



PROCARE

Providing integrated health and social care for older persons issues, problems and solutions

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Providing integrated health and social care for older persons in the Netherlands

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1 Introduction

This report is to tackle the question whether the Dutch policy concerning elderly citizens directs the care system towards an integrated provision, and whether the care system is capable of delivering an integrated supply of health and social care. Following Kodner et al. (2000), integrated care may be defined as: "A discrete set of techniques and organisational models designed to create connectivity, alignment and collaboration within and between the cure and care sectors at the funding, administrative and/or provider level." For the clients these techniques and models should result in getting the care they need, that means adequate amounts of the right types, and delivered in the appropriate order and at the right moment in time. This may be regarded as a definition of integrated care *from the client's perspective*.

1.1 Trends in the demand of care

In an exposition of the care for the elderly in the Netherlands, the *Algemene Rekenkamer* (2002) states that the overall demand for the amount and types of care is influenced by various factors:

- the demographic developments (with respect to population growth and ageing);
- social-cultural developments relating to:
 - the desire to remain living at home as long as possible,
 - changes in the relation between intramural and extramural care,
 - the articulation of a hitherto hidden care-demand (in connection with cultural changes),
 - a postponed demand for care (considering the waiting lists).

We pass these factors in review.

The Netherlands has about 16 million inhabitants. According to the predicted demographic developments, the number of elderly people will grow strongly. The increase of life expectancy will lead to a percentage of the population over 55 years of age, amounting from 23% now to 35% in 2030. Especially the number of very old people (over 85) will grow. This demographic trend implies an increase of chronically intermittent disorders, for which a flexible supply of care is required, consisting of an acute component and a long-term component, and of health care and social components (housing, care and additional provisions). In an integrated system those various components should seamlessly connect to each other. This is especially the case with chronic disorders that demand a clustering of various knowledge and abilities in the medical, paramedical, nursing, caring, and social fields. Influenced by the relative growth of the number of chronically ill, public attention for care, next to the cure, has increased (*Raad voor de Volksgezondheid en Zorg*, 2001). However, the current approach of the health care system lags behind demographic developments and is still too much targeted at acute rather than chronically intermittent disorders (Delnoij, 2002).

Today, elderly people are increasingly active and vigorous to a greater age; they are better educated and, as a consequence, have become more independent and responsible. On top of that, many elderly have achieved a state of (relative) prosperity. As a result, they demand a greater say in matters concerning their health and welfare and expect a wider range of services (Van Ewijk, 1999).

Since the ninety-eighties, independence has become an essential element of the life style of many in the new generation of elderly. The general trend has become to keep older persons as long as possible in their own homes as this is what they want themselves, rather than having to move to a nursing home. Many 'new' elderly also want assistance contributing to a meaningful participation in social life. As a result, 'old' care facilities which were introduced during the ninety-seventies are, wherever possible, replaced by professional home care services co-operating with family and other informal carers. Moreover, the expectations of patients towards the health care system increase, and may best be summarised as: "more, better, faster". There

is also a larger need for differentiation. The care system should be organised in such a manner that (a) the increasing need for differentiation can be met, and (b) those groups of society, who have not yet been able to acquire skills for acting as critical, well-informed patients, continue to get access to the care system.

The new creed is, that the elderly themselves have to be able to decide where and how to live, and which services they will utilise if their need for care increases (Lammers & Driest, 2002). Within this scope, the term '*custom-made care*' is often used. This concept is closely connected to integrated care. 'Custom-made' expresses that the supplied care should match the needs of the person. And because the needs of the elderly often bear upon multiple areas (like problems with health, functional limitations, housing and transport), an integration supply of services from these sectors is necessary.

The Social and Cultural Planning Board (*Sociaal en Cultureel Planbureau, SCP*), who publishes once every two years a comprehensive report on the living situation of the elderly, confirms this view on the position of the elderly. The latest report concludes that most elderly in the Netherlands are doing well, and that their position has improved rather than deteriorated in the nineties. Nevertheless, there still are groups of older persons for whom a definite policy for care and protection is urgently required. This applies, for instance, to elderly with severe physical or mental impairments, who depend on others, and to elderly who dispose of limited resources: people with a low level of education or income, or people with a small social network (De Klerk, 2001).

To what extent does the supply of care cover the demand? Recently, *demand-oriented care* has become a central theme for policy makers, i.e. the supply of care should adapt to the demand for care, rather than making demand dependent on supply. However, the present care demand of the elderly is still insufficiently known. About the demand for facilities, three categories of persons can be distinguished: those who get the care to which they are entitled, those on waiting lists, and those who have not yet expressed their need. The latter indicate a hidden care demand. The group on the waiting list can be divided into two sub-categories, viz. those 'simply' on the waiting list, and those who are on the waiting list but meanwhile are receiving transitional ('bridging') care, e.g. in the form of home care. As a result, however, waiting lists tend to grow in the home care system, too (*Algemene Rekenkamer*, 2002). It is expected that the home care in 2004 will have considerable short of staff: 18,000, that is more than 10% of the present work force (Nivel, 2002).

The information about care supply (utilised capacity) is also insufficient. Neither 'influx', 'through-flux', nor 'out-flux' of clients are fully known. The lack of clarity as to how many people may utilise the existing care supply hampers the policy, that aims at attuning demand and supply of care provisions (*Algemene Rekenkamer*, 2002). That the match between the two is far from perfect becomes only too obvious from the existence of waiting lists.

1.2 Trends in the supply of care

The organisation of the care system in the Netherlands used to be arranged according to target groups: people with a mental disability, people with a physical disability, people over 65, and people who are chronically ill. Based on this arrangement, diverging care systems developed for separate groups of clients or patients. Recently, a different approach arose, which increasingly determines the general discourse: one should not so much take the target group as a point of departure, but rather the functional limitations the individual experiences from his/her illness or disability. Thus, the orientation shifts from the traditional target group to the consequences of an impairment. Furthermore, this implies not to operate anymore from supply for a particular target group (separate provisions for specific impairments or age groups), but to start from the client's needs which may be satisfied by any relevant institution or service.

During the last decades, various solutions have been worked out in order to arrange the care system in such a manner that the older person may receive appropriate care. Since the ninety-

sixties, residential homes and nursing homes for the frail elderly were established and extended. In the period 1963 to 1980 the number of nursing homes increased from 106 to 325. The distinction between somatic nursing homes (primarily for elderly with severe physical disabilities), psycho-geriatric nursing homes (primarily for elderly with dementia) and residential homes (primarily for elderly with less severe disabilities) is diminishing. This results from changes in admission: residential homes increasingly function more or less as nursing homes, by receiving people with severe disabilities. Moreover, mergers have taken place between nursing homes, and between nursing and residential homes. These large-scale institutions offer housing and comprehensive care as one full package. In 2001, the expenditures for nursing homes were 3.6 billion €, for residential homes 3,1 € (Van Mosseveld & Smit, 2002: 28).

Over time, increasing resistance raised against these large-scale facilities, pointing to the loss of independence and freedom of choice for their residents. This resistance was the main driving force behind the development of all sorts of innovations in the direction of downscaled and more independent types of dwelling for the frail elderly, which are described in chapter 3.

In 1999, about 7% of the Dutch citizens over 65 lived in institutions for the elderly, 2% in a nursing home and 5% in a residential home. In the last decade, the overall intramural capacity was reduced. This applies to residential homes: in the period 1990 to 2000 the total number of its residents decreased by 18% (from 131,000 to 107,000). The reduction in capacity was mainly reached by scaling down the size of the residential homes. The newly built homes accommodate considerable less people (the mean is 68) than the old homes which were built before 1970 (the mean is 112). On the other hand, the capacity of the nursing homes was enlarged: In the same period the number of residents increased by 14% (from 50,000 to 57,000). This expansion merely concerns the places for people with dementia; the number of places for elderly with only physical disabilities hardly changed. All in all, the shifts resulted in a net reduction in intramural capacity of almost 10%. This decrease was made possible by a number of developments, such as the 'extramuralisation', meaning that many nursing homes and residential homes now also deliver care outside their walls, such as alarm services and meals-on-wheels (De Klerk, 2001: 5, 108, 184, 203; Raad voor de Volksgezondheid en Zorg, 2001: 95-96; Ooms & Ras, 2002: 21-23).

