

Long-term care in Scandinavia

Exploring insights for the Netherlands

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Foreword

In July 2018, the Standing Committee on Health, Welfare and Sport (VWS) of the House of Representatives asked a number of experts to conduct a brief examination of the differences between long-term care in Scandinavia and long-term care in the Netherlands, and to compare these systems. The VWS committee asked the question in the context of its research agenda, with the aim of strengthening the committee's knowledge and information on the subject.

The committee has earmarked a number of themes in the research agenda for further examination. Among the themes chosen by the VWS Committee for the years 2018 and 2019, is "Lessons from Scandinavian countries in care tasks and long-term care". The interpretation and elaboration of this theme was carried out by a preparation group consisting of the following MPs: Vera Bergkamp (D66), Corinne Ellemeet (GroenLinks), and Sophie Hermans (VVD). After a few months, Leendert de Lange (VVD) took the place of Sophie Hermans.

Upon the invitation of the group, Vilans, the knowledge centre for long-term care, presented a fact sheet on September 19, 2018, comparing the main elements of elderly care in the four Scandinavian countries: Denmark, Finland, Norway, and Sweden. on 19 September 2018. During a discussion with the group on September 25, 2018, we provided an explanation of the factsheet, together with Professor Rudi Westendorp of the University of Copenhagen.

Subsequently, following a related proposal from the preparation group, the VWS Committee asked us to provide more in-depth research into care for older persons and people with disabilities in Denmark and Sweden, in order to provide answers to a number of additional questions. We are also requested to summarise how care is delivered to older people and people with disabilities in Norway and Finland.

It was a pleasure to work on answering these questions, and it was inspiring to see how related countries are able to deliver good care and support from different perspectives. In fact, it involves more than care. In Scandinavia, the issue is how to provide good care for people with long-term care needs, especially how they can find a comfortable place in society in spite of limitations and complex care and lifestyle issues. The question is also how can society best contribute to this.

Comparison with the Netherlands

In this report, we provide a picture of long-term care in Scandinavian countries. We do this per country and for the four countries together. In addition, we make comparisons with the Netherlands on several points. As far as possible, we back-up our findings and conclusions with recognised sources. This comprises mostly scientific sources, government documents, and so-called “grey” literature. This refers to literature that is often not supported by science, or has not been scientifically tested in accordance with the highest standards. Still, these are often very useful sources because they are usually more up-to-date and written from a perspective that is closer to the practice. We have also consulted with some in-country experts on issues we found in sources that were not clearly described. Finally, we asked some Dutch citizens who live in Denmark or Sweden about their experiences.

Social issue

We have worked hard to write a report that is not only of interest to members of the House of Representatives. We hope that the report also finds its way to people who work in healthcare, policy makers, and citizens. After all, solving long-term care issues lies not only with the care sector, but also with society.

In-depth

This report is accompanied by a “clickable PDF” which can be accessed via the internet with direct links to more in-depth information. There are also some videos about Dutch citizens in Denmark and Sweden. We hope not only to reach a large audience, but also that this report comes alive and fuels the discussion. Above all, we hope to stimulate interest in innovation.

Thank you

Before going into the contents of this report, we would like to express our thanks to Professor Rudi Westendorp of the University of Copenhagen, and Kirsten Tinneveld Madsen of the foundation “Maak de Burger Meester”. They have provided us with a lot of useful information about Denmark, shared our thought process, and, as critical readers, kept us sharp. And, certainly not the least important - they have inspired us to look further into what makes elderly care in Denmark so interesting for the Netherlands. We are also grateful to other experts in Scandinavia for the valuable information they have given us (see attachment).

We are also grateful to the staff of the VWS committee of the House of Representatives with whom we were allowed to work: Rolf Noordsij, VWS knowledge coordinator of the Analysis and Research Service; Hans Clemens, deputy clerk of the Standing Committee for VWS; and Willemijn Bernard, information specialist VWS from the Service for Analysis and Research of the House of Representatives. Finally, a word of thanks goes to the members of the preparation group: Vera Bergkamp, Corinne Ellemeet, and Leendert de Lange for the pleasant manner in which we were able to discuss the issue of long-term care in Scandinavia, and the way in which they guided this report.

