 7% of total long-term care expenditures (OECD, 2021). The remaining costs are publicly financed. Providers of institutional care covered by the public LTC insurance scheme receive a bundled payment per client based on the magnitude of his or her needs. The bundled payment varies per care level and is structurally designed for the provision of various integrated long-term care services. Eligible people are classified as belonging to one of eight increasing levels of care (Alders and Schut, 2019).

In 2020, 19.5% of the Dutch population was aged 65 years and older (OECD, 2021). A large share of elderly people resides in long-term care facilities (4.4%) compared to most other OECD countries (Statistics Netherlands, 2021). This is in part explained by the comprehensiveness of the statutory long-term care insurance system and by some adverse incentives promoting entry into institutional care (Kok, Berden, and Sadiraj, 2015). The Netherlands devoted 2.9% of its GDP to long-term care expenditures in 2019, which was more than almost all OECD countries, except Norway (OECD, 2021).

Reforms of long-term care and the gradual shift towards community- and home-based care

In a context of the rapid aging of the population and increased pressure on public finances, the organization of Dutch long-term care and its financing have been the subject of increasing attention on the part of opinion leaders and policy makers. Spending on long-term care has grown at a rapid rate over time and measures to try to contain its growth have multiplied in the last twenty-five years.

In order to address these challenges, Dutch policy makers have first aimed to favour care in a community-based setting instead of the institutional setting. This policy orientation was perceived to be in accordance with patients' preferences

[11] The Long-Term Care Act (WLZ) is funded through a payroll tax of 9.65% on earned income up to a maximum of 34,712 € in 2020. The Health Insurance Act (ZVW) is financed at 45% by a payroll tax of 6.7% on earned income levied on employers up to a maximum of 57,232 € (in 2020) and at 45% by community-rated premiums levied on employees and pensioners; the rest of the funding comes from general taxation (Veghte, 2021).

[12] The first 4,500 € of income for nursing home care and 16,660 € for home care are exempted (Wouterse, Hussem, and Wong, forthcoming).

to stay and live in the community as long as possible, and a less expensive way of delivering the needed services (Kok, Berden, and Sadiraj, 2015; de Meijer, Bakx, van Doorslaer, and Koopmanschap, 2015). Reforms implemented over time were also intended to leave more room for individual patients to choose their provider and organize their own long-term care and services plan (Kruse, Ligtenberg, Oerlemans, Groenewoud, and Jeurissen, 2020). The goal was to shift the balance of power in favour of care recipients.

Hence, instead of obtaining care directly in a nursing home facility, beneficiaries were granted the right to choose to receive it at home or in a nursing home privately funded in part. Since 1997, they can also opt to receive cash benefits (personal budget) and organize themselves to obtain the needed care in the place of their choice (Bakx, Shut, and Wouterse, 2020). They can choose from a variety of private—mostly for-profit—providers that compete in the market (van Eijkel, Kattenberg, and van der Torre, 2018). They can even "hire" family members or relatives and pay for the domestic help or home care with the personal allowance they receive (Marangos, Iedema, de Klerk, Woittiez, and Groenewegen, 2020). There is a maximal annual amount of cash benefits for users depending on the care levels (**table 2**). This amount generally represents between 60% and 75% of the maximum fee paid for equivalent services obtained from formal caregivers. In order to guarantee an appropriate use of the cash benefits, it is the Social Insurance Bank that ensures that the caregivers are directly remunerated according to the contracts signed with the care recipients (Flood, DeJean, Doetter, Quesnel-Vallée, and Schut, 2021).

Another major reform of the LTC system initiated in 2007 accelerated the shift from institutional care to community-based and home-based care and decentralized the responsibilities of all non-residential care to the municipalities (house cleaning, day care, and counseling) and to health-insurance companies (nursing and personal care). Municipalities and private insurers now bear the financial risks for these services, which gives them incentives to negotiate the best possible prices with care providers. This has had the effect of intensifying competition and generating cost savings compared to levels prior to decentralization (Schut, Sorbe, and Høj, 2013).

From that point on, public funding for independent living units for elderly people with mild dependency was gradually phased out (Maarse and Jeurissen, 2016; Bakx, Douven, and Schut, 2021). Access to institutional care in nursing homes is now reserved for people in need of permanent supervision or intensive care and treatments (Alders and Schut, 2019). [13] As a result, the number of elderly people needing

[13] Since 2005, eligibility for publicly funded residential care is determined by the Care Needs Assessment Centre (CIZ), an independent assessor. One basic requirement is that a person need 24-hour constant supervision or close care to be deemed eligible (Ministry of Health, Welfare and Sport, The Netherlands, n.d.).

Table 2: Users of institutional care in the Netherlands, according to care package and type of benefits (in kind or in cash), population of 65 years and older, 2019

Level of care	Description	Users "in-kind"	Users "cash benefit"	Total users	Cash benefit per year (€)
Grade 1	Assisted living with some support	205	0	205	16,918
Grade 2	Assisted living with support or personal care	610	0	610	24,532
Grade 3	Assisted living with support and intensive personal care	1,270	0	1,270	29,863
Grade 4	Assisted living with intensive support and extensive nursing	3,605	2,040	34,645	40,014
Grade 5	Nursing home with extensive dementia care	73,795	4,920	78,715	54,289
Grade 6	Nursing home care with extensive personal care and nursing	29,860	1,415	31,275	54,289
Grade 7	Nursing home care, with focus on supervision (often behavioural problems)	9,715	200	9,915	68,003
Grade 8	Nursing home care with intensive care, with focus on personal care/nursing (problems with ADL and cognitive)	1,595	180	1,775	81,161
Total		**149,655**	**8,755**	**158,410**	

Sources: Zorg Kantoor, 2020; Statistics Netherlands, 2021.

a relatively low level of care (care levels 1–3) who reside in assisted living facilities has declined by 86% from 2015 to 2019. Those needing a lower level of care now represent just 1.4% of all nursing home residents in the Netherlands, as shown in table 2 (Statistics Netherlands, n.d.).

