Health systems and long-term care for older people in Europe
Modelling the interfaces and links between
prevention, rehabilitation, quality of services and informal care

Prevention and rehabilitation in long-term care

Dutch National Report

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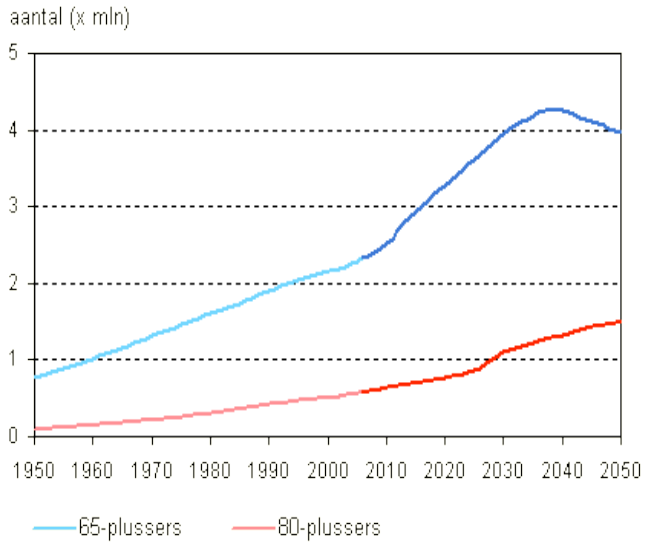
1 Introduction

1.1 Demographic situation

The Netherlands has 16,4 million inhabitants, 4,2 million being over 55 years and 2,4 million over 65 years old. It is estimated that by 2030 and beyond 22.4% of the population will be 65 and over and 2.3% over 85. By 2050 the percentage of over 85s will rise to 3.7%, while the numbers of those with diseases of ageing like Alzheimer's could more than double.

In the 1960s, approximately 10% of the population was over 65; this percentage has risen to 14%. It is estimated that by 2035 as many as 25% of the inhabitants will be over 65. At the same time the number of young people is decreasing. In the 1960s approximately 40% of the population was younger than 20 years old. In the 1990s, this percentage fell to 25%, while it is expected that in 2030 the under-20s will account for 20% of the total population.

Table 1 Number of inhabitants over 65- en 80 years old in the Netherland, 1950-2007 (CBS, Bevolkingsprognose)



In the coming years the proportion of elderly people will increase rapidly, and as result the number of elderly people with multimorbidity will increase as well. Multimorbidity is the co-occurrence of diseases, irrespective of the nature of their relationship. Multimorbidity occurs in all ages, but mostly in the elderly. Around two-thirds of all over-65s have two or more chronic diseases, and this percentage increases with age. Amongst people over 85 years of age, at least 85% have more than two chronic conditions.

Although the life expectancy of the average Dutch person continues to rise gradually and the extra life years are mainly healthy years, the Netherlands is 'only' half way up the European 'health league'. A lot of today's major causes of premature death and lost quality of life are the result of yesterday's lifestyles.

Paradoxical correlations have started to emerge between prosperity and health: as the nation becomes wealthier, people can more easily afford to indulge unhealthy habits, such as smoking or excessive eating or drinking. The way people behave is an important determinant of future health.

1.2 Long term care in the Netherlands

Care for older people in the Netherlands is still firmly rooted in a welfare state tradition. With a population of 16,4 million people around 9% of our GDP is spent on health care.

General Act on Exceptional Medical Expenses (AWBZ)

Under the General Act on Exceptional Medical Expenses, a specific national care fund has been created covering costs for long-term care. Within fixed spending limits, this budget finances care provision to people with a chronic illness, physical disabilities, learning disabilities, mental health problems and to the elderly population. This national care fund is financed through general taxation, with the government supplementing expenditure when necessary. Currently, the AWBZ is under revision. Step-by-step the provider-oriented system is reconstructed to better accommodate for the increasing social demand for consumer-led, needs-based flexible care services.

Traditionally there are three main targets groups in the long-term care of the Netherlands: elderly persons (somatic and demented), disabled persons (the vast majority of them being mentally disabled) and persons with psychiatric disorders. People who are in need for long-term care are – due to the nature of their problems and disorders – often living in residential settings. However a majority of those who are in need for long-term care manage to stay at home.

Table 2 Target groups in different care settings

Target group	*Residential care*	*Home care*
Demented elderly	55.000	17.000
Elderly with somatic disorders	109.000	210.000
Disabled	66.000	47.000
Persons with psychiatric disorders	23.000	61.000
Total	253.000	335.000

Eligibility for home care, residential care and palliative care is monitored by independent need-assessment boards. Local authorities and health care insurers are at regional level responsible for the audit of these assessment centres.

In comparison with other European countries the Netherlands has a very high proportion of the elderly population living in residential care settings. The government aims to relieve the growing pressure on care services by encouraging older people to continue living in their own home and by promoting arrangements for informal and community-based care. Encouraging independent living and respect for

personal lifestyles is also important to the older people themselves. Many senior citizens prefer to live at home as long as possible and, when necessary, to be supported by community care services.

Care at home

Professional community-based care at home encompasses all care, nursing, supervision and monitoring of people who require assistance at home. The care delivered can be provision of domestic services for a few hours per week, assistance with daily activities such as (un)dressing and washing, or the provision of nursing care. However, it may also be quite a comprehensive and intensive package of care, as is the case with the provision of palliative care at home.

Residential care

When describing the range of residential care services available to older people in the Netherlands, a distinction has to be made between nursing homes and residential care homes. What we define as nursing homes are services for those people with the need for intensive forms of (para)medical care and nursing. Older people suffering from Alzheimer's disease account for an increasing number of nursing home patients. Residential care homes meet the needs of older people who are unable to continue living in their own home, even when they would receive various forms of community-based care. In practice, it is increasingly difficult to distinguish between the needs of care home residents and nursing home residents. The boundaries between the services provided through these facilities become more and more blurred. Since 2001 the status of residential care homes has been redefined. New legislation allows them to offer also nursing home facilities. Thus the provision of care has become more flexible.

Since 1995 attempts have been made to develop a system through which a personal budget is allocated to older persons, people with a disability or their carers. It is then for them to decide what form of care they purchase and from which provider. This approach serves two objectives: clients are given a greater say in their own situation, while organizations are encouraged to compete in terms of quality and effectiveness. In the course of 2002 this system was fully implemented for home care services.

Table 3 Number of clients with care – in kind, personal budgets or both

Target group	*Care – in - kind*	*Personal budgets*	*Both*
Older people with dementia	70.000	1.000	1.000
Older people with somatic disorders	295.000	19.000	5.000
Disabled	85.000	19.000	9.000
Persons with psychiatric disorders	50.000	32.000	2.000
Total	500.000	71.000	18.000

Since the introduction of personal budgets (cash care allowances) in the nineties the number of clients with personal budgets did increase. However the number of those who are entitled to "care in kind" did not decrease.

