

Peer Review on Freedom of Choice and Dignity for the Elderly Dutch comments paper

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Whilst reviewing the Swedish country report it appeared to be a difficult task to comment on the issue 'Freedom of choice and dignity for the elderly' in just a few pages, as the topic touches upon participation in society, long term care, social support, acute care, housing and various other issues. Moreover, the reader might need some information on the Dutch system for a full understanding of our response to the Swedish Country Report. Therefore, we first give a brief outline of some key features of the long-term care (LTC)-system in the Netherlands. We will primarily focus on this LTC-system and social support, although the other above mentioned sectors are also relevant to the issue. For those interested in detail in the position of older persons in the Dutch situation, we refer to the 'Report on the elderly 2006' (SCP, 2006).

1. Background information

The Dutch system is often classified as – in terms of Esping-Anderson (1990) – as social-democratic system (see also: Arts and Gelissen, 2002; Tesch-Römer, 2007). The health care components can be best placed in a 'Bismarckian' context. Key characteristics are (Nies, 2002; Mur-Veeman et al., 2003; Ex et al., 2004):

- a health care system based on a social insurance; private health care insurers are responsible for funding acute care and social insurance funds – carried out by regional branches of the private health care insurers - for contracting and funding long term care;
- a strong purchaser-provider split;
- a wide variety of autonomous not-for-profit care and service providing organisations;
- a significant number of semi-public bodies for pricing, eligibility assessment and -testing, control and inspection;
- two levels of government (national and local) for policy, budgeting, planning and – for social support – commissioning;
- high fragmentation and regulation by a complex system of corporatistic arrangements with all the above mentioned bodies and umbrella organisations of service users and professionals.

Current LTC has multiple historic roots: residential homes evolved from the housing sector, home help/domestic assistance and social support from the welfare system and nursing home care and district nursing have their origin in health care (Munnichs, 1984). For the target group under consideration – older people with long-term dependency needs – at least four sources of funding are relevant: health insurance for acute care, Exceptional Medical Expenses Act (AWBZ) for long-term care, the Social Support Act (Wmo) for social support (including amongst others welfare, domestic care, assistive devices, transport) and housing income support (see: appendix 1). Appendix 2 illustrates how (older) people who are in need of care and support get access to services in these four areas. It should be noted that in residential care, the elements housing, social support, personal

care, nursing and treatment and rehabilitation are provided as an individualised coherent package, which is based on a care/living plan.

Sustainability is for all European countries a core challenge. Hence, the need for financially affordable care of a reasonable quality standard, the need for sufficient and sufficiently qualified staff and principles of solidarity are under great pressure. They constitute the key elements of the current policy debate in the Netherlands, as it does in other EU Member States: who cares and who pays for reasonable quality care to meet the needs of the older generations to come? The first issue - the urgency of labour market measures - is well recognised by the Dutch government and the other parties involved (VWS, 2007a). The second question is also high on the agenda of the current government. It is considered by the Social and Economic Council of the Netherlands, where umbrella organisations of employers and employees make up the majority (VWS, 2007b).

In virtually all sectors mechanisms of a so called 'controlled' market are gradually being introduced. This principle intends to lay responsibilities with citizens and with the community in which they live. Public services should be supplementary for those for whom self care and care by the social network is not a viable option or is insufficient (VWS, 2004; VWS, 2006).

Therefore, the systems of social support, long-term care, housing and acute care are in a process of stepwise reforms. A major reform of the acute care system took place in 2005/2006, in which the distinction between public and private insurance systems was abolished. It aimed at a better level playing field for competition between health insurance companies and between health care providers. In 2007 the Social Support Act (Wmo) came into force, thus yielding a greater say to municipalities – amongst others – to improve cohesion at social support at the local level. The AWBZ and Social Support Act can be viewed as communicating vessels. At this moment a revision of the Exceptional Medical Expenses Act (AWBZ) is under consideration. Especially, its function, necessity and coverage will be scrutinised (VWS, 2007b).

As a consequence, processes of decentralisation are ongoing and the role of central government is gradually decreasing, primarily limiting itself to formulating policy objectives and frameworks and establishing macro-budgets. However, national government retains its final responsibility for access to care for all citizens and quality of care.