The majority of the elderly with less extensive care needs have been provided home care in the community. In line with the resistance against living in institutions, the government aims to relieve the growing pressure on residential care services by encouraging older people to continue living in their own home and by promoting arrangements for informal care and assistance-at-home. Professional community-based care at home encompasses all types of care, nursing, supervision and monitoring of people who require assistance at home (Goris, 2002). As a consequence, much has happened in the home care sector during the last ten years: demand increased and became more complex, supply and its organisation became more flexible and more customer-oriented (e.g. services were extended to intensive home care with 7 days and 24 hours accessibility), and competition between home care providers increased, by giving room to commercial home care providers. The home care sector is by far the most important supplier of professional social care for the independent living elderly. In 1999, about 14% of them received home care (De Klerk, 2001: 196). In 2001, the expenditures in home care for all age groups (about 80% of the clients is of old age) amounted to 2.8 billion €. From 1998 to 2001 the expenditures increased with almost 40%. The total expenditures for the most important care sectors (nursing homes, residential homes and home care) were 9.5 billion €, reaching almost the total budget for cure in hospitals (10.9 billion €) (Van Mosseveld & Smit, 2002: 28).

Some ten years ago, institutions started with providing care services in the homes of the elderly living in their neighbourhood. This development was made possible by changes in policy and legislation, yielding an increased responsibility to provincial and local governments, and to involved organisations (such as financiers and care providers, housing corporations, patients' associations and elderly people's unions).

2 Legal and Structural Framework

In the Dutch system of care for the elderly three parties are involved: the authorities who formulate the policy, private non-profit or profit organisations who provide the care, and interest organisations who influence the policy.

While the national government is responsible for health care and income, the local authorities are responsible for housing, well-being, and mobility. The provinces have a task in regional planning of facilities such as care and nursing homes. Together, public policies share the vision that the elderly no longer must be treated as a separate (categorical) group, even if they require more care, but as a regular part of society.

2.1 Policy at the national level

In the Netherlands, the care policy for the elderly is pursued by several ministries, particularly the Ministry of Health, Welfare and Sports (*Volksgezondheid, Welzijn en Sport, VWS*), Ministry of Social Affairs (*Sociale Zaken en Werkgelegenheid, SZW*) and the Ministry of Housing, Planning and Environment (*Volkshuisvesting, Ruimtelijke Ordening en Milieubeheer, VROM*). The responsibility of the national government includes legislation and issuing of regulations, making financial means available, and supervising the efficient performance of the care system (*Algemene Rekenkamer, 2002*).

The central target of the policy on the elderly is to prevent their social exclusion, in which one may think of their health, care, financial situation, housing, and living surroundings. Moreover, the policy frameworks, which the various ministries have formulated, are more or less identical. This policy framework presents a vision of steering, in which the roles of the various actors in the care sector are specified: the government nationally determines the framework within which the finance agencies, providers and interest organisations must take their responsibilities. These tasks and responsibilities have to connect with each other, so that a good accessibility of the care system may be realised (*Rijkschroeff, 2002*).

2.2 Policy at the regional and local level

The regional responsibility is expressed by the fact that provinces and municipalities together are in charge of regional planning of care facilities. Within the framework and support set by the state government, and together with organisations of clients, care providers and regional administrative care offices, the provinces and municipalities define which kind of care should be delivered. They periodically produce a policy document (called *regiovisie*) in which they present their views and objectives concerning care, housing, welfare, and transport for the elderly and disabled people in the region.

During the last two decades, the municipalities have been increasingly involved in matters concerning care for the elderly and disabled people. It was expected that decentralisation could better address local differences, and improve the attuning of supply to demand (*De Klerk, 2001*). The responsibility of the municipalities extends to several areas.

First of all, the local authorities execute the 'Facilities for the Disabled Act' (*Wet Voorzieningen Gehandicapten, WVG*). Previously, this legislation and its provisions were reserved to disabled people under 65 of age. Since a few years ago it also applies to the elderly who need wheelchairs, housing adaptations and adapted transport facilities. By now, the majority of the users of these facilities are over 65 of age.

Since 1988, under the Welfare Act (*Welzijnswet*), the local governments are responsible for the welfare policy concerning the elderly. Three core functions are distinguished in this welfare work:

- social re-activation, concerning stimulating the elderly to fulfil social tasks and promote their own interests in 'self-help organisations';
- social prevention, which involves prevention of social exclusion, support in directing one's own life;
- person-oriented guidance and assistance, which means individual support in retaining or restoring the balance between the person and his or her surroundings.

Since 1997 the municipalities are also responsible for the execution and financing of a part of the so-called 'flanking policy', which aims at additional provisions for the elderly. Among other things, the provision of services by residential homes to people living independently is involved, such as the supply of meals and alarm services.

2.3 The Process of Care Provision

2.3.1 Referral to the Care System

Many people address to their general practitioner for acquiring cure and care. The general practitioner not only the gatekeeper for access to the medical care in the hospital, but also an important guide for access to the care system. Increasingly, the general practitioner has to cooperate with several disciplines in the care.

In acquiring social care and other facilities, the applicant has to deal with several bodies. First, the client has to expose his or her situation and needs at a Regional Assessment Board (RIO¹), whose members decide to what kind of care, facilities or support the person is entitled. After a positive advice, the allocation of services takes place at the administrative care office. It is decided whether the required care can be delivered or whether the client must be placed on a waiting list. This procedure applies to most provisions, such as admission to a residential or a nursing home, day-treatment in an institution, several kinds of home care, adapted transport facilities, housing adaptations, 'meals on wheels' facilities and alarm services.

2.3.2 Care Providers

From the ninety-seventies to the nineties, care policies aimed at substitution² in the care system (De Klerk, 2001). The objective was to shift usage from relatively intensive and costly care to minor and cheaper provisions. Dependent on the situation of the client, this could mean a move from intramural to transmural and extramural provisions, from intensive to extensive care, from long-term to short-term care, from curative to preventive care, and from professional to informal care.

'Extramuralisation' was one of the effects: many nursing homes and residential homes now also deliver care outside their walls. Thus, nursing homes deploy a part of their budgets for elderly who are staying in residential homes. These residents are provided with care from nursing home doctors and other therapists, with the aim to postpone or prevent their transfer to a nursing home. Consequently, the through-flux from residential homes to nursing homes is decreasing. In their turn, residential homes deliver extramural care to elderly living in the area, and to elderly in sheltered housing blocks or 'leaning houses' (*aanleunwoningen*, independent housing,

¹ The role of the RIO's is further discussed in chapter 3.

² Horizontal substitution includes shifts between professions of equal levels (e.g. the different paramedical professions). Vertical substitution includes shifts between various groups of professions. At the 'bottom' of their task list, performances and operations are transferred from specialists to general practitioners, from doctors to nurses and paramedics, from nurses to carers, and to patients themselves and their informal carers. For cost considerations, vertical substitution has been stimulated by the government and the insurers.

next to and 'leaning' against a residential home). To date, about a quarter of those who receive services from nursing or residential homes live outside the walls of those institutions.

2.3.3 Informal Care

It is still common practice that the informal care sector – defined as the assistance by members of the family, neighbours or acquaintances in housekeeping and/or personal care – covers the gaps of the formal care system. When suitable professional care is not available, it is assumed that the family, neighbours and friends will step in.

In the Netherlands, the number of households with elderly persons (55+) receiving informal care, amounts to some 11-13%. This share has remained stable during the past ten years (De Klerk, 2001: 192).

