interlinks

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

Developing and ensuring quality in long-term care

Netherlands National Report

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Contents

1 Introduction

1.1 Health care organization in the Netherlands

The public-private mix in Dutch healthcare

Health care in the Netherlands has a public-private mix of provision and insurance. The system can be characterized by a mixture of steering mechanisms: from government steering, to professional/clinical and self- governance, and the market mechanism. This means that there is a public-private mix at a system level. Central and local governments are constitutionally responsible for the quality, accessibility and efficiency of healthcare services, but dependent on privately owned organizations of providers and health insurers. These private organizations – on their turn – depend strongly on autonomous professionals with their own traditions, codes and regulations. Most organizations in this context can be characterized as hybrid organizations that have to deal with a variety of steering mechanisms. Most of them are privately owned, but serving public goals and using public means. They have to be responsive to the market, as well as society and government (Brandsen et al., 2005).

The introduction of regulated competition

Dutch government has gained a dominant role in regulating the health care system (Den Exter e.a., 2004). With the introduction of the Health Insurance Act in 2006, the health insurance system has been reformed. The traditional division between the mandatory social health insurance and private health insurance has been replaced by a single (private) health insurance covering the entire population, aiming to make health insurance less complex and strengthening solidarity. Another development is the extension of market competition in health insurance. Health insurers must compete on premiums, quality of care and type of policy, since all insured have the right to choose their own insurer and policy type on a yearly basis and all insurers are obliged to accept applicants. According to the new legislation, insurers must set a single flat premium rate for each type of health policy, and are forbidden to vary premium rates with age, gender or health risks. The government pays the premium for children under 18 and people with low incomes receive a government subsidy to maintain income solidarity (Maarse et al., 2006).

With the introduction of market elements, health insurers are encouraged to negotiate favourable contracts with healthcare providers to reinforce their position on the health insurance market. The legislation allows insurers to sign contracts with only a limited number of preferred providers, including specific agreements on prices and waiting periods. Also, since the government seeks to achieve that market competition improves the quality, efficiency and access to health care, public constraints have been introduced. Examples are the obligation to every citizen to purchase health insurance, and the centralized decision-making structure concerning the health care benefits package (which is being determined by government).

The role of transparency and quality assurance

Important conditions for regulated competition are the assurance of a level playing field between providers and insurers, adequate information and transparency about quality and efficiency, and consumer choice. The question is to what extent these conditions are and can be met in a hybrid context. In this report we focus mainly on the role of quality assurance in Dutch healthcare, which links directly to one of the crucial conditions of regulated competition in the Dutch context.

2 Quality assurance, assessment and management

2.1 History

Increasing attention for quality assurance

Four conferences (1989, 1990, 1995, 2000) were organized in the town Leidschendam on the issue of quality management in health care. Present were all parties that had anything to say in the healthcare field, i.e. professional associations, associations of (health)care providers, insurers, clients, the Ministry of Health and the Healthcare Inspectorate. Central theme was the issue of self-regulation and how this should be accomplished. The idea of a 'quality system' for healthcare organizations was developed in the first conference and taken up by the Ministry in the 'Quality Act' of 1996 and in tandem the 'Act on professionals in healthcare' (*Wet Beroepen in de gezondheidszorg*, BIG). Whereas the former regulates quality assurance of healthcare organizations, the latter is focused on individual professionals. Central in the Quality Act is that healthcare organizations are responsible for having in place a quality management system to assure and improve quality of care. Much discussion in the course of the Leidschendam conferences was focused at what such a system should look like. For the healthcare system as a whole, schemes for accreditation and visitation were developed, which led to the founding of organizations like the HKZ (Harmonization Quality Care organizations) and the NIAZ (Dutch Institute for the Accreditation of Care Organizations) and the development of accreditation and visitation methods (Klazinga et al., 1995).

The Leidschendam conferences were important in introducing a system-level, managerial approach to quality management in which quality assurance and improvement became a task, not only of individual professionals but of collective actors such as professional associations, and boards of hospitals. Before that time, quality assurance was mainly organized by external audits and monitoring by the Health Care Inspectorate (IGZ). Much literature of the time uses a 'modernizing' discourse in which quality management was to move away from a 'traditional' approach which is "marked by a medical perspective" towards the application of 'industrial' principles. At the same time, it was the field of (health)care itself that would have to do most of the work, not only in the actual improvement of care, but also in the development of standards and assuring that these would be met. The accreditation bodies – led by the 'parties' in the field of healthcare – would mostly be concerned with quality assurance of organizations and the development of accreditation schemes, whereas professional associations would organize visitations and develop clinical guidelines. The role of government was thought to be one of facilitating the process and assuring that the field would actually perform, that is, government would audit the auditors as it carries so called 'system responsibility'.