Many statutory duties with respect to welfare, housing, social care and prevention have been handed to the local authorities in the Netherlands. For example welfare services that are important in maintaining participation and enhancing opportunities for independent living, such as meals on wheels, personalized alarm facilities but also physical activity, leisure activities and cultural and community-based activities. That is also the case with transport, mobility, and the provision of wheelchairs and other mobility aids and financial assistance for housing adaptations.

1.3 Cultural context: attitudes to ageing/older people and their care needs

There is no formally set age limit for defining the category of 'senior citizens' in the Netherlands. People become eligible for a state pension upon reaching the age of 65, but certain employment contracts offer 'early retirement' opportunities. Most central government policies regarding senior citizens focus on the over-55 age group, whereas studies and agency based policies mostly focus on the age group of 65 and older.

In the Netherlands, as in other industrialized countries, many people have a more or less negative view of being old: old people are perceived as being no longer productive, often ill, depressed, lonely and unhappy. This stereotype also tends to influence how issues affecting older people are approached and tackled. In the Netherlands, several attempts are being made to stimulate a more realistic and diversified public image of the older age groups, and to attach more positive connotations to it.

Some senior citizens perceive the application of age criteria in legislation, rules and regulations as discriminating. In order to combat unfair and unlawful distinctions on the grounds of age, central government has created a national office on age discrimination. Furthermore there is legislation to counteract age discrimination.

1.4 Discussions about LTC/prevention and rehabilitation

The Netherlands' policy is the result of a dialogue between various key actors, such as statutory bodies, organizations and insurers responsible for the purchasing of care and organizations representing the interest of patients and senior citizens themselves. The government does play a central role in this process, at national as well as local level. At central government level, the Ministry of Health, Welfare and Sport (VWS) plays a key role. Efforts are made to establish a demand-driven rather than supply driven system of service provision. This has resulted in more tailor-made approach to service provision where providers collaborate to offer packages of care, which are designed to meet individual needs of service users.

Care for the elderly: concerning the quality if life
The State Secretary of Health, Welfare and Sport, Dr. J Bussemaker (2007)

"At the same time, I do not want to ignore the problems that this sector also has. …….These experiences have reinforced my vision that a radical change is required in the way policy makers think about clients. We have to get away from the business-based approach in which the client experiences a limitation, claims the right to care and then cashes in on this. This is an approach in which the government tries to manage the process in terms of indications, protocols or endless justification issues. Such an approach encourages both citizens and providers to behave in a calculating way. The 'right to care' appears almost more important that the way care is actually put into practice. Clients look for quality of life. I am convinced that good care can be achieved through a relationship between clients and professionals that is based on trust. More time for actual contact between clients and professionals can make a more than proportionate contribution to quality, so that is something I want to invest in. Within this relationship, clients will get the freedom to make their choices and wishes known and to engage in dialogue about these. In addition, professionals will get the freedom to offer good care, based on their skill and knowledge. The actual provision of care takes shape in this dialogue between clients and professionals. The government must have confidence in them and give them the freedom to determine the content of such a relationship and, at the same time, provide a basic guarantee of the quality of care. The sector has already made a big step in this direction by formulating its own, widely supported vision and a set of indicators for quality. Rewarding good quality provides an important stimulus to quality assurance. Attention to quality must no longer be a matter of choice; it has to be embedded in the core of the care process."……

"The care professional has lost his position as an expert. In the perception of the professionals, care has become the domain of managers. The image is that of a bureaucratic manager who does not focus on the professionals' welfare and quality of work; an image that does not apply to every manager. As a result of this position, the professionals feel overwhelmed by regulations and bureaucracy. Their care and attention for the client, based on their skill and knowledge, is given lesser importance than compliance with rules.

Answering for the level of quality of the care provided and for its outcome tends to be quite forgotten. My impression is that professionals are quite prepared to answer for the quality that they provide. In addition, they want the ability to control the quality of care back in their hands. Furthermore, they want their position as the client's confidant back, and the restoration of freedom to develop a good care relationship between the client and the professional.

The possibility for care professionals to reflect on their work and share their skill and knowledge with colleagues is a part of the work, and must be restored. It struck me that many things are done simply because 'that is how it is done', not because it is right for the individual client. A change in working attitude is needed. This is not possible without reflection by the employees themselves, nor is it possible without a dialogue between the professionals and the management."

1.5 Future developments in long term care

A number of starting points has been formulated to create a future-proof AWBZ which would have wide support. This must be an AWBZ that has returned more closely to its original objectives. The following lines of policy are traced out (VWS, 2008).

1. Improving the client's position

This long-term perspective must include a more central focus on the client. They are individuals who rely on the AWBZ and are often vulnerable. And there is also a group of people who may well be physically or mentally vulnerable but who are increasingly articulate and independent-minded. In both cases respect for autonomy and the dignity of each individual are essential.

2. Freedom of choice and variety of options for living

There is no wish to bring the market any further into the situation in the sense of competition between providers on the basis of unregulated prices. Diversity is to be encouraged. Clients must be able to choose how and from whom they receive their care. Care providers must have the space and encouragement to work effectively in this situation. Clients must be able to choose how they want to live. In an increasingly diverse society, not everyone wants to live in the same way. Care provision must take account of this, while ensuring that everyone has equal entitlement to care.

3. Improving the quality of care and encouraging innovation

The cabinet regards quality of life as an important principle. The client's perception is paramount: the human dimension and respect for clients' dignity. 'Normal' life must continue as far as possible, even for people who are heavily reliant on care. It is important that state-of-the-art care is available, that clients can easily and quickly access innovations provided by sufficiently well-trained staff.

4. Guaranteeing solidarity/financial sustainability

The way in which high-quality care is to be assured not only now but in the future needs to be clarified. This could involve tightening up the system by making changes to packages of care. Only then will members of society be prepared to fund mutual solidarity in the long term.

5. Reducing bureaucracy by improving the quality and simplicity of provision

Care provision and the relationship between clients and professionals must be as free from bureaucracy as possible. Organisations under the AWBZ, such as the claim assessment agency (CIZ), care offices and care institutions still have to spend far too much time, money and energy on coordinating different processes. Providing care to people who are vulnerable precisely because they are in need of care must be a personal process, based on trust. Care must be returned to the people. There is far too much bureaucracy burden at the moment. Simplicity and quality of implementation and decisions on care arrangements are the key to improving the system.