The substitution of home-based care for institutional care has resulted in a rise in average health expenditures devoted to individuals cared for in nursing homes, but at the same time entailed a slowdown in the growth of total health expenditures for people aged 65 years and older as a result of the aging-in-place policy and the reallocation of resources (Krabbe-Alkemade, Makai, Shestalova, and Voesenek, 2020). Thus, the reduction in institutional LTC expenditures more than compensated the increase in the use of home care. The Dutch policy of favouring community-based and home-based care not only coincided with the population's preferences, but also contributed to effectively mitigating the impact of population aging on LTC spending (de Meijer, Bakx, van Doorslaer, and Koopmanschap, 2015).

The increasing role of private for-profit providers in institutional care

For a long period of time, the Netherlands was known for its almost exclusively private, non-profit provision of nursing-home care. Until a few years ago, the presence of for-profit providers in this sector was marginal. However, in 2015, long waiting lists combined with scandals about the quality of care and the deteriorating reputation of non-profit homes, led to major changes to the regulatory framework in the long-term care sector (Maarse and Jeurissen, 2016). LTC received extra public funding and private for-profit providers were allowed to step in and enter the market in order to meet the growing demand (Bos, Kruse, and Jeurissen, 2020).

In 2019, there were 274 for-profit nursing homes, or 12.2% of the total number of facilities in the sector (table 3). The number of for-profit providers has experienced considerable growth in recent years, as half of them entered the market between 2016 and 2019 (Bos, Kruse, and Jeurissen, 2020). The range of facilities is quite diverse: while some providers aimed explicitly at delivering care to more affluent seniors, others target elderly people belonging to low- and middle-income groups, or those suffering from cognitive impairments or dementia (Plaisier and den Draak, 2019).

Table 3: Share of non-profit and for-profit nursing homes in the Netherlands, 2019; and differences in their client ratings, 2014–2017

	Non-profit	For-profit
Number of nursing homes	1,968	274
Percentage of total	87.8%	12.2%
Average score on client ratings		
Accommodation (scale 1–10)	7.94	8.78***
Employees (scale 1–10)	8.16	8.77***
Listening (scale 1–10)	7.78	8.39***
Percentage of clients who would recommend the nursing home	92%	95%***

Note: Comparative evaluation of client ratings conducted by Bos, Kruse, and Jeurissen (2020) based on a representative sample of non-profit and for-profit nursing homes. ***p-value < 0.01.
Source: Bos, Kruse, and Jeurissen, 2020: 8.

The care component is almost always paid for by the statutory insurance schemes (personal budget or full home care package), although residents are free to supplement their basic level of services from their personal funds. Health insurers and care providers negotiate prices up to a regulated maximum. Depending on the insurance policies of the resident, the health insurer covers between 70% and 100% of the negotiated price paid to the contracted care provider (Bakx, Schut, and

Wouterse, 2020). Residents must pay a co-payment that varies partially according to income. They must also support the costs associated with meals and accommodation (Plaisier and den Draak, 2019).

According to two researchers from the Office of Social and Cultural Planning of the Dutch government:

> Those behind the private residential care initiative are a mix of enthusiastic care professionals and people from the business world with a passion or with (negative) experience of family members in a care institution. They are often keen to show that things can be done differently and "better", and seek to place greater emphasis on accommodation and well-being. There are also some whose main aim is profit, though this does not mean that they do not offer good-quality care—like other providers, the care they provide has to meet legal quality standards. (Plaisier and den Draak, 2019: 85)

Several conditions have helped create business opportunities for for-profit companies in the institutional-care sector. The first stems from the inability of non-profit organizations to adequately meet the growing demand and needs of a new generation of seniors. The private for-profit sector has been able to develop a client-based approach that better corresponds to the wishes of the elderly than the traditional approach, more focused on medical care, of non-profit nursing homes. The more personalized approach of for-profit providers has allowed them to outrun their non-profit competitors in how much residents appreciate the services provided and to achieve higher satisfaction rates.

> [F]or-profit nursing homes have been more responsive to the increased demand for a "well-being" approach that focuses on well-being rather than the medical aspects of nursing home care and that encourages small-scale nursing homes that feel "just like home". Participants state that for-profit nursing homes are front runners in the implementation of the "wellbeing" approach, whereas the non-profit sector often represents large-scale, bureaucratic, and medically oriented organizations. (Bos, Kruse, and Jeurissen, 2020: 7).

As emphasized by Bos, Kruse, and Jeurissen (2020), the profit motive encourages for-profit companies to enter a market and expand when demand increases or customers need change. In addition, private entrepreneurs are more responsive to these changes in customer preferences than are non-profits. The latter do not necessarily have the incentive to minimize costs or adjust their capacity to demand as much as for-profit companies. As a result of the increasing entry of for-profit organizations, it appears that demand does not exceed supply by a wide margin: the waiting

list for a nursing home place consisted of only 357 persons as of October 2020, 7% of whom were waiting without care for more than 6 weeks (Zorguerzekeraars Nederland, 2020).

Several aspects of the services offered in nursing homes are considered important to residents and influence their well-being. [14] For example, beyond the quality of nursing care, for-profit companies will pay close attention to the living environment of residents, and will strive to ensure that residents can live in large private rooms that they can furnish themselves so that they feel at home. These are details to which non-profit nursing homes do not pay attention (Bos, Kruse, and Jeurissen, 2020).