The foundation of the Health Care Inspectorate

During the time of the Leidschendam conferences, the Healthcare Inspectorate went through considerable changes. In 1995, the Health Care Inspectorate was founded by integrating the then Medical Inspectorate of Health, the Medical Inspectorate of Mental Health and the Inspectorate of Drugs followed by the integration of the inspectors responsible for nursing homes (Kingma, 2004). The new Health Care Inspectorate was well received in the field, yet internally conflicts kept arising as inspectors feared the loss of (regional) autonomy, the closing of their offices, and the rationalization of methods. Also, the three medical inspectorates had always been independent from each other, leading to different working methods and styles. In 1997, as a response to these problems, the Netherlands Court of Audit (Algemene Rekenkamer) decided to conduct an inquiry in order to reorganize the Health Care Inspectorate. The report was exceptionally negative towards the inspectorate. The main conclusions were that the Minister of Health would not be able to judge the quality of care on the basis of the information provided by the inspectorate, and that supervision by the Inspectorate proved to be insufficient for a number of crucial issues (Rekenkamer, 1999).

The Healthcare Inspectorate had to be equipped better and should improve its functioning. This was also needed by the more general Dutch healthcare reform of liberalization of healthcare services, the promotion of consumer choice and competition on quality of healthcare services. Several changes in the functioning of the inspectorate have therefore been implemented, although not all proposed changes have been effected. The growth of the Inspectorate for example has never come about; additional legal instruments, like the possibility to fine healthcare organizations, have not as yet been developed, and more standardized ways of working are introduced, based on “risk management” strategies (Politt et al., 2007).

2.2 Supervisory bodies

Tasks and working methods

Health care organizations annually deliver the data requested in the set of performance indicators to the Inspectorate. Also, each organization is expected to make its own data available in the quality report, which is statutorily required and must be accessible to the public. The Inspectorate responds with its findings to each organization individually and compiles a report of the collected data, which is also publicly available (IGZ, 2005). In 2007, a separate unit at the inspectorate was formed, the ‘Bureau for Transparancy on Quality of Care’ (*Bureau zorgbrede transparantie van kwaliteit*). For every sector of care, new performance indicators will be developed under the guidance of a steering group per (health)care sector in which all parties (insurers, professionals, clients, (health)care organizations, and the Inspectorate) participate. The new indicators should be ready in 2013, starting with medical specialist hospital care.

A second working method is intervention or crisis supervision in case of serious problems or calamities. In these situations, an in-depth investigation is conducted focusing on the cause of the problem, the consequences for the quality of care, and ways of avoiding recurrence in the future. Thematic supervision is a third method and encompasses matters that overarch individual institutions (IGZ, 2009b). Aim is to obtain a national overview of the effects of government policy or specific risks occurring in health care and to trace structural failures and problems in quality and safety. Last, public

health supervision entails gathering information about the health status of the Dutch population, especially vulnerable groups in society. Activities undertaken include the promotion of good mother and childcare, the promotion of a healthy life style, and supervising preparations in order to avoid disasters.

The overview of instruments and working methods of the Health Care Inspectorate makes clear that a few theoretical perspectives are being combined. First of all, we recognize a learning perspective which becomes clear in the effort that is put into tracing medical mistakes, improving working methods and quality over time. Next to that, we see a more hierarchical perspective of sanctioning and rewarding. Also introduced is a third perspective that put the clients/patients more centrally in the Inspectorate's focus, which could be called a more participative perspective. In other words, the Inspectorate's activities focus on different goals under different circumstances (IGZ, 2007).

However, the Health Care Inspectorate is not the only inspectorate controlling healthcare services. Since the introduction of the Health Insurance Act (ZVW) and the Health Care Market Organization Act (WMG) in 2006, supervision has also been rearranged. Multiple public and private supervisory bodies exist. These are described next.

Healthcare Authority

With the Health Care Market Organization Act (WMG) more competition has been introduced in the Dutch health care system. The Dutch government, however, still controls the public goals: quality, accessibility and affordability. The Healthcare Authority (Nederlandse Zorgautoriteit, NZa) is the supervisory body for all healthcare markets in the Netherlands and operate under political responsibility of the Minister of Health, Welfare and Sport and was established on 1 October 2006 (NZa, 2009a). Its tasks are laid down in the Act on Healthcare Competition (*Wet Mededinging Gezondheidszorg*, WMG) and the Healthcare Authority supervises both healthcare providers as well as insurers in the curative and the long-term care markets. Its tasks are to control total (macro) costs by funding healthcare providers and ensuring correct implementation of insurance legislation, and to pro-actively setting conditions for market forces to operate and enforcing these conditions. Aim is to provide consumers with accessible, affordable, and proper health care. This aim requires a proactive approach from the Healthcare Authority and therefore the Authority itself determines a large part of its agenda (NZa, 2009b). In a way, the Healthcare Authority addresses two of the other crucial conditions for regulated competition: the improvement of transparency on quality and efficiency, as well as improving the level playing field. This means that the Health Care Inspectorate and the Healthcare Authority – together – play a crucial role in assuring the realization of public goals in a system of regulated competition.

