

Verwey-Jonker Instituut

Onderzoek naar maatschappelijke vraagstukken



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## **Integrated care in the Netherlands**

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## 1. Introduction

In this lecture I shall outline the major changes in the integration of care in the Netherlands that have taken place over the past few years and that are set to take place in the near future.

In the Briefing paper integrated care is understood as the result of a co-ordination process between health and social care systems to provide user-friendly, seamless service provision in long-term care of persons with physical, mental or other disabilities and respective care needs. This definition stresses the coordination and co-operation from a provider perspective. In the Netherlands integrated care is also defined from a client perspective (Ex, Gorter & Janssen, 2003): For the clients integrated care techniques and models should result in getting the care they need (adequate amounts of the right types and delivered in the appropriate order and at the right moment). Thus, not the supply, but the needs are central in determining the delivery, organisation, governance and financing of care. Moreover, In the Netherlands the emphasis is shifting from a care perspective to a social support perspective. It is not the disease or the disability, but the possibility of leading an independent life and social participation that are central in defining the support. This means not only integration of care, but integration of living, care, welfare and other services in the immediate environments.

I will start with two examples of innovative models. The first example is Zorgvoorziening (care provision) Zijloever in the municipality of Leiden which offers integrated care arrangements for elderly who need permanent care and which promotes itself with the slogan: "The oldest residential home without walls". The second example is the Personal Budget, an instrument to integrate care on the personal level which allows care users to buy in tailor made services.

### *Zorgvoorziening Zijloever*

Let's now watch a short video about Zorgvoorziening Zijloever which will give you an idea of these care arrangements.

Zorgvoorziening Zijloever started as an alternative for an earlier plan to build a new residential home in Leiden-Noord, Zijloever delivers 24-hour care at home to the elderly who are in fact eligible, on medical grounds, for a place in a residential home. Zijloever is one of the few organisations in the Netherlands that delivers total extramural care (that is to say residential care outside an institution) for this category of clients. The organisation promotes itself with the slogan: "The oldest residential home without walls in the Netherlands". In 1990 Zijloever really was a trendsetter. Its design has much in common with the concept of 'care-friendly districts' which are supported by national policies and which are currently being developed in a number of different municipalities. Care-friendly districts have facilities for the provision of small-scale services in neighbourhoods and in local communities for disabled people who live in small groups in specially adapted houses. Zijloever not only delivers care but also welfare services which help promote social participation and prevent social isolation and loneliness. The organisation works closely together with other care and welfare deliverers. Zijloever guarantees that its clients can receive the care they need both day and night, at weekends and during holidays. The care is set out in a care plan which is drawn up together with the client. If the client activates an alarm button, help is available within about 10 minutes. The care is flexible and can be adjusted any time, should needs change. This guarantee seems normal but it is, in fact, rather special in times of scarce resources. Research (Gorter & Tabibian, 2004) indicates that clients are very satisfied with the services delivered and that carers are very satisfied with their working conditions.

### *The Personal Budget*

Care users throughout Europe can nowadays opt for a personal budget to spend on the direct employment of carers who deliver this care in their home. Compared with other European schemes, the Dutch system, which has been in place since 1995, is not only highly regulated, it

allows care users to employ not only professional carers but also family members to care for them. A study by Ramakers in 1998 shows that only 30% of clients bought in regular nursing care and 20% of clients bought in regular home help. According to a study of Beukema (2004) clients as well as carers are very happy with the budget and the number of people with a budget (the so-called 'budget-holders') increases every year. In 1996, around 5400 persons had their own budget, while in 2003 their number increased to 65,000. The Personal Budget accounts for rather a small amount of the expenditure for care (less than 2%). However, the impact is greater than its financial weight. It is a tool for stimulating innovation in care, and it fits into developments in the Netherlands towards a demand-driven and market-oriented provision of care. Clients become not only consumers but operate as commissioners and care becomes a market. The broadly supported Personal budget is seen as a tool that facilitates the autonomy and empowerment of care users and makes them less dependent on professionals. It gives them a free choice which enables them to have more voice. Furthermore, it is expected to increase competition between providers, increase efficiency, and improve the quality of care.