Access to capital, mainly from private equity investors, has also been an important driver of the rise of for-profit providers in the market. This greater access to capital has allowed them to set themselves apart from the non-profit nursing homes, which have had more difficulty obtaining bank loans given their financial difficulties. For private for-profit providers, having access to additional financial sources makes them less dependent on public funding and less vulnerable to government measures to contain costs (Bos, Kruse, and Jeurissen, 2020).

Staff members and health-care professionals generally admit having more time available to care for clients in for-profit nursing homes, given they can avoid the administrative burden or red tape that plagues non-profits. Employees can therefore be more responsive to the varied needs and wishes of residents, take time to listen to their stories, and adapt to their daily pace of life (Kruse, Ligtenberg, Oerlemans, Groenewoud, and Jeurissen, 2020). In turn, these working environments make for-profit providers more attractive to employees. Hence, they do not suffer from labour shortages to the same extent as non-profit providers (Bos, Kruse, and Jeurissen, 2020).

Kruse and colleagues argue that "the for-profit nursing home sector does embrace the logic of the market but reconciles it with other logics (*i.e.* logic of care and logic of professionalism). Importantly, for-profit nursing homes have created an environment in which care professionals can provide person-oriented care, thereby reconciling the logic of the market with the logic of care" (Kruse, Ligtenberg, Oerlemans, Groenewoud, and Jeurissen, 2020).

[14] Quality measurement and public reporting are other important aspects of long-term care in the Netherlands since the introduction of the Quality Framework for Appropriate Care. Elderly people and their relatives have access to a wide range of quality measures and client-related indicators that allow them to compare nursing home providers and make informed choices (Maarse, 2013). These indicators are made publicly available online: <www.zorgkaartnederland.nl>.

Lessons from Sweden

General overview of the Swedish health-care system

The Swedish health-care system provides universal health-insurance coverage to its population, through a tax-funded model, much like the Canadian system (Marchildon, 2021). According to the Health and Medical Service Act, health care must be distributed on equal terms to all citizens and ability to pay should not influence who gets medical care first. Unlike Canadians, however, Swedes may take out private health insurance for medically required care (Kullberg, Blomqvist, and Windblad, forthcoming). Patients pay relatively small user charges on visits to general practitioners or to hospitals, in order to curtail unnecessary visits without denying access to needed services. Overall health spending in Sweden is similar to Canada and there has been slower growth in spending over the past decade despite a relatively older population.

The Swedish health-care system has undergone fundamental changes since the early 1990s, when a severe fiscal crisis hit the country and access to health services deteriorated. The reforms began with the decentralization of decision-making powers to 21 autonomous local authorities and the separation of the responsibilities for financing and for providing health-care services (Labrie, 2007). Each county collects income taxes directly from its population, which form the bulk of their health-care budget.

Hospitals and other health-care facilities are now mostly financed by means of an activity-based system, rather than with global budgets as in Canada. Patients have the freedom to choose in which medical clinic or hospital they wish to receive their treatment and providers, whether public or private, compete on quality to attract them (Lundbäck, 2013). [15] Private medical clinics have increased in number in recent years and now represent around 40% of the overall supply of primary care. These clinics welcome both patients financed by the public health-insurance plan and those holding a private insurance policy, without discrimination (Kullberg, Blomqvist, and Windblad, forthcoming). Management quality is generally higher in private care centres, and better management is associated with speedier access to services (Angelis, Glenngård, and Jordahl, 2021). Contrary to the fears of some, the market-based reforms did not undermine the principle of equity to which the Swedes remain attached (Windblad, Isaksson, and Blomqvist, 2021).

[15] There are six private (for-profit and not-for-profit) hospitals in Sweden that provide care to all patients without discrimination and are funded entirely by county councils, based on contracts (Lundbäck, 2013).

Elderly care

The Swedish long-term care system is also tax funded and has universally covered all citizens since its inception in the 1940s. Long-term care occupies an important place in the health system, and accounted for 2.9% of the GDP as of 2019 (OECD, 2021). All have access to a comprehensive package of long-term care services based on their needs, irrespective of their level of income (MacInnes, Österberg, and Walsh, forthcoming). In 2020, close to 84,000 elderly persons lived in nursing homes, while more than 236,000 received care services in their own home (NBHW, 2021). These numbers represent respectively 4% and 11.3% of the population aged 65 years and older in Sweden (Statistics Sweden, 2021).

The governance structure for LTC in Sweden is highly decentralized. The national government has responsibility for setting priorities and policy objectives, as well as regulating eldercare. While the 21 counties take charge of the provision of hospital and medical care, the 290 municipalities are responsible for the provision of the institutional and home-care services. The three levels of government share the responsibility of financing the services, although most of the costs are supported by the municipalities (85%) (Donehy, Agerholm, Orsini, Schön, and Burstrom, 2020). The central government contributes a relatively small portion of the funding, allowing greater flexibility for local policy makers. However, its transfers to municipalities for elderly care are linked to performance targets based on outcomes (OECD, 2013).

Since 2013, the Health and Social Care Inspectorate, a national state agency commissioned by the Swedish National Board of Health and Welfare (NBHW), has been in charge of supervising residential and home-care services; the supervision includes unannounced inspections to ensure providers comply with stated regulations (Hanberger, Nygren, and Andersson, 2018). The NBHW also carries out an annual user survey (for users of home care and residents of nursing homes) to measure what older people think about eldercare and assess the general satisfaction with the care received (Carlstedt, forthcoming).

A decentralized, market-based approach to nursing home care

From the first half of the 1990s, Swedish eldercare has gradually moved towards a market-based system. Important steps in this direction were taken with the enactment of the Local Government Act and the Act on Public Procurement, which transferred the responsibility for long-term care from the county councils to the local authorities. These legislative changes also established a clear separation between the functions of the purchaser and the provider and introduced elements of competition within the health-care sector (Montin, 2016).