A combination of tools is used to achieve this, aiming at effective supervision in a light and proportional manner that allows an optimum amount of room for individual freedom. If possible, methods of (regulated) market operation are used to achieve efficient market behavior. Monitoring is used to outline developments in markets and submarkets; it provides the basis for forming an opinion on the use of tools on markets (NZa, 2009c). The Healthcare Authority also has an advocacy role, providing recommendations on request but also proactively about policy and regulations, in the interest of further developments of the healthcare system. It can further take action in individual cases, in case competitive conditions are distorted.

For supervision of compliance, a combination of proactive and responsive behavior is used. The Risk Analysis Model (RAM) has been implemented to provide systematic insight into those sectors and markets in which market developments need intensive or less intensive follow-up. Further, signals from the market are important for maintaining supervision. The Healthcare Authority is also developing a vision on how control tools are to be used by consulting market parties with regard to the annual work program. This also includes the consultation of clients and consumers. For the development of tools, the Healthcare Authority works with consultation documents, vision documents and policy regulations so that the market parties are involved in the opinion-forming process and to provide clarity regarding the way in which powers are applied. This increases regulatory certainty, which is of importance for a good investment climate in healthcare markets (NZa, 2009d).

Overall, as was the case with the Health Care Inspectorate, the Healthcare Authority either operates from a more hierarchical perspective in sanctioning market behavior and steering market relationships, or uses a more participative perspective when consulting stakeholders to create support for the Authority's activities, as well as a learning perspective in order to improve market behavior over time.

Other supervisory bodies

Both the Health Care Inspectorate and the Healthcare Authority collaborate with other supervisory bodies on the basis of cooperation agreements:

- The Food and Consumer Product Safety Authority (Voedsel en Waren Autoriteit VWA) protects human and animal health by monitoring food and consumer products to safeguard public health and animal health and welfare. Its main tasks are supervision, risk assessment and risk communication.
- The Labour Inspectorate (Arbeidsinspectie) monitors compliance with occupational safety and health legislation and regulation, and it investigates violations of worker safety, takes action and provides politically relevant information (arbeidsinspectie.szw.nl).
- The Netherlands Competition Authority (Nederlandse Mededingings Autoriteit, NMa) monitors fair competition and takes action against parties that form cartels and fix price agreements, as well as against parties that misuse a position of economic power.
- The Competition Authority also assesses mergers and takeovers in all sectors.
- The Dutch Central Bank (Nederlandse Centrale Bank) supervises the integrity and solvency of health insurance companies.
- The Netherlands Authority for the Financial Markets (Autoriteit Financiële Markten) has the task to supervise the behavior of financial institutions.
- Last, the Data Protection Board (College Bescherming Persoonsgegevens) supervises compliance with the Personal Data Protection Act.

Cooperation protocols between inspectorates

A lot of different public interests are at stake at the same time in healthcare. It is not only about the quality of care services, but also about the accessibility, efficiency, and solidarity in healthcare. Next to that, in a lot of cases social security and working conditions relate to healthcare, as well as environmental and hygiene issues. Besides, efficiency, financial solidarity and prevention of fraud are also at stake. Overall, a lot of different public interests are being supervised by different inspectorates and controlling bodies. The coordination of their activities, especially when different inspectorates have

to make judgments about the functioning of the same organization or the supervision of the same care services, is very important in order to prevent an increase in financial and bureaucratic costs and long procedures, but also in order to really weigh and prioritize the different public interests. Therefore, the Dutch government has developed protocols of cooperation in collaboration with these inspectorates. The Health Care Inspectorate, for example, has protocols of cooperation with the Healthcare Authority and the Food and Nutrition Authority. These protocols divide tasks and responsibilities, e.g. what kind of advice is given to each other in cases in which the quality of healthcare is at stake. They also arrange the exchange of information and expertise. In practice, these protocols are still being developed and have to be improved further. The Health Care Inspectorate further cooperates with the Netherlands Competition Authority, the Dutch Central Bank, the Inspection for Working Conditions, and the Environmental Inspection, however, without cooperation protocols.

One notable development is the development of the *Jaardocument Zorg* (Annual healthcare document) in which supervisory work together to coordinate both the questions they ask from healthcare organizations and the timing of those questions. This development is part of the overall governmental strategy to decrease the administrative burden on society.

2.3 Non-governmental quality assurance

Accreditation

Besides these public bodies, private bodies exist that supervise (helth)care providers. Among these are the two accreditation bodies that have been erected by the healthcare field itself (i.e. provider organizations, client organizations and insurers) and that are increasingly influential, if only because of governmental and 'market' pressure to get accredited. The two dominant organizations are:

NIAZ is the Dutch Institute for Accreditation in Hospitals and is a private accreditation body for Dutch hospitals (although other segments may participate as well) and was founded by three umbrella organizations (hospitals, medical specialists and university hospitals) and an accreditation organization. The 'Plan-Do-Check-Act cycle' is the basis of the NIAZ accreditation program (NIAZ 2009).

