

The right care in the right place

Who dares?

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01

Reasons for genuine change

Francis ter Horst - Lotterman talks to us



“I’m visually handicapped and also diabetic, among other things. Because of my diabetes, I have to see the internal medicine specialist and the diabetes nurse every month. I have to note down my blood values in a notebook for this.

And because of my visual limitations, I can’t even do that myself! I’m not able to cycle to the hospital either and have to travel for two hours by public transport to hand this paper notebook over. While I actually wear a digital pump system that I can link to my PC.

All the data it collects is converted into nice graphs and I can also save any events in the associated log. I could easily e-mail this myself to my internal medicine specialist and the nurse practitioner.

But transferring data digitally is unfortunately not possible at the moment.”

The essence of 'The right care in the right place' is avoiding expensive care, moving the point of care delivery closer to people's homes and replacing care delivery with other forms such as e-health.

That means:

- > Working from the way people function in their environments as the starting point
- > Paying attention to health, behaviour, prevention and detecting illnesses early
- > Accessible support and care for everybody
- > Suitable and effective care that fits in with learning experiences and the context
- > With good outcomes in terms of the perceived quality of life
- > At an affordable social cost

The Taskforce has gratefully used the recent KPMG report *The right care in the right place – A study of the conditions and the consequences* (Juiste zorg op de juiste plek – onderzoek naar condities en consequenties, April 2018). The approach and the recommendations are largely in line with this report. The KPMG report pays particular attention to the patient's journeys for several groups. That makes reading the report all the more worthwhile.

In this report, the Taskforce focuses above all on the social domain and on medical care, although the report does also provide starting points for involving e.g. youth care and long-term care.

- > When focusing on the way people – male or female – function, we are referring to a resident, client, patient or person with a care need. These terms are used interchangeably in this report.
- > "Client" can generally be substituted where "patient" is used, and vice versa.
- > A "person with a care need" can be either.

The Taskforce is a team of experts from various care domains and disciplines who have drawn up this report in a private capacity, led by and backed by the Ministry of Health, Welfare and Sport (hereinafter also "VWS").

1.1 Urgent reasons for genuine change

The health of the Dutch could be handled much better. How we organise care is generally good, but it could be so much better. We see a great deal of potential around us. That is why we are improving the healthcare system step by step, experimenting with new formats and learning from good examples. That is needed, but it is not enough.

Delving deeper into care delivery, the Taskforce has noted that continuing as it is now will get us stuck in a rut. More is definitely needed. The Taskforce believes that the bar should be set higher. First of all, there should be a different perspective on sickness and health. One where it is not about what the care system has to offer or about the interests of the healthcare providers, but instead about what people need in order to be able to function as well and as independently as possible for as long as possible. To achieve this, what is on offer must be tuned better to the demand and we will have to make optimum use of the opportunities presented by technological innovation.

People are the key – we are the key!

Genuine changes in our behaviour start with a shared goal and shared vision. With us seeing opportunities and being capable of

utilising them. But above all, with us having the motivation to do so. With us understanding the 'why' of the change and feeling that this is aligned to our own wishes and professional ambitions. Working with the movement that will put the right care at the right place cannot be optional for anyone. Being ready, capable and bold! It is important that there should be scope for initiatives and control. Sometimes the right preconditions have to be created for us to let go of the old and embrace the new. The right care in the right place needs to be more highly valued and better rewarded.

The Dutch care system is good, but it needs to be so much better.

From sickness to health

We say all too often that the patient is the focal point, but in practice this is not the case often enough. The emphasis is still too frequently placed on someone's limitations, on their specific condition and its medical treatment. We are suffering collectively – and that includes the patients – from a medicalisation and hospitalisation syndrome. There is not always a medical answer to every human need and the best care is not by definition given using medicines or in a hospital. We think too much in terms of treatment and care delivery. We should be thinking much more in terms of health and well-being. This also means investing in prevention, lifestyle advice, early detection and a broad assessment of what is genuinely needed. That is much more pleasant for many people and can prevent a lot of expensive care further down the chain later on.


It is therefore better to focus on **how people function** in their surroundings. Not only in medical terms but socially too. Does that person have enough contacts? Are there any debts? What is the family situation like? Starting from people's

capabilities, their own vitality, resilience and wishes, professionals are able to add value to the quality of life of people throughout their lives and for society as a whole. It will reveal more quickly who the vulnerable people are, for example because of a combination of physical, psychological and social issues. These people are often less capable of getting their own lives in order and keeping the support and care that they receive under control. Whereas these are the very people with whom institutions and healthcare providers are most often involved and where control and cohesion are important.

Doing things smarter, and differently

The growing numbers of older people and chronic illnesses requires care delivery to be organised differently. Currently, one person in seven works in the care sector. If we continue organising it as we do now, one person in four will be working in the care sector by 2040. That is not feasible. It is already difficult to find enough staff for the care sector. On top of that, we also want to make sure people are available for other key sectors in society where there are also shortages, such as education, the police and technical professions. Preventing illnesses, increasing people's ability to cope and expanding their horizons, embracing and using new and smart technology in the care sector, training and deploying healthcare providers differently – these are not merely desirable but also badly needed if we are going to be able to offer the elderly and the chronically ill the care they need in future.

From rising costs to long-term affordability

Continuing along the current path is moreover financially **untenable** . Healthcare expenditure will be growing twice as fast

as the rest of the economy over the coming years. This means that we, as a society, are spending relatively more money on care. This is to the detriment of other important expenditure in sectors such as education, security and the road network. People will also feel the increases in healthcare expenditure hitting their wallets. At the moment, all told, an adult spends almost €5,700 a year on care. By the end of the current cabinet's term of office, that will have grown to nearer €7,000. This could start putting pressure on people's readiness to stand together on the issue. A quarter of the money spent on care goes to the most expensive 1% of patients. The costs for having an elderly person in a nursing home are now up to roughly a hundred thousand euros a year. Households where social and medical problems accumulate bring in numerous professionals – often too late – and this puts pressure on municipal finances. In short, there are two options for doing something about the increasing costs: either people put their shoulders to the wheel so that care can be organised much more effectively, by offering the right care in the right place, prioritising people's ability to cope and their functioning, or else there will be blunt cuts – less care in the basic benefits package and more co-payments by patients.

From primary, secondary and tertiary to cohesive care

The current care system, warts and all, has become too much of a culture. That has got to change. The assistance and care that are currently on offer are by no means always sufficient for people's needs. People who need care sometimes wander endlessly through 'the system'. Professionals work on parallel tracks, making separate appointments when they could all be planned on a single day. Patients having to keep repeating their story, being shunted from pillar to post. People have to put a huge amount of time and energy into this and it often fails to yield the desired improvement in

their daily lives. Healthcare providers sometimes deliver care when they should know better: unnecessary referrals or hospital treatments, or double diagnostics. Care should be pigeon-holed less and become more with the people and about the people, with scope for differences between people. When care is delivered more cohesively, current cost-based thinking will also shift towards thinking about the results for the patient. In five or ten years' time, we must be able to say to each other that we used to talk about primary, secondary and tertiary care but now refer to the value of the care for the people. What are the outcomes of care provided for reasonable costs?

Digitisation: from off-line to everywhere

The tempo of digitisation in society is increasing. This is going to have a dislocating effect on health and the care sector. Because increasing numbers of companies – including those from outside the care sector – are offering digital services (such as apps) for self-management or diagnostics, the organisation of healthcare is going to change significantly. There is no longer a choice as to whether this digitisation is going to result in changes and a stronger position for patients: the question is how we are going to make optimum use of the opportunities this presents.

Data is going to play an increasingly important role in care. Patients will for instance in future be able to obtain all their own health records. That makes it easier to organise cohesiveness in the care sector because all the information then converges on the patient. This places demands on the healthcare provider and therefore on the training courses. Healthcare providers will have to be capable of dealing with well-informed, vocal patients and they will have to overcome their unwillingness to go in at the deep end with new technology. It also demands involvement from enterprising

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parties outside the care sector who have already acquired more experience in this area and are able to apply it in the care sector.

Who dares? The right care in the right place.

The **Taskforce** is aiming to use this report to fuel the movement that is already underway and to broaden it. Numerous examples of successful shifts and innovations in care can be seen at the local and regional levels, but there is not yet a clearly-defined, broader movement. It is about much more than shifting and substituting elements of secondary care into the primary line. It is about better organisation of the social support and the medical care that will benefit the way people function. This ought also to involve a shift towards the people, aiming for self-management and letting them control their own lives, with assistance for those who cannot. The intention is that this – along with the ‘Werken in de zorg’ (Working in the Care Sector) action programme, the ‘Ontregel de Zorg’ (Cut the Care Red Tape) programme and **other initiatives** – will become a key theme in the discussions about governmental commitment at the national level. It must above all provide an impulse for improving practices throughout the country. What is important is to get the **movement** rolling and to back it, to learn with and from actual practice, to make better use of the possibilities and eliminate the obstacles, leaving space for diversity. Not taking part must be the exception; transformation must be the rule.

The Taskforce wants to use this report to assist the necessary transformation to having the right care in the right place. Members of the Taskforce would like to explain this perspective to organisations and professionals help them put it into practice. Sessions will be organised throughout the country on this theme. A repository will be made for the increasing number of good initiatives. The findings and recommendations in this report will also demand follow-ups and action.



1.2 The core of the movement

The theme of having *the right care in the right place* is elaborated upon in the following chapters from various angles, but always asking the same three questions:

- > What does the movement look like? What are the perspectives?
- > What do we need to do? How can we expect others to help?
- > Where can we see the start of a movement in practice?

The examples mentioned are just a selection of the many initiatives already under way and they show the new approaches that people are taking, sometimes on a smaller and more limited scale and sometimes more widely and expansively. These initiatives and the results deserve a follow-up!

Chapter 1 Reasons for genuine change

- > How we organise care can be better and must be better
- > Genuine change starts with the people themselves and their perspectives on health and sickness
- > The task for the employment market is substantial and healthcare expenditure has a limited shelf-life
- > Changing from thinking linearly and in pigeon-holes to thinking about integral care for people
- > It is highly inspirational to see that the transformation is already beginning to take shape in practice
- > This movement needs expansion and fuel if it is going to engender transformation
- > That demands a culture of practical learning and controlling frameworks

Chapter 2 Basing it all on how people function

- > A shift from illness and care to health and behaviour
- > Investing in health skills and self-management
- > Lifestyle and functioning become a fixed part of visits to the doctor
- > Taking decisions together and utilising tools to help make the right choices
- > Not progressing on to medical care too quickly
- > District nursing teams and associated non-medical professions are important in a multi-step approach
- > Align social support with medical care

Chapter 3 The right commitment

- > Mismatch between supply and demand for care
- > Required: commitment to ensure care is organised better and with a lower price tag
- > This demands a cultural and behavioural change at all levels
- > Professionals and organisations should address each other about this
- > A communal view of the tasks in the region will drive that commitment
- > A nationwide commitment shows the way, but it must actually happen in the regions

Chapter 4 The right image of the common task

- > Produce a shared vision together of health and care in the region that will motivate people
- > Bring data from the various existing sources and domains together
- > Determine the tasks together for the region, municipalities and districts
- > The decision that this will happen is at the national level, without deciding what is done regionally
- > Each party takes its own responsibility for making a contribution
- > A focus on chronic conditions and vulnerable groups is desirable

Chapter 5 Information at the right place and at the right time

- > E-health promotes self-management, making decisions together, cooperating and care networking
- > Information at the right place at the right time is an integral part of good care
- > Give people their own data in their own individual healthcare environments (IHE)
- > Make sure there is a quality framework for exchanging data electronically
- > Encourage evaluation of the effectiveness and efficacy of new innovations
- > Strengthen the digital skills of professionals and people in general further
- > The governmental authorities provide clarity about the use of personal data and privacy

Chapter 6 The right professional in the right place

- > Where people are in the controlling roles, professionals can also be coaches and advisers
- > Holding the conversations differently demands other skills from the professionals
- > The functionally-oriented approach is a central element of training and continuous learning
- > Care delivery at people's homes means a change in the essence of the care relationship and encourages integral care
- > The other professionals know and understand what they are capable of and must do; cooperation
- > Required: more and other professionals, a different kind of organisation, splitting tasks off
- > Regional action plans for working in the care sector must be developed

Chapter 7 Towards added value in the right place

- > Encouraging added value by evaluating new and existing care
- > More time for clients and patients and more cooperation within the district network
- > More consultative cooperation between professionals
- > Using the medically affiliated professions and district nursing avoids unnecessary care
- > Less reimbursement of hospital care if it can also be done at home or closer to home
- > Rewarding the care outcomes (as they are perceived)

Chapter 8 Towards broader triage at the right moment

- > Proper information and support for clients to assist the options for 'self-triage'
- > The triage has to be broadly based, i.e. the medical and social domains together (district network)
- > Financing is needed for the coordination and control of broad triage
- > Assessment is a recurring process for scaling care and support up and down
- > Primary care is principally a switching point and there needs to be limits on it in terms of the duration
- > Better cooperation for formally determining the indications (access to and allocation of care)

Chapter 9 Towards organising the right care in the right place

- > Stop thinking in terms of primary, secondary and tertiary care; start organising in chains and networks
- > Treatment of psychological complaints in the patient's own surroundings
- > Hospital care can be given at home or closer to home much more often
- > Consider organising care delivery from the perspective of the people and not the buildings
- > Contracting will ensure that capacity in numbers of beds is reduced
- > Cooperation is a precondition for delivering good care
- > Use and reuse data about people and make sure that those involved know what others are doing for that person too

Chapter 10 The transformation has to be viable

- > The right care in the right place needs to be better rewarded
- > Innovative contracts are often possible without modifying the funding rules
- > Contracting in backs up the organisational capacity and cooperation in the districts
- > More use of bundled care packages, integral rates and fixed sums per client
- > Care insurers and municipalities use their purchasing power to push towards a better care landscape
- > Concentration of complex care and high-quality care facilities is desirable

Chapter 11 Steering towards transformation

- > People must push hard towards transformation (and they must be able to do so)
- > Administrative commitment is needed at the national level
- > Budgetary frameworks are allowed to squeeze but must assist the movement
- > Move from cutting down care 'within the walls' towards building up care closer by
- > This requires temporary transformation resources and investment in cooperation
- > Those who pay the premiums must benefit from the right care in the right place
- > The right care in the right place must be part of the quality standards

Achieving these goals will require efforts from people, care professionals and managers. That needs courage. At the same time, this report shows that the requisite courage is already being shown at various places – successfully too. The Taskforce calls on all parties to pull together and help speed the transformation up and make sure it succeeds. Who wants to join in?

Who dares?

The right care in the right place. Who dares?

02

Basing it all on how people function

Basing it all on the core of how people function

A shift from illness and care to health and behaviour

Investing in health skills and self-management

Lifestyle and functioning become a fixed part of visits to the doctor

Taking decisions together and utilising tools to help make the right choices

Not progressing on to medical care too quickly

District nursing teams and associated non-medical professions are important in any multi-step approach

Align social support with medical care

Linda van Dam talks to us

Linda is caught in the middle, caring for both her mother and her adult son. Her mother is not very mobile and has dementia. Her son has an autism spectrum disorder.