A further step was taken when the Social Democrats initiated the *Ädel reformen* (elderly reform) in 1992, aimed at improving efficiency and quality in LTC by promoting users' choice across public and private providers and by setting performance-based

targets (OECD, 2013). The reform was intended to solve the persistent problem of so-called "bed blockers"—elderly patients in need of long-term care who were waiting for a place in a nursing home—, which had the unintended effect of lengthening waiting times to acute and specialized care in the hospital system. The municipalities were then forced to reimburse the county councils for the costs of care of elderly patients who remained in hospital for a longer time than needed (Trydegård, 2003).

Hence, another objective was to improve the cost-efficiency of the services provided in the entire health system. Care for the elderly in hospitals is not only more expensive than in nursing homes, it has negative health consequences for other patients who see their access to required treatment being delayed. Prior to the reform, it was not uncommon for elderly persons to wait for weeks or months in overcrowded wards of hospitals before being discharged to another, more appropriate, care setting (Andersson and Persson, 2000).

Outsourcing of nursing home management

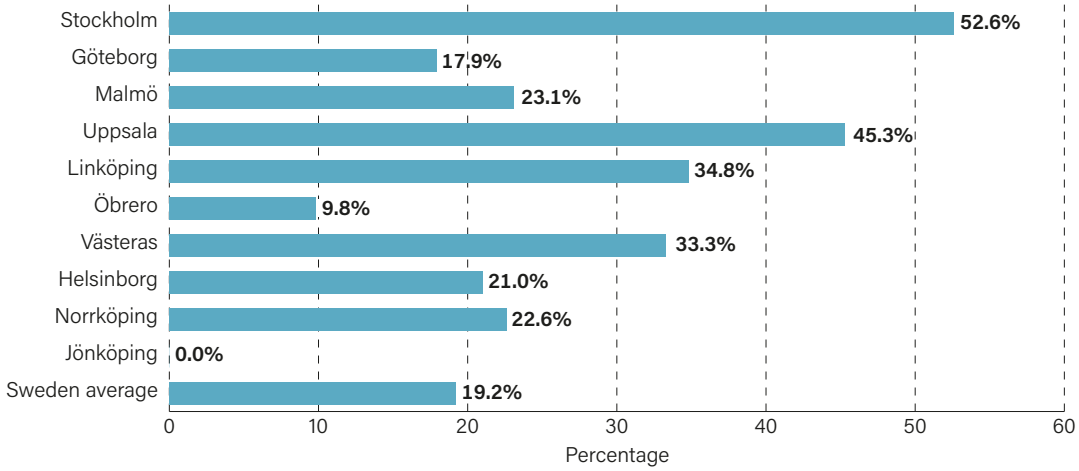
Since the *Ädel reform*, several municipalities in Sweden have been outsourcing the management and operation of nursing homes. There are two ways by which they can outsource these tasks to the private sector. They may contract out nursing-home care either through procurement processes or via a user-choice system. In the former case, contracts for nursing-home care are awarded after a competitive tendering process where the winning provider is chosen by the municipality, generally to the offer with the best quality-to-price ratio (Bergman, Johansson, Lundberg, and Spagnolo, 2016). In the choice system, the municipality specifies some minimal quality standards, sets a maximum price it wishes to pay, and lets customers choose from among a list of authorized providers, public or private, the one they prefer (Broms, Dahlström, and Nistotskaya, 2020). Private providers called upon to manage nursing-home facilities must comply with the same set of rules and regulations as municipal providers, and several accountability mechanisms exist to make sure agreed-upon standards are met (Blomqvist and Winblad, 2020). Thus, private and public providers operate on a level playing field with respect to quality standards, safety requirements, and audit measures (Winblad, Blomqvist, and Karlsson, 2017).

The contracts are funded on the basis of a pre-determined fee per resident, with generally a duration of four years (extendable once or twice for an additional four years). A provider must accept every person whose condition necessitates a placement in a nursing home, if its capacity—defined in the contract—allows it (Bergman, Johansson, Lundberg, and Spagnolo, 2016). An assessment to determine the needs of the elder person is made by a municipal care manager. The residents in either public or private nursing homes have to pay a relatively low level of fees for their care, which are means-tested and capped at 2,100 Swedish krona per month—about CA$305—since 2020 (Sweden/Sveridge, 2021). These fees may vary from one municipality to

another, as local authorities retain full autonomy in this area. Some elderly people with income below a certain threshold are exempt from paying any user fee. The costs of rents and meals are not covered by the public scheme and must be paid for by the residents themselves (Blix and Jordahl, 2021). Out-of-pocket expenditures—which exclude rents and meals—represent on average about 7% of the cost of residential home care (OECD, 2021).

Before the 1990s, most nursing homes were owned and operated by the county councils. However, the private for-profit provision of elderly care has grown steadily since the implementation of the *Ädel reform*. Indeed, the share of nursing homes managed by private for-profit operators increased from 1% in 1990 (Stolt, Blomqvist, and Winblad, 2011) to 19% in 2020 (NBHW, 2021). Private participation in the management of nursing homes varies from one municipality to another, being higher in Stockholm (52.6%), Uppsala (45.3%), Gävle (37.6%) and Linköping (34.8%) and lower in Örebro (9.8%) and Jönköping (0%) (**figure 8**). The presence of various types of care providers creates competition among them aimed at improving the quality of services and the efficiency with which they are provided, as has been shown to be the case in the Swedish health-care sector in general (Rudholm, Nordmark, and Marklund, 2011).