However, there are also a number of critical remarks that can be made. The choices are limited, the market is not transparent, and it is difficult to find a good care provider. The bureaucracy involved is hard to tackle, and this has, in fact, led to a new profession – that of care consultants who guide and support the budget holder, and also to an organisation for budget holders (Per Saldo) to help them with their questions. The budget holder has considerable responsibility - he is an employer and is partly responsible for the quality of care.

## **2. Integration of care and other services**

### *Integration of health care, social care and prevention*

Until now, health care has primarily been financed by the Health Insurance Fund and (domiciliary, supportive, activating and nursing) care is financed under the Exceptional Medical Expenses Act. Stakeholders are health insurers, professional institutions and user organisations.

In the past decade the integration of care focused predominantly on extramuralisation (a shift from care in an institution to care at home or in small groups in houses) and on co-operation between health care (GPs and hospitals), care (home care, institutions for psychiatric patients, the handicapped and the elderly) and prevention. Transmural (or seamless) care demands more intensive co-operation between the hospital and its specialists, and community care. However, co-operation is hampered by the increasing levels of specialisation in medical care. There is also a strong movement towards disease management, where insurers, professionals, government agencies and patient organisations, cooperate in order to organise a chain of health care, care and prevention provisions for major diseases such as diabetes, Alzheimer's, and COPD.

In nursing homes and residential homes, there is a considerable amount of internal integration at the levels of professional and organisational integration as all the disciplines involved in the care process are present at the same place in which the elderly, the chronically ill or disabled people live. In community care, integration is more complex for providers, local government and citizens due to the different financing systems and regulations and the 'cultural' differences among various stakeholders. Nevertheless, co-operation is on the increase. Examples include the 'liaison nurse' from home care who is posted in the hospital to co-ordinate the patient's transfer home, and also the working hours of district nurses in outpatient clinics. But patients who are discharged from hospital and still find themselves in need of home care or institutional care, are often confronted with waiting lists. So, the throughput in the hospital not only depends on internal processes, but also on the limited capacity of all the other extramural facilities in particular. To solve these problems, the Regional Care Offices (responsible for care allocation) and local care providers have started working together with the hospitals. In some of these initiatives care assignment offices have been created that organise a smooth transition from medi-

cal care to care at home, social care or care in an intermediary facility should the needed care not be available.

Other impeding factors stem from fault lines in the financing system. There is a dichotomy in the Dutch system between what is referred to as primary and secondary health care. General practitioners and district nurses, together with social workers and home carers, are the four core disciplines in the front line. Hospitals and nursing homes are secondary care facilities. Consequently, general practitioners are active in the primary sector but not in hospitals or nursing homes.

The divisions that have developed in the financing and the organisation of the care system now constitute the major demarcation lines that impede the development of integrated care. Care has mainly been financed under the Exceptional Medical Expenses Act (AWBZ), while health care is funded by 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 elderly people and the chronically ill also demands co-operation between health care and care (especially as far as nursing and caring are concerned), and between (health) care and social or welfare provisions.

### *From care to social support*

In the Netherlands integrated care is defined more broadly than co-operation and coordination between health care and social care; it entails also the incorporation of welfare facilities.

Until now, the integration of care and service delivery has been the main responsibility of care providers and health insurance companies. In the near future, local government will have more administrative responsibility for the integration of care and welfare services. A new law is being drafted which should control the ever increasing costs of care and support the integration of care and other services on the local level: the Social Support Act. The Social Support Act encompasses the Services for Disabled Act and the Social Welfare Act and parts of the Exceptional Medical Expenses Act. Domiciliary, supportive and activating care will no longer be insured under the Exceptional Medical Expenses Act. Only personal and nursing care will then be insured by the Exceptional Medical Expenses Act. An exception will be made for patients who need long term intensive care in a residential setting.

The integration of care and welfare services will be the responsibility of local government. Financing integrated care will be more complex since medical care will be financed pursuant to the Care Insurance Act, nursing care pursuant to the Exceptional Medical Expenses Act and welfare services pursuant to the Social Support Act. The most important objective of the Ministry's proposals is the provision of integrated care and social support for individuals and cohesion in the services for these people in their immediate environments, to enable them to live independently for as long as possible.