Linda would never leave that care task to anyone else. She knows better than anyone what her mother and son need. And there are so many beautiful, loving moments. But it is also often frenetic, exhausting and a heavy burden. So much so that Linda sometimes thinks she can't cope. Who's going to look after her?

Patient: "Being ill affects your everyday functioning. They often don't pay attention to that and it's too much about treatment and medicines."

Source: ZonMw memo entitled 'Meaning of Care'.

What does the movement look like?

How people function

- > The starting point for the right care in the right place is making it possible for people to function as well as possible within the context of their illness. This is about promoting, **retaining or recovering the ability to function** in the broadest sense of the term.
- > This implies a shift in focus from illness and care to **health and behaviour**¹. Care is then aimed at the functioning, enabling people to function in their own living environments for as long as possible and as well as possible.
- > It is essential to promote good functioning (prevention) and to limit or if possible reverse the effects in the event of illness (treatment).
- > The term 'functioning' covers **physical, mental and social functions**. The WHO describes functioning in terms of functions (physiological and mental characteristics), activities (a person's activities in daily life) and participation (taking part in social life, such as living and working)².
- > In addition to illness, external factors such as the social and living environments determine how people function. The way in which someone responds to illness in their behaviour, emotions and thoughts depends heavily on how it affects their functioning³. Concepts such as coming to terms with things and their meanings, mental well-being and quality of life are often called upon when talking about how people function.

Chronic conditions

- > In 2015, about 8.5 million people in the Netherlands had one or more **chronic conditions**⁴. It is expected that this number will grow to almost 10 million by 2040 (54% of the population⁵). This is referring primarily to arthrosis, diabetes, COPD, heart failure and rheumatism.
- > This group of chronic illnesses is heterogeneous in terms of the condition and the background. The risk of getting one or more chronic conditions increases with age, but some chronic conditions are occurring increasingly early in life.
- > People often have **more than one chronic disease** (comorbidity and multiple morbidity). The increasing numbers of options for medical treatment mean that people are able to continue living with these conditions for a long time.
- > Chronic diseases and other conditions can have major effects on **how people function**. This results in a **changing care demand**⁶, creating a major impact on informal care and resulting in lost social productivity.
- > Not all chronic conditions have an equal **impact**. One condition can have more effect on day-to-day functioning than another. A substantial proportion of the population do not see very well without corrective lenses, but do not experience that as an illness. The impact on functioning is therefore limited in most cases. The extent to which a limitation has an effect on day-to-day functioning is one of the determining factors for whether that limitation is accepted by people.
- > There are possibilities for people to function well despite the

presence of illnesses. This is also referred to using terms such as resilience, learning to cope with disease, self-management and positive health⁵.

Parties involved

- > The **affected individual**: preparing for a talk, adapting and **self-management** (the active role that people with a chronic condition must take in order to prevent complications and to fix the condition into their daily lives properly).
- > The **social system, the living surroundings and the district**, which provide support for the way the person functions to a significant extent.
- > The **associated non-medical professions and nursing disciplines**, which focus on encouraging and maintaining optimum functioning, either at home or in an institution.
- > The **psychological disciplines**, which help people's mental well-being and behaviour.
- > The **medical disciplines**, which treat ill people as agreed with them. (This includes lifestyle medicine.)

1 RVZ. Look after your health! Behaviour and health: the new order, 2010.

2 World Health Organization. International Classification of Functioning, Disability and Health. Geneva: WHO, 2001.

3 Dekker J, de Groot V. Psychological adjustment to chronic disease and rehabilitation – an exploration. Disability and Rehabilitation, 2018;40(1):116-120.

4 www.vtz2018.nl


5 <https://iph.nl/positieve-gezondheid/wat-is-het/> <http://www.allesisgezondheid.nl/content/positieve-gezondheid>.

What do we need to do?

Basing it all on how people function demands a very different way of looking at things and doing things. It means investing more in people's health skills and making decisions with them rather than about them. It also means measuring and knowing what the outcomes of care are, as seen by the people themselves. Nursing staff are often close to people and know the social environment well, as well as being familiar with the social facilities in the area. They can help prevent people's needs becoming medicalised too quickly.




Health skills

- > Everyone is the primary **care provider for themselves**: they have the possibility of learning more about health and illness and taking control (or more control) over their own care and welfare. The thinking when answering questions about people's limitations must not become too medical too quickly.
- > To allow people to help think about their care and **make decisions about their care**, it is important to encourage their **health skills** , both preventive and curative. That starts at school: children must learn more about how to get healthy and stay healthy⁶.
- > Functioning as well as possible and assessing the quality of life are tasks that are primarily the **responsibility** of people themselves. Their surroundings, including care providers, can help, because not everybody is equally skilled at this. This demands an integrated approach to care and welfare, at the level of individual people and their district and/or municipality⁷.
- > This requires continuous efforts at various levels, for which numerous suggestions have already been made⁸. Examples: this topic is being put on the agenda at national level; healthcare providers have organisation-wide policies for health skills; care providers are using visual materials in their existing communications strategy; the government and health insurers take account of people with low levels of health skills, e.g. when communicating about insurance policies, through **clear and accessible communication**.
- > Stimuli are needed for encouraging health skills, for training in the ability to cope, the options for prevention and lifestyle inter-

ventions. Good examples of an alternative way of providing care and deploying people whose expertise is based on experience can help the patient make decisions about subsequent steps (the right care, no unnecessary care). Apps and websites such as thuisarts.nl and naarjehuisarts.nl can also be helpful. As can the 'Stimuleren gezondheid door eHealth'⁹ programme (Encouraging health through eHealth).

Samen Beslissen

- > **'Samen Beslissen'**  - taking decisions together - must be the norm: the patient, carer and care provider decide jointly on what care is most suitable. Representatives of patients, care providers and health insurers can promote **awareness** of Samen Beslissen among their membership or followers. Examples are the further implementation of the campaigns 'Betere zorg begint met een goed gesprek' (Better care starts with a good talk) and '3 goede vragen' (3 good questions): What options do I have? What are the pros and cons of those options? What does that mean in my situation?
- > Carers and care providers need better skills if they are to present information to patients understandably about their conditions and include the personal context and preferences of the patients in the decisions made about assistance and care.

⁶ http://www.pharos.nl/documents/doc/factsheet_beperkte%20gezondheidsvaardigheden_en_laaggeletterdheid.pdf

⁷ www.gezondin.nu/praktijkvoorbeelden

⁸ NIVEL Kennisvraag 2016: Zorg op maat (Knowledge Survey 2016: Customized Care). How can we align care better for people with low levels of health skills? Utrecht: NIVEL, 2016.

⁹ <https://www.zorgvoorrinnen.nl/nieuws/detail/in-2020-heeft-10-van-nederland-ehealth-gebruikt-voor-persoonlijke-preventie>

Care providers can discuss full or abridged **decision-making tools** for the care process. Patients can prepare for the consultations with their care provider by running through a decision-making tool in advance. This results in more aware choices and often in fewer medical interventions and less follow-up care.

- > Not everyone is capable of **taking control** of their own situation. The care provider must not take over control too quickly, yet at the same time must not wait too long. That is not always easy to estimate. Professionals can help each other in this. Close involvement with the informal carer can also help.
- > Health insurers can facilitate Samen Beslisten by making agreements while purchasing care about **sufficient time for a proper discussion** and, if possible, time to consider the treatment options and choices.

Care outcomes

- > The right care must be based on how people function. In addition to traditional endpoints such as mortality and morbidity, the effects on how people function must also be the **touchstone for the quality of care**.
- > Irrespective of whether someone is able to take control, the majority of people are able to indicate whether **the care that they are receiving is helpful** to them.
- > To get reliable information about the quality and outcomes of the care provided, it needs to be quantified. This must be about **results that really help the patient**. The quality of care can for instance be measured by asking patients using *patient-reported*

outcome measures (PROMs) about the effect that the care had on their perceived health. PROMs also provide input for patients and care providers for taking decisions about treatment together.

Prevention, associated non-medical professions and nursing

- > If people with chronic conditions or other limitations are to function properly, it is important that attention is paid to mental well-being, the quality of life, prevention, the social system, the living environment and the district in addition to the medical disciplines (www.gezondnl.nl).
- > Where possible, care must be provided by **Wmo- (Social Support Act) assistants, welfare workers, primary healthcare psychologists, associated non-medical professions and nursing staff**. The diagnosis – determining the starting point for interventions – and treatment are in these disciplines primarily targeted at improving functioning. The step to medical care is often taken too quickly, meaning that appropriate and economical care is not provided.
- > This can be improved by introducing and using a **multi-step approach** for specific illnesses. This could be done for instance in the process of knee arthrosis, in which conservative interventions such as exercise therapy and dietary advice (losing weight) are applied first, before an operation is considered.
- > It could also be done by introducing and using an ergotherapy programme nationwide for elderly people with dementia and their informal caregivers, to prevent or postpone admission to a nursing home.

Where can we see the start of the movement in practice?

- > Increasing numbers of care providers are offering **informational material and decision-making tools**. There are also increasing numbers of patients who are using this material or e.g. the ‘3 good questions’ to prepare for their meetings with the carers and care providers. A good example of a way to speed up the implementation of Samen Beslisten is a program called ‘Beslist Samen!’ (‘Decided together!’). The knowledge that is gained is also shared with hospitals that are not participating in the project¹⁰.
- > There are GP practices that work with the **positive health** vision in order to reduce the number of referrals through to secondary care. Longer or more numerous visits to the doctor give scope to find out what people really need. In a few cases, GP practices, municipalities and health insurers have set up a **social team** together. All team members are trained in positive health so that everyone is using the same approach. This requires cross-organisation cooperation that focuses on how people function. Examples are the GP practices in Afferden and Gorinchem that are cooperating with the health insurer VGZ and their respective municipalities.
- > The website **18takecontrol** gives important information for people who are turning eighteen in language that young people will understand. The William Schrikker Expertise Centre has produced a practical methodology for professionals using visual tools, which they can also use when young people have a mild

¹⁰ <http://www.begineengoesprek.nl/uitgelicht-post/vijf-vragen-over-het-programma-beslist-samen/>

01 intellectual disability, have already had difficulties, or forcibly
02 made to receive assistance. The forum provided by 18takecon-
03 trol can help the young people themselves work deliberately
04 towards an independent existence after their eighteenth
05 birthday, assisted by professionals or carers. The folder is one
06 element of 'Krachtplan 18+' (Eighteen-plus Power Plan), a
07 methodology that offers youth aid workers concrete points to
08 help young people prepare in good time with them for life after
09 they turn eighteen".

- 10 > There are regions where the way people function is used as the
11 starting point for healthcare, based on positive health. Various
parties are involved in this, such as schools, shops, sports
associations and care providers. Health has an impact on
multiple aspects of life and vice versa. Not only medical care,
but also **acceptance and participation** help people function
better. This is different for every individual, so it is about
dialogue and fitting in with what people want. Control from
above does not work without input from the people who have
to get down to business and who have their own ideas about it.
- > Some municipalities put this into effect through **campaigns** in
which the municipality aims to pique residents' curiosity and
show them easy ways of looking after their health. Other
municipalities do this through **subsidies** for which organisations
have to show that they are playing a part in the social effect by
helping residents' health. Examples include 'Gezond Veluwe',
the municipality of Nieuwkoop, 'Hart voor Voerendaal',
'Leenden gezond dorp' and 'Limburg positief gezond'¹².
- > There are also examples of care or welfare organisations that
are joining forces and want to work in an **integrated and
multidisciplinary** way. The approach focuses on the transitions

from care and illness to behaviour and health, plus people and
society. The underlying principle is the residents' own strength
and their own networks.

These are good examples that provide inspiration for other parties.
It is important that these do not remain mere examples. It must
become a widespread practice and experience. Ultimately, the
starting point to care for everybody must be their own functioning.

¹¹ www.krachtplan18plus.nl

¹² <https://www.gezondveluwe.nl/nieuws/twee-jaar-gezondveluwe-evaluatie-van-de-opbrengsten.htm> , <http://www.hartvoorvoerendaal.nl/> ,
<https://limburgpositiefgezond.nl/inspiratie/> , <http://gezonddorp.nl/>

03

The right commitment

The heart of the right commitment

Mismatch between supply and demand for care

Required: commitment to ensure care is organised better and with a lower price tag

This demands a cultural and behavioural change at all levels

Professionals and organisations should address each other about this

A communal view of the tasks in the region will drive that commitment

A nationwide commitment shows the way, but it must actually happen in the regions

Joanne Simonsz talks to us

“Osteogenesis imperfecta – OI – is a condition in which the connective tissue is less tough. As a result my bones break very easily, for example.



OI is a rare and complex illness, for which I cannot simply go to any random hospital. I'm currently being treated at an OI expertise centre within the hospital. The care professionals at this expertise centre are thoroughly familiar with my situation and my clinical picture in particular.

In addition, the internal medicine specialist, the radiologist, the rehabilitation doctor, the clinical geneticist, the nursing specialist, the ergotherapist and the nursing staff for the ultrasound, cardiac and pulmonary function investigations all contact each other very frequently. They also have good contacts with my GP. This means that treatments in the hospital and at home can be set up and run through quickly, and that gives the best possible results.”

What does the movement look like?

From problem-based: the care that is on offer is increasingly less well aligned with demand

- > The increasing **care demand** comes less from patients with a single condition than from patients with complex needs. Think of vulnerable people, such as patients with various chronic conditions, patients with needs in a variety of domains of their lives, and people who need broader-based support and care.
- > The **care that is on offer** is specialised and fragmented, too much so. That fragmentation can be seen in the training, the professional groups, the way they work, the quality system, the organisation, the funding and financing, and the policy.
- > The **mismatch** between care needs and the care on offer results in delays, hassle and frustration, a low perceived level of quality, limited improvement in how people actually function and costs that are higher than necessary and desirable.
- > There is a **societal imperative** to base things on how people function on the one hand, and to keep care accessible, affordable and high-quality on the other.

This societal instruction must be felt and experienced by people, care providers, organisations, financiers and policy-makers. Continuing along the current path means being stuck in a rut.

Controlled by a vision: integrated care focusing on how people function

- > The movement targets a **shared vision** of what is required. Why do we want a genuinely different way of organising, delivering and financing care?
- > Because the care has to fit in better with what people need in order to function. That motivates patients and professionals.
- > Because the better organisation of care results in a higher perceived level of quality and less growth in costs. That motivates administrators and managers.
- > Because eliminating inefficiencies from the current system helps make air higher quality and more affordable and results in a more healthy population (*Triple Aim*).
- > In essence, it is about a **cultural and behavioural change**. Motives relating to the content must prevail over those relating to the financing. In other words, “how does this help people

function” and not “what does this mean to me and my organisation?” Cohesion, cooperation and integration of care and support must be seen as the main objective, instead of the most quantifiable, controllable partial solutions.

- > It is about an irrevocable **commitment** to a new standard: the right care in the right place. New initiatives are put in the shop window, front-line professionals and administrators are placed up on stage, and the results are made clear to people. To get more positive energy and encourage other people to examine organisations and practices from their own perspectives and to innovate.
- > Put even more strongly: not taking action is no longer acceptable. We address each other about our behaviour and hold each other to account, literally and figuratively. Shying away from the responsibility to make care better is no longer accepted and rewarded.

“From sweeping the porch to keeping the street clean.

Not taking care out of people’s hands, but tackling it together.” – Taskforce



What do we need to do?