HKZ stands for *Harmonization of quality review in health care and welfare*, and is a Dutch initiative of health care providers, insurers and clients. Its mission is harmonization and accomplishment of quality management systems and external review of such systems. To achieve this goal, HKZ produces ISO 9001 compatible certification schemes for a variety of health care and welfare institutions. HKZ stimulates the implementation of these schemes. HKZ facilitates the Council of Experts in the Health Care Sector. All certifications are developed under the authorization of this council, which is acknowledged by the Dutch Board of Accreditation (HKZ 2009).

Other forms of Quality Assurance

Quality Framework for Responsible care: When care providers in the Netherlands wants to systematically improve their quality of care, they will look for a quality instrument or guidance system. For many organizations the search for an appropriate instrument or system is a long and difficult

process. There are many different quality instruments and systems developed and the differences between them are often little and unclear. Since April 2007, organizations can use the Quality framework for responsible care (QFRC). It contains measurable indicators that show if the organization provides responsible care. This QFRC is the development of two documents about the future of care: 'Towards standards for responsible institutional care' and 'Standards for Responsible home care'. In these documents client representatives, professionals, insurers and the IGZ (healthcare inspectorate) have prepared and documented their requirements for responsible care. The impetus of these vision documents is that there should be a coherence between clients, personnel and organization. Good care for clients is the central theme, but this can only be realized when staff members do their job well. And to deliver good quality of care the management must support and motivate their personnel en listen to what clients have to say. Care associations, professional groups and client representatives have come to an agreement on working nationwide with standards for responsible care. Responsible care is 'high-quality of care, which is effective, efficient, safe and client-oriented'. A control and check framework has been drafted to ascertain what is done in practice, to improve quality and to render an account of delivered quality of care. How quality should be assured and on which points is documented accurately, as well as the roles of management, client representation, inspectorate and insurers. Parties have also agreed upon the manner of accountability on the results of the checks.

PREZO gives a practical model for the daily work in care organizations and an instrument for managers to steer on performances. A new program targets on Responsible Enterprise: Audits can be performed to check on 50 performances so care organizations can achieve a (silver or golden) quality mark.

Next to these forms of quality measurement, also client and consumer organizations have become increasingly active in 'controlling' care providers, e.g. by collecting and publishing performance information. Insurers, which are private organizations in the Netherlands, also have become very active in collecting information on quality of care from healthcare providers, as has the media, which publishes annual rankings.

The CQ-index (Consumer Quality Index) is a standardized system for measuring, analyzing and reporting customer (clients) experience in healthcare. The system was developed by the NIVEL (Dutch Institute for research in Healthcare) in cooperation with the Department of Social Medicine of the AMC Hospital, funded by Agis, the Foundation Miletus (an association of insurers) and ZonMw. The CQ-index shows the quality of care from the clients perspective in a standardized way. The questionnaires provide insight in two things (website NIVEL, 2009):

- what do clients find important
- what is their experience with care

The CQ-index is a good example for the fact that in the past years we indeed want to know what clients experience and what kind of care they wish to get.

Figure 1 One Example of a question from the CQ-index

Indicator	The extent in which clients and representatives experience good mental support
CQ-index list	- Clients who live in the residential home - Representatives - Clients who live at home
Questionnaire CQ-index	Clients who live in the residential home 47. Do caregivers have enough attention about your wellbeing? 48. How often are you worried? 49. Do you feel lonely? 55. Do you feel at home here? Representatives 33. Do the caregivers have enough attention about the wellbeing of the clients?

Source: QFRC (2007)

Only external (accredited) agencies may work with the CQ-Index. The research takes place in accordance to the standards and guidelines of the *Centrum Klantervaring Zorg* (translation: Centre of Customer Care). A healthcare organization has to arrange this once every two years.

The information from the CQ-index can be used by:

- Clients, to choose a health insurer or health professionals;
- Client organizations, representing the interests of their members;
- Insurers, who want to buy good quality care;
- Managers and professionals, who want to improve their quality of care;
- The Healthcare Inspectorate (IGZ) and the Dutch Care Authority, who monitor the care in the Netherlands;
- The Ministry of Health, Welfare and Sports.

The CQ-Index is a substantial part of QFRC. The results of the QFRC are being showed on the website KiesBeter.nl (translation: choosebetter.nl). The intention of presenting these results is transparency of data and that organizations are stimulated to improve their quality of care (website NIVEL, 2009).

3 Nine questions to be answered

3.1 By what mechanisms is quality in the components of LTC assessed and ensured in the Netherlands?

Health care organizations can be visited by the Inspectorate (IGZ) in order to examine the safeguards that are in place to ensure provision of good quality care.