1.6 Chronic diseases and multimorbidity

More than 10% of the population in the Netherlands suffers from a chronic somatic illness; over 16% have to deal with long-term psychological disorders. In the Netherlands, chronic illnesses are defined as "illnesses which involve long-term or frequently recurring health problems." Common examples of chronic illnesses are chronic obstructive pulmonary disease (COPD), arthritis, diabetes and rheumatism. Less common examples include Parkinson's disease, multiple sclerosis, psoriasis and cystic fibrosis.

It is assumed that approximately half of all people suffering from a chronic illness experience considerable problems as a result. Three objectives form the basis for the public health policy which includes the chronically ill:

- increasing life expectancy
- preventing avoidable deaths
- improving the quality of life

The government's intention is to create a new long-term care and support system; a socially acceptable system which also meets the requirement that individuals and institutions should take on more responsibility for themselves. This system also should provide a powerful impetus for shifting the emphasis onto extramural care, and in doing so meeting people's wishes to continue to live independently in their own environment as much and for as long as possible.

Little is yet known about the growing group of frail elderly with comorbid problems (RGO, 2006). There is insufficient information on how the depletion of the mental and physical reserves in old age leads to frailty, as well as on how this process could be prevented, slowed down or stopped. Moreover, very little is known about the relation between frailty, comorbidity (having more than one disease at the same time), and the development of functional impairment, as well as about the possible ways to intervene in this process.

For patients multimorbidity becomes a real problem mainly if it limits daily functioning and if it leads to a loss of vitality (GR, 2009). In such cases, care providers not only have to ensure continuity and cohesion in the generally complex medical and nursing care, but they also have to prevent further loss of functioning and social participation. In this respect the co-occurrence of medical and psychiatric illnesses need special attention. Four areas need further development. The Health Council of the Netherlands is of the opinion that the current healthcare provisions are not adequately set up to deal with elderly patients with multimorbidity. In order to bring about integrated care for the elderly, development is required in four areas which currently fall short:

- Timely identification of health risks related to multimorbidity
- The management of an integrated provision of care for home dwelling elderly with multimorbidity
- The provision of diagnostic and therapeutic advice to GP and home care nurses by medical specialists
- The application of scientific knowledge about complex multimorbidity within the clinical setting.

The Health Council is of the opinion that regional agreements about care pathways for elderly patients with complex multimorbidity, in which these four issues are implemented, are required. These regional

agreements should involve all relevant professionals and organisations, as well as the insurers. To support such an initiative and to promote further development of the geriatric service, the Health Council has made the following recommendations:

- Improve the availability and accessibility of information. It is vitally important that the relevant care providers have easy access to accessible and up-to-date (electronic) patient records.
- Stimulate training on multimorbidity. Cross-disciplinary training modules have been found to be very useful in promoting interdisciplinary cooperation. The Health Council therefore recommends offering extra training on multimorbidity in an interdisciplinary setting, which is not only open to medical professionals (general practitioners, nursing home doctors, clinical geriatricians, geriatric internists, geriatric psychiatrists, surgeons, neurologists), but also to nurses, nursing specialists, paramedics and psychologists. As well as the subject-specific areas (such as ways to maintain health and promote recovery in elderly people, and medical options for typical old-age conditions), there should also be a focus in this training on care pathway coordination, on the collaboration involved in such a pathway, and on how to support those in the patient's immediate environment (informal caregivers).
- Stimulate scientific research. Research into the content and organisation of medical and nursing care for elderly patients with complex multimorbidity is particularly scarce. The Health Council therefore recommends developing a coordinated research effort which would fill the largest knowledge gaps. The Health Council endorses the recommendations from the Advisory Council on Health Research (RGO, 2006) entitled "Research into medical care for the elderly" to (1) stimulate the design of clinical research in a way that permits making inferences on interventions for the elderly, (2) to concentrate the research on the medical care of vulnerable elderly patients with multiple problems, guidelines for diseases in the elderly and healthcare organisation (3) to concentrate the research in cooperative associations between healthcare practitioners and research institutions.
- Ensure that the boundary conditions for the planned geriatric service are met. Setting up the planned regional care pathways and establishing effective coordination will, particularly in the beginning, require extra time and resources. To be able to continue providing the planned geriatric services, additional resources will also be necessary in the longer term.

The Advisory Council on Health Research and the Health Council recommend giving extra attention to research into prevention, such as instruments/methods for timely identification of complex multimorbidity, and into ways of supporting informal caregivers. Priority should also be given to research into the efficacy of periodic medication monitoring and the way in which patients are involved in the choices concerning their medication and other components of their treatment and care.

1.7 Prevention in the elderly: Focus on functioning in daily life

With old age come ailments, and often one or more chronic diseases. In this case treatment does not always mean cure, but often preventing worse, by combating and reducing the effects. This may require different care from what is currently being offered. With this in mind, the Minister of Health, Welfare and Sport asked the Health Council of the Netherlands how 'prevention and proactivity might play a

significant role' in the effective and efficient care for the elderly. This care must lead to, among other things, 'a decreased burden of disease, better functioning and less disability'.

The advisory report Prevention in the elderly: Focus on functioning in daily life (GR, 2009) outlines how these questions may be answered. It supports the focus on functioning in daily life, but points out that a great deal is still necessary if this intention is to be realised. Healthy ageing is a prominent theme in various national and international policy memoranda, plans of action and research programmes. This is not limited to maintaining good physical and mental health, but importantly also promotes a process that enables elderly people to live, and continue to live, lives of good quality, as independently as possible, and to continue participating in society. In other words, healthy and successful ageing is not just about preventing and postponing disease and death, but also about preventing disability and reducing dependency on care. Addressing these issues of functioning also serves the wellbeing of elderly people.

Why is it that people experience greater difficulty when performing regular daily activities – such as caring for themselves, shopping and maintaining social contacts – as they grow older? And why do elderly people experience these problems differently, even when their medical situations are largely similar? Of the partial causes that contribute to the occurrence and development of such limitations, chronic disease and physical and mental impairments are the most important. These become more common with increasing age. Personal factors, such as lifestyle, coping skills in dealing with disease and the motivation to remain socially active, also play a part. The same holds for environmental factors, such as socioeconomic position and living conditions. All of these factors are also closely interrelated (see model of the disablement process, ICF, WHO)

In order to fully utilise the potential for healthy ageing, a new perspective on prevention in the elderly is needed. Prevention of limitations to function is necessary in addition to prevention of disease. The Health Council calls this 'function-oriented prevention'.

This form of prevention is not focused on a specific disease and its consequences, but on a problem with functioning; it looks at activities that may prevent disability independently of or in addition to a disease-oriented approach through specific prevention of functional deterioration and limitations, strengthening the individual's potential for maintaining or promoting functioning in daily life, and influencing non-disease linked factors that threaten this functioning. For several diseases, no breakthroughs in prevention and treatment are expected in the short term, so function-oriented prevention is the only thing that may add to a better effect. Importantly, it may also limit the need for care.