Figure 8: Share of nursing homes under private, for-profit management in the ten largest municipalities of Sweden, 2020



Source: NBHW, 2021.

Choice and competition bring efficiency gains and quality improvements

In Sweden, several indicators are measured and collected with the aim of comparing quality of nursing homes according to ownership status. These quality indicators use structural measures (*e.g.*, staff levels, staff education), processual measures

(*e.g.,* proportion of residents participating in the formulation of care plan, duration between meals, number of food alternatives), and outcome-based measures (*e.g.,* prevalence of pressure ulcers, use of physical restraints, number of deficiencies in governmental assessments). They are available on line and people can use them to compare care providers and make informed choices. Not only does this bring more transparency to the public sector, but the performance of the private providers can serve as a benchmark against which public organization can be compared and evaluated (Blix and Jordahl, 2021).

The reports of these indicators have enabled several groups of academics to evaluate the efficiency and quality of care provided in long-term care facilities in Sweden. Researchers have paid particular attention to the impact of changes that have fostered the growth of private providers and competition in the long-term care market in recent years. According to economists Blix and Jordahl, who made a comprehensive review of the evidence on the subject, "private nursing homes have the upper hand on most of [the quality indicators]" (Blix and Jordahl, 2021).

For indicators of processual quality—the ones that have the highest impact on user satisfaction (Kajonius and Kazemi, 2016)—private for-profit nursing homes tend to outperform public ones. Stolt, Blomqvist, and Winblad (2011), for instance, have demonstrated that a higher proportion of residents participate in the formulation of their care plan, benefit from a reasonable duration between the evening meal and breakfast, and have a larger diversity of food options offered to them. Also, the authors found no indications that private providers tended to select the least complex cases and avoid residents needing more care (so called "cream-skimming"). Results obtained by Windblad, Blomqvist, and Karlsson (2017) follow a similar pattern. A significantly larger share of residents is screened for falls (20.2 percentage points), pressure ulcers (16.1 percentage points), and malnutrition (15.7 percentage points) in privately operated nursing homes, compared to public homes, after controlling for several confounding factors. Private for-profit providers also managed to outperform public ones on several other quality measures, such as user participation, updated care plan, and medication review, while maintaining a smaller staffing ratio per resident than public homes.

A thorough study, using municipal level data, sought to examine the impact of increased private provision and competition on the quality of care provided in nursing homes. After taking into account a series of confounders in their analysis, the authors found that such a shift has significantly reduced the risk of mortality while at the same time lowering the cost per resident (Bergman, Johansson, Lundberg, and Spagnolo, 2016). This shows us that efficiency gains can be obtained and improvements can be observed even for quality dimensions that are not an integral part of contracts with private suppliers (mortality risks).

According to Bergman and colleagues (2016), private-sector organizations do not necessarily choose to participate in a tendering process. However, even in this situation, the benefits of "potential" competition can be felt. This comes from the fact that providers, be they public or private, are required to be accountable to the population in a transparent manner and are subject to a benchmarking exercise that allows their relative performance to be assessed. Thus, as noted by Bergman and colleagues, "even if no private provider enters the market there may be an effect on quality as the in-house provider may increase its quality in response to potential competition" (Bergman, Johansson, Lundberg, and Spagnolo, 2016: 112).

Other researchers, using more recent data, showed that private and public providers performed equally well on several measures of quality in institutional care. Public nursing homes had a higher staffing level of nurses, while private nursing homes were more likely to offer an updated care plan to their residents (a processual quality measure). The authors also noted that privately run nursing homes operating under the choice system have higher nurse-to-resident ratios and better educated staff than their public counterparts. They interpreted this result as "indicative of the choice system being better equipped to handle more complex aspects of structural quality". However, they could not find a statistically significant relationship between the number of bidders in public procurement processes (a proxy for competition) and five quality indicators (Broms, Dahlström, and Nistotskaya, 2020). [16]

In a study comparing the management practices of publicly and privately owned nursing homes, some Swedish researchers showed that the performance of private establishments consistently outperformed public ones. They noted that far fewer private homes were at the bottom of the performance scale and more of them had very high scores, compared to public and non-profit institutions. Private nursing homes were better able to use incentives to improve staff performance and provide care better suited to residents' demands (Angelis and Jordahl, 2015). Recent evidence also reveals that private-sector involvement in the management of nursing homes has contributed to improved user satisfaction with the provision of care (Spangler, Blomqvist, Lindberg, and Windblad, 2019).

Of course, the presence of for-profit providers in the elder-care sector remains a polarized issue in Sweden (Guo and Willner, 2017). But accusations of "quality shirking" or mistreatment against for-profit providers have been shown to be based on questionable, often ideological, motives rather than facts (Jönson, 2016). The empirical literature almost unanimously shows that the overall quality of elder care has improved with increased reliance on private providers and competition in Sweden.

[16] This result is contested by Blix and Jordahl, who argue that "the absence of a relation between the number of bidders and quality does not capture the effect of competition since the type of procurement (price, quality or a mix of the two) is not taken into account" (Blix and Jordahl, 2021)

A shift from institutional care to home care

Over time, the eldercare policy in Sweden has shifted from institutional care to home-based care. This "aging-in-place" strategy coincided with the preferences of the elderly, who wished to live in their own residence for as long as possible, and with those of the local authorities, which saw a way to generate savings on the costs of institutional care. Priority for places in nursing homes is now given to elderly people with increased care needs and suffering from dementia. As a result, the share of Swedes aged 65 and older living in a care facility diminished by a third from 2007 to 2020 (NBHW, 2021).