Figure 2 Components of Long Term Care (LTC) and availability of quality assurance

LTC	Inspectorate (IGZ)	Certification (HKZ)	Bench-marking	QFRC	ISO 9001: 2008	PREZO	NIAZ	NPA
Hospital	X						X	
Nursing home	X	X	X	X	X			
Residential homes	X	X	X	X	X	X		
Home care	X	X	X	X	X	X		
Social services		X			X			
GP practice	X				X			X
Mental Health services	X		X					

Short explanation of some abbreviations in the matrix:

- QFRC = Quality Framework for Responsible Care. It contains measurable indicators that show if the organization provides responsible care. The QFRC is obligatory to become a member of the Netherlands organization of Care Providers (ActiZ)
- PREZO = PREZO stands for performance in health care. It is an integral system for residential care and home care.
- NIAZ = Dutch institute for Accreditation in Hospitals.
- ISO = Certification by the International Organization for Standardization.
- NPA = NHG (Dutch GPs society) Netherlands Practice Accreditation (NPA) is an independent accreditation organization.

Some of these instruments are not only monitored by the inspectorate, but also used by insurers for commissioning / contracting.

To prioritize the inspectorate visits, a risk-based working method consisting of three phases has been introduced, in which each step along the supervision path acts as a filter to the next step: In the first phase, healthcare organizations report on their performance on the basis of a set of performance indicators; In the next phase, those healthcare organizations are visited by inspectors that show poor

performance on the basis of indicators (or, as is the case with acute care hospitals: all organizations are visited, but they are extensively asked on those indicators where they show poor performance); In the last phase, the Inspectorate will take measures to restore good quality of care and products. In all phases indicators for quality and output are crucial. A lot of effort is put into developing and improving quality measures and quality management. Performance indicators form part of the set of preventive research instruments that can be used for subsequent prioritization of supervision on the basis of risk assessment. Annually, a set of performance indicators concerned with client safety and effectiveness is presented to all Dutch health care organizations, except for specialized institutions, independent treatment centers, and private clinics with a limited health care package. The performance indicators are in line with similar developments in other countries and are based on information obtained from reference literature on international indicator projects and subsequently set in close cooperation with organizations of professionals and healthcare providers.

The Quality framework for Responsible Care (QFRC) to ensure responsible care was launched in 2006, on basis of an agreement of service providers, professionals and service users on what indicators should be used. This went together with a paradigm shift: not quality of care should be the final aim, but quality of life. Since 2008 there is an objective and widely supported comparable set of quality indicators available. The QFRC will improve transparency of care provision and may support competition on quality between providers. It will enable service users and commissioners to contract services based on quality and to monitor the quality of care. Each professional is committed to standards. There are standards for instance for handling problematic behavior of the client and use of safety measures. Also on organizational and professional level several guidelines are to be met, for example the guideline Dementia published by the Dutch Institute for Healthcare Improvement CBO in 2005.

3.2 What is assessed?

Accreditation, Certification, Benchmarking and Audits assess:

- Client's perceptions: satisfaction, knowledge, empowerment
- Outcomes for informal carers
- Service utilization (structure, process measures)
- Care workers' measures: satisfactions, sickness figures, drop out, education etc, qualifications.
- Clinical outcomes (not only in hospitals, but also in care homes and home care)

3.3 What are the incentives/sanctions to measure, ensure and/or improve quality in everyday practice. What are the barriers? How successful have they been?

The Healthcare Inspectorate (IGZ) promotes healthcare by effective enforcement of quality of care, prevention and medical products. The Healthcare Inspectorate examines and considers impartial, professional, diligent and independent of political affiliation or predominant healthcare system.

The QFRC must be incorporated and completed by every long term care organization in The Netherlands.

3.4 Is there a quality-policy for informal care/volunteers? If so, what are the general principles and measures?

Quality of informal care is a dualistic point on the boundary between private and collective responsibility. On one hand you can not compare the quality of professional care with the quality of informal care, but on the other hand there must be some kind of monitoring on the quality of informal care (MOVISIE, 2009).

There is no quality-policy for informal care/volunteers in the Netherlands. However, there is an increasing demand for such a quality-policy. The Dutch Association for Hospitals (NVZ) and several health professionals are very interested in the development of a quality-policy for informal care (MOVISIE, 2009).

3.5 Are there quality indicators (or will they be developed shortly) to monitor client pathways across services?

Indicators for integrated care

The Healthcare Inspectorate (IGZ) will determine in 2009 which set of data healthcare providers have to deliver in 2010 for integrated care. These sets concern four diseases: diabetes, COPD, heart failure and CVA.