This kind of movement places high demands on all parties involved:

- > **People** who are actively involved in their health and welfare, trying to avoid needing care and support, making good use of their networks, finding professionals in good time when needed and learning to cope with their limitations. Appropriate support is needed for people who have lower levels of health skills.

- > **Professionals** must get a clear picture of the actual care requirements and the underlying needs of people by discussing things with them. Advice, support and treatment are based on *evidence* *and* experience *and* the individual's situation. With scope for diversity. It has to be about learning in practice, to generate new *evidence* and help people further, not about applying these standardised norms that suggest that all people in the same context have the same requirements.

- > **Administrators** must manage care organisations in a way that helps the health and welfare of the entire population – seen in terms of effective deployment of resources – as the standard as a matter of principle, and less exclusively steering towards financial results. They question professionals about their contribution to the right care in the right place and reward them for it.

- > **Health insurers, health administration offices and municipalities** must help create a picture of the overall task in a region, municipality and/or district. They must hold institutions and professionals to account for the content in terms of cooperation, integrated care and the efforts towards and realisation of the outcomes as experienced (Chapter 10). Financiers such as banks and innovative entrepreneurs can help achieve genuine change.

- > **External supervisory bodies** must treat the social annual report as being just as important as the financial one.

- > **Policy-makers** must suppress the tendency to control this movement top-down with new structures, models or even blueprints. That only results in shifting boundaries and less room to manoeuvre, whereas it is precisely that space and oxygen that are needed for ownership and creativity in practice.

The solution is therefore more in assisting people, professionals and administrators in learning to cope with the current restrictions and in softening or eliminating severe limitations. One instrument that policymakers have that is underestimated is the “*capacity to convene*”: address parties, call them together and organise the discussions until the problem is solved.

- > The task of **national politics** is to express a vision, create the correct preconditions, monitor the quality and affordability of care and take control if necessary. Everything does not have to be arranged uniformly, but parties can be asked to explain why the approaches or results in certain regions differ from others.

- > **At the national level**, the parties confirmed their commitment to the movement towards the right care in the right place and take their members along with them. The governmental authorities express that perspective consistently, together with the parties.

- > This commitment will need to be translated in the regions by creating a shared image. What is the healthcare situation now, how do we organise and provide care, what is our **common task**, and what needs to be done in order to achieve better health and welfare among the population? Based on that picture, the parties can get down to work – given their separately defined roles. Ducking and shifting responsibilities must not be possible.

- > In order to encourage the **capacity to learn** more broadly throughout the country, a “learning pact” can be set up with the support of insurers and municipalities between regions that are in the lead and those that have progressed less far as yet.

Where can we see the start of the movement in practice?

Commitment to set care up differently, working together across professional and financial domains, demands a change in behaviour. There are examples to show this.

Krijtmolenalliantie in Amsterdam Noord

- > In Amsterdam Noord at the end of 2010, nine providers of healthcare and welfare united in the Krijtmolenalliantie (KMA) and signed a cooperative agreement so that they could help the residents of that part of the city better. One initiative of the KMA is **Beter Samen in Noord** (Better Together in the North), which aims to develop a uniform multidisciplinary working method – triage and case management – in that part of the city for professionals employed in welfare, healthcare and work & income. The working method features a rapid and expert determination of the problems and determining who and what is needed for a suitable, client-focused approach. This approach focuses on the transition from care and sickness (two Zs in Dutch) to behaviour and health (two Gs in Dutch) and people and society (two Ms in Dutch) for residents with complex, multiple problems or those who can only fend for themselves to a lesser extent. The general public are encouraged as much as possible to make use of their own strength and call upon their own social networks. Professionals and organisations have embedded the approach in their regular care offerings and the applicable financial system. <https://www.betersameninn Noord.nl/historie/krijt-molen-alliantie>

Pilots for a population-oriented approach

- > Experiments were started in 2013 with pilots for a "**population-oriented approach**". What this approach means is that providers of prevention, care and welfare, health insurers, municipalities and the general public make efforts to improve the health of the population and the quality of care, as well as controlling the costs ('Triple aim'). As proposed by health insurers, the Dutch Ministry of Health, Welfare and Sport has designated nine of this type of cooperative venture as 'pilots for better care with lower costs'. New developments and experiences in these pilots will be presented by RIVM (National Institute for Public Health and the Environment) in the Landelijke Monitor Proeftuinen (LMP, National Pilot Monitor).
- > One of those pilots is Blauwe Zorg (www.blauwezorg.nl), which focuses on sustainability of healthcare. Blauwe Zorg is not so much a project as a movement or a philosophy. It has two cornerstones: **changes to the organisation of care and behavioural change within the parties**. The first pillar consists of a number of interventions that are intended to improve care as per the *Triple Aim*. The interventions are aimed at the

pharmacy, the use of medical specialists, referrals to follow-up care, mental healthcare services, care chains and municipal decentralisation. These themes are a logical consequence of the analysis of where the major health expenditures are. Interventions have been started up for each theme. The principle is that the care process must be set up differently and unnecessary care at the wrong places must be prevented, i.e. not that less care must be provided.

- > The second cornerstone of Blauwe Zorg focuses on the cultural change in the region that has to take place at three levels: the administrator or manager, professionals and the people with a care need. The broad realisation that traditional wait-and-see policy, in which each only has responsibility for their own part of care, has to be transformed into an active follow-up policy with an equally large responsibility for all healthcare providers for the entire population. We can see how this change in mentality and ultimately in behaviour can be achieved by looking at the environment. We have succeeded in getting producers and consumers to deal differently with sustainability for the environment (such as "green electricity"). We can learn from that. Care providers must take responsibility together for a care organisation that is set up efficiently. The patient – the person with a care need – must also be included and must get a better understanding and a clearer picture of their own role and responsibility. The 'Blauwe Zorg in de Wijk' project focuses in particular on getting the ball rolling for this behavioural change at all levels.

*"Managers, this is *your* battle:
the real fight is against ourselves, against
our bureaucracy and our complexity."*

– Yves Morieux and Peter Tollman, *Six Simple Rules (How to Manage Complexity without Getting Complicated)*, 2014

Prinses Máxima Centrum: the patient's interests are paramount

- > Some 600 children are diagnosed with cancer every year. Cancer is still the commonest cause of death among children: every two days, a child in the Netherlands dies of the disease. Treatment for most forms of rare and other cancers among children used to be dispersed over a number of hospitals and the Netherlands. At the time, the oncologists involved asked the question, "Suppose your own child had cancer: where would you want them to be treated?" In the best hospital. The parties joined forces and looked beyond their own interests to organise a top quality cooperative venture.
- > Expertise, both national and international, in care and research came together at the Prinses Máxima Centrum. Together with twenty hospitals throughout the country, complete oncological care is offered for children. Together with the parents of children with cancer, the care is organised in such a way as to allow the development of the child and family to continue as much as possible. That transpired to be the added value: the centre does everything to optimise the intake, supervision and development, as well as excellent treatment. There are eighty-five rooms for parents and child: admission rooms with their own place for the parents. This means that parents can be with their child day and night. The care is genuinely organised around the child so that people feel more welcome and more at home. It improves the resilience of children, parents, brothers and sisters and helps give control back to them.
<https://www.youtube.com/watch?v=o4apM1Q87dc>

04

The right image of the common task

The essence of their right image of the common task:

- Produce a shared vision together of health and care in the region that will motivate people
- Bring data from the various existing sources and domains together
- Determine the tasks together for the region, municipalities and districts
- The decision that this will happen is made at the national level, without deciding what is done regionally
- Each party takes its responsibility for making a contribution
- A focus on chronic conditions and vulnerable groups is desirable


Charles Wijnands talks to us



"I work as a GP in a deprived area of Maastricht. Every day, I see that my patients have lots of problems on lots of fronts: financial, psychological, education, physical health, etc. And in particular as regards their social functioning."

I work with the social team and other groups providing help in the district, but I often note that what is on offer does not match the demand properly. We have recently been given lots of figures about our patients via the municipality, health insurer and municipal public health service. Relevant figures that confirmed that there are indeed many psychosocial problems. As well as confirming that my feeling was correct: what is on offer does not always target the right problems. And now I can start addressing that, armed with figures."

What does the movement look like?

- > **Tackling the fragmentation together.** The numerous forms of formal and informal care and support are largely organised and provided separately from each other. There are people with a need for care who do not end up at the right place; there are people who are backed up by all kinds of different informal caregivers and professionals, but are not actually helped by that. There are lots of good intentions to provide good care and support, but the results are often less than optimal. That applies within the social and medical domains, and certainly between the two domains. It turns out too often that they are “different worlds”, each with their own language, working methods, ethics and expertise¹³. People who have to deal with the various providers of care and help often perceive their different perspectives as unclear, burdensome and contradictory. This needs exchanges of information, cooperation and direction.
- > Cooperation at the **purchasing level** . What applies at the micro-level of care providers and help providers and their organisations also applies at the level of those funding care and support. The decentralisation of parts of the AWBZ (Exceptional Medical Expenses Act) to insurers (district nursing) and municipalities (household help, guidance and day programmes,

which also includes youth care) is a relatively recent phenomenon and it has cost a great deal of time and energy. More is now expected than in the past of healthcare administration offices, as the purchasers of proper care for the disabled and the elderly. The process of transition has been typified as that of repairing a ship out on the open sea, rather than in a dry dock. The ship does have to keep sailing. That phase is now largely behind us. The following phase is transformation: more together on the ship, determining the course together, then allocating tasks and tackling them in order to reach the destination.

- > **Determining the task in the region together.** Between the irrevocable commitment (Chapter 3) and the practical realisation of the right care in the right place (Chapters 5 to 9), it is extremely important to create a “shared image” of the region, municipality or district. Together with healthcare providers, professionals, patients and their environments, the health insurers, health offices and local councils ensure that this happens. What overarching tasks are we facing across the domains in this region: what needs to happen if the right care at the right place is to be organised and supplied in this region? Given that picture, each of the parties – given their various responsibilities – makes agreements about care organisation and healthcare procurement. That task thus helps guide the purchasing by local councils, insurers and care offices and helps guide the way that providers organise care and professionals

provide care. Professionals in the social and medical domains must have the right tools to be able to get down to business with this task.¹⁴

- > **From paper to practice.** Creating the shared image is not an aim in itself, but a way to encourage action. The added value is that the task is taken up and problems are tackled. That the parties speak to each other. We can't have one party saying to the other, “Your side of the ship is leaking.” That applies when purchasers are defining policy and in the actual process of contracting in. It applies to the organisations and professionals at the micro-level so that their care and support fits in better with the actual and changing care needs. It is logical to start with groups that will benefit most from better organisation and the right care being provided in the right place.
- > **Practice has the prime role.** It is important at the national level that there are agreements between the parties and that this approach is followed in the regions. This means that parties at the national level can also provide an impetus for their own membership. Exactly what agreements are made in the regions are not defined at the national level. The regions are too different from each other for this, and there are also important benefits to allowing scope for distinctiveness, variation, creativity and innovation. If there is reason to do so, the progress can be discussed at the national level.

“An integrated database may offer relevant input for new health policy and for strategic choices about new forms of care, care arrangements, healthcare procurement and alternatives to care.” – (Annet Joustra, monitoring knowledge manager at Robuust)

¹³ Rob (Council for Public Administration, 2017). Ensuring cohesive care. About care legislation that is implemented by the local councils. The Hague: Council for Public Administration.

¹⁴ Article 14a of the Health Insurance Act states that the health insurer makes sure that the content of the care that is purchased matches the agreements made with municipalities as described in Article 5.4.1 of the Social Support Act, with the municipalities agreeing their tasks with the health insurers.



What do we need to do?

- > Creating a shared image of the social and health situations does not mean gathering new information, but **combining data from different sources** across domains. There is a wealth of public information available (see the table in the appendix to this chapter) for analysis at the regional or local level, without it having to impinge upon the privacy of personal data. Organisations such as RIVM, Statistics Netherlands, VEKTIS, Stichting Inlichtingenbureau, the Dutch Data Protection Authority and consultancy agencies can support this.


> Health insurers, municipalities and care offices ensure that this process gets underway and that it is translated into the tasks for the regions. This is done in consultation with the providers of care and support in the regions, experienced professionals and in particular the people themselves. Doing it together creates a **common basis**, shared responsibility and ownership. Practice teaches us that sharing and combining information yields other insights, often unexpected ones. That leads to a different discussion between the parties involved about the content, as well as about determining the priorities, accepting unintended effects, about what can be done regionally and locally and what has to be tackled nationally.


> Health insurers, municipalities and care administration offices fund the development of this shared image and utilise it for their **contracting** in the region. They arrange their own purchasing policy so that it supports the regional task. This also benefits the organisational capacity of the care on offer within the region. Managers and professionals use the shared picture as input for organising and providing care and support. Good examples can be put in the spotlights, learning networks are set up (regional partnerships) and a 'flying squad' of experts is deployed. Collecting and utilising data at the level of individual care needs is a separate question, as is providing care and what is and is not possible in that regard.

> In a region, it seems obvious that the largest health insurer, the care administration office in question and representatives of the local councils concerned should take the lead. Other parties then try to follow them, given their own responsibilities to their residents and the insured parties. The movement will require additional capacity and resources from the parties involved, but it should also yield some good returns.

> Situations can arise in which the correct picture of the common tasks can be reached; the causes of such failures must however never been down to a lack of will. It is a good idea to discuss the progress of the initiatives across all regions regularly at the national level. The RIVM has recently issued a monitor about the cooperation between local councils and health insurers. https://rivm.nl/Documenten_en_publicaties/Algemeen_Actueel/Uitgaven/Preventie_Ziekte_Zorg/VPZ/Evaluatie_Preventie_in_het_Zorgstelsel.

Where can we see the start of the movement in practice?

> **District Scan by the Municipality of Enschede.** It is not only the utilisation of care (and its predictability) that is important: the characteristics of the population and the care infrastructure that is present are essential information for defining and implementing policy. These data flows are often not combined in the first instance. A prime example of where this is done is the municipality of Enschede. Information from health insurers is combined at the district level with data from the Social Support Act. That information is supplemented by the infrastructure that is present in the district, population characteristics (via data from Statistics Netherlands and the Municipal Public Health Service). A useful tool in this is the **district scan** , which makes it clear to all users what combinations of data are required.

> Regional **knowledge centre in Zwolle** , Zorgalliantie Zwolle also wanted to combine data from different sources. To that end, they set up a regional knowledge centre. Its task is to bring together and make available relevant care information from

various sources that the stakeholders in the region need and use in their primary tasks and processes.

- > The Programma Gedeelde zorg (Shared Care Programme) in Gouda has listed the process steps that have to be done through when setting up their data gathering: (a) starting up a data working group; (b) setting up an infrastructure for a continuous process of data analysis; (c) using an external expertise agency for support; (d) starting setting up the first dashboards.