In parallel, a market-based approach has also been adopted in the field of home-care services. Indeed, the Free Choice Act was enacted in 2009 to promote even further user-choice and competition in eldercare services delivered at home. Once a responsible care manager of the municipality has granted access to tax-funded home-care services, individuals can choose among a diversity of service providers, be they public or private and for-profit or not, that have been authorized to operate. [17] There are over 500 private providers, mostly of small size, to choose from (Feltenius and Wide, forthcoming). As of 2020, 167 of the 290 municipalities had implemented (or had decided to introduce) a choice system (ALAR, 2021).

Quality indicators are measured and published on line to assist patients in their choices (OECD, 2013). Those who are unable or unwilling to exercise their choice are assigned a provider according to a rotation list. Users who are not satisfied with the services received from a provider may switch to another one (Leichsenring, Rodrigues, Winkelmann, and Falk, 2015). As stated in the government bill that led to the choice system,

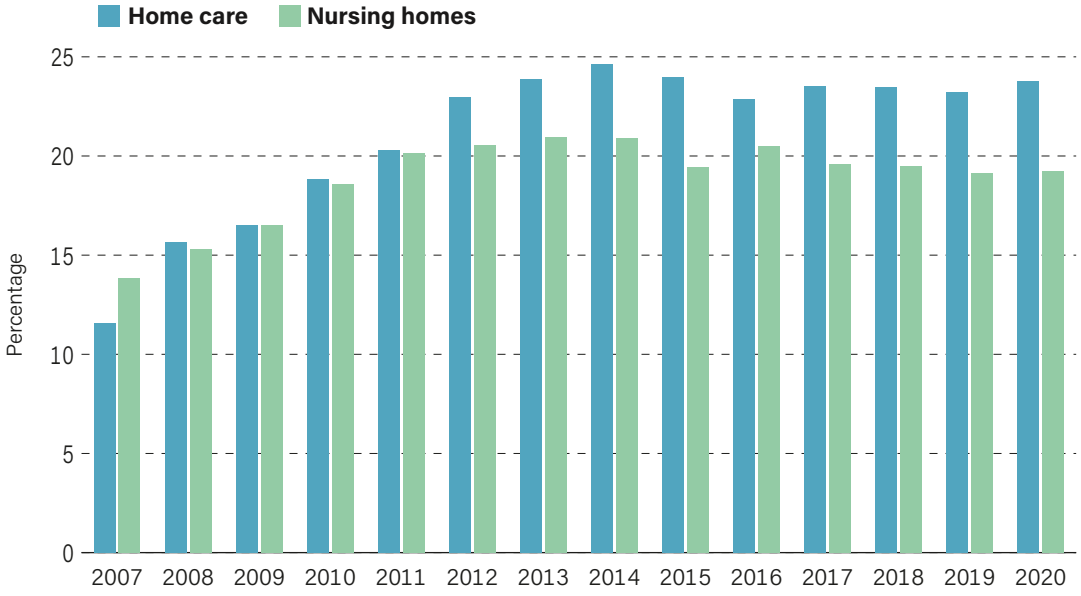
> one of the fundamental pillars in a choice system is the individual's right to re-choose a service provider if he or she so wishes. The right to re-choose means that the providers need to care about their users in order not to lose them as "customers" and thereby reduce their revenue. Since the supplier should have a reasonable interest in keeping their customers, the right to exit will thus ultimately lead to better service quality (Government Bill 2008, 94: 9). (cited in Moberg, forthcoming).

The proportion of hours of home-care services provided by private entrepreneurs has doubled since the passage of the Freedom of Choice Act, from 12% in 2007 to

[17] In Sweden, a cash-benefit scheme exists (Attendance Allowance), the amount of which varies by municipality. It is delivered to elderly according to their level of dependence and the number of hours of care needed per week. The cash payments are considered "symbolic payments" to support family caregivers and represent a tiny proportion of the LTC provision in the country (Da Roit and le Bihan, 2010).

24% in 2020 (**figure 9**). Private provision of home care is particularly important in metropolitan areas characterized by a higher density of population. In the county of Stockholm, for instance, 62% of all the hours of home-care services are now provided by private for-profit businesses (NBHW, 2021).

Figure 9: Share (%) of home care provided (hours) and nursing homes managed by private, for-profit entrepreneurs in Sweden, 2007–2020



Sources: NBHW, 2021: tables 9, 10.

It is true that the number of municipalities adopting the choice system has stagnated since 2015. Some municipalities have decided to abolish their choice system in recent years, mostly those with lower population density, and often for ideological reasons (Guo and Willner, 2017). [18] However, as argued by Jordahl and Persson (2020), the decision of those municipalities was not related to scandals or to dissatisfaction with the system, since the level of user satisfaction was close to (88% in the lowest case) or higher than (98% is the highest case) the mean level of satisfaction in "choice" municipalities (90% in 2018).

Research has shown that user satisfaction in home care significantly increased in the municipalities that adopted a choice system, compared with those that did not (Bergman, Jordahl, and Lundberg, 2018). Surveys conducted over time, notably by the city of Stockholm, have consistently shown that private provision is associated

[18] For these municipalities that do not allow customer choice, home care is either provided in-house by their own providers or is allocated to private companies by districts (Bergman, Jordahl, and Lundberg, 2018).

with a higher level of satisfaction among users. Among other things, users of home care especially appreciate the availability and punctuality of care workers and the opportunity to spend time outdoors with them (Blix and Jordahl, 2021). According to economists Blix and Jordahl, "the users of home care enjoy, and want to keep, the freedom of choice associated with the act" (Blix and Jordahl, 2021).