2.3.4 Sheltered Accommodation

Sheltered or 'protective' types of housing supply a combination of 'normal' living and the provision of care services. In the Netherlands, a growing number of different types of sheltered housing for the elderly are implemented, for instance as a row of houses near residential units ('leaning dwellings') and sheltered housing complexes (*woonzorgcomplexen*). The number of units per institution is lower at a sheltered housing complex than at residential homes. This indicates a decreasing scale in newly constructed forms of sheltered housing. 70% of these dwellings are situated near a residential home, 9% near a service centre, and 10% near another form of service. The main reasons for older persons to move to a sheltered type of housing are the unsuitability of the former independent home and the fear of disabling health problems with no help network around (Van Dugteren, 2001).

Residential homes focus on elderly people who are unable to live independently, even with the assistance of home care and informal care. The reasons for moving to a residential home are much more prompted by (possible future) care needs and the heavy burden of having to arrange one's own household. Also the care supply influences the decision, if home care services and/or the family can no longer cope. Nursing homes focus on those who need the most intensive care and nursing with an increasing share of older people suffering from Alzheimer's disease.

2.3.5 Home Care

Professional home care encompasses all care, nursing, supervision and monitoring of people who require assistance at home. Home care used to be carried out by separate organisations for family care, maternity care and district nursing services. Recently most of them merged into large home care organisations, which combine these three areas of work. People can also turn to home care organisations to borrow or buy (medical) aids. Terminally ill people are offered intensive home care. This may involve day and night care.

In the home care sector more than 175,000 persons are employed (about 60.000 fte), delivering various services to about two million clients per year. They serve different target groups, like new-born babies and their mothers, pre-schoolers, disabled persons, mental patients, chronically ill, terminal patients and elderly people. The latter outnumber: in 2001, 80% of the clients were over 65 years of age. The home care organisations are spread over the country. In 1999, there were 104 non-profit organisations and 217 (generally small) profit organisations. They delivered on average 2,300 hours of home care per 1,000 people living at home (Nivel, 2002). In addition, people can employ cleaning personnel for their household work. In 1999, 14% of the households with elderly persons (55+) received home care from non-profit organisations, and 11% received care (usually domestic chores) from a private person or profit organisation (De

Klerk, 2001: 197). It is found that the elderly of foreign origin (an increasing group in the Netherlands) make relatively little use of the professional home care.

Long waiting lists and the fact that the amount of care is considered insufficient are an important source of discontent within the regular home care system. In 2000, 54,300 people entitled to nursing and care services found themselves on a waiting list. Approximately half of those do meanwhile receive some kind of transitional care.

2.4 Stakeholders

In the preceding sections, the national and local authorities, the several care providers, the insurance bodies, and the assessment agencies were already introduced the main stakeholders in the Dutch care system. In this section we would therefore like to focus on another most important stakeholder, engaged in interest representation. The General Dutch Union for the Elderly (*ANBO*) is the largest interest organisation. Furthermore – as an expression of the pillarization – there are unions with Catholic and Protestant persuasion (*KBO* and *PCBO*).

The *ANBO* and the other unions are organisations pursuing independence and freedom of choice for the elderly in housing, care, mobility, and activities, and also availability of affordable facilities in those areas. Together with other organisations, the union dedicates itself at all levels (national, provincial and local) to the improvement of social, material, and cultural position of the over-50s in society. With almost 180,000 members and some 575 local branches spread all over the country, they deal with social integration of and participation by senior citizens of both Dutch as well as other descent.

Concerning care for the elderly, the union emphasises the importance of independent living and functioning. That requires proximity of facilities, safety, and availability of (home) care. It is held that the informal carer must not be a necessity for living at home, but an additional source of care. Furthermore, additional facilities for informal carers are claimed.

The union states that elderly people have different desires and needs, and therefore desire freedom of choice. That implies sufficient options for senior citizens in housing, care institutions, and service packages, and an independent needs assessment. They also insist on a sufficient offer of cultural and social-cultural activities, within and without the *ANBO*-organisation.

Scarcity of facilities impedes freedom of choice and independence. Therefore, availability has become an important theme to the elderly. Especially in this area, the union meets with other parties, such as insurers, service providers, and housing corporations. Such contacts concern issues such as the addition of provisions to the basic package of the care insurance, removing waiting lists, and gaining clarity as to the measure of actually required and supplied assistance. Furthermore, the union insists on adequately equipped and sufficient housing and care facilities, and suitable housing for the elderly in general. In addition, accessible and frequently operating public transport is stressed as important for the mobility of the elderly.

2.5 Financing care for the elderly

In the Netherlands, care for the elderly is mainly funded by the following sources:

- Short-term medical care is insured via the (public) health insurance fund (*Ziekenfonds*) and private health insurances.
- Home care, nursing homes and residential homes for the elderly are covered by the Exceptional Medical Expenses Act (*Algemene Wet Bijzondere Ziektekosten, AWBZ*). The money for it is raised from special taxes, which all inhabitants in the Netherlands have to pay. Clients are required to contribute an amount of money in proportion to their income. Users of home care are charged from Euro 2.20 to 124.60 per week. For the financing of the products, next to the regular sources of financing, non-regular sources such as sponsoring, subsidies, donations and gifts, funds, and commercial activities, are exploited. The costs of the

residential and home care for the elderly is covered for 84% by the AWBZ, for 15% by contributions of the clients, and for 1% by other sources (Ooms & Ras, 2002: 10).

- The Provisions for the Disabled Act (*Wet Voorzieningen Gehandicapten, WVG*), implemented by local authorities, are financed by the national government from tax revenues.

2.6 Problems in integrating health and care services

As the previous sections show, a certain degree of integration has been accomplished in the Netherlands. However, integration of the various forms of care services for the elderly may take place at various levels and to various degrees. Delnoij (2001) distinguishes:

- clinical integration which takes place at the micro-level of the primary process, where we have to think of 'chains of care' and transmural care;
- professional integration of professionals mutually, and of professionals and institutions;
- organisational integration in the form of mergers, or the creation of networks between institutions;
- functional integration of cure, care, and prevention.

In principle, good pre-conditions have been created for co-operation and substitution within the nursing and caring sectors. In nursing homes and residential homes, a great degree of internal integration is realised at the levels of professional and organisational integration as all disciplines involved in the care process are present at the same place in which the elderly person is living. However, for those older persons who live independently, this kind of integration is much more difficult to achieve. In practice, the clustering of capacities is insufficient in the co-operation between hospitals, specialists, and general practitioners on the one hand, and the nursing and caring staff on the other hand. Nevertheless, co-operation is increasing. Examples are the 'liaison nurse' from the home care who is posted in the hospital to co-ordinate the transition to the home of the patient, and the office hours of district nurses in outpatient clinics. But patients who are discharged from hospitals and still find themselves in need of home care or institutional care are often confronted with waiting lists. So, the through-flux in the hospital is not only dependent on internal processes, but in particular also on the (limited) capacity of all other (extramural) facilities.

It is increasingly possible to organise specialist care and knowledge outside the hospital walls, in the form of care at home and transmural care. Transmural care demands more intensive co-operation between the hospital and its specialists, and community care. However, co-operation is hampered by the increasing specialisation in medical care.

Care for the elderly increasingly extends over various assistance providers, institutions, and insurance compartments. In order to promote the interests of individual clients, the assistance provider not only has to know what to provide, but also what others have to offer, and under which terms of insurance and financing that care is accessible to the client. Functional integration constitutes a major problem in its concrete implementation at an institutional level as the overall design of the care system is still too much aimed at acute care, rather than at chronically intermittent diseases. In addition, the system of care, cure and prevention does not adapt sufficiently to the rapidly changing needs of the population (Delnoij, 2001).