The available knowledge of determinants provides a large number of potential starting points for function-oriented prevention; ultimately it is all about identifying which can actually be influenced positively and how. Explicit attention should also be given to influencing personal and environmental factors, not only as determinants for functional limitations but also as sources of motivation for functioning independently in daily life. Examples include general programmes for self-management, stimulation of self-confidence and safety, and improvements around the house. In more general terms, prevention of disability – depending on the nature of the problems – will have to encompass a narrower or broader scale of integrated measures, ranging from medical treatment and rehabilitation to support with activities, devices, care facilities and modifications to the physical and social environment. The

function-oriented perspective should also play a greater role in care-related (tertiary) prevention than is currently common.

With the advancement of years the differences between elderly individuals are considerable. At one end of the spectrum is the active, well-off elderly person, at the other the vulnerable geriatric patient. Between these two extremes lie a multitude of profiles, depending on functioning, burden of disease, vulnerability, and the corresponding complexity of care demands. The essential precondition for successful prevention is to tailor the desired goals and planned measures to the individual or target group. Methods to determine risk profiles and identify at-risk groups are essential in this process. A validated, coherent instrument for this does not yet exist, but tools are available for individual elements. The heterogeneity of the elderly population is reflected by the gains prevention may achieve. In healthy, active elderly people, maintaining health and participation will be the primary concern. It is important to address the need for functional recovery immediately in the event of temporary functional deterioration. For vulnerable geriatric patients, the focus will likely be on wellbeing rather than functioning in daily life. The groups in between will benefit from a variety of forms of prevention focused on maintaining function, depending on their specific risk profiles.

The Health Council note that we know a great deal about the determinants of limitations and dependency on care, but that knowledge of the effectiveness of preventive interventions is fragmented, heterogenic and still lacking in a variety of areas. It is the opinion of the Health Council that the following general and specific themes deserve a place on the research agenda:

- It is important that various determinants of functional limitations be mapped out systematically. Explicit attention for psychosocial factors is needed. Additionally, there is a need for operationalisation and validation of measurement instruments for functioning in daily life.
- As a follow-up to the study of determinants, research into the development and evaluation of interventions focused on promoting independent functioning in daily life is needed.
- The best way to draw up risk profiles in order to determine the best target group must also be evaluated.
- The necessity, effectiveness, efficiency and most suitable target groups must be assessed for screening programmes targeting functional deterioration.
- Research into organisational design of interventions is crucial, including the examination of the factors that contribute to effective implementation. Potential forms of cooperation between primary and secondary care deserve special attention.

These themes can be implemented as part of the Nationaal Programma Ouderenzorg (National Programme for Elderly Care) in the Netherlands. However, the crucial development of knowledge in this complex field demands a longer term programme.

There are numerous indications that there are gains to be made in this broad preventive field, but the Health Council feels all parties need to do their part. A proactive stance should be expected from care professionals within and outside the medical sector. This means they must actively identify the risks elderly patients run of a cascade of functional deterioration and the associated care needs, by looking beyond the boundaries of their own discipline. Primary care plays a key role in this process, particularly regarding elderly patients whose independent functioning in daily life is threatened or limited. Elements that deserve attention include:

- Profiles for vulnerability and functioning: map risk factor clusters, taking into account an individual's physical, mental and social status.
- Interventions and organisational structures: analyse the competencies required on medical and non-medical levels to help elderly individuals with certain risk profiles. Determine the best management approach through experiments.

The Health Council recommends explicit attention to functioning in daily life in the further creation of professional treatment guidelines. Education and training must take the lead in strongly promoting the perspective on prevention in the care of the elderly. However, guidelines, daily practice, educational and training also require greater insight into the effectiveness and efficiency of preventive measures and facilities, with indicators for functioning and wellbeing as outcome measures. It is up to the government to stimulate a long term research programme in this area. That government will also have to address involved parties, from umbrella organisations to professional groups, to encourage them to implement preventive measures of proven value. Results require investment in all areas: knowledge, professional development, organisation, legislation and regulation, financing, and last but not least, actual involvement of the elderly themselves.

2 Practice of prevention and rehabilitation

In the Netherlands, prevention and early tracing of life-threatening and chronic diseases is accomplished by immunisation and screening programmes. Apart from classical prevention, the policy also aims at the improvement of public health.

The following prevention methods can be identified:

- Prevention of diseases by immunisation, screening and medication. These methods aim to prevent individuals from sickness or to trace diseases at an individual level.
- Health protection by developing and enforcing laws and legislation (for example on smoking in public spaces), people are less exposed to health threatening circumstances.
- Health promotion by offering general information and tailor-made advises and the creation of social and physical surroundings that stimulate healthy behaviour.

A strong focus on prevention is the key to establishing health. By tackling issues such as smoking and obesity, massive healthcare costs in the future can be saved. Measures such as awareness-raising on healthy lifestyles, screening and legislation cost relatively little and can trigger important savings. Being overweight, for example, is a rapidly growing problem. The combination of lifestyles that involve less exercise and excessive eating habits is creating weight problems for vast groups in the Netherlands including the elderly. Overweight is associated with diabetes type 2, an elevated risk of cardiovascular disease and premature death. On average, an obese person lives 4½ years less than someone of a healthy weight. The patterns of alcohol use and smoking in the Netherlands also give cause for concern.

Dutch adults are among the heaviest smokers in Europe, and the nation's young people among the heaviest drinkers. There is a growing percentage of heavy drinkers in the older population.

2.1 Forms of prevention

Preventive care is the term applied to the body of measures, employed within the health care sector and elsewhere, whose aim is the protection of health through the prevention of disease and other health problems. Within this definition, it is possible to categorise preventive care on the basis of criteria such as the extent to which the intervention is unsolicited, whether intervention is collective or individualised, and the extent to which intervention is aimed at healthy people or at those with health problems. Subdivision can also be made on the basis of disease stage, the extent to which individual behaviour is addressed, and the nature of the activity involved. The various ways of categorising preventive care are based on different dimensions.

Subdivision on the basis of disease stage is common: *primary prevention* involves removing or reducing the causes of disease, risk factors and exposure to them; *secondary prevention* consists of the identification and treatment of risk factors and predispositions; *tertiary prevention* entails monitoring existing disease and preventing complications. A more recent approach to the categorisation of preventive care, which was used in the CVZ's report (2007), focuses on the structure and funding of the care and distinguishes between *universal, selective, indicated and care-related* interventions. Selective prevention is aiming at groups at risk, people with (chronic) illnesses and specific health problems are target group for indicated and care-related interventions.