Local initiatives in a decentralized system

Since the adoption of reforms to decentralize and allow more user-choice and competition in Sweden, concerns were raised that these would contribute to a fragmentation of the health-care system. However, the choice model did not impede the emergence of local initiatives with care integration. Many municipalities have developed their own model of coordinated care while adopting at the same time a choice system, among which are Gävle, Jönköping, and Norrtälje (OECD, 2013; Gray, Winblad, and Sarnak, 2016; Leichsenring, Rodrigues, Winkelmann, and Falk, 2015; Le Bihan and Sopadzihan, 2019). The experience of Norrtälje provides a convincing example of how an integrated-care initiative can be successfully matched with a user-choice system in which a diversity of providers competes. Norrtälje is geographically the largest municipality in the County of Stockholm. With 27% of the population aged 65 and over, it is also one of the cities in Sweden where the impact of an aging population is most felt (Statistics Sweden, 2021).

The implementation of integrated care in Norrtälje was an initiative launched in 2006 when a public acute-care hospital was threatened with closure as a result of financial difficulties. This prompted several stakeholders to come together in an effort to save the local hospital (Donehy, Agerholm, Orsinin, Schön, Burström, 2020). Indeed, the municipality of Norrtälje, along with the Council of Stockholm and the hospital board gathered and decided to create a new joint organization with the objective of providing care to elderly citizens in an integrated manner. TioHundra AB was then constituted as a stock company owned by the municipality that would perform a comprehensive range of functions in health and social care in Norrtälje, from social psychiatry and mental counselling to rehabilitation and home-care services (Leichsenring, Rodrigues, Winkelmann, and Falk, 2015).

The implementation of this integrated-care model occurred before the changes in orientation towards increasing freedom of choice for users and competition between providers that began in 2009. The municipality has maintained over the last decade its commitment to the guiding principles of integration and choice: citizens are free to choose their home-care service provider among a variety of authorized providers, whether public or private; however, the private providers must be able to deliver the whole range of required services for the elderly (social support, rehabilitation, and nursing care at home). In the words of Leichsenring and colleagues,

> the user-choice model was implemented in Norrtälje based on the main goals and ideas of the integration and coordination of care services through a coherent chain of care. This requirement is imposed equally on all providers. In order to be accredited as a home care provider in Norrtälje the organisation must be able to supply for home care, home rehabilitation and basic home nursing. (Leichsenring, Rodrigues, Winkelmann, and Falk, 2015: 29)

The example of Norrtälje shows that integrated care may be implemented with perhaps more success in a decentralized system through a bottom-up approach (at the local level) than through a top-down approach (at the national or provincial level), as seen in some parts of Canada (Breton, Wankah, Guillette, Couturier, Belzile, Gagnon, *et al.*, 2019). Different groups of researchers have recently shown that the implementation of integrated care in the municipality was associated with a decrease in the trend towards visits to emergency departments and hospitalizations among elderly patients (Doheny, Agerholm, Orsinin, Schön, Burström, 2020; Agerholm, Ponce de Leon, Schön, Burström, 2021). These positive results were obtained in a municipality where free choice is highly valued by the population and the role of private providers is preponderant. In 2020, half of elderly patients in need of institutional care in Norrtälje lived in nursing homes operated by private entrepreneurs and 64% of those needing home-care services chose a for-profit provider (NBHW, 2021).

Discussion and conclusion

The nursing-home sector in Canada has received a lot of media attention since the beginning of the COVID-19 pandemic. However, the difficulties in meeting the needs of the elderly in nursing homes or at home precede the arrival of the pandemic in the country. As in many other aspects of their health system, provinces struggle to provide needed long-term care for the elderly population in a timely fashion. In the nursing-home sector, the wait time to obtain a place can drag on for many months in several provinces. Admissions to publicly financed institutions are controlled by governments and providers' revenues do not depend on the quality of service provided. In home care as well, access is limited and determined in each province on the basis of a standardized needs assessment performed by public authorities. Most patients have very few options and have little control over the basket of services offered to them. Over one third of Canadians aged 65 and older have unmet home care needs (Gilmour, 2018).

This is just the tip of the iceberg. Given the accelerated aging of the population and the increasing prevalence of chronic diseases among the elderly, the provincial health systems will have to cope with even greater home- and institutional-care needs in the future. They do not seem to be well prepared to take up the challenge.

For some time now, calls for the integration of long-term care into the public health systems in Canada have multiplied. Various lobby groups are pushing provincial governments to undertake major reforms and inject additional public funds into the system. Other opinion leaders have even suggested that we get rid of private for-profit providers, accusing them of being at the root of the many failings observed in the sector.

This study has examined how four countries—Germany, Japan, the Netherlands and Sweden—have integrated long-term care into their health systems. Like Canada, these countries have been grappling for several years with major issues related to the accelerated aging of their population and the increased prevalence of chronic diseases. However, in order to cope with these unavoidable challenges, they have successfully reformed their long-term care system by adopting an effective collaborative approach between government and the private sector. There are important public-policy lessons to be learned from the experience of these countries.

1. Universality of access is not hampered by cost sharing

In all four countries, patients have universal access to the long-term care and the services they need regardless of their income and pre-existing health conditions. In each country examined, universality refers to eligibility and access to long-term

care, and does not mean that care needs of elderly citizens are fully financed by governments. Indeed, patients must contribute to the financing of a non-negligible part of the costs of care, through cost sharing. The co-payments give patients incentives to use long-term care services in a more cost-efficient manner. Only a portion of them—those with incomes below a certain threshold—receive full public funding (see table 4). Costs of accommodations and meals are generally not covered by public insurance schemes. Cost-sharing is an integral part of these foreign health systems, and does not lead to inequitable or reduced access to needed care (Ilinca, Rodrigues, and Schmidt, 2017).