2. Relevance for the Netherlands

The Swedish Country Report including the analysis by professor Tesch-Römer (2007) is highly relevant for The Netherlands as there are many similarities (see next paragraph), but also because there are some essential differences between both countries. The positive aspects of some of these differences might be worth considering in The Netherlands in developing the ongoing renewal of its system of long term care. In this respect one of the interesting features of the Swedish system is the role of the municipalities as the governmental layer which holds large responsibilities for funding and provision of long-term and social support. This is an option which is seriously considered and advocated in the Netherlands, although not to an extent that the Swedish model will be copied. According to some prestigious advisory bodies, one of the scenario's of revising the AWBZ in order to strengthen sustainability of long-term care, is to transfer funding and policy development of a number of functions of the Act to municipalities (e.g. RVZ, 2005).

Further, a close look at the Swedish system is relevant because the proportion of older people in Sweden is at a level that The Netherlands will achieve in about 10 years (CBS, 2006). How does Sweden deal with the higher demand for long term care, which is connected to population ageing, whilst ensuring high quality levels? In that respect the awareness in Sweden of the necessity to improve dementia care and to strengthen the position and support for informal carers is recognised in the Netherlands as well (e.g. Gezondheidsraad, 2002). The Netherlands has well formulated

policies on these issues, as well as ambitious strategies for improvement. So mutual learning and exchange on these issues has already been established (for instance in applying principles of collaboratives in improvement programmes and in supporting informal care), but this can be elaborated.

Further, income policies are relevant, especially with regard to intergenerational solidarity. How exactly does Sweden avert the risk of putting the future burden of old age pensions not on the shoulders of the generations to come and how does the Maintenance Support Act support this objective?

Another field of relevance relates to the role of competition in long-term care. As the Swedish Country Report describes, competition is primarily on (assumed) levels of quality, not on tariffs of services. In the Dutch system – as mentioned above – mechanisms of a controlled market are applied. In some (but certainly not all) fields of care competition is to some extent based on tariffs. In the very near future (2008), however, an objective and widely supported comparable set of quality indicators will be available (Quality framework Norms to ensure responsible care, 2006). This framework will improve transparency of care provision and may support competition on quality. It will enable service users and commissioners to contracting services based on quality and to monitor the quality of care and support that is provided. The search for meaningful outcome indicators may be a field for mutual exchange.

Another relevant aspect is the impact of competition on collaboration. There are signs in the Dutch system that incentives for competition may run counter to the aim of providing a coherent system of integrated care. Part of the discussion is also the difficult collaboration between the insurance-system (health insurance and AWBZ-insurance) and social support, as it is governed by the municipalities. The apparently successful policy of Sweden in using well targeted incentives, for instance to connect acute care with long term care might be a good example for the Netherlands as well.

3. Similarities and differences

First of all, Sweden and The Netherlands both have a history of high levels of residential care and both have carried out a policy of strengthening care in the community and reducing residential care. Around 1975 approximately 11.5 % of the Dutch population 65 and over were living in residential care, 9.3 % in residential homes and 2.2 % in nursing homes (Tester, 1994). However, from the seventies a so called substitution policy was issued consisting of three main mechanisms: legislation to control the supply of residential and nursing homes (planning, budgets), control of prices and charges, and assessment procedures to limit eligibility to residential care only to the most severe clients (Munnichs, 1984; Coolen, 1985). Moreover, large expansion of intermediate care, out-reaching functions of nursing and residential homes, respite services and targeted housing policies contributed to the current moderate provision of residential care: 4.3 % in residential homes and 2.4 % in 2004 (Nies, 1997; CBS, 2006). The percentage of older people who use home care services mounts up to 21.8 % (CBS, 2006).

Percentages of people in short stay accommodation are hard to compare. Dutch nursing homes have - apart from their long stay function - a rehabilitative function as well, for instance for stroke patients. They employ medical, paramedical and psychosocial staff, which in other countries are usually based in geriatric wards of hospitals (Nies, 2002). In 2003 1.3% of the population of 65 years and over used the option of short term admission in residential care and 1 % used day care as provided by residential homes (calculated from: SCP, 2006; CBS, online).