Five indicators each (minimal data sets) must be pursued in the execution of integrated care for clients having one or more of the chronic ailments mentioned above. Healthcare providers who have a contract with an insurer are required to supply the data and for other organizations it will be on a voluntary basis. The IGZ expects to have a full set of indicators for integrated care in 2012. The set will be mandatory nationwide. For dementia there already two indicator sets have been developed. But both have no official status yet. The IGZ is aiming for the integration of those two sets in due time.

The QFRC contains just one quality indicator that monitors client pathways across services: *The extent to which clients or representatives experience consistency in healthcare services.*

3.6 Is cultural diversity a subject in quality management? If so, in what sense?

Diversity in the organizational culture of a care provider

In the past three decennia the clients in Dutch residential homes have been patronized too much by the personnel. Clients couldn't decide things for themselves because the staff members in the homes made decisions for them: for example what clients could do in their free time, what they could watch on television, how late the wake-up call would be. Self direction of the clients was taken over by staff and informal carers. This was believed to affect quality of life of the clients in a negative sense. Clients became passive and sometimes even depressed. Nowadays we want to give the self management back to the clients by making a care and live plan (zorgleefplan). Since January 1st 2008 care organizations in the Netherlands are obliged to make a 'zorgleefplan' for each client. By making this plan/document the organization will know what the needs of their clients are so the caregivers can connect with their wishes. The organization describes on behalf of the client how he or she wants to live and on what kind of support they can count from the care workers. By following the 'rules' of the plan the client can lead the life that he or she really wants (Website Zorgplanwijzer, 2009).

Speaking of cultural differences in the way working processes are organized and managed: these differ for instance between residential homes and hospitals. In a hospital more attention is given to improvements, quality, quality measurements and outcome indicators with regard to cure rather than care. There is a higher emphasis on outcome indicators rather than process and structure indicators. In a residential home care is much more important than cure. They focus on process and structure indicators. A few examples are; availability of good food and beverage, living space, and day-activities. Care providers look as well at outcomes, for example treatment of clients, change in behavior , or safety on medications.

Cultural differences of personnel

Care providers have more "color" nowadays. The number of personnel differing in cultural background is growing rapidly. The diversity of cultures brings about new challenges. Each culture has its own vision on dealing with the wishes and questions of clients in care. Working in a intercultural sense demands new approaches. This richness of multiculturalism deserves specific attention in the education and training of professionals in the care and welfare. A national policy on this item has hardly been developed up till now.

3.7 Who uses Quality indicators and for which purposes?

On Policy/strategy level

Example 1 :The QFRC contains measurable indicators that show if the organization provides responsible care. The QFRC offers the board of directors the opportunity to review whether the management is 'in control' on the quality and responsible care. Based on the results of the QFRC the board can speak with the management about how the results are translated to quality policy and quality improvements, the measures that are taken and the extent to which these improvements are actually achieved. QFRC is important for membership of the Netherlands Organization of Care providers.

Example 2: Commissioning gives care providers reason to assure quality of their services in their region and to pursue performance indicators. Also a regional network of providers can consider jointly to what extent they should measure quality in integrated care.

On Management/Organization level

Example 1: PREZO describes which activities of professionals and the organization can help to give the client responsible care. Also PREZO looks into which conditions are necessary to carry out those activities. For instance, organization X scores low on the quality indicator: 'Percentage of clients that suffer from pressure ulcers stage 2 t/m 4 that started in the residential care facilities/ during the care at home' (Quality Framework for Responsible Care/QFRC, October 2007).

The organization has to create conditions for the activities of professionals by:

- ensuring an adequate and competent staff
- ensuring appropriateness devices
- ensuring adequate method for information and communication
- organizing a cyclical secured care plan living system.

The organization monitors the effectiveness of these conditions on the quality indicator and if necessary sets in improvement actions (Care for Better program).

Example 2: Benchmarking is a good means for an organization that wants to compare their organization with other organizations and/or if they are looking for ways to develop their organization. Benchmarking is a management tool that by means of comparing performance aims to get a view of the coherence of all kinds results and performance, in order to learn and to improve them. It is also a tool to know how care is performing. For managers and supervisors it is a useful source of information and organizational learning.

On Professionals/Executive level

Example 1: The QFRC contains measurable indicators that show whether the organization provides responsible care. The professionals are actively involved in the preparation and execution of measurements for the Quality Framework. For example, to measure the quality indicator 'Percentage of clients that have experienced a fall incident the past 30 days' multiple sources must be used: the client file and the registration of faults and incidents (both are the responsibility of the professional). The QFRC is an important part of the work of professionals and connects with ambition of the professional to deliver responsible and good care. Results from the QFRC provide a basis for further discussion with professionals. In this discussion the results can directly be translated into concrete improvements and adjustments in programs and practices.