2. Choice and competition among a diversity of providers bring positive results

In all four countries analyzed, private for-profit entrepreneurs are increasingly called upon to play an important role in the provision of long-term care and are subject to the same regulatory standards as the other (public or non-profit) providers. It is not so much the number of private providers that distinguishes these countries but the way in which governments have integrated them into the universal system so that they can get the most out of their contribution. Hence, innovative private initiatives have emerged to meet the challenges posed by the aging of the population and the increased health-care needs of senior citizens. In fact, the implementation of the universal long-term care systems has ushered in a new era of eldercare entrepreneurship in Germany, Japan, the Netherlands, and Sweden. In that sense, they are not that different from many other developed countries with universal health-care systems that have taken this route over the past few decades (Damian, Pastor-Barriuso, Garcia-Lopez, Ruigomez, Martinez-Martin, and de Pedro-Cuesta, 2019; Garavaglia, Lettieri, Agasistis, and Lopez, 2011; Hjelmar, Bhatti, Helby Petersen, Rostgaard, and Vrangbæk, 2018; Holum, 2018; Mercereau, 2020).

Choice and competition among care providers have been encouraged by policy makers, and have helped improve the quality of care provided to the elderly. Unlike the practice in Canada, care providers in these four countries have no guarantee that they will operate at full capacity, and good quality is rewarded through user choice. The profit motive has also provided strong incentives to improve the efficiency of the LTC systems. The entrepreneur who operates in a competitive environment and who aspires to turn a profit must strive to meet the needs of his customers effectively; otherwise they will go elsewhere. It is no different in the area of health care and long-term care when choice and competition are present (Barua and Esmail, 2015; Labrie, 2014; Laporte, 2014). The experiences of the four countries described in this report eloquently demonstrate that this is not merely a theory.

Table 4. International comparisons of long-term policies in Canada and 4 other OECD countries with universal health care systems

	Canada	Germany	Japan	Netherlands	Sweden
Eligibility criteria	Needs-based and means-tested	Universal (eligibility test)	Universal (eligibility test)	Universal (eligibility test)	Universal (eligibility test)
Governance	Decentralized at the provincial level (regional level in some provinces)	Decentralized at the municipal level	Decentralized at the municipal level	Decentralized at the municipal level	Decentralized at the municipal level
Financing (2019)	Public/mandatory: 78.4%; Private insurance: 3.3%; Out-of-pocket: 18.3%	Public/mandatory: 72.1%; Private insurance: 4.1%; Out-of-pocket: 23.8%	Public/mandatory: 90.8%; Private insurance: 1.2%; Out-of-pocket: 8.2%	Public/mandatory: 93.3%; Private insurance: 0%; Out-of-pocket: 6.7%	Public/mandatory: 93.1%; Private insurance: 0%; Out-of-pocket: 6.9%
Provision (institutional care)	Public: 46%; Private not-for-profit: 23%; Private for-profit: 29%	Public: 4%; Private not-for-profit: 53%; Private for-profit: 43%	Public: 7.0%; Private not-for-profit: 79.1%; Private for-profit: 13.9%	Public: 0%; Private not-for-profit: 87.8%; Private for-profit: 12.2%	Public: 79.9%; Private not-for-profit: 0.9%; Private for-profit: 19.2%
Cash benefit program	No cash benefit (except Quebec with its "chèque emploi-service")	Option of cash allowance, care-in-kind or combination of the two	No cash benefit	Personal budget available to all those qualifying for long-term care	Cash payments—minimum need of 17 hours of care per week
Choice of caregivers	Limited	Yes	Yes	Yes	Yes
Total expenditures on LTC (% of GDP) (2019)	2.0%	2.2%	2.0%	2.9%	2.9%
Population aged 65 years and older (%) (2020)	18.0%	21.8%	28.9%	19.5%	20.0%
Residents of LTC institutions (% of pop. 65 years and older) (2019)	3.8%	4.2%	3.6%	4.4%	4.2%

Sources: Adapted from Olivares-Tirado and Tamiya, 2014: 129; data comes from OECD, 2021, except for provision of institutional care (see figure 2).

3. Home care is a preferred and lower-cost alternative to institutional care

The vast majority of long-term care in Canada is still provided in institutions, unlike the situation generally prevailing in the four high-performing universal health-care countries examined in this report. These four countries have made a major shift towards home care, in line with the preferences of people who want to continue living in their homes for as long as possible. It is also a means of providing the required services to citizens at a lower cost. Access to institutional care in nursing homes is now reserved for people in need of permanent supervision or intensive care and treatments.

In Germany and the Netherlands, in particular, a system of cash benefits (cash-for-care schemes) has been set up to give more options to patients and to promote care delivered at home or in the community. In this way, power has been transferred from the hands of the care providers to the beneficiaries. As Canadian researchers have already shown, giving patients choice in home care would not only allow them to participate more actively in decisions about their health but also lower the costs of caring for the elderly (McWilliam, Stewart, Vingilis, Ward-Griffin, Donner, Anderson, *et al.*, 2007).

4. The road to success begins with decentralization

In recent years, several Canadian provinces have adopted governance reforms, merging regional health authorities (RHA) that were meant to be autonomous intermediary bodies responsible for liaising between service providers and the population. By removing governance and decision-making power from RHA and health institutions—from hospitals to nursing homes—, these reforms have led to greater centralization.

This centralized approach goes against the trend observed in the four countries examined here. Successful health-care systems that serve their populations well, like those analyzed in this report, are characterized by decentralized decision-making, which is based on the notion that managers and other actors in the field are better able to understand the local needs and specific preferences of patients and the means most likely to adequately address them. Canadian policy-makers should consider the benefits of such decentralized approaches when attempting to coordinate the actions of millions of people with varying preferences and knowledge in increasingly complex health-care systems.

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