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On behalf of the research team,

Prof. dr. Dr. Henk Nies

Conclusions

The research into long-term care in Scandinavia provides the following insights that are of interest to the Netherlands.

Background and ideology

Long-term care in Scandinavia has a different historical and cultural background than in the Netherlands. The key starting points are ideologically related: equality of people regardless of limitations; self-determination and independence; being able to (continue to) live independently; affordability of care for everyone; solidarity with vulnerable fellow citizens; an accessible society; a caring government that guarantees that people can receive good care and can participate in society. However, the impact of these values varies between countries. Large-scale residential facilities have been phased out in Scandinavia much more than in the Netherlands. In addition, care has been integrated into society, mainly under the supervision of municipal authorities.

The principles governing long-term care have been around in Scandinavia for decades. Therefore, work has been going on for decades to incorporate these principles into care, housing, work, education, income and social participation. This means that a move towards “longer at home” or a “participation society”, as advocated by us in the Netherlands, cannot be achieved in one transition phase. It takes years, with choices sometimes being reversed or adjusted - as we see in Scandinavia.

The policy perspectives in Scandinavia are predominantly long-term and consistent. This is only possible because they are also deeply rooted in society. It is worth investigating further how a country like Denmark, made the transition to de-institutionalisation in recent decades, by asking the following questions:

- What administrative measures were needed?
- Which care-related measures were considered - from the point of view of treatment, care and support, as well as prevention and reablement?
- How did the views held by society influence policy and care?
- How has society reacted to the idea of standardisation?
- How has Denmark managed to ensure that vulnerable people have a place in society without highly specialised facilities?

Such an analysis falls outside the scope of this study, but is instructive for policy that could lead to substantial innovation in the Netherlands.

Transformation and reablement

In Scandinavia, transformation and standardisation have been developed primarily from the healthcare sector. A concept, such as reablement, aims to improve the way people function, and allows them to (re) learn skills that are considered to be important in their daily lives. It is a mutual obligation between governments and their citizens: the governments are intensely committed to providing this support, while the citizens who are at risk, strive for self-reliance.

In Denmark, this is even a condition for long-term care benefits. It is an approach that fits well with the goals and objectives of citizens in their daily lives. Even in Scandinavia, there is criticism levelled at such approaches. For example, Norway makes a similar choice, not in elderly care, but in care for people with disabilities. It means that the concepts of “caring that” and “caring with”, rather than “caring for”, have a higher degree of acceptance within the social and care profession in Scandinavia than in the Netherlands.

Allocation of resources

The Scandinavian countries are characterised as ideal welfare states. There are good social benefits, there is solidarity with vulnerable people in society, and governments accept a high degree of responsibility. The result is that the collective costs of care are high from an international perspective. However, in the Netherlands, the costs, specifically for care are even higher - while the rate of population ageing is lower (see Figure 1).

The prognosis for cost increases in the Netherlands far exceeds that of the Scandinavian countries, according to OECD figures.

Although the reasons for these differences are difficult to explain, it seems that the simplicity of the Scandinavian model, in regard to both the management of care, as well as its implementation, contributes to the effective use of financial resources. Local governments play a significant role in healthcare, both financially and in terms of content, and are fully responsible for healthcare delivery. There is also a form of area-specific financing. Healthcare in Scandinavia is more future-proof compared with the situation in the Netherlands.

The role of municipalities

On average, municipalities in Scandinavia operate on a smaller scale than in the Netherlands. The scale of municipalities results in many problems. Very small municipalities often work together.