Other impeding factors derive from flaw lines in the financing system. The Dutch system shows a dichotomy between the so-called primary and secondary health care, which was established in the ninety-sixties and seventies. In the Memorandum on Primary Care (*Nota Eerstelijnszorg*), general practitioners and district nurses, together with social workers and home carers, were acclaimed the four core disciplines in the front line. Hospitals and nursing homes are secondary care facilities. With that choice a strong bond of the professionals to these distinguished care sectors has developed. General practitioners are active in the primary sector but not in hospitals or nursing homes. At the same time, specialists in the hospital are not considered and/or considering themselves as a referral point in the care system. This 'echelonisation principle' has been institutionalised in the referral system of the health insurance fund. The partitions that have developed in the financing and organisation of the care system, now constitute the major

demarcation lines impeding the development of integrated care. Care has mainly been financed from the Exceptional Medical Expenses Act (*AWBZ*), while cure is funded by the private and compulsory health insurances. As a result of this separation in the financing structure, organisational integration mainly occurs between nursing homes and residential homes. However, the increasing number of the elderly and the chronically ill also demands a co-operation between cure and care (especially as concerns nursing and caring), and between health care and social provisions. In this context, the *Raad voor de Volksgezondheid en Zorg* (2001) stated: When trying to arrange for a smooth transition between care and cure, i.e. between *AWBZ* (Exceptional Medical Expenses Act) and *ZFW* (Compulsory Health Insurance Act), one runs into a wall of tight regulations, which determine whether a facility will be reimbursed by the health insurance fund or via the *AWBZ*; this impedes a further development of the community care systems.

3 Innovative Models

3.1 Introduction

Due to the described developments and difficulties, the Dutch care system is in motion. It is generally acknowledged that no longer the care *supply* should be the point of departure, but the desire of the care requester. In the new perspective, the user should be central: care services have to come to the client. The elderly user, too, should no longer have to rely on just one care institution or organisation, but should be able to make use of a combination of services, like independent housing, welfare and health care services. As far as possible, the care for the elderly has to be moved from institutions to districts, enabling independent living. And if admission to an institution becomes inevitable because of severe mental or physical disabilities of the person, a small-scale facility is preferable.

In many areas, innovations have been initiated. At the regional level, the Regional Assessment Boards (*RIOs*) and individual budgets are examples. Locally, municipal initiatives have led to sheltered housing zones, projects in lifetime housing, service centres, and consultants for elderly people. Innovations in the care system occur against the background of social developments in which individualisation, emancipation and increasing (material) welfare lead to higher demands posed on the provision of services. The elderly too, present themselves ever more often as critical consumers. Reforms in the care system are targeted at offering integrated care, contributing to the client's satisfaction and his or her quality of life. Expressions of these reforms can, amongst other things, be found in the tendency towards the individualisation of the care system (the individual as the point of departure), in combining independent housing with care, in working inter-sectorally, in the development of care-networks, but also in older people's pursuit of participation in society – the so-called 'socialisation' of the care system (Coolen et al., 2001), which is also referred to as transmural care or community care (Lammers & Driest, 2002).

3.2 Regional Assessment Board (RIO)

In the new care scenario, *receiving* care begins with formulating the correct demand. Since 1997/98 there are regional organisations for the conversion of care needs into care requests, the RIOs (Regional Assessment Boards). They attend to care requests, which they may grant by needs assessment for relief in the area of *care*: nursing and (personal) care, care for the disabled, mental health care, wheelchair, living and transportation facilities. The introduction of an *independent needs assessment*, in which the care need is determined individually, is a manifestation of the trend towards individualisation. Here, independent means: "without being influenced by the parties involved in the needs assessment, financing and care allocation" (Schrijvers et al. 2001: 5).

When the RIO deems the care need to be necessary, the care request is passed on to the *administrative care office* in the region. Which kind of care is required, is determined on the basis of seven functions: housekeeping assistance, personal care, nursing, supporting guidance, activating/advising guidance, treatment, and accommodation (Schrijvers, Jedeloo, Jorg, Hoogerduin, 2001). Subsequently, the administrative care office is responsible for purchasing the required care. But this office too, has to agree with the allocation of care, because only after a positive decision on the needs assessment services and aids can be financed from public funds. The administrative office, on behalf of the client, purchases care from a care provider.

Thus, if an elderly and/or disabled person articulates a care need in the area of nursing, home care, or material support (e.g. transport or housing facilities), then (s)he has to turn to a Regional Assessment Board (RIO). In mutual consultation with the client, a special trained 'assessment consultant' determines the kind of care that is needed. To assess the care need, consultants make use of a standard, and nationally used, protocol (the so-called 'model protocol')

in which criteria for the access to specialised care are formulated. In general, RIOs are responsible for objectively assessing care, attuned to the *request* and *need* of the client. The Netherlands dispose of some 85 RIOs, whose functioning falls under municipal responsibility. Recently, there is a trend for smaller RIOs to merge, which will decrease their number.

The introduction of RIOs is part of modernising the care system. They have been called into existence to enable the client to choose from various kinds of care through 'one window'. RIOs are a first step on the way to care integration by rendering different sources of care accessible to a client. They constitute the starting point in the chain of needs assessment, care allocation, and delivery of care. Even in case of heavy care needs it is examined whether, and if so, how this may be addressed by a combination of specific arrangements and facilities (e.g. home care plus housing adaptation). Severely frail elderly or elderly with dementia consult their general practitioner first, accompanied by a family member or intimate.

The RIOs have to meet a number of quality aspects. First, *not* the available care supply has to be the basis of the needs assessment, but the client's request and need – *supply follows demand* being the primary consideration. Clients have to be able to call on the RIO for various forms of care supply – '*integrality*' is the motto. Personal traits of the client and the assessment consultant may not influence the assessment decision – *objectivity* must be guaranteed. The needs assessment, as discussed before, must be free of the influence of municipalities, care agencies, care providers, those passing referrals, and patient interest groups – *independence* must be warranted. The needs assessment decision must be made within a maximum of six weeks (to guard the processing speed), and the number of assessment decisions per assessment consultant must be optimal – *efficiency* is the ambition (Schrijvers et al., 2001).

Presently, the role, mode of operation, and added value of RIOs are under discussion. The quality of the needs assessment still needs a lot of improvement, especially with regard to integrality and demand orientation. Furthermore, The question is, for instance, whether RIOs lead to more bureaucracy, and, because of their municipal status, whether they differ too much between themselves with respect to the integrated care they offer.

In a first national evaluation study (Jedeloo et al., 2001), which was finished in 1999, it was found that clients were generally satisfied with the advice they received, and with the manner in which their needs were provided for. This is similar to what Knapen (2002) recently has remarked on the matter, viz. that "the system works". Still, the system deserves improvement with respect to instruction and information, during the needs assessment, and with respect to the allocation and implementation of the care plan.

About a quarter of the clients from the said study indeed appear only moderately satisfied with the information they received. They desired more information about the time in which care might be expected, and about the number of hours to be allocated to them. Also, they wished to know more about alternatives, in case their care request would be ignored. Knapen (2002: 6) notices, that "the response to a submitted care need is structurally suspended, as a result of which no timely solace is offered for short term care needs". Subsequently, a call must be made on family, volunteers or private care. That also applies to long-term or chronic care needs. As a result, a part of the care needs or care requests is 'structurally papered away', writes Knapen (2002). By the deployment of informal carers – family, friends, volunteers – the real care needs remain hidden, and the real care request does not arise. The outcome of the assessment reveals more about the amount of care the relatives can provide than about the care needs of the patient. Van Vliet et al. (2003:18) also argue that both the insight in the care needs of the clients and in the burden of informal carers disappears if the contribution of the informal cares is taken for granted.

In determining the *real* care need, the assessment consultant should leave partner, family and neighbours initially out of consideration, and determine in mutual consultation to what extent they wish and are able to contribute to the care (Van Nispen et al., 2002). In assessing the care need, however, the RIO considers care at home to be additional to care provided by family, friends, or volunteers. In case a person is a member of a household, relatives are expected to

take part in the care to an acceptable degree. On a national level, the number of people that make a request for care at home, is unknown. Well-known is the fact that the number of people whose care request is rewarded, exceeds the present-day capacity of the home care.