3.8 How financially sustainable are the approaches being adopted?

Costs involved for cross boundary approaches/activities are to be labeled in the near future. A new policy regarding chronic disease is being implemented in 2010. On several chronic diseases principles

and mechanisms of disease management are introduced as is a system of output funding across services. So-called care standards are to be followed and funds will given to those networks of service providers who deliver according to these standards. The Chronic Care Model (Wagner, 2001) is one of the leading models. It may be that dementia will be one of the diseases to be incorporated in this policy. It will be the first one that bridges several funding systems. Involvement of insurance companies, inspectorate and municipalities in new approaches in quality of integrated care will be necessary.

3.9 A brief (critical) evaluation of quality management in our country as well an appraisal of where quality management is heading to in our country

Rules and regulations

In the Netherlands a lot of different stakeholders, institutions and instruments are being used to inspect the quality of healthcare services. On the one hand, this has got to do with the division of tasks between central and local government bodies, which changes due to the decentralization of tasks towards local communities. On the other hand, this has got to do with the division of responsibilities between public, private and professional actors within the hybrid insurance-based healthcare system, which also changes due to the introduction of competition and market incentives. In addition to the existing supervisory bodies, we see benchmarks, monitors and accreditation procedures being developed from within the sector itself (private, bottom up, self regulation), but also individual health care insurers start to monitor aspects of quality. In all, decentralization and liberalization do change the roles in healthcare and increase the amount of public and private actors and instruments involved with the supervision of quality. This also affects the role of the Health Care Inspectorate.

The national law on quality sets the general (minimal) goals for providers, insurers and professionals in healthcare. The activities of the Inspection are steered by these regulations. Yet, a variety of internal and external stakeholders and supervisors – such as politicians, clients, ministries, inspectorates and boards of trustees – also address aspects of quality assurance. With the decentralization and liberalization a growing set of public and private organizations are involved with quality assurance. Next to the variety of stakeholders, a diversity of instruments for quality assurance and client safety is also being used within the healthcare system. There is a mixture of proactive and reactive instruments (prevention versus sanction), the so-called 'gefaseerd toezicht' (phased inspection) and thematic inspection.

In the center of this hybrid system we see the growing importance of clear relationships between the Healthcare Inspectorate and the Healthcare Authority. In practice, a few cases are known in which judgments about quality and creation of a level playing field do not always coincide. In the case of mergers between healthcare organizations huge players in the healthcare market are created. This leads to discussions about guaranteeing a level playing field on the one side and the effects on quality and accessibility on the other side. A huge healthcare organization can be a monopolist, but does not necessarily have bad consequences for quality. Here we see that the cooperation between inspectorates is crucial in weighing public interests. The Healthcare Inspectorate and the Healthcare Authority both look at quality issues, yet the Inspectorate is merely focused on quality of care and the Authority on quality of information for clients and insurers about this quality and accessibility of care. Both

inspectorates have intensified their relationships in the past years, in order to deal adequately with conflicting priorities. The relationships between the Authority and the Inspectorate are structured through a protocol of cooperation and regular meetings at all organizational levels. Meetings between the Board of the Healthcare Authority and the Inspector General take place regularly, as well as between researchers and inspectors. This does not mean that conflicts do not arise, such as in a recent case, a merger between healthcare and housing organizations in the Netherlands. Different judgments about this merger led to a lot of confusion. This will probably influence the relationships between inspectorates and authorities in the future. So, in a changing healthcare system, also their relationships are part of a growing model.

This structuring and coordination of relationships is necessary due to the introduction of market incentives and the necessity to make quality of care more transparent on one hand, and due to medical crises and numbers about the increasing amount of incidents in healthcare organizations on the other hand. We see a trend from reactive towards proactive inspection, meaning a shift from sanctioning and rewarding afterwards to prevention of quality deterioration. Here, the role of severe incidents has been crucial, such as in the case the deterioration of quality of heart surgery in a large hospital, due to amongst others the miscommunication between doctors. In these cases, it is increasingly important that both inspectorates use common figures about quality and work complementary in order to prevent conflicting judgments about market behavior. Yet, they also point to the fact that there is no such thing as a database with clear facts and figures to be used. Currently, there are debates about the forming of a 'Healthcare quality institute' that may perform this function, but it is still very unclear which tasks and functions this might have.

Possibilities of securing quality in the continuum of care

Looking at the pathways between the different care services for chronic clients, at this moment there are hardly any examples of assuring quality of care *across services*.

Coordination of care sometimes enables a joint venture on professional level, with the aim also to follow and evaluate (review) the care given to the client. This is still more exceptional than done on regular basis.

Coordinating mechanisms can work, and it has been tested in the context of patient care. Boundary spanners, also known as cross-functional liaisons, are individuals whose primary task is to integrate the work of other people. In healthcare settings, boundary spanner roles include case managers and primary nurses. Case managers are staff members responsible for coordinating the care of the patients assigned to them. According to organization design theory, boundary spanners increase performance of interdependent work processes by facilitating interaction among participants in a work process, and are increasingly effective under conditions of high uncertainty. Although there is little or no empirical evidence that boundary spanners improve performance by facilitating interactions among participants, some have found empirical evidence supporting the proposition that boundary spanners are increasingly effective as uncertainty increases. This evidence, however, has taken the form of observed correlations between the degree of uncertainly and the use of boundary spanners rather than testing whether indeed boundary spanners are more effective in high uncertainty settings. The findings from the research suggest that routines, as well as boundary spanners and team meetings, work by strengthening relational coordination among participants (Gittel, 2002).