The steering committee first focused on acute care of the elderly. A second dashboard will be looking at dementia care. [http://www.transmuraalnetwerk.nl/Portals/1/Def%20Visiedocument%20GZMH%20aanoniem%20\[Compatibiliteits-modus\].pdf](http://www.transmuraalnetwerk.nl/Portals/1/Def%20Visiedocument%20GZMH%20aanoniem%20[Compatibiliteits-modus].pdf)

- > www.versterkensamenwerking.nl. The managers of a large number of councils and the managers of the largest insurers started the Jongerius Forum in 2014 with support from the Ministry of Health, Welfare and Sport, under the motto “Inspiring, learning from each other and developing further”. The common objective is better health for as many residents and insured parties as possible, by deploying resources effectively. This informal evening forum (named after the location of the first meeting, the Jongeriusgebouw in Utrecht) was later supplemented by a number of learning conferences in the regions about specific substantive themes such as prevention, corporation in the district, mental healthcare services, and issues for young people. The forum is still active.
- > “Cooperation maps” have also been produced for the cooperation between councils and insurers in the regions for the whole of the Netherlands: in which regions is the

“Big Data can be a flywheel for individually focused, effective care. Data becomes valuable if you understand it when you look at it.” – (Eric Hiddink and Ron Herings of the ‘Gezonde zorg’ pilot)

cooperation more intense or less intense on specific themes, and which regions are lagging behind? These maps are also on the agenda for the administrative meetings between insurers, municipalities and the Ministry of Health, Welfare and Sport, in addition to the exchange of good examples and discussing the bottlenecks. https://vng.nl/files/vng/nieuws_attachments/2017/samenwerkingskaarten_zorgverzekeraars_en_gemeenten_de_huidige_samenwerk.pdf

- > The draft of the nationwide model for “A chain-wide approach for overweight and obese children” was recently delivered. Together with the municipalities of Almere, Amsterdam, Arnhem, Den Bosch, Maastricht, Oss, Smallerland and Zaanstad, C4Q described the structure for an approach within the care chain for overweight and obese children. The draft nationwide model for “A chain-wide approach for overweight and obese children” describes the structure for setting up a local, chain-based approach to overweight or obese children. It is based on practical experiences from the eight pilots. The wish underlying the draft nationwide model is that “Every child who is overweight stays in scope (along with the parents) and gets the care and support they need. The professionals involved look not only at the lifestyle, but also expressly at the circumstances of the child and their family.” <https://www.c4o-proeftuinen.nl/over-proeftuinen/model-ketenaanpak>

- > The inventory shows that a lot is already being done, but it is heavily concentrated in the larger municipalities. It also often remains small-scale and so there is still too little further development in the region and/or structural embedding of interventions that work. In addition, the learning capacity across regions could be improved. The VNG (Association of Netherlands Municipalities) is therefore offering ten regions the opportunity in 2018, with expert **process guidance**, to take their cooperation with the largest health insurers up to the next level on one specific theme.

Use public data (refer to the appendix to this chapter) and take account of what is already happening in this field; the local council may already be using the ‘arrangements monitor’ <https://arrangementenmonitor.nl/>. The tips may also help to get a better picture of health <http://www.atlasleefomgeving.nl/web/gezondeleefomgeving/gezondheid-in-beeld>, as may the tips for drawing up district profiles and examples of district profiles. <https://www.loketgezondleven.nl/gezonde-gemeente/lokaal-gezondheidsbeleid/wijkgezondheidsprofiel/voorbeelden-wijkgezondheidsprofiel>. There is also the RIVM toolkit for prevention in the district <https://www.rivm.nl/dsresource?objectid=c2ab49d8-d001-4e57-99ac-5fa991a639d7&type=pdf&disposition=inline>

Data sources with information at the regional/local level

Environment – residents and their characteristics, living etc.

Source	What can be found?	At what level of detail?	For which years?
www.waarstaatjegemeente.nl For comparable information, see also: http://mlzstatline.cbs.nl/Statweb/search/?SPT=True&SP-V=True&SPD=True&USESEARCHPARAMETERS=True&RC=G-Mo358&LA=NL and http://www.buurtintegratie.nl/ and www.woonzorgwijzer.info	Health differences, socioeconomic status, percentage of five chronic complaints, behaviour and skills (including exercise/sport), poverty, informal care, loneliness, participation, living environment. General public survey. Utilisation of care (numbers and costs) in the Zvw (Health Insurance Act) and the Awbz/Wlz (Exceptional Medical Expenses Act and Long-Term Care Act), per sector (GP, pharmacy, mental healthcare services, medical specialists). Number of care providers within the Zvw and Awbz/Wlz. Social domain monitor (facilities, type of support, youth, client experiences, use of primary care), debts. See also http://statline.cbs.nl/Statweb/publication/?DM=SLNL&PA=8326zNED The living and residential climates, public order and safety, work and income, education, youth, local authority financing, general public survey, local monitor on living, industry and the economy, energy and climate.	Municipalities (mutually comparable ones) with district profiles for some data	2016 and for some parts also a history since 2009
https://www.cbs.nl/nl-nl/dossier/nederland-regionaal/wegwijzer/cbs-in-uw-buurt	Number of residents, male/female, age, marital status, births & deaths, origins, household composition, income/education/work, social security. Number of residences, type of accommodation, parental/sale, inherited/uninhabited, year of construction, WOZ (Valuation of Immovable Property Act) value. GP, pharmacy, hospital. Facilities for the retail trade, catering, education and childcare sectors, and others. Use of energy/land, companies, motor vehicles.	Municipality, district and street (where mutually comparable)	2000 - 2016
https://www.volksgezondheidenzorg.info/onderwerp/gezondheidsmonitor-volwassenen-en-ouderen/regionaal	Chronic diseases and multiple morbidity, perceived health, psychological health, sports and exercise, smoking behaviour & alcohol use, overweight, informal care, problems functioning, hearing/sight issues, loneliness	Per GGD (Municipal Health Service) per region and sometimes per district, for adults and the elderly.	2016
https://www.rivm.nl/media/profielen/gemeentelijst.html	Health profiles: demographics, health & determinants, vaccinations, accessibility of care facilities, socioeconomic status, livability.	Municipality	1990 to 2013 and prognoses for 2014 to 2040.
http://www.atlasleefomgeving.nl/web/gezondeleefomgeving/gezondheid-in-beeld	Tips for getting a picture of health	district	
https://www.loketgezondleven.nl/gezonde-gemeente/lokaal-gezondheidsbeleid/wijkgezondheidsprofiel/voorbeelden-wijkgezondheidsprofiel	Tips for drawing up district profiles and examples of district profiles	district	
https://www.rivm.nl/dsresource?objectid=c2aba9d8-d001-4e57-99ac-5fa991a639d7&type=pdf&disposition=inline	Toolkit for prevention in the district	district	

Care –utilisation of care, costs, cash flows

Source	What can be found?	At what level of detail?	For which years?
https://www.zorgprismaopenbaar.nl/producten/zorg-dichtbij/zorg-in-gemeenten/ en www.woonzorgwijzer.info	Utilisation of care, costs and the differences between age categories. Care from the Zvw: such as medical specialist care, care using pharmaceuticals, mental healthcare, GP care (registration fee, visits to the doctor, other, multidisciplinary), resources, oral care (children), associated non-medical professions, transport of the sick and maternity care. Includes cross-border costs. The costs are broken down by gender and age.	Municipality. Q1 2018 also information at the level of the district (closed portal for municipalities), postcode and municipality	2014 - 2016 2011 - 2015
https://www.vektis.nl/intelligence/	Demographics, utilisation of care in terms of numbers and costs, number of care providers involved for: natal care, COPD/asthma, paediatric care, care for the elderly, diabetes. Information about GP care Information about hospital care Information about mental healthcare services Care close to home Care costs NOT PUBLIC For health insurers: a database containing all care cost declarations nationwide. And information about the quality of care, including mental healthcare, medical specialist care and primary care. And information for care administration offices letting them follow the use of the available resources under the WLZ (Long-Term Care Act). For GPs, hospitals, mental healthcare services: comparative 'mirror information'.	Municipality National/provincial Per municipality/hospital Municipality Municipality Municipality	History and prediction for the current year
City Deals - Agenda Stad - 'arrangements monitor' / folder https://arrangementenmonitor.nl	NOT PUBLIC This gives 24 municipalities and the health insurer VGZ a picture of the financial cash flows per district (and postcode, and sometimes per household), the facilities, etc.	District, postcode, household	
http://www.doktersrekening.nl/zoek/top_behandelingen.php	Data about hospital treatments on which the most money is spent (rate x number), broken down by specialist field, with a description of what the treatment involves. (NB: not Accident and Emergency (A&E))	Per hospital	2014

Labour market

Source	What can be found?	At what level of detail?	For which years?
http://arbeidsmarktinformatie.regioplus.nl/	Regional labour market for care and WJK (welfare and social services, youth care and child care). Information about nursing, caring and social behavioural staff: number of staff working for each level of training, number of training courses, shortage/excess, working conditions, mobility & pension. The 'Regionale zorgvraag en personeel' (Regional care demand and staffing) project of RegioPIs and Prismant: getting a better picture of future staff requirements together with care institutions, training institutions and municipalities. https://www.skipr.nl/actueel/id33610-regioplus-en-prismant-gaan-personeelstekort-in-zorg-aanpakken.html	For each employment region	Current and prognosis through to 2020
www.capaciteitsorgaan.nl	Estimates of medical specialists and supporting professions.	Primarily at the national level, sometimes per province	Current and prognosis through to 2034

05

Information at the right place and at the right time

The essence of the information at the right place and at the right time

E-health promotes self-management, making decisions together, cooperating and care networking

Information at the right place at the right time is an integral part of good care

Give people their own data in their own individual healthcare environments (IHEs)

Make sure there is a quality framework for exchanging data electronically

Encourage evaluation of the effectiveness and efficacy of new innovations

Strengthen the digital skills of professionals and people in general further

The governmental authorities provide clarity about the use of personal data and privacy

Igor Dirkx talks to us



"Because of persistent black stools and a haemoglobin level that was much too low, the GP recently referred me to A&E, where I was admitted as an emergency to the local hospital.

That is a different hospital from the one that is treating me for my intestinal condition, Crohn's disease. It turned out that I needed keyhole surgery of the stomach – gastroscopy. I tried to insist that the doctor treating me ought to contact the physician who has been treating me for years for Crohn's disease. They took no notice of that request or a request for the gastroscopy to be done under anaesthesia.

The gastroscopy went wrong, and I had a traumatic experience. After that they did contact my usual doctor and an investigation was then done using a camera pill. That examination was a lot less problematic for me. When I went to my check-up for Crohn's disease a few months later, it turned out that the results of the examination with the camera pill hadn't been sent to my usual doctor. These results could not be linked to my electronic medical record (EMR) and so they could not be made visible from one hospital to the other.

What does the movement look like?

- > Prevention is the medicine of the future and information makes it possible to aim for prevention. The transformation to keeping people healthy, making decisions together and integrated care will only work if information can flow digitally and seamlessly between those needing help and those providing help and between help providers so that it is available when needed. This must become an integral element of what we deem to be good care and what we fund.
- > People who are chronically ill or have a rare condition use medical and other care and social facilities heavily for their health, care and social functioning. People with a rare disease often have the further disadvantage that knowledge about the clinical picture of their condition and the consequences and treatment options is scarce and difficult to locate or deploy. It is important that care and support for vulnerable people can be scaled up and down as needed. To do that, professionals need an **up-to-date picture** of the availability of care and follow-up. The right information at the right time at the right place is therefore especially important for these groups.

Information for care without barriers

- > **Good, up-to-date information** is crucial for people if they are to take control of their own health and for their social environment and the professionals who want to support them properly. An up-to-date medication overview that has been verified together with the patient, for instance,

prevents avoidable hospital admissions due to **medication errors**.

- > The effectiveness of **self-management** has been demonstrated for people with diabetes. Self-management by asthma patients also results in less follow-up care. In the past, we used to exchange information by fax, letter and phone. We will soon be finding that old-fashioned. Making appointments online, video calls with the doctor, seeing our lab results online, talking to people in the same boat on the Internet – these are all examples of things that we are going to start finding more normal.
- > What we will also find normal is that we collect our medical and lifestyle data ourselves in our **individual healthcare environment (IHE)** – data that was previously fragmented among various care professionals: from vaccinations to test results, from treatments to prescriptions. We add our own health data ourselves to that, which we collect using e-health applications. Whereas professionals generally have to destroy our data after fifteen years, we ourselves can keep it lifelong. We always have access to that information and we determine for ourselves which information is shared with which providers of help and care. This ‘patient-following information’ saves people and professionals a huge amount of work and time, prevents unnecessary repeated questions and examinations, and ensures more integrated care. In short: give people their own data!
- > Information follows the people, across traditional boundaries as well. All the information from various domains is brought together in an IHE. When information flows have become digitised, professionals must be able to understand each other, despite differences in the language used. This will have consequences for electronic transfer, which will have to be plain

and straightforward about what is intended. However it also demands **harmonisation** of the wide variety of terminologies that are currently used in different domains. “The patient can wash themselves” has a very different meaning in a hospital where there are washing facilities in the room than in the home situation where the shower is upstairs.

From waiting room to living room

- > Care is shifting increasingly from the waiting room to the living room. Care services are being made available via computers and smartphones. Already, for example, thuisarts.nl is preventing large numbers of GP contacts from being needed. People measure their sleeping patterns, exercise, blood pressure, glucose and much more and share the data via the Internet and apps with their healthcare providers, informal carers and others. Together with them, it gives them **improved control** over their own health and lifestyles. This allows the new methods to get a place in the healthcare pathways.
- > Care professionals are exchanging **information in digital form** increasingly often. Digitisation can no longer be stopped. Not only in a technical sense: it is also changing the organisation of care. E-health is about digitally supported process innovations and it engenders changes in the roles and working methods of people and professionals. We can see how radical that is in the process innovations at banks (remote banking), the hotel market (Airbnb) and taxis (Uber).
- > Talkspace, for example, offers an ‘all-you-can-text therapy’ for 25 dollars a week. This service connects you to a professional psychologist with whom you can have contact as much as

01 you want. According to the research, this is just as effective as
02 traditional therapy but at one third of the cost and with improved
03 satisfaction in terms of ease of use and response times.

- 04 > The supercomputer Watson made the correct diagnosis for a
05 sixty-year-old Japanese woman who was suffering from a rare
06 form of leukaemia. That took ten minutes, whereas the
07 researchers at the University of Tokyo could not work it out.

08 Cold technology for warm care

- 09 > Digitally supported care helps people and their social networks
10 take control for themselves of their health, making **Samen**
11 **Beslissen** with a team of professionals a great deal easier. It
also makes it possible to learn automatically from the health
data and to allow digital algorithms to support decisions.
- > All those involved are kept up to date and can therefore
optimise their guidance. People receive care from ma-
de-to-measure care networks that are context-oriented and
integrated, small-scale at home or close to home, linked up to
specific expertise from centre such as university medical centres
(UMCs). The care is no longer associated with a time or place or
dependent on a domain or specifically on primary or secondary
care. Introducing **e-health applications and domotics** can
allow vulnerable people to stay at home for longer.
- > Care becomes increasingly individualised, because tailored care
becomes possible when data (including Big Data) and artificial
intelligence are used. One-off recording of data by registration
at the source and maximum automation makes it possible to
use data for advice and treatment that are tailored to suit the

person. The information can also be used for creating
decision-making tools in order to obtain a better picture of the
outcomes of care and to learn from them in research. Adminis-
trative burdens for the patient and professional can be reduced
and the pressure on the labour market becomes less.