Secondly, a number of relevant demographic characteristics are quite similar. Both countries have about EU average life expectancy. Moreover, the fertility rates are the same and comparable

proportions of very old people are living alone or as a couple, whereas in both countries only few very old people live with their families. Also the proportion of older people who receive help from their children do not differ too much (see appendix 3). These data suggest that a number of cultural characteristics and values are quite similar. However, one important difference seems to be relevant in terms of culture: the Swedish population seems to be comfortable with the welfare state and experiences it as good value for money. The Dutch are much more critical of health care and long-term care, its quality and its expenses.

Thirdly, both countries share a high level of provision of professional care, high quality standards and high expectations of public services (although they are not always met). The public expenditures on health care as a percentage of the GDP are fairly similar. However, the expenditures on long term care seem to differ a lot, according relevant EC and OECD data (OECD, 2005; EC, 2007). It should be noted that because of the decentralised funding of LTC in many countries, statistics might be less reliable and, therefore, less comparable for LTC than for acute care.

Probably the most important difference lies in the system. The Swedish system is a typical Beveridge-model: public provision of services and 'single payer' financing from taxes, where the payer is largely responsible for managing the services, or – in other words – were there is no or little purchase-provider split. The introduction of market mechanisms is much less pronounced in Sweden than in the Netherlands, which can be seen as a Bismarckian state (see above). The insurance-system is dominant (€ 22.5 bln. for long term care, of which approximately € 13 bln. for care for older people); the role of municipalities (social support: € 4 bln.) is small compared to Swedish situation.

As a consequence the overall responsibility for care for older people in The Netherlands rests with the national government. The Dutch state carries system responsibility, but the various elements of responsibility lie with many partners, as shown before. In Sweden, primarily democratically controlled bodies at national, regional and local level appear to be responsible for policy development, planning, funding, control and inspection, commissioning and eligibility testing.

On the other hand, equality thinking is deeply grounded in Dutch health care. The idea of differences between regions, different entitlement, different expenses and different quality issues such as in Sweden meets strong objection by the stakeholders but also by the general population. Income policy is closely connected to service provision, in the sense that personal payments for care, service provision, social support and housing is income dependent. The housing (in residential and nursing homes) is part of the insurance, while in Sweden people pay rent. As a consequence, quality levels of care and housing are very equal all over The Netherlands. From a point of equal access, this may be an advantage, but in order to meet individual and local or regional needs, this may be a shortcoming. But in general, differences in service provision according to income or social class is discarded by large parts of the Dutch population. However, there is under-utilisation of publicly funded long-term and social support by people with higher income levels, especially in residential homes. Paradoxically, to some extent social exclusion in elderly care tends to take place at the upper levels of society!

4. Potential transferability

It appears that there are many fields of transferability. In fact all the objectives of Swedish government that are outlined under the heading 'Ageing with dignity' are objectives of the Dutch government as well. Both countries share their main policy objectives and values concerning care for older people, such as to live active lives, to participate in society, so have a say, to retain independence, to support older people to live in their own homes and to have good access to health and social support services. Both countries can demonstrate and exchange good practices of policies, practice examples as well as improvement programmes.

Additional objectives that are very relevant in the Dutch debate on long-term care is to reduce bureaucracy while improving transparency. The role of privately funded services and private for-profit providers might be an issue for mutual exchange. Moreover, the labour force is a highly relevant issue for exchange of experiences and good practices. The Swedish Country Report only lightly touches upon questions of labour force. Large shortages are expected in the Netherlands, which may make it an issue for knowledge transfer. The current percentage of 11 % of people working in the care sector should almost double in the next two decades in order to meet increasing demand, especially because of the ageing of the population (RVZ, 2006). As a consequence, combining care and family life would be a topic of interest, given the future pressure on labour participation by women.

Finally, freedom of choice is an issue: what are the limitations in a sustainable system; how to ensure freedom of choice in a primarily demand driven system; freedom of choice and to what price; what ethical dilemmas are envisaged; how can service users and their carers be empowered? The Netherlands has a rich tradition in legislation and methodology to empower services users. Also, the implementation of personal budgets has been quite successful in The Netherlands. But, although the progress that has been made, still numerous imperfections exist and could be an issue for transfer between Member States.