There are also examples of disparity in the rights of citizens among different municipalities. There is discontent about the role of municipalities in a number of cases, and there are discussions concerning scale and responsibilities. There are also discussions about which management level is the most qualified. In Finland, there is a debate on recentralisation, and in Denmark, the position of the regions is under discussion. Specifically, these regions are tasked with curative healthcare. In other words, the systemic discussions in Scandinavia are current and dynamic. Local government institutions in Scandinavia have considerably more control than in the Netherlands, and the population also expects them to take that responsibility.

At the same time, it can be seen that many municipalities are capable of adequately executing the comprehensive care and social security tasks needed for their citizens. In addition to the budget allocations that Danish and Swedish municipalities receive from the state, they also have the responsibility to levy taxes themselves. It is worth investigating in follow-up research, what size of municipalities in the various countries is seen as optimal to achieve high-quality and affordable infrastructure for care, welfare and social security.

The conclusion that many Scandinavian municipalities can take overall responsibility for long-term care also fits in with the observation that they have been operating from this level of responsibility for decades, and that they will continue to do so.

Participation

Client participation in long-term care is well developed in Scandinavian countries. It is in keeping with the great value placed on autonomy, self-determination, and independence. In many instances, it is required to include participation at the municipal level, and this is complied with. In the Netherlands, participation is organised in many different ways, at municipal level and by care organisations (Participation Act Clients of Care Institutions).

Integrated approach

In Scandinavia, great expectations are not only placed on the government, but the society is aware that it must also play a role in solving the issues related to long-term care. Lifestyle changes, social cohesion, or an accessible society are essential to keeping people as vital as possible, and the demand for care as limited as possible. This requires an inclusive approach from social partners, and sometimes an overhaul of other sectors in the society. Various examples show that governments with an integrated mission statement can play an important role in this. In the Netherlands, we are also seeing an increase in integrated approaches to care, housing, work, education, income, entrepreneurship, transport and accessibility. Perhaps the countries can learn from this, whereby it may be relevant to see how governments can facilitate this from an administrative point of view.

Market forces

Despite the major role of governments, there is also a call in Scandinavia for more competition in healthcare. Nevertheless, the use of private care is very limited compared with the Netherlands. It should also be noted, however, that in the Netherlands, unlike in Scandinavia, healthcare is mainly private not-for-profit, and that the private for-profit segment, is limited. However, this has been increasing in recent years, and is also being encouraged by the government in Sweden.

The demand for more competition in Scandinavia seems to be aimed primarily at putting a counterbalance in the system, so that citizens have more choices available to them, and providers that operate on behalf of the government, remain 'sharp'.

Freedom of choice

One aspect that is related to freedom of choice and control among citizens, is the use of "vouchers" in Sweden and Finland, with which citizens can purchase care from the provider of their choice. It is also possible to receive a personal assistance budget in Sweden. In addition, Denmark and Sweden also offer the possibility of financial compensation to informal caregivers, in order for care and support to be organized as close as possible to the person.

Less complex

In Scandinavia, citizens are of the opinion that the organisation of care is considerably less complex than in the Netherlands, and therefore easier to understand. For care and support they turn to the doctor and the municipality. The latter arranges care and support with the clients involved and their loved ones. Of course, more complex problems must be coordinated with multiple organisations. However, fragmentation and collaboration issues can also occur, even when there is a strong relationship between local and public partnerships - as appears in Sweden and other countries.

Regulatory pressure

Despite the apparent simplicity of the system, administrative burden also exists in Scandinavian countries. A lot is registered and monitored, often also for care-related reasons. It is not clear whether there is more or less administrative burden in Scandinavia than in the Netherlands.

Cost Control

Managing cost is also an issue in Scandinavia. In many cases, the costs can be controlled fairly well because there is a budgeting system in place per administrative level. However, this can be accompanied by quality problems or reduced access to care, and lead to waiting lists. It is difficult to determine whether cost control is simpler or more difficult compared with the Netherlands.

However, the international projections in the coming decades show that cost development for long-term care is advancing at a more moderate pace in Scandinavia than in the Netherlands (see Figure 12).