2.2 Health policy for the elderly at local level

Health policy is increasingly important at the municipal level. Nevertheless, further improvements can be made. Many municipalities have problems implementing their plans. Numerous municipalities have insufficient insight into the local health situation of the older population to enable them to define appropriate priorities. Not enough use is being made of measures whose effectiveness was proven (IGZ, 2005). In the implementation of local policy, the municipal health services (GGD'en, which are owned by individual municipalities or groups of municipalities) play a key role. However, an increasingly important part is played by home care organisations, which were traditionally responsible for caring for the elderly and people with chronic diseases.

The municipalities can play a vital role the local level directing and encouraging the relevant actors to cooperate. Parties active in the field of prevention for the elderly population include the home care organisations, mental health care organisations, and municipal health services.

In the field of public health, there are specific measures aimed at providing more effective care for elderly in the lower socioeconomic groups and for older people in ethnic minorities. The aim is to include measures such as helping people to give up smoking, providing physical exercise courses, etc. Structured approaches are also being developed for people suffering from chronic illness.

2.3 Quick scan preventive care for older people in the Netherlands

Very recently Vilans carried out a quick scan on preventive care for the elderly in the Netherlands on the ministry of VWS' order (Schippers et al., not yet published). The reason for this research project is a new law that is accepted in the Dutch parliament on public health care in the Netherlands. Older people are a new target group in this law. The municipalities will be responsibility for preventive care for elderly people.

We will present here some of the results of this project. The notion "prevention" is used in a broad sense: physical, psychological and social aspects of functioning of older people are taken into account. Part of the research was an inventory of the preventive activities for elderly people on local level. The results show that, in the category "addictions", there are no special programs in the Netherlands aiming at the elderly regarding prevention of alcohol misuse, the use of narcotics and cessation of smoking. Nevertheless there are activities for people with chronic diseases as COPD and cardiovascular diseases to help them to stop smoking. For these target groups there are also specially designed courses and different forms of counselling. For people with chronic diseases and older people at risk for falling there are courses and forms of (psycho)education to reduce the use of tranquilizers and sleeping medication.

In the category "healthy lifestyle" we asked for activities to reduce overweight, to stimulate physical activity and healthy nutrition. In this category we found many different activities aiming at the elderly as target group. Special target groups for these activities are frail elderly, elderly with chronic illnesses, older carers, elderly people with low incomes and older migrants. As interventions we found different kind of individual approaches and group courses to stimulate healthy life styles, often combining physical activity with information about healthy (and affordable) food. Examples of interventions in this category are the Groningen Active Living Model (GALM), Big!Move, Flash and Health and vital for Turkish elderly .

In the category "safety" we asked for prevention of falls, the use of domotica and polipharmacy. Here we found different evidence based training programs to prevent falls like A Matter of Balance aiming at people who were at risk for falling, elderly people (75+) living at home and people with chronic diseases. Some municipalities were active in promoting the use of domotica, especially for monitoring elderly persons living alone. To reduce the use of all kinds of medicines there are workshops for elderly people with psychiatric disorders and home visits.

In the category "prevention of psychological problems" we found home visits for persons with a chronic illness, older carers and frail elderly with problems related to dementia, anxiety and depression. There is attention for the morning process of people who lost their partner recently. We also found evidence based interventions to manage depression and anxiety (Be down and brighten up, or Coping with depression), memory training and courses like Looking for the meaning of life.

In the category "social support" we found all kind of activities to stimulate contact between senior citizens and to prevent loneliness. Among them are facilities to eat together, telling each other life stories and buddy projects for homosexual elderly people and people with chronic illnesses. On the other hand there are different forms of support and courses for older carers.

In the category "participation" we found examples of ICT projects, like the internet community 50plusnet, meeting centres, buddy projects, courses aimed at giving meaning to life in old age (In anticipation of the golden years, and Successful Ageing) and the stimulation of elderly people to become active as volunteers.

In the category "self management" we found courses for people with chronic diseases to deal wit their illness, home visits by professionals or volunteers in the role of councillor or advisor for frail elderly and Health Centre for the Elderly (Consultatiebureaus voor ouderen, see box 1).

Conclusions

The overall conclusions are (Schippers et al., not yet published):

- A wide variety of preventive activities and interventions is available for older people on a local level
- The supply is fragmented, in some areas there is an overlap, in other categories there are gaps
- Not all activities and interventions are specially designed for older people or for special target groups of older people at risk
- In many cases there is evidence of the effective and cost effectiveness of the interventions is lacking
- It is hard to reach the target groups at risk. This applies mostly to older people with low incomes and older migrants
- The financing of preventive activities comes from different sources (AWBZ, Wmo, Wvw, other funding, contributions of older people themselves and other funding)
- The municipalities will be able to play their role in coordinating public health care for the older people is they manage to create a leading position in this field
- It is important to involve older people in set priorities and developing plans for preventive activities on local level to tailor the supplies to the needs and wishes of target groups

Box 1: Health Centres for the Elderly

Type/scope:
A Health Centre for the Elderly is a consultation centre in which several social, life style and health aspects are addressed. The Health Centres for the Elderly are situated in several cities in the Netherlands. Health Centres have been set up as projects in almost every province in the Netherlands. In many provinces several centres are operative. Some projects are in the pilot phase, others are already more embedded. Throughout the Netherlands these projects are known under different names, such as 'Consultation Centre for the Elderly', 'Elderly consultation', 'Preventive Health Check', or 'Senior Consultation'. The organisations involved are home care organisations, senior citizens' organisations and public health care organisations of municipalities

Background/aims:

- Preventing health problems of the elderly, on a physical as well as a mental and social level and reducing the negative effects of health problems in daily life
- Creating a process of awareness among elderly people with regard to their (health) behaviour and giving tailor made advice about healthy life styles
- Making it easier for the elderly to find their way to the available activities, facilities and services.

Content and method:

In most cases a community nurse is the consultant in the Health Centres for the Elderly. The consultation takes an hour; the follow up visit takes half an hour. A key question is: "How do you spend your day?" The aspects addressed in the consultation are: BMI, cholesterol, blood pressure, history of health problems, physical activity, nutrition, hearing- and vision impairments, cognitive, mental and social functioning and other issues, like, for example, problems of a overburdened carer.

In the consultation evidence-based are used to establish a sound model of prevention and health promotion for older people (Vilans, 2008). The main activities are:

- Making an assessment of potential health problems, cardiovascular problems, risks regarding falling and bone fractures, and psychosocial problems
- Providing individual advice based on the outcome of the assessment
- Showing elderly people the way to other health care organisations
- Follow-up and evaluation.

Target groups

The target group of the Health Centre for the Elderly in one third of the projects are people over 50 years old. In the rest of the pilots the targets groups are older. Special target groups are older carers, socio-economically disadvantaged older people, older migrants and people with chronic diseases.