The evaluation study (Jedeloo et al., 2001) showed that efficiency can be improved too. In the perception of most clients, the time span between submission and assessment was too long. Moreover, the allocation and realisation of care involves struggling with long waiting lists and waiting times, and bottlenecks around the deployment of temporary solutions for transitional ('bridging') purposes. It is the regional administrative care offices which in the future will become ever more responsible for the waiting list management.

The *RIOs*, who passes the care allowance to the regional administrative office, have to contend with scarcity on the supply side. Until recently home care was bound to a legal ceiling: on the average 3 hours per day home care was applicable, or 21 hours per week (Knapen, 2002). Furthermore, given a care intensity above a certain number of hours, the administrative office will refer a person to a care centre or nursing home, because the costs of care at home far outweigh those of institutional care.

Therefore, the attuning between real needs, assessed care, allocated care, and realised care falls short at various levels. However, an objective, integrated, and functional needs assessment is of great importance, for effective demand-orientation and budgetary manageability, as concludes the IBO (*Interdepartementaal Beleidsonderzoek*, 2002). Such an assessment does occur in formulating the care needs. But often that is as far as it goes. Integration is found to be lacking as concerns their conversion into the client's entitlement to care (Coolen et al., 2002).

To reach demand-driven care and to give the clients control, other forms of financing are also aimed for, such as the 'individual budgets'.

3.3 Individual Budgets

Changes are taking place in the financing of the care as well. Individual budgets (*PGB*) for care users have been introduced: a sum of money in stead of receiving care in kind. A *PGB* has been introduced for those people who are in need of long term care because of chronicle illness, ageing, psychological problems, or a physical handicap.

It is assumed, that the introduction of individual budgets (*PGB*) is better geared to innovations in the care system. The regional administrative care office gives the person concerned a sum of money or a bond – a voucher – as a means to pay for public services (upon the consent of the *RIO*). In this case, it is not the care office that purchases services, but the client himself. Individuals may, according to their own views, determine from which provider they will purchase care. The Regional Assessment Board (*RIO*) determines for which kind of care needs money is to be awarded. Various interest-organisations of care-requesters have intervened in favour of an extension of these individual budgets, which give clients more individual autonomy and flexibility.

With a *PGB* someone opts to negotiate himself with providers about the care arrangement and the related price (*Ministerie van Volksgezondheid, Welzijn en Sport*, 2001a), or chooses a mediator or agency to do it instead. Moreover, a *PGB* is individually assigned, and therefore is a personal, client-related, budget. Since the introduction of the individual budget, the number of budget holders has increased from 4,000 in 1996 to over 16,000 in 2000 (De Klerk, 2001: 195).

Until now there do exist different kinds of *PGBs*, which are related to specialised forms of care: a *PGB* (*V&V*) for care and nursing, a *PGB* (*VG*) for intensive home care, and a *PGB* (*GGZ*) for mental health care, for instance. In order to meet the care needed, a client may combine different *PGBs*. In 2003 these different kind of *PGBs* will going to be substituted by one general *PGB*. For nursing and care, a *PGB* is limited to a maximum of 136 Euro per day for three hours of care a day. In case the client needs more care than the maximum three hours (intensive home

care), he or she receives another 136 Euro a day, in addition to the PGB provided. Again, the RIO has to legitimate this. A part of the individual budget (called 'the drawing right') is reserved at the PGB office of the National Insurance Institute (SVB). This Institute is responsible for carrying out the payments to the care providers on behalf of the client. Another part of the budget (called 'the fixed sum') is directly booked to the account of the client (1089 Euro a year) and can be spend to care and mediation facilities in accordance with her or his view.

In the case of an 'individual-trailing budget' (*PVB*) the client receives care in kind, and is free to compile a care arrangement at a care provider he or she wants, or may enter into a care arrangement compiled by the care provider (and which is contracted by the insurer). In this case, the payment 'trails' the client. The regional administrative care office pays the providers for the care they have delivered to the client. In both cases (*PGB* or *PVB*), the needs assessment is identical, and should be aimed at the required care, and not at the supply (*Ministerie van Volksgezondheid, Welzijn en Sport, 2001a*).

With the introduction of this form of financing, the power of decision moves more into the hands of the individual. In principle, the recipient may determine how and where specific services are purchased. Furthermore, someone may opt for a more fanciful type of care than the needs assessment prescribes. In this case, however, the client will have to pay for extra costs. For the care providers, this implies thinking and working more market and client-oriented (Knapen, 2002). Nursing and residential homes may for instance begin providing care outside the institution, to people with a nursing or care need. That presents more space for private initiative, hence for competition.

The individual budgets are being introduced in various areas. Not only for the purchase of physical care, but also for material care such as housing. Their introduction is still in very early stages of development. The present *PGB* scheme is rigid, as concludes the elderly people's union (*ANBO, 2002*), especially because it is still attuned to the specific sectors of nursing and care (home care, residential home, and nursing home care). Next to that, the present *PGB* schemes still carries along much administrative red-tape, which renders the scheme attractive to only a limited number of people (*ANBO, 2002*). Therefore, the group of elderly with a socially or cognitively vulnerable position, has to rely on op basic provisions in their own neighbourhood or place of residence, by means of accepting care in kind.

Recently, an interdepartmental policy study *IBO (Interdepartementaal Beleidsonderzoek, 2002)*, has grappled with the introduction of individual budgets (*PGBs*) in the area of independent housing with care. These *PGBs* must enable elderly people with a greater care need to attune housing, care, and welfare facilities according to their own choice.

A number of conditions have to be realised if the introduction of *PGBs* really is to yield added value. For instance, consumers must have insight into the existent possibilities, whether on their own initiative or through the mediation of consultants. In other words: the supply must be transparent. Sufficient competition between providers is another important condition. After all, there is no real choice if all providers offer the same on equal conditions.

The introduction of truly and maximally integrated *PGBs* is still in the future. It is a long-term issue, because more insight is required into the preconditions, and into issues concerning design and implementation (*IBO, 2002*). Also, more insight needs to be gained into the experiences of the clients themselves, and into the influence of individual budgets on their purchasing behaviour. There are still obscurities for instance about the size of the various individual budgets, and also about the question which 'critical group' of care requesters shall be taken as a basis for the calculation of the cost price.

3.4 Housing, Welfare, Care

In the area of housing and care changes are occurring as well, not only as a result of the shift towards demand-oriented care, but also in the discourse on the elderly having to be able to function and be accommodated independently for as long as possible (*Ouderenzorg*, 2002).

National policies support this point of view with the concept of 'care-friendly districts', i.e. areas in which explicit attention is paid to the improvement of the living surroundings, infrastructure, and facilities (*Ministerie van Volksgezondheid, Welzijn en Sport*, 2001c : 6).

As a result, there is co-operation at policy level too, for instance between the Ministries of Housing, Planning and Environment (*VROM*) and Health, Welfare and Sports (*VWS*). After all, the policy sectors welfare and (public) housing both come into the picture. From this co-operation, as from October 2000, 'sheltered housing stimulation arrangements' have issued. By means of these schemes, projects are subsidised which are aiming at improving the interfaces between housing, care, and service (*Ministerie van Volksgezondheid, Welzijn en Sport*, 2001c).

These schemes have found expression in many other initiatives. Care providers have begun operating across their sectors and offer intensive home care at ever more locations. Housing corporations are, in co-operation with municipalities and institutions for care and welfare, modernising existent residential and nursing homes into new care centres, and are also building new sheltered care centres where clients may remain living independently, with care. Also, housing corporations began to develop more sheltered care projects in the medium price, possibly in co-operation with private financiers (*Aedes Arcares*, 2002).