- > **Health skills** will also include digital skills. The possibilities
associated with e-health mean that everyone in the care sector
will have to have sufficient digital skills. Patients, informal
caregivers, care professionals, managers and administrators
must all be sufficiently well equipped to make proper use of the



possibilities. They must also be capable of making choices from
among the almost unlimited options. For people who cannot or
do not want to do that, the care professional and the consulting
room will always be available.

- > The transformation to making decisions together (**Samen Beslissen**), people controlling their own health and care at the right place at the right time also requires **change management skills** that should not be underestimated and will be associated with disruptive changes. The transition to digitally supported care must be guided along the right path.

What do we need to do?

An acceleration is required in the scaling up of e-health applications, innovations (in processes and otherwise) and digitally supported care. That acceleration needs a climate that is positive about innovation and provides fertile soil for standards for electronic data exchange.

A positive climate for innovation

- > E-health applications must become standard if they are to offer added value safely. Where digital support makes an effective contribution to the quality and the outcomes of care (including those as experienced), it must become part of the **quality norms**.
- > That will increasingly often make using e-health the norm and a regular part of the provision of care, contracting and supervision. Where digitally supported care becomes the norm, it will be funded instead of, or in combination with, traditional

forms of care. Purchasers of care and support and care providers pay attention to the innovative possibilities as standard when **contracting care in**.

- > There are already performance descriptions for e-consultations and joint visits to the doctor (involving specialist and GP). Any existing bottlenecks in the funding must be removed where possible and knowledge about the options and experiments for declaring the costs of digitally supported care must be extended.
- > Professionals inform people (and their social networks) proactively about the options for effective applications and the use of an individual healthcare environment. Information will also be distributed about this by VWS (the Ministry of Health, Welfare and Sport) to the relevant parties in the field.
- > The governmental authorities encourage an ecosystem to flourish that contains promising innovations and makes efforts – including by providing financial stimuli (e.g. for IHEs) – to encourage e-health applications and the use of digitally supported care and to remove obstacles to its use.
- > This is done inter alia by helping develop the digital and innovation skills of the general public and professionals, by investing in scaling up highly promising initiatives and by reducing the obstacles in the pipeline that adds innovative treatments and applications into the health insurance packages.

Insights into added value support innovations

- > Research has shown that investing in more and better **evaluation** of the effectiveness and efficacy of highly promising

interventions offers numerous opportunities for improving innovation practices. An important obstacle to scaling up is the lack of evidence as to whether an innovation is effective or efficient. Digital innovations will be adopted more quickly by professionals if the added value of the innovation is clear.

- > The flipside of the lack of insights into the added value is that about 250,000 care-related applications are available via Apple's app store for which the efficacy has not been demonstrated or that could even be harmful. Using e-health incorrectly can result in unnecessary medicalisation or indeed in serious health risks being detected too late.
- > The cooperation between e-health developers and care professionals is also crucial if responsible digital care is to be offered. It is important to the parties always reach a widely accepted judgement about how the digital care can be embedded in the clinical pathways and in cooperative agreements between the professional groups involved.
- > A good example of how the authorities can encourage this is the creation of a Dutch version of **orcha.co.uk**. This website is an international guide to medical apps, including assessments made by scientists/professional groups and users¹⁵.

Fertile ground for electronic data exchange

- > Obstacles to the exchange and use of patient-related and other data must be removed as quickly as possible. Binding agreements are required about safe and efficient exchange and standardisation of data. This is referring to the unity of terminology and the method of exchange (in terms of both the “envelope” and the “mailboxes”).


- > All care providers must implement the standards as agreed, including the MedMij standards for IHEs. Only then can all relevant information about care and support genuinely be gathered by people and made to flow seamlessly between care providers.
- > This also demands a quality framework for safe electronic data exchange for which the regular supervisory toolkit can be used: the National Healthcare Institute sets the framework, the Dutch Healthcare Authority sets its policy rules up within that framework, the Dutch Health and Youth Care Inspectorate (IGJ) monitors compliance with the standards and insurers contract in their purchases on that basis.
- > Faxes and paper printouts will disappear. The entire information chain, between professionals and with patience, informal caregivers, etc. must become digital and must be based upon structured information, with attention being paid to recording that is supported as much as possible and automatic recording where possible.
- > Confidence in digitally supported care goes hand-in-hand with confidence in data protection and the treatment perspective where it relates to **privacy** and data sharing. Professionals want to make use of data from multiple domains in order to offer the best possible care and support. People want to have confidence that they will not be tempted to release data without good reason, that they know who is using which data for what ends, and that their data is in safe hands and will not be misused.

¹⁵ <https://www.orchaco.uk/>

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- > The Netherlands is in the vanguard of innovations in this field, for example with MedMij and the Personal Health Train. At the same time, practice needs clarity and workable frameworks. It is typically a responsibility of the governmental authorities to work on this together with all those involved, including patients and informal carers.

- > Together with the parties in the field of care and support, the authorities must set up a help desk for the implications of the new **General Data Protection Regulation (GDPR)**. Too much is currently unclear about the implications of the GDPR and this is frustrating the requisite innovation.

- > The **Informatieberaad Zorg** , in which a large number of umbrella organisations are united and which is chaired by VWS, defines agreements, standards and facilities for a lasting information system. Four outcome targets (associated with the medication safety, individual healthcare environments, standardised information exchange and one-time recording) point the way for implementation in programmes and projects.

- > There are numerous examples of e-health applications and digitally supported care that help get the right information to the right place at the right time. It often only results in success if **patients and professionals** are involved seriously and in good time, if managers and financiers have the courage to persevere and free up resources, and if the broader aim and embedding in the care system are considered carefully. Proper testing of the options by the users is crucial; there is often only one chance to convince them of the benefits.

- > Initiatives relating to data exchange are often more complex because data is power. This requires professionals and

managers of care organisations to adopt an attitude that is curious and **shows their vulnerability**, as well as a common conviction that it really will help people. There is also often a vendor lock-in problem¹⁶ and the roles and interests of IT companies must not be underestimated when changes are made. Any resistance may change into partnership if the partners in the care sector are all thinking along the same lines. If that does not happen, the governmental authorities must then take on the directing role.

Where can we see the start of the movement in practice?

- > The concept of the “**patient as information carrier**” has been developed for muscular diseases and about fifty rare disorders; it has been used and tested for a number of years now. Specific information is developed for a professional group (e.g. general practitioners or company doctors) about the care tasks for a specific condition, in close cooperation with the professional organisation concerned. The patients themselves are responsible for the distribution. In other words, the patient takes this information (e.g. as a brochure) along with them when meeting the care provider concerned in the consulting room. That makes the right information available at the right time in the right place. These brochures are also available in digital format.

<https://www.spierziekten.nl/nieuws/artikel/patient-als-informatiedrager/>, <https://www.nhg.org/thema/zeldzame-ziekten>

- > Through “COPD in beeld” (COPD in the picture), people can measure their lung values at home and send them through to the care providers. This replaces hospital visits for check-ups

and avoids admissions and readmissions. The initiative, which began as a cooperative effort between Sensire, Slingeland Hospital and Menzis, is now being followed up at a number of locations in the Netherlands. <https://www.youtube.com/watch?v=zHWOgKkURGo>, <https://www.skipr.nl/actueel/id33341-e-health-toepassing-voor-copd-patient-wordt-breed-beschikbaar.html>

- > All parties (informal carers, family and care providers) who are involved in the care and welfare of a client are brought together via **OZOverbindzorg**. A network is created around the client, in which the client determined who is involved. OZOverbindzorg is now being used at numerous locations throughout the country. <https://www.ozoverbindzorg.nl/>

- > Smart technology is being used by people themselves in care practice (e.g. for measuring their own weight, glucose levels, etc.). “**Smart medical devices**”, both large and small, have proved their added value for digital and other care, such as for instance the “smart pill-box app” that warns when medication has not been taken, thereby improving therapy compliance. Or a “smart bed” that receives biometric data from the sleeper and for example can warm the feet more, or is able to detect sleep apnoea and apply a stimulus to the sleeper to make them turn over, or alleviate other sleeping problems. This data can be stored in an IHE and shared with a care provider.

- > All GGDs and GGD-GHOR Nederland (the Municipal Public Health Services and Regional Medical Assistance Organisations)

¹⁶ Vendor lock-in makes a customer dependent on a single supplier for its products and services because the customer is then no longer capable of changing suppliers without substantial switch-over costs or other such problems.

are working with knowledge institutes and patient and consumer organisations on the **GGD AppStore**. The aim of the GGD AppStore is to provide a comprehensible and transparent overview of relevant and reliable health apps and websites (referred to as E-Public Health applications).

https://www.ggdappstore.nl/Appstore/Homepage/Sessie_Medewerker.Button

- > At Philadelphia, an institution for people with intellectual disabilities, all the clients are offered Beeldzorg (care via video contact) as standard. The same also applies for increasing numbers of institutions for long-term care.
<https://www.denieuwepraktijk.nl/praktijk/philadelphia-digicontract-clienten-verstandelijke-beperking/>
- > Gastrointestinal/liver doctors in the Groningen region only call chronic patients up for a visit when necessary. The same applies for **ALS patients** at the UMC Utrecht. Neonatologists at UMC Utrecht are now able to predict septicaemia six hours earlier than previously, based on real-time data. In the north of the Netherlands, all participants in the Lifelines cohort study will shortly have all the research data about themselves made available. <https://www.als-centrum.nl/zorg/>
- > **Communication platforms** (portals) are appearing at the expertise centres that make the specific information available to patients and their care providers/networks quickly that is needed for effective and safe care delivery. An initial platform was built very recently for this for a small number of expertise centres for muscular diseases at four UMCs.
- > The **Homerun project** run by the four centres for home ventilation is experimenting with adjusting ventilation in the

home situation in which the patient is monitored remotely.

Until now, patients' ventilation had to be adjusted in the intensive care ward of a university hospital. That is a very pricey procedure and not a nice environment for the patient for whom the adjustments are being made. <https://www.zonmw.nl/nl/onderzoek-resultaten/preventie/programmas/project-detail/doelmatigheidsonderzoek/homeruninitiation-of-home-mechanical-ventilation-at-home-in-a-selective-group-of-patients-with-chro/>

- > There are already numerous portals for patients that are linked to specific care delivery systems. Individual healthcare environments take it a step further, by linking to more care providers. Examples: www.digitalezorggids.nl.
- > The first IHEs are already being used. "Ikdus" in the north of the country, for example. And several institutions in the disability sector are already using an individual healthcare environment such as Quli. The MedMij system of agreements, which will be available in 2018, should provide a major impetus for this. <http://ikdus.nl/>, <https://www.quli.nl/>, <https://www.medmij.nl/>, www.psynet.nl

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The right professional in the right place

The essence of the right professional in the right place

Where patients are in management roles, professionals can also be coaches and advisers

Holding the conversations differently demands other skills from the professionals

The functionally-oriented approach is a central element of training *and* continuous learning

Care delivery at people's homes means an change in the essence of the care relationship and encourages integral care

The other professionals know and understand what they are capable of and must do; cooperation

Required: more than other professionals, a different kind of organisation, splitting tasks off

Regional action plans for working in the care sector must be developed

Maud van Vlerken talks to us



Maud van Vlerken is a nurse practitioner who has been working for ten years at the Schultz & Van de Kerkhof GP practice in Deurne. "The nicest aspect of my job is the variation. Variation in the work and in the contacts with patients. As well as delivering top quality. And we have the time and space to do that."

"The added value of a nurse practitioner is that they back up the GP by seeing the everyday complaints and patients quickly during surgery hours so that those times don't get overcrowded. In addition, I also see what the processes are like in practice – and what we can improve to make it run more smoothly for the patients."

Ulrich Schultz, GP: "The benefit is in particular that they take a lot of work out of my hands. Patient care in particular, but also organisational aspects. I'm also aware that she knows her limits. So at moments when she's not comfortable with a diagnosis or a complaint, there's virtually no barrier to discussing it with me. She's my sparring partner. And thanks to her, I get my work done in time."

What does the movement look like?

- > The *patient will see you now*. Using the **personal functioning of people** as the starting point for care and support implies a lot for the competences of professionals and the way they offer care and support. It was stated in Chapter 2 that people are “their own healthcare providers” to start with, in the sense that they are able to learn more about illness and health and take more control of their own care and welfare. The added value of professionals follows from that. Naturally, it differs according to the level of health skills that people have.
- > Healthcare providers will have to think (together with the patient) about how the condition can best be integrated into people’s lives and what is needed in order to do so. Supporting patients and their environments when making choices or when formulating their wishes and needs is therefore one of the new tasks for healthcare providers.
- > It means **providing help and care in a different way** because that’s what both the care provider and the patient want. If only one of the two changes, the change will fail. More and more people with chronic conditions are able to live relatively normal lives for longer. A different approach is needed because the increasing shortages on the labour market require it. That requires optimum efforts from the healthcare provider, appropriate for their knowledge and experience, the shifting or splitting of tasks, the use of innovative technology, in line with the situation and the person’s ability and environment. We are moving from people having to adapt to the range of care available to a range of care that adapts itself to the people and their environment.

This chapter focuses specifically on the **individual healthcare provider**¹⁷. As a healthcare provider, people will be looking for different skills and a different definition of your role:

- > Take the possibilities and the **personal functioning** of people as the starting point: a shift from a focus on illness and care to a focus on health and behaviour.
- > Consider the patient as a **partner** with capabilities: from a focus on decision-making based on medical expertise to a focus on shared decision-making.
- > In addition to your role as the treating physician with your own expertise to a role that is more and more that of a **coach or adviser**, with an eye for the broader context of the patient. Take more time for a proper conversation about the underlying need: what is the question behind the question?
- > As an expert, work more from the **information** that people have gathered themselves and position yourself as an intermediary between the person who needs the care and the field of expertise.
- > **Organise** the care. Keep looking for the optimum distribution of tasks within your own domain and look to collaborate with professionals from other disciplines.
- > Offer the **optimum care** for the patient. Just because we can do something, doesn’t mean we have to. Non-treatment can also be an option; solutions can sometimes be found in an adjacent domain.
- > Embrace **e-health**, digitally supported care and other technological possibilities and be satisfied if they allow the patient to stay at home.

- > Consider **prevention and early detection** as part of your care services. Promoting a healthy lifestyle and improving the social situation is often a better medicine than prescribing medication or referrals.



¹⁷ See also: Medical Specialist 2025, ambition, trust, collaboration, FMS, 2017.


What do we need to do?