Figure 3 Examples of coordination in the continuum of care

QUALITY SYSTEM				
		YES	NO	EXPLANATION
COORDINATION MECHANISM	Case managers		X	At this moment there are no commonly accepted components for case managers in the Netherlands. At this moment a study is searching for a (accepted) model for case management. The question in this research is: What are key components of case management in dementia? How are these components offered. There are no Q-indicators Source: www.casemanagement-dementie.nl
	Wmo-service counter (Wmo is the law for social support)	X		To ensure the quality of Wmo-service counters they developed *a guide star*. This is an instrument from the perspective of the client. They developed a couple of norms to evaluate the counters. The counters in the municipalities received stars when they meet these norms. Source: www.movisie.nl
	PGB (Personal Budget)	X		The client can asses the quality of care. Per Saldo and Vilans developed an instrument to measure the quality of the given care. The instrument has got three parts: 1. A selection assistance 2. An evaluation test: 3. A (non-)satisfaction instrument Source: www.pgb.nl
	Indication Assessment		X	The assessment system has as no certification yet
	EPD (Electronic Patient File)			The EPD is still in a developmental stage and has yet to be assured for safety reasons
	Care plan	X		ZIP is a Self-Evaluation Instrument for care plans in the care sector. The power of the ZIP Care instrument is that the care plan is reviewed for consistency. A good plan corresponds in substance to the vision of the organization, the needs of the client and the indication of the client. By this instrument, the professional is able to assess whether a care plan is of sufficient quality. The ZIP Care can also be used as a management tool. By structurally filling in the questionnaire, the management can get a view on the quality of the care plans in their organization. Source: www.zipcare.nl

Personal care at home in the client's familiar community (Buurtzorg The Netherlands)

Buurtzorg The Netherlands offers an alternative to home care in the Netherlands. Care provided by highly trained district nurses and carers in small autonomous 'district care teams'. This 'district care teams' are being supported by a national organization. It uses modern ICT applications that bring administrative costs down to a minimum. The costs of overhead and management are also as limited as possible. In summary: better care at lower costs, an attractive perspective for client, the professional and insurance.

In care for the elderly, for people with disabilities and people with a chronic disease a dedicated and efficient attitude to clients is to be encountered. The district nurses and carers play a central role. In consultation with the client the nurse/carer makes immediate decisions about the content and process of the given care. Buurtzorg The Netherlands is based on the professional autonomy of the carers and supports their autonomy. Knowledge of the specific neighborhood conditions provide an additional ingredient for the professional act of the carers.

Buurtzorg The Netherlands provides dedicated care by working with small teams with well trained and experienced staff. It distinguishes itself from other homecare organizations because: Buurtzorg searches together with the client and his/her network for solutions for more independence and a better quality of life of the client. The given care is the responsibility of care workers. It provides professional care according to professional standards, evidence based and monitored. Care is not provided longer than necessary. Effectiveness of care is very important (website Buurtzorg Nederland, 2009).

Research on job satisfaction of care workers

The motivation of the staff members is crucial for the quality of care provided by the care home. A care provider needs motivated staff to deliver good quality of care. Research on the satisfaction level of the staff members gives direct insight and opportunities for improvement of the quality of care (website Tevredenheidsonderzoek, 2009)

CCM (Chronic Care Model)

Identified elements and clusters provide a basis for a comprehensive quality management model for integrated care. This model differs from other quality management models with respect to its general approach of multiple patient categories, its broad definition of integrated care and its specification into nine different clusters. The model furthermore accentuates conditions for effective collaboration such as commitment, clear roles and tasks and entrepreneurship. The model could serve evaluation and improvement purposes in integrated care practice (Minkman and Binkhorst, 2006).

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6 Appendix

Barriers to inter-agency collaboration could include:

- **Structural** (fragmentation of service responsibilities across agency boundaries, within and between sectors)
- **Procedural** (differences in planning horizons and cycles; differences in budgetary cycles and procedures; differences in information systems and protocols regarding confidentiality and access)
- **Financial** (differences in funding mechanisms and bases; differences in the stocks and flows of financial resources)
- **Professional** (professional self-interest and autonomy and inter-professional competition for domains; competitive ideologies and values; threats to job security; conflicting views about clients/consumers interests and roles)
- **Status and legitimacy** (organizational self-interest and autonomy and inter-organizational competition for domains; differences in legitimacy between elected and appointed agencies)