Technology

Technology in healthcare is well developed in Scandinavia, partly because the government plays a strong role in this. Technology can help to bridge the large distances in the sparsely populated areas of Scandinavia. In Norway, Sweden and Denmark, citizens have personal files in which a large number of care-related data can be found, as well as information on other government services. Scandinavian countries have explicit policies in place to stimulate the development and application of technology, and computerization of services. The objectives are cost control, equal access for target groups in the various regions and population groups, labour efficiency, and quality improvement. National standardisation has not yet been achieved in all Scandinavian countries, certainly not between curative and long-term care. This leads to (unwanted) differences between regions and healthcare providers, and eventual uncertainty for citizens. The impression is that the Netherlands is considerably less advanced in technology than Scandinavian countries, certainly when it comes to citizens being able to use their own data. In Sweden and Denmark, for example, personal health records are already available to all citizens.

Standardisation

With regard to housing and care, we see that in comparison with the Netherlands, standardisation and integration into society are important and deeply rooted in society. Nursing homes still exist in Norway, but in the other Scandinavian countries these are only present to a limited extent. There are cluster houses and protected living arrangements for people with intensive care needs. These have shared spaces and care facilities, as well as care providers on call. Although these facilities and residential care units, from a Dutch perspective, sometimes resemble modern nursing homes or facilities for disabled persons, they are housing configurations where care and living are kept separate. It gives the impression of having your own home as well as a nursing “home”, including the feeling of being the “boss in your own home”. In a number of cases, these types of residences are not specific to certain target groups. The connection with society therefore seems to be better guaranteed. However, it has also become clear in Scandinavia that embedding people with disabilities and vulnerable elderly people into society cannot be achieved solely through independent forms of housing.

Informal care

Care in Scandinavia has been largely professionalised. Intensive informal care is not seen as a duty, it is at most, a wish from loved ones, and increasingly, as a necessary solution. Municipalities are responsible for providing support for informal care. This takes various forms. Volunteer work is well developed. There is also a policy whereby municipalities play a stimulating role. There are also many good examples of selfless social involvement of citizens despite the fact that professional care is the norm. The Netherlands also has a good reputation when it comes to informal care and voluntary work. In Scandinavia, there are examples of voluntary work and support for informal care that are strongly focused on self-reliance and prevention. It is not clear whether these are anecdotal examples or whether they represent a different vision and interpretation of informal care in Scandinavia.

Labour market

The labour market problem is great in Scandinavia, just like in the Netherlands. It is worth noting that relatively more people work in long-term care in Sweden than in the Netherlands, and at comparable costs. Comparison of international data shows that the Netherlands has a relatively large number of part-time care workers. This reflects a different work ethic. In Scandinavia, full-time work is more the norm than in the Netherlands.

If we extend the comparison between the Netherlands and Scandinavia on a one-on-one basis, we can assume that what is possible in the Nordics is also possible in the Netherlands, then there is still capacity in the Dutch labour market. This deserves a more detailed examination as to whether this impression is entirely correct and, if so, what is the explanation for this capacity.

Loneliness

Loneliness among elderly people and a negative perception also play a role in Scandinavia. Moreover, the image that there is a lot of loneliness among elderly persons is an example of negative perception. By international standards, elderly people in Scandinavian countries are relatively less lonely, just like in the Netherlands, and in comparison with people from other age groups, they do not feel particularly more lonely. It should be noted that being lonely is something other than "being alone". Nevertheless, the problem exists for significant groups of people. There are indications that "community living" (Denmark) contributes to fewer feelings of loneliness among very vulnerable people.

In conclusion

All in all, elderly care in Scandinavia bears many similarities with that in the Netherlands. There is, however, inspiration for innovation in these countries on various points, just as the Netherlands has many interesting examples for them. By international standards, the Netherlands has a particularly good reputation in the field of elderly care and care for people with disabilities. However, with regard to its sustainability in terms of affordability and the labour market, the Netherlands faces major challenges. In that sense it is important to look at other countries, whereby Denmark, Sweden, and also Finland and Norway, can certainly be sources for new solutions.



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