Boldness, leadership and the ability to empathise

- > “It is important that healthcare providers **first experience for themselves** how hard it is to decide to change something by or for yourself and to stick with that resolution,” says Machteld Huber, former general practitioner and founder of the Institute for Positive Health (IPH). As well as what it is like to receive care (through empathising sessions).
- > **Don't be afraid to start the conversation.** It is quite something to intervene in someone's life and lifestyle. People find it hard to start such a conversation – although they often state that they do want it.
- > Use the opportunities that are available to **organise things differently**: the associated non-medical professions can offer relief in busy GP practices and even for medical specialists. Just like nursing staff, they are ‘at home’ in people's homes. Automation, robotics and other new developments can offer a lot of support in the care process.
- > Experience shows that the place where care is given matters a lot: conversations are different **at people's homes** than at outpatient clinics. The care provider also gets a better image of the social setting. In addition, travelling back and forth to the hospital doesn't help many patients get better. Other effects of the outpatient setting are:


- > there is a more equal relationship between professionals and patients;
- > social and environmental factors that may cause the dysfunctioning become more visible to the care provider;
- > it is easier to involve and mobilise social networks;
- > teaching appropriate, long-term coping strategies is easier when done in the place where people use them, i.e. in the home situation.
- > Treatment in your own environment gets **results** sooner. This is good not only for the person in question, but also for the care provider. It is more satisfying.
- > Although self-management in care gives the patient a large degree of autonomy, it also causes **tension** in their relationship with healthcare providers. What is important for the healthcare provider is not always important for the patient. Autonomy also means that patients have the freedom to deviate from proven effective treatments. Many people with diabetes think it is important that they can choose how to deal with their condition themselves, without being accused of being undisciplined or not trying hard enough to stick to the diabetes regime. This is another type of conversation that requires other skills.
- > Conversely, it is increasingly possible that people want more care and support than professionals think is sensible. In addition to tensions in the relationship, this can also trigger **uncertainty** in people. It is important that healthcare providers are aware of this possibility and try to help people along towards a different way of setting up care. Medical treatment is not always the best answer and care in a hospital is not always the best possible care.

Cooperation and reflection

- > **Knowing what others can do.** A task can only be left to a care professional – or a patient or relative – with confidence by a care professional if they know that the other person is trained for a treatment. **Learn from each other** by offering a public stage to good examples and by visiting living labs.
- > Cooperation is not a guarantee; where many parties are working together on a single case there is often also a lack of coordination, which can make the care worse. Determine who is **controlling** a certain care demand is therefore relevant. After all, as far as the person with a care need is concerned, the network is only as strong as its weakest link.
- > It is helpful to work with a **well-trained care provider** at the start of a care process, for instance a community psychiatric nurse or possibly a doctor's medical assistant in mental healthcare who can determine whether there is a psychological disorder or a social problem. This means that the patient can get the appropriate follow-up help from the very beginning.
- > **Mirroring information for professionals** gives insights into the actions of others and puts your own actions in perspective. The **'Better not done' and 'Better left out'**  initiatives support this. These are lists of medical procedures that are not proven to be effective. Insurers can also provide insights into the variation in practice.
- > The programme called ‘Verstandig Kiezen’ (Choosing Wisely) examines when it is sensible to be cautious with certain procedures. For example, there is a study evaluating the choice between a cast and an operation for elderly patients with

wrist fractures. <https://www.demedischspecialist.nl/nieuws/meer-aandacht-voor-niet-effectieve-medische-handelingen> and https://issuu.com/radboudumc/docs/beter_laten_aanbevelingen_21-06-2017?e=28355229/50617182

Enough healthcare providers

- > If we continue as we are now, by 2022 there will be a shortage of 100,000 to 125,000 employees in the care sector. This demands a lot from a number of different parties.
- > Educating **more professionals** is everyone's responsibility. But just training more people is not enough. We must organise the work and education of healthcare providers **differently and better**.
- > More attention needs to be paid during training to aspects such as a **functionally oriented approach** , prevention, learning across professions, making decisions together and working with the patient and their family. Not to mention dealing with the digital and technological possibilities. Learning how to be adaptive and how to cope with change is a precondition.
- > Holding a conversation **as an expert or coach** requires other conversation skills. Healthcare providers need more of the skills for acting in the role of coach – in addition to developing their specific expertise, which is of course still required.
- > For the professionals, it means **continuous learning**. That more people can keep working in the care sector, thanks to healthier ways of working, less work pressure, less sickness absence, less aggression and greater job security. As well as more use of

innovation, technology, digitisation and e-health to support both patients and healthcare providers.

- > Greater focus on finding the **optimum ratio** in education: do not over-educate (medical specialists) and do not over-specialise or sub-specialise more than is necessary.
- > The focus of the approach is in the regions – where people live, work and learn. **Regional action plans** are made through the [Working in the Care Sector action programme](#).

Where can we see the start of the movement in practice?

- > Attention is increasingly being paid to organising care differently, for instance via reallocation of tasks. Research shows that this gives more time for patients' care requirements while retaining quality, and people feel they are being helped more quickly at the GP's surgery and in hospitals. It is essential that everyone is aware of the possibilities. See for example the educational films about the work of a nurse practitioner and a doctor's assistant: <https://www.stichtingkoh.nl/taakherschikking/publicaties/filmpjes/> and at <http://www.platformzorgmatters.nl/implementatie-3/filmpjes/>
- > Initiatives for getting the right healthcare provider at the right place have more chance of success when there is a common motivation, for example when the **pressure of work** is high. There are shortages of paediatric physicians and ophthalmologists in various areas in the Netherlands. The municipal public health services in **Gelderland-Midden** have reallocated a lot of

tasks within youth healthcare services. Children get fewer checks by a doctor at the child health clinic and at school, but are seen more often by a nurse or doctor's assistant. The money that this saves is used for the children who need more care. We are seeing similar developments elsewhere. One example is the Rotterdam Eye Hospital, where people with simple cases of cataracts are helped closer to home by an optician instead of by an ophthalmologist.

- > In addition to the pressure of work, **financial constraints** or fewer facilities (social services facilities, care homes) can motivate people to do things differently. Since last year, a trial has been running that uses primary care nursing staff for vulnerable elderly people (aged 75 and over) in three districts in **Zoetermeer**. The role consists of a mix of activities that were previously done by a community nurse, a doctor's medical assistant and a case manager. <https://zorgenz.nl/nieuws/combi-eerstelijns-verpleegkundige-en-wijkverpleegkundige/>
- > The **child check** is specifically intended for people who work with adult clients, such as GPs, nursing staff, social workers, psychiatrists and psychologists. The child check is part of the Reporting Code for Domestic Violence and Child Abuse Act. The child check means that where professionals have adult clients, they must also check whether there are children in the family and assess whether they are safe. This can lead to a report being sent to 'Veilig Thuis' (Safe at Home). The child check helps obtain a picture of signals about parents and increases the capabilities for detecting child abuse. It is a nice tool for helping professionals take a look at the whole client system. <https://kindcheck-ggz.nl/>
- > Argos Zorggroep uses **Google Glass** as an instruction tool for

01 informal carers so that they themselves can carry out care activi-
02 ties, such as putting on compression stockings and sticking on
03 medication patches) without having to wait for the healthcare
04 providers.

- 05 > The project called 'Weg met de klok' (No more clocks) by the
06 Zuiderhart nursing home in Hengelo found a different way of
07 working that fits the wishes of the residents better. The
08 management has inspired and encouraged the team of carers to
09 work differently and not immediately fall back to attracting
10 more staff. [https://www.innovatiekringdementie.nl/a-1683/
11 weg-met-de-klok](https://www.innovatiekringdementie.nl/a-1683/weg-met-de-klok)
- > The environment or the context of the clients can also be
influenced. In the approach for **combating stigma**
(www.samensterkzonderstigma.nl), employees of corporations,
welfare organisations, volunteers, family members, neighbours,
police, special investigating officers, counter staff and
supermarket staff are made aware of what stigmatisation does
to people with psychiatric conditions. Combining this with
offering a course on Mental Health First Aid (www.Mhfa.nl),
gives them ways of making contact when people have mental
issues – how to listen, to assess whether immediate help is
needed and to motivate those involved to get help. The
municipalities around Utrecht are putting this into practice.

07

Added value at the right place

The essence of added value at the right place

Encouraging added value by evaluating new and existing care

More time for the client and patient and more cooperation within the district network

More consultative cooperation between professionals

Using the medically affiliated professions and district nursing avoids unnecessary care

Less reimbursement of hospital care if it can also be done at home or closer to home

Rewarding the care outcomes (as they are perceived)

Truus Cornelissen talks to us



I think the care sector still pays too little attention to how you fit together, as a person. It's important that someone takes the time to listen to my situation and explain well what the pros and cons of a procedure are.

I got diagnosed with spinal stenosis – narrowing of the spinal cord channel. In my regional hospital, they said that I needed surgery, because otherwise my leg would end up paralysed. The hospital had a long waiting list for the surgery. That's why I started calling around for a second opinion. Eventually I ended up at another hospital where I had an extensive consultation with the doctor. We discussed all the advantages and disadvantages of operating. We also discussed the possibility of not operating. Based on that conversation, I decided not to have surgery, because of the risk of damage to the spinal cord during the operation, which could result in paralysis in both my legs. I still suffer from tingling now, but surgery will still be an option if I get acute problems. I'm happy that I was able to make the decision, together with my doctor. With the knowledge I have now I would have left my first healthcare provider sooner.

"I promise that I will practice medicine as well as I can in the service of my fellow men... The interests of the patient are paramount and I will respect their opinions... I acknowledge the limits of my capabilities." These elements of the Hippocratic Oath are particularly important for promoting care in the right place, not just for doctors but also for other professionals in the social and medical domains.

What does the movement look like?

- > **Ownership** of people's own lives means they are responsible for functioning as well as possible and assessing their own quality of life. It is about people and not primarily about illnesses. Equal partnership and Samen Beslissen are the core. 'Big Data' and self-diagnosis' make the relationship between patient and healthcare provider less strict, although personal attention and wisdom from experience are hugely important for many people.
- > As stated in Chapter 6, the care professional is increasingly taking on the role of **coach or adviser** in addition to their role as the treating physician, with an eye for the broader context of the patient. That means more time for conversations about people's underlying needs. It also requires more investment in the social domain, at the gateway to the medical domain and in cooperation that transcends domains and disciplines.
- > Good **early detection** of vulnerabilities in the elderly who live at home needs cooperation across domains and disciplines – between municipalities, GPs and district nurses, if possible with the help of a specialist in geriatric medicine.
- > **Prevention and early detection** play an important role in the contacts between the patient and the professional. Promoting a healthy lifestyle and improving the social situation are often a better remedy than prescribing medication or referring people. In their role as financiers, the municipalities and insurers work together on this.

Added value of care through better evaluation

- > A professional can provide added value if they have a clear picture of the best treatment for the patient. Evaluating care through **studies** into the effectiveness and efficiency of healthcare professionals helps to improve care and the appropriate use of care, as well as lowering healthcare costs.
- > Before new care can be put into effect responsibly, the key question is whether a new treatment, medical technique or medication has added value compared to the existing treatments. This requires data to be collected about the cost-effectiveness of the new care. It is important that the evaluation of **promising innovations** should be broadly accelerated so that they reach the patients faster. This requires a cultural change that makes the proper evaluation of new care obvious.
- > It is also desirable that this care should be broadly adopted as quickly as possible once its added value is has been demonstrated. This movement can be backed up by transforming the current regulations for conditional licensing of care packages into an accessible, simple subsidy scheme with few barriers. The **new regulations** provide financial and research support for research into the added value of promising care ideas and helps build a culture of evaluation of physical effectiveness and cost-effectiveness.
- > Insights into which treatments can best help the patient are constantly subject to change. That is why it is important that existing care is also continuously evaluated. **Care evaluation** is more than a study: it is an improvement cycle for good care that consists of at least three focal points: (1) measuring and

evaluating, (2) describing in guidelines, and (3) applying good care in practice, with package management if necessary. The goal of the improvement cycle is to evaluate medical actions: this is essential for meaningful and efficient care.

- > The National Healthcare Institute should develop its role as the **chair and facilitator** of a platform where interested parties from the care sector are involved. The goal of this platform is to take care evaluation up to the next level, with harmonisation of the agenda and the approach. The key question for this platform is how the quality and appropriate use of existing care can be promoted. This will let quality policy, care evaluation and package management help produce care with proven added value – care that is actually put into practice.

Location of care



- > The place where medical care is given now has a strong influence on the substantive **content of care**. The low likelihood beforehand of any specific diagnosis makes the risk of over-treatment in primary healthcare higher than in secondary or tertiary services. That is why the GP will generally be more cautious (with reason) than a secondary healthcare provider, who is in fact more likely to wrongly miss something serious.
- > This means that someone who is seen at the **wrong place** by a healthcare provider with an inadequate frame of reference is running unnecessary risks, can suffer unnecessary harm and can generate unnecessary costs. The rule should be that care must be close by and simple if possible, further away with greater medical effort if necessary. It must be made clear to people that not all care is necessarily good for them.

- > The future organisation of medical care transcends the boundary between primary, secondary and tertiary care, starting with appropriate **consultative cooperation** between GPs and specialists. Consulting a specialist, for example, means that GPs will make unnecessary referrals less often. Conversely, consulting a GP lets specialists prevent vulnerable people with multiple morbidity from being exposed to fragmented over-treatment by super-specialists, with all the concomitant risks. It is conceivable that the cooperation will eventually lead to local care centres for non-complex care close to home that also collaborate with other healthcare professionals and nursing staff for treatment and follow-up care.
- > More **patient-oriented care** also means that the involvement of the medical specialist becomes less tied to a specific location. Specialists in both the somatic and the mental fields will go to the patient more and more, instead of the other way around. This is done together with specialist nursing staff and using of digital remote care: institutional care in the home (a “**hospital at home**”). Hospital care will therefore have to become less focused on being ‘within its own walls’ and must get closer to the patients or even in their homes.¹⁸

Distribution within the healthcare landscape

- > More care is being moved from ‘within the walls’ of hospitals to other places. We are seeing the traditional hospitals (including outpatient clinics) developing into centres for complex care, with major concentration and high volumes ensuring quality and efficiency. One of the ways to do this is buying in **low-complexity elective** procedures such as orthopaedic, dermatological and ophthalmological procedures in specialised centres with a

strong focus on quality and service. In care institutions, the accommodation function can be disconnected more and more from the care function, creating a new supply of accommodation possibilities. Long-term financial agreements can support this fundamental transformation.

- > Over the past thirty years, the number of hospitalisation days has decreased by 60% while the number of stays has remained the same. Over the coming ten years, the number of stays will also decrease and the number of hospitalisation days will again decrease substantially. **Healthcare real estate** will have to be sustainable and flexible if it is to continue to respond to current needs. That means cheaper construction for a shorter intervals – aiming for 20 years instead of the current 40 – and more modular construction so that buildings can also be used for other purposes: a medical specialist who also partially ‘lives in’ at the GP practice, for example ([Haskoning](#) , *Functional Healthcare Real Estate is like a Swiss army knife* , 2018).
- > **Large university knowledge centres** remain and they will play an active role as knowledge centres. The traditional competences of care, education and research will still be what distinguishes them from other hospitals. The university centres will focus more on optimising the treatment of complex patient groups, trauma and multiple morbidity. The public role of the UMCs will also fulfil a networking function with other healthcare providers, particularly when it comes to acute care.
- > Care will focus even more on the **care value**, i.e. outcomes in terms of the perceived quality of life in relation to costs. Insights into medical outcomes and the results as experienced and reported by patients are crucial for helping professionals to

learn, for better organisation of care in teams and for better conversations with patients at the doctor’s office or at home.




¹⁸ See also: Ziekenzorg in cijfers – Brancherapport algemene ziekenhuizen 2017 (Patient care in numbers: Sector report for general hospitals), NVZ (Dutch Hospitals’ Association), 2017.

What do we need to do?