As shown in the examples of the Personal Budget and Zijloever, we can speak of an important shift in perspective: it is not the supply, but the needs that are central in determining the delivery, organisation, governance and financing of care in the Netherlands. Moreover, the emphasis is shifting from a care perspective to a social support perspective. It is not the disease or the disability, but the possibility of leading an independent life and social participation that are central in defining the support. This means not only integration of care, but integration of living, care, welfare and other services in the immediate environments. At the same time, current policies emphasize citizens' own responsibility. The starting point is what people can do and arrange individually and together. In fact, the new Social Support Act and the modernisation of the Exceptional Medical Expenses Act are based on this principle. Under the new Social Support Act, local government will only provide support for those people who really need it, but cannot organize it themselves.

### 3. Main issues

Local governments will be responsible for determining which services they will offer and to whom. They will need systematic information about vulnerable groups and their specific needs. There is growing awareness of the difficult position of people with severe and multiple problems who live in social isolation. At the same time, tolerance for the homeless, among whom drug abuse and psychiatric problems are rife, decreases. There is also a growing group of handicapped and older people who are unable to care for themselves and who live in social isolation. Attention for these groups is fragmented and local governments lack information about these groups. Local governments, professional organisations and patient and consumer organisations are critical about the new Social Support Act. For a long time the Netherlands was well-known for its extensive institutional care and health insurance, where the rights to long term care were extensively regulated. The shift to community care leads to much uncertainty and doubts for patient organisations, local governments and professionals. The debate focuses on the question of whether local governments have the capacities (budgets, know how) to realise the integration of care and social support and to improve the quality of life of the users of long term care. Patient organisations and care managers fear that the differences between the local governments will lead to will huge differences between the positions of long term care users.

Furthermore, the position of informal carers requires attention. Nowadays, there is more attention for the support of the carers who play an essential role in the care of the elderly and the handicapped. In the new Social Support Act, support for informal carers is one of the performance fields. However, the starting point that people are responsible for themselves as much as possible may lead to the restriction of formal care delivery and thus to increased pressure on informal care.

Integration of care and service deliveries is one step. The next step is the fight against the social isolation and exclusion of people with limitations. The law on equal treatment has been implemented in the field of transport, education and work. Organisations of older people and handicapped people use empowerment strategies. There is also a national campaign to improve the image of people with handicaps.

The shift to community care and the integration of services requires a new kind of professional, where reflective skills and communication with other professionals and informal carers and other professionals are more important than specialist knowledge.

#### Personal Budget:

The consequences of implementing the Social Support Act will mean that an important part of the services which can now be bought by the budget holder will become the responsibility of the local government and are no longer included in the budget. Professional and client organisations fear that the Social Support Act will have negative consequences for the Personal Budget. The Health Care Insurance Board estimates that 85% of people with a personal budget will lose all or some of that budget as a result of the transfer of domiciliary and supportive and activating care to the Social Support Act.

#### Zijloever:

What are the consequences of implementing the Social Support Act and changes in the Exceptional Medical Expenses Act? Under the Social Support Act, Zijloever will have to compete with other service providers in the region to deliver care and welfare services for their own clients.

#### 4. Concluding remarks

Integration of care and social and practical support for citizens who are dependent on long-term care is the challenge for the Dutch care system.

Integrative care in long-term care in the Netherlands has evolved in three steps.

Care and health care	Extramuralisation	Health Insurance Exceptional Medical Expenses Act	National level
Care and welfare	Social support	Social Support Act	Local level
... and housing, work, education, ...	Social participation	Equal Treatment Act	Local level

The first step was extramuralisation, where the long-term care moved from institutional care to home care and the organisation of professional care in the immediate environment of the long term care user. The professional institutions, the insurers and user organisations play a key role. The second step is the integration of care and welfare services to social support, where the local government has a key role. An important question here is whether the local government is capable of organising innovative stimuli for the professionals and private providers to sustain or improve the quality of life of long term care users.

The keys to success will be the role of civil society – that is the users and family carers. Will they support this shift and co-operate with professionals and local governments? Will there be enough support for carers and users to improve their quality of life?

The third step is the realisation of equal treatment for long term users, to invest in the capacities of long-term users to participate in the local community, in education, in work and voluntary associations. Therefore it is also necessary to improve the image of long-term users for employers and other citizens.