5. Current policy issues in The Netherlands

Quality of care is a very crucial issue in Dutch health care and in elderly care in particular. There is a lot of criticism of Dutch nursing homes in particular. A number of measures are issued to tackle this problem, such as large scale improvement programmes, a clear inspection policy and the formulation outcome indicators. Where The Netherlands had a system where service providers were responsible for quality and government mainly monitored whether quality systems were applied, one realised that that was insufficient (VWS, 2003). Thus, a roadmap to monitoring and commissioning care, based on outcome indicators was issued. Service providers, professionals and service users came to an agreement on what indicators should be used. This went hand-in-hand with a paradigm shift: all parties agreed that quality of care should not be the final aim, but quality of life. It was operationalised in a number of indicators covering four main fields: physical wellbeing and health, housing and living conditions, participation and mental well-being. The sets of indicators are tested and will be implemented in 2008. The outcomes will be published in order to inform service users while taking their decision. The outcomes will also be the basis for funding, next to cost-effectiveness.

Moreover, the new government has formulated a policy which takes quality of life as the leading paradigm, in which the relationship between the older person and the care professional is redefined. The government also aims to strengthen and increase consumer's choice and user-direction, transparency and quality based purchasing, new initiatives in the field of housing and care (accessible housing, small scale housing, 'life span proof' neighbourhoods), the implementation of ICT and smart housing, integrated care for older people, the connection of geriatrics and (para)medical nursing home care with general practitioners, patient safety, the labour force and a reduction of bureaucracy (VWS, 2007a; 2007b).

The latter is an issue of high priority, as is cost-effectiveness in order to achieve a sustainable system of long-term care. There are significant differences between service providers in terms of cost-effectiveness. Large scale multi-dimensional benchmarking has taken place among home care and residential care organisations. The differences between cost-effective service providers are to be further explored. A systematic inefficiency in Dutch care for older people is the bureaucracy: it does not contribute to quality care and to entrepreneurship. On the contrary, it is seen as a severe

burden and a waste in the system. The new Dutch government has formulated an objective to reduce bureaucracy by 25%.

Potentially the largest challenge to sustainable elderly care is the labour force. The future percentage of people working in the elderly care is seen as a serious barrier to future economic development of The Netherlands. Therefore, the Dutch government wants to improve the image of those who are working in the elderly care. As in many EC countries, this work has low status and too many staff are poorly qualified. New professions may also provide some relief, such as the case manager of the workers in small scale housing units. Further, an innovation agenda has been formulated between government and the umbrella organisations to increase labour productivity. However, little evidence exists on which measures are most effective. Technology might be one of the promising fields, but as far as the Swedish Country Reports reveals, the aspirations of Sweden on technology are as moderate as the Dutch.

It appears that labour participation of women is a key factor in solving this issue. There has been an enormous increase in female labour participation during the last two decades. But this increase was much larger for part-time work (which in the 45+ age cohorts doubled) than for full-time work. How important this percentage is, is demonstrated by the figure that if the nursing staff would – on average - work 12 more minutes per day, it would reduce the expected shortage in 2010 by 15%. More than 80% of the people working in the Dutch care sector is female, but they are usually employed by small contracts: around 44% works less than 24 hours per week (RVZ, 2006). The labour market situation seems to be related to affordable high quality childcare and care of other dependents, shared family and domestic responsibilities between men and women, reduced gender pay gap, enhanced gender equality and equal opportunities, according to the European Commission (2007a). It further states, that countries that have achieved the highest female labour force participation also display high fertility rates. In other words, work and caring can go together very well, also in the field of long-term and social care. Where Sweden is one of the EU champions of children who benefit from professional childcare, is the Netherlands on the other side of the spectre (European Commission, 2007b).

6. Potential contribution to Swedish policy

Sweden and The Netherlands have been quite successful in applying mechanisms to substitute expensive clinical services and residential care by long-term and social support, by their housing policies and by supportive measures to strengthen informal care. The development of stroke services in The Netherlands for instance has been very successful (Huijsman et al., 2001) and as were experiments with small scale housing for people with dementia. Also the concept of life-cycle friendly (or: 'life cycle resistant housing') might be transferable or find its counterparts in Sweden.