In January 1996, the Netherlands Centre for Housing of Old People (*NCHB*) and the Humanist Building Society for Old People (*HBB*) joined forces in order to achieve modern housing for senior citizens. They involved the housing corporation *Woonzorg Nederland* (Housing Care Netherlands), the largest national association for the housing of senior citizens. The main target was to bring their housing supply in line with the users' (modern) expectations:

- installing information and communication technology, e.g. connection to the Internet;
- adaptable and adapted construction (building houses suitable for being lived in up to an advanced age, also in the case of functional limitations of the occupants; and
- application of the so-called *all-living concept*: the vision that senior citizens have to be able to call on a well arranged package of services based on the client's requirements and desires.

Along this line, similar initiatives have led to the development of projects in lifetime housing (40 of which in 2001) and sheltered housing 'complexes' (blocks) (700 in 2001). The projects in lifetime housing aim at creating such conditions in a district or village (with about 10,000 inhabitants), that elderly and disabled inhabitants can maintain their independence by staying in their own homes in stead of moving into an institution. Sufficient adapted houses, an accessible environment and adequate care facilities are the main elements. The care is offered on a level that is comparable to that in residential homes and nursing homes. In the centre of the district a community care centre operates as the base for the various services, to be delivered at home or in the centre. Next to care and welfare functions, the centre also accommodates commercial services. The concrete arrangement of the community centre depends on the local context (*Aedes Arcares*, 2002).

A sheltered housing complex is a housing block of independent dwellings constructed in a manner geared to sheltered housing, including an agreed care and service arrangement. Sheltered housing complexes function as a replacement of residential homes and nursing homes. The houses meet adaptability standards. The greater part of the sheltered housing complexes have been built in the 'social rented sector' and consist of three-room houses. Only 3% of the complexes has been realised in the owner-occupied property sector. There are some complexes (6%) with a combination of (expensive) rental and owner-occupied apartments. Well over half of the sheltered housing complexes are situated in the proximity of a care institution, 43% are de-

tached houses in the district. Most sheltered housing complexes have communal rooms and/or care rooms (Aedes Arcares, 2002).

All these sheltered housing initiatives are not realised without struggle. The financial feasibility of projects constitutes one of the problems, as governmental contributions are low. At times, another bottleneck is presented by the limited number of services to be delivered, especially with respect to 'well-being'. Next, the legislation is still found to be lagging behind the demand. Neither do the procedures of the Ministries of *VROM* (Housing, Planning and Environment) and *VWS* (Health, Welfare and Sports) always match each other. Finally, insufficient co-operation between care providers may result in an inadequate care-infrastructure (Aedes Arcares, 2002).

Not only do such initiatives by housing corporations form the basis of new projects, but also initiatives of the Board of Health Care Insurers lead to innovations. In 1999, the Board initiated an innovation programme, which was given shape in six pilot projects. Meanwhile, these projects have been evaluated. We will shed light on two of them as case studies: the life time housing-project in the rural municipality of Trynwalden (province of Friesland), and a project geared to a better connection of care and cure in the municipality of Woerden (from: Coolen et al., 2001).

3.4.1 Municipality of Trynwalden: The sheltered housing zone

"In the Frisian Trynwalden (10,000 inhabitants), the former residential home Heemstra State has been replaced by a complex of hundreds of apartments. With the support of the municipality, housing corporations, elderly people's organisations, and the regional administrative care office, a type of integrated care for the elderly has been developed. A coherent supply of provisions has been created, surrounding care, welfare, and adapted housing, which enables elderly people to opt for independent housing with suitable care-at-home. To that end, a collaboration structure has been formed, with participation of home care, the residential home, the nursing home, the welfare work for the elderly, the housing corporation, and the WVG window. The occupants rent a certain type of apartment and may there receive custom-made care within the boundaries of the needs assessment. The care network also supplies the required care to elderly people living independently elsewhere."

In Trynwalden the accent is placed on living independently with care, on the development of integrated care, and on working demand-oriented: individually attuning supply to demand.

Trynwalden wishes to support the elderly in directing their own lives. The so-called *omtinker* (consultant for the elderly) clarifies, together with the elderly person, the individual need for care and nursing, explores how and where the desired support can be acquired, and – when necessary – mediates between requester and provider.

Crucial here is a vision of support, which goes beyond the traditional notion of care. The emphasis is placed on connecting care and nursing, adapted housing, resources, and welfare services. Examples of the latter include nursing, housekeeping assistance, a linen service, provision of meals and a shopping service. Even education, clubs and associations providing a broad range of social-recreational activities are available.

In executing of the Trynwalden experiment, various bottlenecks were encountered. As was found, the idea of custom-made care does not easily find expression in a standard supply of provisions, as it is (still) described by the assessment agency (*RIO*). In other words: the systematics of the needs assessment often do not match, and are still prompted with a view on the supply side, rather than on personal demand. Additionally, in order to offer integrated care, the old definitions of care need changing into integrated descriptions of care products, or care packages.

An evaluation amongst clients of Trynwalden shows that supply and demand are well attuned to each other. What the elderly receive in terms of types and contents of care, fits neatly with their request and the support they need regarding their disabilities. In terms of added value, the Trynwalden project offers an extension of options. The occupants are of the opinion that the care is better than before the start of the project (40% of them had previously been involved in 'regular' care). Moreover, people were very satisfied with the mode of operation and the role of the *omtinker*. The elderly find important to be able to discuss types and contents of their care arrangement, even if the *omtinker's* influence on the final result is not always as clear to them.

3.4.2 Woerden: cure plus care project

"In the region of Woerden, various initiatives have been put into motion, which have to promote custom-made care. 14 organisations were involved in the project (from hospital to the Foundation Welfare for the Elderly) which had for its pursuit: custom-made care for long-term care-dependent elderly people."

The Woerden experiment was especially aimed at optimising the chain 'needs assessment – care allocation – care delivery'. A good supply of information is an essential precondition to this end. In the region of Woerden, people were struggling with problems surrounding the supply of information. It took elderly people too long to collect information about care, and the time span between care needs assessment and their delivery was too long. Also, the capacity of various service institutions in the region was found not to be utilised optimally.

The Woerden experiment was supposed to result in an improved supply of information for, and about, the elderly. On the one hand, in order to accelerate the communication between institutions, for instance between hospital and home care or nursing home – via the *RIO* or the regional administrative care office. On the other hand, in order to increase the accessibility of the information to the clients – via one window – so that it would be clear to them which facilities and services exist in the area of care and welfare.

Simultaneously, the experiment was required to offer elderly people with a care request the opportunity to be able to remain living in an own home or district for as long as possible.

The objective of an integrated care supply was not achieved. It required more time, in order for the parties involved to be able to solve, and overcome, impediments of a staffing, organisational and financial nature. Indeed, there appeared to be a basis for a better and non-ambiguous supply of information. The 'failure' of the project can partially be attributed to the absence of a problem shared by all parties. The experiment, as it were, was forced onto the parties involved. The lesson is, that such an innovation only stands a chance of success if the initiative for the solution of problems comes from the bottom, and is carried by all concerned. This lesson is generally acknowledged, since the objective of Woerden as a pilot study was to learn more about factors that hampered or promoted integrated care.

3.5 Individualisation of the Care System: Functions & One Window

In order to offer custom-made care, since 1990 service providing institutions have worked to improve individual care plans. Sometimes, they proceeded to develop specific professions, such as case managers, assistants independent housing, personal care consultants or 'brokers', all of whom are supposed to further the attuning of supply and demand. An example is the previously mentioned *omtinker* of the Trynwalden project, who carries out his function on the basis of case management.

3.5.1 Case management

In the region of Steenwijk and the North-East Polder, co-operating care institutions have set up a form of case management for the benefit of old people with a weak social network and decreasing self-direction. Mainly it concerns elderly people over 75 to 80 years of age, living alone. With targeted, short-term guidance, i.e. case management, these elderly may be assisted in order to get more grip on their lives at home. Amongst other things, by means of agreements concerning better arranged home care, suitable transportation, and meaningful day-time spending (Coolen et al., 2001).