Organisation and cooperation

- > Every person with a care need will from now on be asking themselves, “What do I know myself, what can I do myself, and what do I need?” Every professional will have to ask the patient, “What is important for you, what can you do yourself, and how can we help you?” “We” – the care professionals in the social and medical domain – should look for added value for the patient, with networked care as the aim. **Networked care** takes the needs of patients as the starting point, with the various players in the network able to add value for the patient at different moments. The managers ask professionals about their approach and results and publicise them. There is often too little ‘residual capacity’ for change. It is important that the parties can make more time for this.
- > In our system, the function of ‘gatekeeper’ – the first port of call, traditionally linked to the role of the GP – is important and proven. Medicalisation and hospitalisation do not necessarily make people get better and sometimes the care is unnecessary and expensive. That **gatekeeper** function should become a broad responsibility of the GP, community nurse and the social district team, collaborating in a physical or virtual district network. These various parties need more time for early detection of vulnerabilities, more time to determine their underlying needs together with people, and more time for coordination between professionals.
- > Focusing on how people are functioning also means **more time for patients, consultative collaboration with medical**

specialists and collaboration in the district network. How this will work in practice depends on the situation. There are various possibilities: smaller numbers of patients per GP and GP practice; reducing the time GPs spend that is not patient-specific; medical assistants; deployment of doctor’s assistants and nurse practitioners; reducing the regulatory pressure, etc. The extra resources can benefit these activities without affecting the income and working hours. The first pilots with a higher ‘licence fee’ have shown that the number of referrals decreases and patient satisfaction increases. In this context, the **development and innovation performance**  can also be better utilised in the costs. GP practices monitor the results using an agreed method.

- > The same applies to district nursing: **collaboration and coordination** must be rewarded more. It is important for vulnerable elderly people that care can easily be scaled up and down so that people are not left at the wayside. This can be done by specifically rewarding coordination or collaboration between community nurses. The health insurer is involved in this. That specific instruction must also apply to the social district team that is run by the municipality. District teams, community psychiatric nurses, other nursing staff, the GP and sometimes other associated non-medical health professionals can add more value in the first phase of support and care, which can prevent a lot of follow-up care. For follow-up care, the providers of long-term care need to be involved in time and not only when there is a real need. The need for an indication under the Long-Term Care Act can be looked at together with the Care Needs Assessment Centre. This requires a joint approach by the health insurer, the municipality and the care administration office (Chapter 4).

Relocating care: close by where possible, concentrated where necessary

- > **Lifestyle** becomes a standard part of a visit to the doctor. When applied sufficiently, all the relevant guidelines for conditions in which there is a lifestyle component must contain references to effective lifestyle interventions (exercise, healthy eating, relaxation). The scientific professional associations will provide the input for this.
- > **Early detection** by district social work teams (municipalities), GPs, district nurses and if possible specialists in geriatric medicine. They produce a picture in good time of the potential vulnerabilities of elderly people living at home in terms of e.g. loneliness, dementia or mobility (the risk of them falling), so that action can be taken to limit this risk and if possible prevent the situation of that elderly person from escalating and leading to them needing urgent care.
- > Shifting elements of secondary care into the primary line can still have treatment in the secondary line as a possible (and remunerable) option. The Taskforce believes that if certain diagnoses and treatments can be given closer to home or shifted to the home, they ought in principle no longer to be carried out in a hospital setting. It recommends that a tripartite working group should examine what care (in terms of diagnosis-treatment combinations or DRGs) can be considered for contracting in primarily outside the hospital setting, as the final element of the contact as seen by professionals, insurers and patients.
- > Some 30% to 50% of DTCs (similar to DRGs) currently are not based on a referral by a GP. Deploying a nurse – e.g. geriatric or

nursing support staff – and in some cases a GP in a hospital can help patients weigh up the considerations about their treatment. This is certainly true for patients with multiple disorders. Health insurers can make agreements with the hospitals about this.

- > The managers of academic and general hospitals make agreements about cooperation, as a step towards **medical networks** for complex care. Non-complex care must disappear from the UMCs and should be transferred to general hospitals, outpatient centres and mixed primary and secondary care centres, so that care closer to home can also be ensured. Continued treatment (by people working together) is then possible, instead of referring them on. This means that the specialists will come from one hospital to the patients in another hospital, rather than the other way around. This makes cooperation a good alternative to mergers. The authorities can make template documentation available for new forms of cooperation.
- > The current contracts between insurers and healthcare providers in secondary care already often contain no volume-related driving factors, and appropriate care at the institutional level becomes viable. It is important to make agreement in contracts about collection and publication of **care outcomes** and to scrap other reporting obligations (**value-based healthcare**). At the same time, the incomes of the healthcare providers are still often dependent on the scale of the care that they provide. Getting everything aligned and convergent is crucial in the care sector: it is about everyone's common interest in offering the patient high-quality and effective care.
- > The transformation of the **healthcare landscape** will have to take shape through the insurers' contracts. Long-term contracts

can help this transformation and should be made more rewarding. This also requires funding for the costs of reducing the physical capacities. An improved care delivery organisation has returns on investment that could also be attractive to financial parties such as banks, pension funds, InvestNL and the European Investment Bank. A licence requirement could be introduced for the expansion of hospitals¹⁹.

Where can we see the start of the movement in practice?

There are many examples of professionals deliberately reflecting on what their added value is and acting accordingly, of professionals looking to collaborate across domains and choosing different organisational forms. A small sample is given below to illustrate that this movement has started. This does not yet constitute a genuine change in the care landscape with shifts, reallocation of tasks and concentration.

- > An example of a project that strongly encourages **appropriate utilisation** is the 'Leading the Change' (LtC) project funded by the Netherlands Organisation for Health Research and Development (ZonMw). The aim of the LtC project is to demonstrably lead to implementation of the care that has been proven to be most effective, with a reduction in variation between practices (and therefore in costs) as a result. The essence of this plan is going through the entire quality cycle: evaluation of existing and new forms of care delivery using care delivery evaluations, implementation of the outcomes of the evaluation through guidelines, and validation of the implementation in the healthcare procurement process. It is essential that

all elements of the quality cycle are addressed at the same time; only then will it be genuinely possible to obtain the care with the highest quality for the lowest cost. That makes this project unique.

- > The RIVAS group in Gorinchem – GPs, specialists at the Beatrix Hospital and the health insurer VGZ – have jointly set up the 'Kwaliteit Als Medicijn' (Quality As Medicine, KAM) programme, which focuses on delivering the right care in the right place in a range of projects. Examples of these projects are post-care checks at the GP surgery, or administering an infusion in the home rather than as an outpatient day treatment in the hospital. More information can be found at <https://www.rivas.nl/over-rivas/kwaliteit/kwaliteit-als-medicijn-kam/>
- > **Powerful basic care** in Overvecht: in the district of Overvecht in Utrecht, agreements have been made between primary care providers and the municipality/neighbourhood teams to work together more closely in the care and support for clients. GPs have also been given more money so that they can spend more time on positive health. This has led to an increase in the perceived health, a rise in the number of local residents who exercise, a reduction in the costs for outpatient care and mental

¹⁹ Berenschot is carrying out a study of the transition and friction costs incurred in the re-location of 'care delivery to the right place' for the NVZ (Dutch Hospitals Association), the NFU (Netherlands Federation of University Medical Centres), Patiëntenfederatie Nederland (the Dutch Patient Federation), ZKN (Independent Clinics of the Netherlands), the FMS (Federation of Medical Specialists), ZN (Dutch health insurers) and V&VN (the professional association for nurses and care workers). The study focuses on the types of transition and friction costs that occur if care is delivered at the right place, how organisational and financial transition and friction costs are dealt with around the country, and how these costs should be dealt with in order to move care delivery to the right place.

01 healthcare services and an improvement in the efficient
02 prescription of medicines. What this example shows is that
03 more appropriate care can be delivered through the use of the
04 right care and other professionals at an earlier point in the
05 healthcare delivery chain. This was measured using the
06 perceived health and healthcare costs.

- 07 > The health insurer CZ set up pilots in various parts of the
08 Netherlands with a new approach to **wound care**. In the case of
09 a complex wound, a wound coordinator draws up a treatment
10 plan and a digital record is kept of progress. Special wound
11 nurses are deployed who have received additional training for
this function. They have the right knowledge and can easily link
the hospital, the GP and the home situation together. The pilot
has increased welfare for the patient and their informal
caregiver and has reduced the cost of materials. This example
shows that by deploying additional expertise and staff for a
tailored solution at the right point, you can save on the costs
further along in the process and at the same time deliver better
care.
- > The Hospital at Home care programme aims to offer a new clinical pathway in which hospital care can be delivered in the patient's own home. Most patients with cognitive disorders live at home with the help of informal caregivers and specialised home care. In the case of these patients, urgent hospital admissions are often more complex due to the occurrence of hospital-related complications such as falls, delirium, new infections, malnourishment and functional and cognitive deterioration. Many of these patients cannot return home after being discharged from hospital and have to stay (temporarily) in a nursing home. The aim of the care programme is to prevent hospital-related complications and delays in admission to a

nursing home. People often arrive via A&E. In order to make sure care in the home is properly arranged, the patient has to stay in hospital until everything has been organised. The patient will go home on the morning following the A&E visit. Then there is hospital care delivered in the home; the 'Hospital at Home' physician and nurses come to the home for the care and treatment. Treatment is the responsibility of the hospital (the 'Hospital at Home' doctor). The content of the care is the same as in the hospital; only the location of the care delivery is different: at home. For more information, see <http://hospitalathome.nl/>.

o8

Towards broader triage at the right moment

The essence of broader triage at the right moment

Proper information and support for clients to assist the options for 'self-triage'

The triage has to be broadly based, i.e. the medical and social domains together (district network)

Financing is needed for the coordination and control of broad triage

Assessment is a recurring process for scaling the care and support up and down

Primary care is principally a switching point and there need to be limits on it in terms of the duration

Better cooperation for formally determining the indications (access to and allocation of care)

Anne-Miek Vroom talks to us



The care for my rare condition is offered to me as standard in my regional hospital. The care is coordinated by the nurse practitioner. However, it's sometimes not clear whether I can contact the hospital directly or whether I have to go through the GP.

For example, once I called my GP because I thought I had a vertebral fracture. The assistant said I should come along to the practice to have it checked. I said I didn't think that was a good idea because I reckoned that my expertise meant I could judge whether something was wrong. She urged me again very eloquently to come along to the practice and said the GP couldn't pay a home visit to assess the situation. I said that wasn't possible and so I decided to call the hospital directly, though I know that the hospital thinks the GP should do the initial triage.

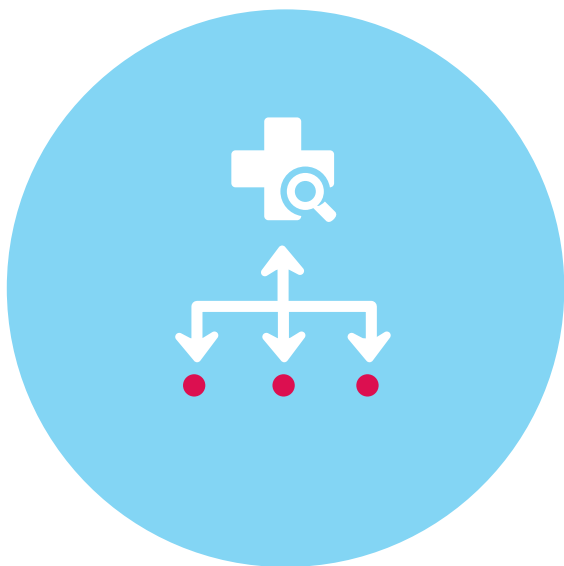
I discussed this unfortunate incident later with my GP and he was shocked it had gone like this. We discussed the general procedure for the triage and made agreements together about it. What's more, whenever the doctor's assistant opens my file, a huge message appears on the screen: "Whenever this lady requests a home visit, you must always schedule it." However, I wonder what will happen if I call the GP out-of-hours surgery in the evenings or weekends. I fear I might still have to call the hospital myself then...

What does the movement look like?

Triage was first used on a large scale during the First World War, to select the wounded on the battlefield on the basis of urgency rather than military rank as in the past. Three categories were distinguished: the untreatable, treatable on the field and to be transported to the hospital. In the triage that is carried out these days by GPs and their assistants in a hospital's A&E, the options are sending the patient back home, treating them then and there or admitting them to a care institution.

Triage of the near future will be **broadly-based triage** with the following characteristics:

- > The starting point is the care requirements of the general public, as this returns **personal control** over their functioning (ownership) to them. IT applications are making more self-diagnosis, self-triage and self-management possible, with or without the support of *remote monitoring*.
- > This always involves **joint** detection and assessment of underlying problems within both the social and medical domains. The focus may be more on the social domain on one occasion, and more on the medical domain on the next.
- > It should be normal for every professional in the district to know their colleagues who also deal with their client/patient. They should have time available for building and maintaining a **district network**, which should lead to agreements about the division of tasks and ultimately to adapted organisational structures (broad-based district centres) as well.
- > **Early signalling** in the social domain of people who have few sources of assistance, the vulnerable elderly who are living at home for longer and people who are (temporarily) less able to cope avoids having people receive unnecessary medical care.
- > It encourages cooperation between different professionals, with a decision being taken on who is the **coordinator**. Furthermore, this gives an opportunity for **peer review**: professionals in isolation often continue treatment for longer than when they are in a team.
- > Information is stored in the person's **individual healthcare environment** (IHE) and can be exchanged between professionals with the patient's consent so that all relevant healthcare providers are sufficiently well informed.
- > Broad-based triage should take place at various **switchover points** in people's care journey. Each time, this involves an assessment of what new or follow-up care is best. Sometimes that will be a question of scaling up, at other times of scaling down.
- > For a proper triage, it should not matter when and where people report to, whether this is from their home, in the social domain, in primary care or at the hospital. Broadly based triage, whether virtual or physical, should be just as well-regulated in the **evening, night or weekend** as during the day.
- > A broad-based assessment increases the quality and efficiency of the care and reduces the risk of people getting unnecessary care, falling between the cracks, getting shunted from pillar to post between care providers or having to wait for care.
- > Whether a preventive geriatric team in the district is involved, a mixed primary/secondary care centre or a bridge between inpatient and outpatient care, making agreements in advance about **funding** is crucial in order to arrive at a broadly based assessment that crosses healthcare systems. We have seen from experience that if this is not done, the interests of the organisation continue to take priority over integrated care delivery.
- > Good triage is only worthwhile if good follow-up care is arranged. In future, the people who perform triage will have a good overview of what care is available. That is particularly relevant for vulnerable people whose support systems can suddenly collapse and who need urgent assistance – social, medical or psychiatric.
- > The **formal indication process** will also be organised more as triage with the relevant healthcare providers, with people experiencing as little disruption as possible from the transition between funding domains during their support and care pathway.



What do we need to do?



Start with the people themselves

- > Proper triage starts with **good information** about what care makes sense at what location and what points in time, and where you can go for the required support. Campaigns focused on professionals and the general public help reduce the inappropriate use of care at various levels, in particular outside regular hours.
- > Promoting and extending **thuisarts.nl** as a website and app is


an excellent opportunity to encourage triage at home (for minor medical questions); it is also highly suited to being used as a source of answers to questions that can help self-management. Modern applications allow information to be exchanged with healthcare providers and let care be delivered remotely.

- > In addition to deploying professionals and help in the locality, it is important that people have good access at the start and throughout their care to independent client support in municipalities. Healthcare providers could also make use of people with first-hand experience more often and the training for this should be extended.