Results, evidence

More than half of the visitors of a Health Centre for the Elderly is over 70 years old (Schippers et al., not yet published). These visitors are mostly elderly people with some health problems. Frail elderly persons and the vital ones visit the Health Centres less often.

It is hard to reach the special target groups like older people with low incomes, migrants and older carers. It takes a lot of effort, time and money to reach them. Frequently seen problems are overweight (72%), high percentage of cholesterol (62%), high blood pressure (50%), too little physical activity (33%) and loneliness (30%).

The visitors are very satisfied about the Health Centres. They appreciate the personal attention and the individualised health advises. They visit the Health Centres because they want to know if they are healthy, what they can do themselves to age in a healthy way, but also because the threshold to visit a GP is rather high. The consultants have the opinion that a Health centre for the Elderly is complementary to the GP. 1. In 75% of the cases, the elderly persons follow the advice of the Health Centre and change their lifestyle and / or make an appointment with their general practitioner or a dietician. Until now there is no hard scientific evidence of the positive effects and the cost effectiveness of the Health Centres for the Elderly.

Current state

The number of Health Centres for the Elderly is steadily growing. One of the problems they face is the lack of structural financing. Another problem is the lack of cooperation with the GP's in some areas. There are signs of competition between home care organisations and the GP's regarding preventive care for the elderly.

More information www.vilans.nl or a.schippers@vilans.nl

2.3.1 Rehabilitation

Most of the rehabilitation for older people is carried out at home or in residential settings (nursing homes). Pilot projects encompassing the planning and funding of long-term care, needs assessment and service delivery have been set up in cities and rural areas to look at the consequences of building integrated pathways and service networks. A good example is the development and implementation of stroke units in the Netherlands. Another fine example is the National Dementia Programme. In Rotterdam, there are experiments with multiagency transmural care where care is provided to terminally ill patients within their own homes. The care package involves a community care team (GP, community nurse, home care worker, et cetera), one person designated as the care manager, a reserved bed in a nursing home (as a last resort when needed).

2.3.2 Intermediate care

Intermediate care is not a special category or form of care in the Netherlands, neither is there a special form of funding available for intermediate care. Nevertheless there is short term care in care hotels or nursing homes (for rehabilitation after knee or hip surgery or for stroke patients), acute care beds in residential care homes (so called “sickbays”).

Form of respite care to relieve family members are available in day care centres, day care or night care in nursing homes, but also in so called “care farms” mostly used by persons with dementia or psychiatric disorders.

2.3.3 Hospital care

Stroke units are well implemented and established in the Netherlands. Bigger hospitals in the Netherlands do have geriatric departments and policlinic facilities for out door patients with dementia (geheugenpoli). In the hospital is special attention to prevent the onset of a delirium in older persons that are ill or need an operation.

3 Description of the ‘good practice discourse’

Evidence-based prevention and health promotion is an important concept in the Netherlands. The choice for an intervention must be based on its expected effects. However, it is not easy for prevention and health promotion to meet the criteria of evidence-based practice. There is a lack of research in the field of prevention. To stimulate the effectiveness of prevention and health promotion, the NIGZ together with practitioners, developed the Preffi. The main objective was to develop a list of guidelines for practitioners to improve prevention and health promotion programmes.

Preffi 2.0 consists of 8 clusters that have their origin in theory and practice. Each cluster is subdivided into a number of criteria that can be scored as 'weak', 'moderate' or 'strong'. With these scores interventions or programs can be given a report mark. Based on these assessments, points for improvement can be identified and actions can be formulated. The Preffi criteria are:

- Contextual conditions and feasibility
- Problem analysis
- Determinants
- Target group
- Objectives
- Intervention development
- Implementation
- Evaluation

The RIVM has established a Healthy Living Centre. This centre will be a point where supply and demand can meet in the field of health information; it will also manage the supply of behaviour-influencing methods and work to achieve better cooperation in the field of prevention and health promotion. Better

organisation of the available knowledge will enable the professionals working at the municipal health services and elsewhere to focus on tailoring knowledge to their professional needs and on good-quality knowledge application. This should reduce the proliferation of standalone projects and the constant "reinvention of the wheel". Local innovations that prove to be promising should be quickly disseminated across the country.

The preventive care programme of ZonMw (organisation for health research) contributes to the expansion of knowledge about preventive care and preventive care initiatives. The programme focuses on the development and application of effective measures, and on efficiency, effectiveness and implementation. The gaps in what is presently known about preventive care have been mapped out.

Alongside the need for better control of the knowledge management process, there is also a need for greater insight into the cost-effectiveness of various forms of intervention. Without such insight, it is difficult to formulate optimal programmes. In many cases, only some of the costs, benefits and effects are considered in the context of project evaluation, it is not known what effect measures have on particular target groups (e.g. low-SES individuals or older people) and further research is often needed in order to ascertain the circumstances under which general rollout is likely to prove successful. Trials involving interventions that have proved effective can yield further information about viable investment in preventive care.

4 Special topics

4.1 Social inequality: equal access, age, gender and diversity issues

In the Netherlands, the less well-educated have a life expectancy that is more than two years below the national average. They also experience an additional five years of ill health in later life, on average. Health inequalities in the Netherlands are relatively small, compared with other countries. By Dutch standards, however, the differences involved are substantial. The health situation for ethnic minorities is slightly worse.

Poor health is, to some extent, avoidable. The necessary steps can be taken by individuals, care providers, employers, schools, local authorities, and the government. The government has put in motion measures aimed at helping to reduce socio-economic deprivation in areas such as participation, a healthy living environment, and the protection of low-wage earners. Government policy places special emphasis in the approach to strong communities.

Little clinical research on the elderly is carried out, due partly to the fact that the elderly are often excluded from research programmes for reasons of methodology. Because older persons are often excluded from clinical trials, many of the guidelines for the elderly have insufficient validity. Moreover, many elderly patients suffer from more than one disease but guidelines for the treatment of these different diseases are sometimes incompatible or difficult to reconcile.

Immigrants are more likely to provide family care giving, but they risk their position in the labour market as a result. Attracting immigrants to voluntary work demands an extra effort but repays double, because it also has an integrating and emancipating effect. It is important that local authorities and care providers familiarise non-natives with family care giving support in order to prevent non-native women from missing out on educational opportunities or chances in the job market.

4.2 Involvement of older people in developing prevention and rehabilitation

The Health Council emphasises that elderly people can and must play an active part in defining the goals and form of preventive activities. This applies at all levels: from daily practice to government policy. There may well be tension between the propagated promotion of health and social participation on the one hand, and on the other hand the potentially differing desires among elderly people in the face of changing priorities that gain importance as they approach the ends of their lives. Preventive policies should be careful to take this into account. Also in the development of professional guidelines the relevant professional groups and groups representing the interests of patients or clients must both have their say. It is important that professionals tailor their actual daily practice to the needs of individual patients or clients.