It might be useful to share experiences with regard to information to service users, in order to support their decision making. Well developed internet sites have been developed in The Netherlands and are streamlined with consumer information (www.kiesbeter.nl). Moreover, Dutch experiences with multi-dimensional benchmarking may be relevant to Sweden, as The Netherlands has extensive experience with benchmarking of residential and home care services. The benchmarking system has been qualified by the OECD as exemplary because it includes quality, efficiency, patient and staff satisfaction (PWC, 2005).

Elsewhere in this text we have also presented suggestions for exchange, where both countries could improve their policies and practices and contribute to each others situation by mutual exchange.

7. Concluding remarks

While studying the Swedish documents a number of dilemmas in Dutch policy development became apparent. These dilemmas could be an agenda for mutual learning:

- How to balance private provision within the public domain of care for older people and how far should this public domain extend?
- How can a government issue market mechanisms in a field as care of older people with respect for freedom of choice and dignity and ensuring solidarity?
- What role should income policy have in ensuring freedom of choice and dignity?
- What are the views and practical implications of balancing formal and informal care?
- How can supply driven care be substituted by demand driven care without an enormous increase of demand?
- How can innovations in long term care be furthered in order to resolve the sustainability questions of long-term and social care?
- Given the expected shortages of staff (in LTC) in the future, what solutions can be identified (incl. how to stimulate labour force participation, both in numbers as in employment rates)?
- How to balance and integrate long-term care with social care and with the domains of housing amongst others given the fundamentally different systems underlying?

Freedom of choice and dignity are appealing values, but it is still a long way to go to achieve them. The exchange between EU Member States will hopefully give a new impetus to this challenge!

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Appendix 1: Services for older people in their policy context

Health care	Long-Term care	Social support	Housing
National health care insurers	Regional long term care insurance agencies	Municipalities	National government: Ministry of housing Municipalities
<i>Domiciliary services</i>			
General practitioner	District nursing	Home help	Regular housing
Paramedical (Physiotherapist, occupational therapist, speech therapist etc)	Community mental health care	Welfare services for older people	Adapted/special design housing
Dentist	Outreach multiple care provided by nursing homes and residential homes	Meals on wheels	Smart homes
	Assistive technology	Sitting services	Service flats
		Keep-fit-exercises	Alarm systems
		Social work	
		Adaptations in dwellings	
		Alarm systems	
		Assistive devices	
<i>Intermediate care</i>			
	Sheltered housing (care component)	Day care	Sheltered housing (housing component)
	Small scale, communal living (care component)		Small scale, communal living (care component)
	Day hospital/day care		
	Respite care		
	Use of services of residential homes		
<i>Residential services</i>			
Hospitals	Nursing homes (including rehabilitation, medical care)		
Psychiatric hospitals	Residential homes		
	Psychiatric hospitals (long stay)		
	Rehabilitation clinics		
	Residential care for mentally and physically disabled people		

Appendix 2: System of access to care in The Netherlands

Fehler! Es ist nicht möglich, durch die Bearbeitung von Feldfunktionen Objekte zu erstellen.

AD = assistive devices
WF = welfare
DS = domiciliary support

OB = supportive care
AC = activating care
PC = personal care
VP = nursing
TR = treatment
HS = housing (as a consequence of care needs)

HS-needs = independent housing

Appendix 3: Key-figures (2004/2005)

(source :European Commission, 2007)

	Sweden	Netherlands
Population (x 1,000,000)	9	16
Population 65+ % of total population men	16	12
Population 65+ % of total population women	25	19
Life expectancy men	78	76
Life expectancy women	82	81
Fertility rate	1.8	1.8
Old age dependency ratio (15-64)	26	21
Old age dependency ratio (15-64) 2030	29	37
Old age dependency ratio (15-64) 2050	41	39
People 80+ not institutionalised: living with family	2.6	3.0
People 80+ not institutionalised: living alone	66.3	62.7
People 80+ not institutionalised: living as couple	31.1	34.3
People 80+ not institutionalised: help from children	39.4	30.9
Public spending on LTC (as % of GDP)	3.8	0.5
% Public dept as % of GDP	50.3	52.9
% Public expenditures on health care as % of GDP	6.7	6.1