3.5.2 Waiting list management

In the region of Zwolle, care agencies and providers are developing a new approach to the care for the disabled, specifically for persons on a waiting list for long-term care. Here, it is attempted to find a suitable response to a care request, by addressing a combination of existent categorical provisions (adapted housing, home care, supervised working, etc.). In doing so, an individual approach maintained, which is supported by the application of an individual trailing budget (Coolen et al., 2001).

3.5.3 Consultant for the elderly

In order to offer custom made care, the consultant for the elderly is introduced and widely supported by the Dutch policy. The rather new function fits neatly with the new idea of demand-steered care. The consultants are independent well-trained professionals who are related to a municipal, and operate in well-fare institutions, municipal information desks, but also at care providers and organisations for the elderly. At this moment 60% of the local well-fare organisations do have a consultant at their disposal. Upon request of a client, the consultant for the elderly (or 'support worker') informs, advises, and mediates, in the areas of welfare, housing, and care. This occurs on the basis of a 'working visit', or a referral. As an expert, the consultant is tasked with promoting the independent functioning of an elderly person, and to increase his or her self-coping ability and well-being (finding oneself well). His tasks also include signalling trends in the demand of the elderly, and of lacunas and bottlenecks in the supply (VOG, 2001).

3.5.4 The One-Window Idea

Partially, the above mentioned functions constitute an overlap with so-called 'windows' where the client may obtain information and advice about available services and facilities. The one-window idea meanwhile has become a true household notion in political Holland (*Congreskrant* OL2000, 2002). In various municipalities this has led to projects of integrated services, in which information and communication technology are essential. Municipalities are free in the manner in which to arrange the window. Indeed, the demand-oriented vision would prompt each municipality to adapt to the needs and questions of their residents.

In general, the one-window is a central service point for advise, information and help in clarifying the care need, sometimes located in a small-scale community centre. The *Vraagwijzer*-window (query-guide window) may serve as an example. This window aims at improving access to public information in the areas of both care and wellbeing. For the most part, physical windows (or telephonic windows) are created, sometimes they are established as an electronic window.

The physical window is a central point where people may go and address their questions to an adviser in the area of care and wellbeing. People are served immediately, or are brought into contact with bodies that can help them on their way. This may concern application of rent subsidy, or the arrangement of an intake-interview at the *R/O*. Sometimes these windows function

as a gate of the RIO's: clients may apply for an assessment concerning home care or admission to a nursing home.

By the end of 2002, 125 municipalities are supposed to have such a window. In principle, each Dutch citizen should have a query-guide window in his or her proximity in 2006. Meanwhile, an electronic window is being developed, where citizens may directly obtain their information by means of internet.

The central issue is whether the query guide window, as a so-called 'front-office', realises to make effective contacts with various provisions and functions in the 'back-office': (in fact) the local service providers. The better the mutual co-operation between these providers, the better the chance that the query-guide window facility succeed. And that is what finally constitutes both the field of tension and challenge (*Congreskrant* OL2000, 2002).

4 Conclusions

In the Netherlands, the modernisation of the care for the elderly and disabled people is clearly in motion, in particular with regard to the replacement of large-scale institutions by small-scale facilities and by community care.

Moreover, the policy aimed at the substitution of the supply-driven care by a *demand-driven* system. Demand-driven care, in our view, simultaneously means *integrated care* for, when the requests and needs which the client may experience in various areas are met, integrated care is provided. Integration is realised when (s)he can dispose of the required care provisions, the adequate types, the accurate quantity, and delivered in the appropriate order and at the right moment in time. From the client perspective, this could be adopted as a definition of integrated care.

Another, related notion is *freedom of choice*. If the clients are offered the opportunity of choice, they are capable of arranging the package of provisions themselves, which fits with their needs. In this report, we have described various attempts to accomplish integrated care systems in the Netherlands, Starting from the new system of needs assessment that is expressly targeted at taking the entire living and needs situation of the client into consideration, independently of the available supply with all its boundaries. The development of sheltered housing zones is another expression of the idea of integration. In these projects, small-scale housing and care facilities are designed, which are supposed to replace the huge large-scale institutions in the future. In this area, the ambition is to integrate facilities in the sphere of housing, care and well-being. Finally, individual budgets were introduced to offer clients more freedom of choice, and thus the possibility to obtain the desired care according to their own wishes.

User choice and participation require that clients are well-informed. In practice, however, many frail elderly persons need support in finding their way in the complicated care system and its regulations, despite the strivings to make it easier for them by creating 'one window'. Consultants, case managers and accessible information services are supposed to assist persons in articulating and expressing their care needs, and assist them in the procedures to acquire integrated care.

Especially people with dementia are unable to look after their own interests. In needs assessment and contacts with service providers, usually partners or relatives are consulted. The impact of dementia on health and social care is increasing. The expenditures for this condition already far exceed all other chronic diseases (De Klerk, 2001: 131). Furthermore, the trend towards 'extramuralisation', expanding the opportunity for frail elderly persons to live in small-scale dwelling arrangements, is not yet realised for people with dementia. The statistical data show that the number of places for these people in the nursing homes has increased during the last decade, while those for the elderly with physical disabilities and diseases were reduced in favour of housing conditions which offer more independence.

Despite the policy intentions to create a more demand-oriented system, in practise the supply-oriented approach is still dominant. Up to presently, the care system was constructed highly sectorally and categorically, organised in various groups of professions and sectors, each with their own language, traditions, and cultures. Those cultural differences often impede the cooperation and communication, and lead to conflicts of interest. All of that endangers the objective of policy-makers to obtain a system in which the client's demand determines which care (s)he receives. It could result in a half-hearted system, in which the client's demand is once again converted into the existing possibilities (Knapen, 2002). In particular the fact that the streams of money are still not sufficiently trailing the streams of care, is partially indebted to this state of affairs (Raad voor de Volksgezondheid en Zorg, 2001; Knapen, 2002). In sum, practice markedly lags behind intentions.

Besides these factors impeding integration in the care system, there are deficiencies in the quantitative supply of care for the elderly. Endeavours to reduce the waiting lists, which have been undertaken now for more than ten years, have largely failed. The scarcity of facilities impedes both innovations in the care system and the client's freedom of choice. After all, a shortage of facilities in practice leaves little to choose from. The elderly concerned are sometimes allotted a temporary 'bridging' provision, while others have to settle for a less desired solution.

In such cases it is especially the informal carer who often has to fill the gaps. Thus, the overburdening of these informal carers is an issue that increasingly demands attention. However, there still are only a few facilities to support the informal carer. This too, can be labelled as an integration problem, if we widen the scope to the network of the needy elderly person.

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Annex: List of Dutch (statutory) regulations and agencies

ANBO (*Algemene Nederlandse Bond voor Ouderen*):

General Dutch Union for Elderly People

AWBZ (*Algemene Wet Bijzondere Ziektekosten*):

In the Netherlands, most long-term care is financed by special taxes under a social insurance law, called the Exceptional Medical Expenses Act.

Administrative care office (*zorgkantoor*):

These offices, which operate on a regional level, are responsible for all administrative tasks resulting from the AWBZ (e.g., the purchase of care and consultation between the parties involved).

First compartment in the health care:

The first compartment concerns the long-term care and the uninsurable risks (home care, care and nursing homes, care for the disabled, and a large part of the mental health care). Financing occurs from the AWBZ, and the execution is conducted by the regional administrative offices. Cure constitutes the second compartment, which is financed by premiums according to the *Ziekenfondswet* or private insurance.

Individual budget (*PGB – persoonsgebonden budget*):

A person receives a sum of money or a bond – a voucher – as a means for payment for public service (upon the consent of the RIO). With a PGB someone opts to negotiate himself with providers about the care arrangement and the related price.

Individual-trailing budget (*PVB – persoonsvolgend budget*):

In the case of an 'individual-trailing budget' (*PVB*) a person receives the care in kind, whereas the payment 'trails' the client: the administrative office pays the providers for the care they have delivered to the client.