The Health Council feels a client-centred approach and tailoring to the actual needs of the elderly individual must take a central role in the design and implementation of concrete preventive activities. Elderly patients, by learning to deal with all manner of aspects of disease and (potential) disabilities in a individual manner, can contribute to the maintenance of functioning independently as well as to the effectiveness and efficiency of the care provided. Empowering elderly people to sustain this active role is an important social development. Even if an individual's ability to make an active contribution diminishes, determining and realising personal goals remain of major importance.

4.3 Quality assurance

In collaboration with health care insurers, central government sets the quality framework for services as provided by private not-for-profit organizations. The Health Care Inspectorate, which is linked to the VWS Ministry, audits the quality of residential and home care provided to senior citizens.

The Health Care Inspectorate protects and promotes health and healthcare by ensuring that care providers, care institutions and companies comply with laws and regulations. The inspectorate makes impartial decisions and reports on request and at its own initiative to the Minister of Health, Welfare and Sport.

The Health Care Inspectorate acts in the public interest and concentrates mostly on problems that members of the public are unable to assess or influence themselves. People must be able to rely on the quality and safety of care and products. The mission focuses on patient safety, effective care and care that is patient orientated.

4.4 Informal carers' needs and contributions to LTC

Family carers and volunteer caregivers make an important contribution to long-term care. They contribute time, quality and attention that professional carers often cannot provide or cannot provide to the same extent. It is anticipated that in the Netherlands greater demands will be made in the years to come on informal care (care provided by family carers and volunteers) as a result of developments such as the increasing ageing of the population, higher thresholds for the allocation of professional care and labour market problems.

Various national and international research studies have shown that no shortage of informal carers should be expected in the Netherlands if present circumstances remain unchanged over the next 5-10 years. If the present trend continues, supply may even outstrip demand. Some observations however need to be made. First of all it is possible that circumstances will change (for example, due to the continuing extramuralisation of care, budgetary restrictions and labour shortages). In addition, there are two competing policy aims that could have negative consequences; namely, an increase in the participation of women and the elderly in the labour market, and greater demands on informal carers. If the government wants to achieve two competing policy goals, namely greater participation in the labour force by women and the elderly and a stronger appeal to the deployment of family carers and volunteers, then this demands that bridges be built between work and care.

Formal and informal care badly need each other and will have to accept each other as partners in the care process. It is important that the family caregiver and the professional carer collaborate from the needs assessment stage onwards, supplemented on occasion by volunteers. Regular communication, harmonisation and task allocation (as well as a shared vision of the approach to care tasks) can improve the quality of care for the care recipients, prevent family carers from suffering excessive stress, and prevent or postpone expensive admissions. Family carers must not only be seen as co-carers. They are often also co-clients and need supervision and support. Supervising and supporting family carers not only benefits them, but also has a positive impact on the state of health of the care recipient. Local authorities should implement structural and financial measures for respite care within the framework of the Social Support Act (Wmo) by purchasing care from care providers and volunteers. This could be done, for example, via a voucher system for respite care.

Informal carers are an indispensable but vulnerable link in the care chain. With the support and guidance of professional carers, they can stick at their task for longer and the admission of the person in need of help can be prevented or postponed. We should encourage professional care institutions to give volunteer caregiving and family caregiving a structural place in their quality policy. This is necessary to guarantee a sufficient quality and quantity of informal carers in long-term care. Professional care has a great deal to offer informal care, such as advice, guidance, skills training and the sharing of knowledge. Conversely, professional carers also benefit from good communications with the family caregiver. This can be achieved via regular exchange of information, harmonisation of views and the sharing of care tasks.

5 Governance and financing

Dutch health care is divided into three 'pillars':

- The 2006 Health Care Insurance Act (Zvw) that set up mandatory private health care insurance, covering general practitioners, therapists, medication, hospital care and all the auxiliary needs.
- The Long-term Care Insurance Act (AWBZ), introduced in 1967 that covers all mandatory public long-term care insurance for nursing homes/homes for the elderly, home care and institutional care for frail elderly people and those with psychiatric disorders or physical disabilities. The cost and number of clients has grown considerably since 1967.
- The 2007 Social Support Act (WMO) run by local authorities and supported by national government to provide services for those in need.

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).

5.1 The Exceptional Medical Expenses Act (AWBZ, the long-term care insurance act)

In 1962 a plan was put forward in the Netherlands for an insurance scheme to cover the whole population against major medical risks. This scheme was intended to provide for the financial consequences of serious long-term sicknesses or disorders, in particular the cost of caring for disabled people with congenital physical or mental disorders and psychiatric patients requiring long-term nursing and care. The risk of incurring such costs is not particularly great, but nobody can bear such costs themselves; hence the term "exceptional medical expenses". The Exceptional Medical Expenses Act ("AWBZ") became law on 14 December 1967.

Insurance under the Act is statutory: everyone who meets the criteria spelled out is automatically insured and consequently obliged to pay the statutory contribution, irrespective of whether the individual wants to make use of the benefits provided by the legislation.
The AWBZ insurance scheme is funded by premiums paid by the people whom the scheme covers, by the State Subsidy and by personal contributions from care recipients. A Dutch person on an average income pays about € 320 a month as his or her AWBZ premium.

The health insurers operate the AWBZ scheme on their clients' behalf. The bodies that implement the provisions of the Act delegate various responsibilities – in particular the contracting of health care providers, the collection of patient contributions and the organisation of regional consultations – to regional health care offices ("zorgkantoren"). The Health insurance Board sets the budget and it is subject to the approval of the Minister of Health, Welfare and Sport. Each health care office carries out tasks in a particular region.

In the field of health and social care provision, central government has a key role in rationing services, in providing guidelines and regulations, and in setting budgets. This manifests itself in the annual allocation of financial resources distributed over the various care sectors and regions.

The bodies that implement the AWBZ have a "duty of care" in that they are required to ensure that their clients can obtain the health care to which they are entitled to. To this end, the bodies or the health care offices they engage enter into contracts with health care providers and institutions. These contracts regulate the volumes of health care services that will be provided.

Eligibility

Before a person can qualify for care under the AWBZ, it is necessary to establish whether care is required and what type of care and how much care is needed. This 'indication' is issued by an organisation called CIZ. CIZ is an independent organisation responsible for determining impartially, objectively and thoroughly what care is required. The client has the choice of receiving his/her entitlement as care in kind, or in the form of a personal care budget; a combination of the two is also possible.

Care in kind is the provision of indicated care directly to the client by a health care provider that is contracted to provide such care. A person who is entitled to care does not have to obtain all his/her care from the same provider; he or she may receive some of his/her care in kind from one provider and some (also in kind) from another provider.

A person who is entitled to care under the AWBZ can opt not to take care in kind, but to receive a personal care budget. The budget is a sum of money awarded to the client to enable him/her to purchase care independently. However, the budgets are available only for certain functional forms of care, such as nursing, general care and guidance; they are not available for treatment or institutional accommodation. The latter forms of care are always made available in kind.

Someone who has been awarded a budget is free to choose when and from whom they obtain care. Many budget recipients like receiving assistance from a particular carer whom they choose themselves and who does not change from day to day. In many cases the carer will be a personal acquaintance, such as a neighbour or friend, but the client is also free to use the services of a health care organisation. Obligations are also attached to the budget. Requirements include procurement of a responsible standard of care and the discharge of regular financial accountability to the care office.

Personal contribution

For most types of care under the Act, clients are required to make personal contributions towards the costs. The size of this contribution depends on the client's income and domestic circumstances (whether he or she lives at home or in an institution). If the client is receiving a personal care budget, the personal contribution is deducted directly from the budget.

Care entitlements under the Act

Assistance is available only if the CIZ has decided that the insured person is in need of a particular type of care. The entitlements that exist under the AWBZ have been defined in terms of functions. The focus

is now on the needs of people entitled to care rather than on the available supply of care. This change in emphasis is expected to pave the way for providing customised care. The need to switch from a supply-side approach to a demand-side one came about as a result of a changing society in which people increasingly voice their wishes and want to organise their lives in the way they see fit. Another basic principle of the AWBZ is that people should continue to live at home for as long as possible. They can receive care either in the home or at a healthcare institution.

Six broadly-defined functions create considerable freedom for arranging indicated care in consultation with a care provider. They are:

- Personal care: e.g. help with taking a shower, bed baths, dressing, shaving, skin care, going to the toilet, eating and drinking.
- Nursing: e.g. dressing wounds, administering medication, giving injections, advising on how to cope with illness, showing clients how to self-inject.
- Supportive guidance: helping the client organise his/her day and manage his/her life better, as well as day-care or provision of daytime activities, or helping the client to look after his/her own household.
- Activating guidance: e.g. talking to the client to help him/her modifying his/her behaviour or learn new forms of behaviour in cases where behavioural or psychological problems exist.
- Treatment: e.g. care in connection with an ailment, e.g. rehabilitation following a stroke.
- Living, services and care/treatment: some people are not capable of living independent lives, but require, for example, sheltered housing or continuous supervision in connection with serious absent-mindedness. In other cases, a client's care requirements may be too great to address in a home environment, making admission to an institution necessary.

5.2 Sustainability of the system

In the last ten years the financial growth of the AWBZ was far greater than could be expected based on demographic developments. This was leading to the question of affordability and maintaining solidarity. Since sustainability is clearly at stake, changes are necessary in order to achieve that long-term care can remain accessible, of high quality, and affordable. The increase of the cost of long-term care has a cumulative character.

Table 5 Costs, number of clients and premium AWBZ

	1968	*1998*	*2008*
Costs AWBZ-care (milliard €'s)	< € 1	€ 12,8	€ 20,5
Number of clients	Circa 55.000	almost 900.000 (or almost 500.000 excl. psychiatric care-extramural)	almost 600.000
Premium AWBZ	0,41 %	9,60%	12,15%

Measures to guarantee the sustainability of long-term care have been taken in two ways. The first is to increase the insight in what care is provided under the AWBZ. In the course of time all kinds of care, welfare and other means were provided that had little to do with the original intention of the AWBZ. By making transparent what was provided for which groups, the choices could be made when people were entitled to AWBZ care and the government would step in. Currently a rearrangement of what care people are entitled to is made by redefining the responsibilities between government and the individual and his family on the basis of principles as "autonomy" and "participation". Three functions (supportive guidance, activating guidance and treatment) will be rearranged under two new functions: support and treatment. The new 'support' function will be limited. The current supportive and activating guidance functions have two aims at present: "autonomy" and "participation". The new support function will only address the first aim (autonomy).

A second way to ensure the sustainability of the AWBZ is to make the system more efficient. To get rid of the stimulus of budget maximising by care-foundations and to go to an output-based system in which there is not too big a gap between supply and demand for care. That means redirecting the financial system and its incentives. Pay for demand, not for supply. This way the growth of the AWBZ should be in line with demographic expectations and there should be a relative decline, seen the cut back on what people are entitled too.

Labour market problems

It has been said the Netherlands needs a 'Deltaplan' – a large scale and multi-comprehensive approach combining different strategies – to provide sustainable care for its ageing population and shrinking workforce. If policies remain the same, the health workforce will not be able to cope: today about 13% of the total Dutch workforce are in the health care sector but by 2020 it will take an estimated 25%. There are three possible solutions:

Reduce the need for care

Prevent diseases of ageing that require care, such as heart disease or high blood pressure by encouraging a health lifestyle. Give more support to informal care and with a growing number of people (mainly women) combining caring for an elderly relative and a career, introduce legislation to make it financially easier to combine work and family care.

Expand the use of new technologies, such as ICT, to aid caring at a distance and for research into diseases such as Parkinson's. Decentralise administrative and executive policies, using the example of the Dutch Social Support Act (WMO) which transferred social support responsibilities from national to local level, simplifying the administration and cutting costs.

Improving labour productivity – 'Work smarter, not harder'

Promote new technology, and follow the example of the Dutch Ministry of Health, Welfare and Sport, which in 2008 set up a commission to promote this (ZIP). Innovate at work by introducing new work routines, dividing tasks between medical professionals and health care workers and introducing job differentiation to make work more interesting.

Enlarging the health workforce

Recruit more workers by improving the image of the sector; offer practical learning and work experience for students in care institutions ('stages'); make special funding available for health care specialists so they can rise up the career structure and target new groups – such as less educated youngsters – to consider health care as a career.

Keep people at work and stimulate them to work more, by enhancing the attractiveness of the sector, reducing work pressure, offering more flexible work schedules for those with children or older relatives, and an inspiring work climate, with opportunities for job advancement. Research indicates that work pressure is by far the strongest factor leading to drop out. The Dutch government has introduced policies to discourage female health care workers over 50 leaving, which has happened in the past, seriously depleting the work force. Reduce the 'part-time factor' in care work and encourage more full-time work.

Working until retirement and pension

In the past people were encouraged to retire before age 60 to create jobs for young people. Today the Dutch government is creating financial incentives to encourage people to continue working, is redesigning work patterns to accommodate older people - for example reassigning physically strenuous work to younger people and is increasing job differentiation and creating more senior position for older workers. At the same time the Dutch pension age is being raised from 65 to 67, although some employers complain that older workers are more expensive.

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7 Appendix: 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
Domiciliary services			
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	
Intermediate care			
	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		
Residential services			
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		