'Leaning houses' (*aanleunwoningen*):

The lightest form of sheltered housing, where people live independently but next to (and if need be, lean on) the residential or nursing home, and may opt to use facilities thereof.

Regional Assessment Board (*RIO – Regionaal Indicatie Orgaan*):

Body responsible for determining type and amount of need in response to a request for care.

Second compartment in health care:

The second compartment contains those provisions, which are part of the 'basic package' of the curative care (general practitioners, specialists, hospital care, and paramedics). Financing takes place under the *ZFW* (*Ziekenfondswet*) or private insurance. The execution is conducted by the (public) health insurance funds and private health cost insurers.

Substitution:

Substitution in the care for the elderly is aimed at realising relative shifts in the utilisation of provisions. The direction of the contemplated shift moves from intramural to extramural provisions, from intensive to extensive care, from professional to informal care, and from expensive to cheap provisions.

WVG (*Wet Voorzieningen Gehandicapten*):

The Provisions for the Disabled Act covers provision of care facilities such as transportation, housing adjustments and wheelchairs.

ZFW (*Ziekenfondswet*):

Compulsory Health Insurance Act, applicable for those with income under a certain level, over which one should obtain private health insurance. Albeit with said income restriction, the Dutch ziekenfonds (public health insurance fund) systematics best compare to the British NHS.

Annexes

Annex 1

Name	Regional Assessment Board (RIO)
Provider	Municipality
Objectives	The RIO attends to care requests of clients, which it may grant by needs assessment for relief in the area of care: nursing and (personal) care, care for the disabled, mental health care, wheelchair, living and transportation facilities.
Target Group	Those who need care in the area of nursing and (personal) care, care for the disabled, mental health care, wheelchair, living and transportation facilities.
Practice domain	Clients own homes
Staff involved	People (social workers, or nurses) who followed a higher vocational training as Assessment Consultant.
Methods used	Assessment on the basis of protocols and criteria, in dialog with the client.
Related agencies	When the RIO deems the care need to be necessary, the care request is passed on to the administrative care office in the region. Subsequently, this office is responsible for purchasing the required care.
Strengths	Rio's have been called into existence to enable the client to choose from various kinds of care through one window. RIO's are a first step on the way to care integration by rendering different sources of care accessible to a client. They constitute the starting point in the chain of needs assessment, care allocation, and delivery of care.
Weaknesses	Municipal differences in the provision of integrated care The real care need (often) remains hidden by including the possible contributions of family members or other informal assistants in assessing the need In practice, only to a limited extent does the demand optimally direct the supply

Annex 2

Name	Personal Budgets (PGB)
Provider	Regional administrative care offices and National Insurance Institute (SVB)
Objectives	It is assumed, that the introduction of individual budgets (PGB) is better geared to innovations in the care system. The administrative care office gives the person concerned a sum of money or a bond – a voucher – as a means to pay for public services in stead of receiving care in kind.
Target Group	A PGB has been introduced for those people who are in need of long term care because of chronic illness, ageing, psychological problems, or a physical disability.
Practice domain	It is a financing system for clients.

Staff involved	Employers of administrative care offices, and National Insurance Institute (SVB)
Methods used	Individual approach
Related agencies	When the RIO deems the care need to be justified, the care allowance is passed on to the administrative care office in the region, which finally awards the care and the budget.
Strengths	It gives clients more individual autonomy and flexibility, and freedom of choice.
Weaknesses	The present PGB scheme is rigid, it is still attuned to the specific sectors of care and nursing The present PGB schemes still carries along much administrative red-tape, which renders the scheme attractive to only a limited number of people

Annex 3

Name	Sheltered housing complexes and zones (e.g., <i>Trynwalden</i>)
Provider	Municipality, administrative care office, housing corporations, and service providers
Objectives	The main target is to bring the housing supply in line with the users' (modern) expectations. A sheltered housing zone is a normal district or village (with about 10,000 inhabitants), where care is offered in the manner in which was once only supplied intramural (e.g. in residential homes and nursing homes). A sheltered housing complex is a housing block of independent dwellings constructed in a manner geared to sheltered housing, including an agreed care and services arrangement. Sheltered housing complexes function as a replacement of residential homes and nursing homes, and may be part of a sheltered housing zone.
Target Group	Elderly with care needs
Practice domain	Living areas in which explicit attention is paid to the improvement of the living surroundings, infrastructure, and facilities
Related agencies	Netherlands Centre for Housing of Old People (NCHB) and the Humanist Building Society for Old People (HBB) joined forces in order to achieve modern housing for senior citizens. Not only do such initiatives by housing corporations form the basis of new projects, but also initiatives of the Board of Health Care Insurers lead to innovations. Municipality plays an active role as mediator: bringing the parties together.
Strengths	The supply and demand are well attuned to each other. There is an extension of options for clients: they are able to discuss types and contents of their care arrangement
Weaknesses	The financial feasibility of projects constitutes one of the problems. The limited number of services to be delivered, especially with respect to 'well-being'. The legislation is still found to be lagging behind the demand.

Annex 4

Name	Optimising the chain 'needs assessment, care allocation and care delivery' (e.g. <i>Woerden</i>)
Provider	Regional administrative care offices, care providers, municipality
Objectives	<p>An improved supply of information for, and about, the elderly. To offer elderly people with a care request the opportunity to be able to remain living in an own home or district for as long as possible to accelerate the communication between institutions.</p> <ul style="list-style-type: none">• to increase the accessibility of the information to the clients – via one window• to accelerate the communication between institutions, for instance between hospital and home care or nursing home – via the RIO or the administrative care office.
Target Group	Long-term care-dependent elderly people
Practice domain	Living arrangements for elderly in need of care
Staff involved	Staff of the different parties involved
Related agencies	14 organisations were involved in the project (from hospital to the Foundation Welfare for the Elderly).
Strengths	Non-ambiguous supply of information to elderly from 'one window'.
Weaknesses	The objective of an integrated care supply was not fully achieved because the parties involved needed more time, and a more concrete aim (focus) to develop their strategy.

Annex 5

Name	Specific professions, such as case managers, assistants independent housing, personal care consultants, or 'brokers'.
Provider	Social insurance agencies, well-fare institutions, housing corporations
Objectives	<p>The attuning of supply and demand to offer custom-made care for elderly</p> <p>The <i>consultant for the elderly</i> (or 'support worker'): informs, advises, and mediates, in the areas of well fare, housing, and care.</p> <p><i>Case managers</i> exist for the benefit of old people with a weak social network and decreasing abilities of self-direction. With targeted, short-term guidance these elderly may be assisted in order to get more grip on their lives at home. Amongst other things, by means of agreements concerning better arranged home care, suitable transportation, and meaningful daytime spending</p> <p><i>Waiting list managers</i> attempt to find a suitable response to a care request, by addressing a combination of existent categorical provisions (adapted housing, home care, supervised working, etc.)</p>
Target Group	Elderly clients in need of care
Practice domain	Care requests in the areas of welfare, housing, and care.

Staff involved	Consultants
Methods used	An individual approach
Strengths	To be able to consider types and contents of their care arrangement in mutual consultation with a professional.
Weaknesses	none

Annex 6

Name	Information desks constituting 'one window': the query-guide window may their questions, or are brought into contact with bodies that can help them on their way.
Provider	Municipalities and public service providers
Objectives	'Windows' where the client is served immediately, and may obtain information and advice about available services and facilities.
Target Group	(Elderly) clients in need of care
Practice domain	Care requests in the areas of welfare, housing, and care.
Staff involved	Employers of the information desks
Methods used	An individual approach
Related agencies	The local service providers
Strengths	The better the mutual co-operation between these providers, the better the chance that the query-guide window facility succeeds.
Weaknesses	The central questions is whether the query guide window as a so-called 'front-office' realises contacts effectively with various provisions and functions in the 'back-office': the local service providers.

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