Organising broad-based triage


- > Well-equipped and **responsive district teams** are essential for supporting high-risk groups and preventing them from having to resort to medical care. In the case of early warning systems, particular attention should be given to tackling **debts** , which often go hand in hand with medical complaints and medical costs.
- > One party should take on the **coordinating role**  in close consultation with the person with a care need. This coordinator knows the 'social and medical lie of the ground' within a municipality or region, organises the broad-based triage and makes decisions in consultation with the other parties.
- > It is more important to get this coordinating role filled than to decide in advance who should fulfil it. That depends on the local situation. Municipalities and/or insurers should provide **structural funding** for this role and also make it financially

possible for other parties such as welfare workers, district nurses, associated non-medical practitioners, practice assistants, GPs and mental healthcare service professionals to be engaged where needed.

- > Patients with urgent psychiatric issues benefit from intensification of the implementation of **intensive home treatment teams** (IHT). These teams carry out urgent assessments and admissions for replacement treatment at home. They can also serve as a useful gatekeeper for the clinic, they can do multiple home visits per day and they have a multidisciplinary makeup.
- > There are **Flexible Assertive Community Treatment** (FACT) teams for people with severe psychiatric conditions who need treatment and counselling over a longer period. FACT teams also have a multidisciplinary makeup (e.g. with a psychiatrist, psychologist, community psychiatric nurse, social worker, sheltered housing supervisors and someone with relevant first-hand experience). The professionals visit people in their own homes so that they can receive care in familiar surroundings.
- > Better use/deployment of technological developments ('**care enablers**') is required so that both those requiring care and healthcare providers have access to medical records (the individual healthcare environment). This allows the medical history to be used to determine what care is required at what point. The scientific evidence for triage systems also needs to improve.
- > It is advisable to review the staffing of the **GP out-of-hours surgery or the accident & emergency**  (A&E), including the deployment of specialists. The deployment of a district nurse, for example, or geriatric nurses reduces hospital admissions by offering people extra support at home.

Organising good follow-up care

- > Care professionals must **broaden their own focus** to achieve proper cooperation between the social work team, the GP and the hospital. If A&E in the hospital only screens for medical problems, it is not clear for the district network which elderly patients require extra attention in non-medical areas after they return home.
- > In hospitals, a **transfer nurse** should become the norm. Knowing about appropriate follow-up care and a sufficient overview of the available alternatives when going back home would not be a sensible option both help ensure that people do not stay in hospital any longer than necessary. This applies in particular to vulnerable elderly people who often spend longer in hospital than is needed. The introduction of regional coordination points for all forms of follow-up care can make a significant contribution in this regard.
After triage at A&E or after admission to a hospital, a primary-care stay or geriatric rehabilitation care, it is important that the district network is informed of the situation in good time and can make sure that the patient can return **home safely**. Someone within the district network should then make contact with the treating professional or transfer nurse.
- > The **primary-care stay** is a good option in the case of the vulnerable elderly in particular, but it must not be too much of a separate form of care alongside other forms; it should be limited in principle to a few weeks at most. In the meantime, an assessment can be made of whether the patient can return home again or have to go to a nursing home after all.

- > Municipalities, insurers and care administration offices collaborate more as funders of support and care when **contracting in** care. Contracting-in of urgent care, intensive forms of respite care, emergency care under the Social Support Act and district nursing in the evening, night and weekend hours must be coordinated.
- > **Local comprehensive agreements** are needed between funding parties on the allocation of such costs, either beforehand or retrospectively. Drawing up template agreements can be worthwhile.
- > The **formal indication process** and allocation of care are organised in such a way that people have all their tests and interviews on a single day at a single location; the decision on what care in what domain and in what place is taken then, and this fits with what people need.
- > The phenomenon known as the **care trap**  needs to be tackled. Most elderly people want to stay in their own home, in their familiar surroundings for as long as possible. Care and support in the home can be provided on the basis of the Health Insurance Act, the Social Support Act and/or the Long-Term Care Act. As a result, people with a care need may have to deal with differences between the systems and may as a result suffer an unwanted drop in the amount of care they receive and an increase in the financial contribution they have to make. It is important to review the information provided to people, the cooperation between the professionals involved and the demarcation between domains and to facilitate a smoother care journey. This may require changes to legislation and regulations.

Where can we see the start of the movement in practice?

Many places across the country are starting to work with broadly based triage and assessment or reassessment. Professionals are looking to collaborate across domains.

- > In Amsterdam, a pharmacy serves as a place where people with confused behaviour can be spotted at an early stage. Care workers are notified in good time if someone fails to collect their medicines from the pharmacy and they can then contact patients quickly to avert a possible crisis. <https://www.trouw.nl/samenleving/amsterdamse-apotheker-krijgt-rol-in-het-opsporen-van-verwarde-personen~ao6625a4/>
- > Several municipalities in Groningen and Drenthe have accumulated experience over the past few years with the **SamenOud** care model (Old Together). In this model, each GP has their own Elderly Care Team and all people registered with the practice and aged over 75 are invited to take part. Participating seniors receive a questionnaire once a year that is used to determine their risk profile. The Elderly Care Team then offers appropriate preventative care and support. In addition to the GP, the team consists of geriatric specialist, a district nurse and a social worker. SamenOud has been embedded in the daily procedures because of the positive experiences and the research results. www.samenoud.nl
- > In mixed primary/secondary care centres, GPs and specialists work closely together. Because GPs can call on the help of a specialist immediately in cases of doubt, serious diagnoses can be ruled out and patients can be sent home reassured or,

if necessary, referred to the hospital. This is being done in the MijnZorg pilot in Oostelijk Zuid-Limburg, for example, and De Werf in Joure has also just started a mixed primary/secondary care centre. <http://www.mijnzorg-ozl.nl/> and <http://dewerfjoure.nl/>

- > Hospitals and home care organisations are collaborating in more and more places to create a **bridge between inpatient and outpatient care** so that the transition from hospital to home goes smoothly. An example is the Martini hospital in Groningen. In the Deventer area, the regional transfer centre arranges the transfers from primary care and A&E to the intramural facilities (Social Support Act care, respite care, primary-care stays, geriatric revalidation care, and Long-Term Care Act care). As a result, GPs and intramural institutions no longer have to spend hours arranging a transfer. In the Gouda area, they are also working on using the transfer centre as a point of access for **urgent (geriatric) care** so that the right diagnosis can be made and treatment plan drawn up and the transfer can be arranged. <https://www.umcg.nl/NL/UMCG/Nieuws/Nieuwsberichten/Paginas/Transmurale-Zorg-brug-van-start-in-Groningen-en-Drenthe.aspx>
- > Various places in the Netherlands are experimenting with using district nurses in GP out-of-hours surgeries and in A&E. The district nurse organises home care for vulnerable elderly people during the evening, night-time and weekend shifts. This improves the care for the elderly and prevents unnecessary admissions and re-admissions to A&E. Hospitals that have acquired experience with this include OLVG, MST and the Zuyderland hospital. <https://www.mst.nl/nieuws/kwetsbare-ouderen-eerder-thuis-door-samenwerking-seh-en-wijkverpleegkundige/>, <https://www.zuyderland.nl/nieuws/>

[de-wijkverpleegkundige-als-nieuwe-collega-van-de-hapseh/](#)

- > The care organisation Omring has clustered complex primary care beds in the hospital so that the hospital can easily refer patients on to these beds. A **primary care beds app** is used that shows the availability of all primary care beds offered by all providers in West-Friesland and Noord-Holland-Noord. A central triage team assesses whether a primary care stay is needed or whether that person can be cared for at home. <http://www.de-eerstelijns.nl/2018/03/kortste-weg-juiste-eerstelijnsbed/>
- > In view of the efforts to tackle waiting lists in the mental healthcare services, it is extremely important for people with a care need to be offered the right care immediately in the right place through the right triage. At Altrecht, the number of unjustified referrals has declined substantially since the introduction of the **4D model** by Utrecht's GP practices. The 4D model arose in the search for answers to the questions of 'What should have priority in tackling the complaints?' and 'Who does what (including the patient)?' The 4D model helps GPs when talking to the patient and assists them in making referrals and in collaborating with other parties. For more information, see <http://www.overvechtgezond.nl/files/het%204d-model%20-%20volte.pdf>

These are examples where broad triage and assessment (or reassessment) are applied at a single point in the care-and-support chain. Ultimately, this broader triage must be the principle applied throughout the chain, no matter who is making the assessment or when and where.

09

Towards organising the right care in the right place

The essence of organising the right care in the right place

Stop thinking in terms of primary, secondary and tertiary care; start organising in chains and networks

Treatment of psychological complaints in the patient's own surroundings

Hospital care can be given at home or closer to home much more often

Consider organising care delivery from the perspective of the people and not the buildings

Contracting will ensure that capacity in numbers of beds is reduced

Cooperation is a precondition for delivering good care

Use and reuse data about people and make sure that those involved know what others are doing for that person too

Joost Coffeng talks to us



“The doctor’s medical assistant for mental healthcare at the district health centre has contacted Joost Coffeng, who heads the ‘Mental healthcare services in the district’ pilot team. She is concerned about Mr K,

a local resident who has stopped picking up his prescribed medication (antipsychotics). The gentleman’s administrator has also not been contact with him for some time. And Mr K has also not been turning up to appointments with the medical assistant for mental healthcare. But his letterbox is being emptied. The mental healthcare medical assistant asks us whether we see any way of making contact with Mr K.

We get onto it, initiate an ‘intervening care process’ and drop in regularly on our rounds of the district to make contact with him. The housing corporation’s housing consultant contacts the community psychiatric nurse, who is now coordinating that process, and tells them that there have been regular disturbances due to screaming at night. The housing corporation needs to get into the house because of a leak, but the gentleman won’t open the door. The police and the community psychiatric nurse in the ‘Mental healthcare services in the district’ team are asked to accompany them to the man’s house.

This is the first contact with the man, and the first practical arrangements are made. It also turns out the man isn’t taking his medication as prescribed. Structure is introduced into the medication administration. A weekly home visit is agreed, there is contact with the neighbours and the administrator, and contact is also restored with the family. There is less night-time screaming and the neighbours experience less disturbance. When the situation stabilises in due course, the community psychiatric nurse can let go again and the care for Mr K can revert to the medical assistant for mental healthcare.”

What does the movement look like?

- > Health is about more than not having symptoms; recovery is about living with (and learning to live with) a condition or impairment that can be highly disruptive. A person's capabilities and inner strength take centre stage, with recovery becoming an individual and personal process in which functioning (again) in social roles is an important goal.
- > The **transition in mental healthcare services** is a good example of the movement: instead of being far removed from communities, mental healthcare services have become increasingly integrated into society, but are still somewhat segregated. A stay in a hospital still means you are separated from your own living environment, family and community; as a result, this leads to a loss of social roles. On a ward, people have to fit in with the ward's schedule in terms of the daily rhythm, activities etc. What is more, admission is not just something that has a big impact on the individual in question: it is also a major predictor of long-term utilisation of care, certainly in the mental healthcare sector.
- > This does not help **recovery and participation**. People who make use of healthcare, in whatever form, do not do better if they are forced too much into the role of patient. A different approach is required, certainly for people with chronic conditions who want to continue with their 'normal lives' as much as possible.
- > Care therefore needs to focus more on treatment in the person's **own environment**. That makes it easier for people to maintain or recover their social roles. This change fits in with the need patients and those close to them: they want to stay involved.

Not "walled in" and "pigeon-holed"

- > The care sector still has a lot of '**compartmentalisation**': domains, levels, organisations, specialist fields and officials. The people who use care services are continually moving between these compartments. This system has become too much part of the culture. All the professionals involved do their very best within their particular 'pigeon-hole' but they rarely have a picture of what it looks like from the perspective of the lay person. They often don't know what people's personal needs are and they lack information about their contributions to the care outcomes. Making a real difference for people is precisely what motivated many professionals to choose jobs in the care sector. That is why working to help day-to-day functioning is an improvement both for the person with a care need and the healthcare provider (see chapters 2 and 6).
- > Healthcare professionals should form a **network** around the patient, in which levels, organisations, specialist fields and official roles are of secondary importance. Concepts such as the primary, secondary and tertiary levels of care should disappear. That may mean that a medical specialist should continue coordinating the care for someone who undergoes kidney dialysis at home. Or that a nurse trains someone to make use of e-health, which could save them outpatient clinic visits. Or that a dermatologist has a surgery in a GP practice. As a result, care is delivered near to the patient wherever possible. Networks are used not just for clinical recovery but also for recovery in a social sense (reintegration after an illness). The network adapts as the patient's health and requirements change.
- > If the recovery of functions or learning to cope with a certain state is **multi-dimensional**, the care must be too. But care is

usually not multi-dimensional. The severity of psychiatric symptoms is often not an isolated phenomenon; rather, it is linked to other problems such as unemployment, housing and financial problems and relationship difficulties, which are often a factor in admissions to mental healthcare.

- > Cooperation between professionals requires **trust**. You can only build trust by getting to know one another. Care professionals currently operating in different areas and 'compartments' should drop in on one another more often and learn to appreciate each other's work. Cooperation also means taking responsibility and holding each other to account for the added value they may or may not be delivering for patients.
- > The care sector is divided into 'pigeon-holes' that not only have their own specialist fields but also their own **interests**, positions of power and funding. A lot of healthcare focuses on treatment in the medical domain. But that is often only one aspect (and a minor one at that) of recovery in functioning. Collaboration between the medical side and the social work side is needed to help people more to function.
- > Health insurers and municipalities reward cooperation when **contracting in** care. That means that rather than arranging contracts with a hospital or a home-care organisation, they have contracts with collaborative ventures for certain types of care. It is important that this should not result in new compartments; these should be collaborative ventures that overlap and are flexible – not just diabetes care, for example, but also that type of care combined with other forms such as for COPD and cardiac failure. Or hospital care and district nursing to make the transition to the home environment go as smoothly as possible.



What do we need to do?

- > Health insurers, care administration offices, municipalities and healthcare providers know what the **care task** involves and act correspondingly. This analysis makes the discussions go well: are we doing the right things, and are we doing the right things in the right way? Is it genuinely helping people? All the care organisations have their own responsibilities here, proportionately split, large and small, broad or highly specific (Chapter 4).

- > They create a picture of **who needs to cooperate with whom** in order to provide better care and support for people; this is primarily about the people who deliver the actual care, not about organisations or hospitals or practices. These can be very different parties when discussing care for the elderly in a particular district than when talking about some rare condition. Municipalities, care administration offices and health insurers thus ensure there is a position for the non-assignable tasks, as in district nursing.

- > Cooperation is a key dimension of the quality of care. Within five years, cooperation ought to become a **precondition** for being able to deliver good care and thus a precondition for contracting in that care. Together with the people who utilise the care, the minimum criteria for that cooperation must be defined. This could cover aspects such as knowing each other and what each party can do, exchanging information, contacting each other when needed.

- > **What care can be provided at home or closer to home** will be determined together with the users of the care provided, for example using e-health or consulting hours on site. Hospital buildings or practices are by no means always a requirement for all professionals to be able to do their work. This includes making sure there are no barriers for access to the healthcare providers: being able to make your own appointments digitally, being able to send e-mails to a nurse, using FaceTime to talk to your doctor, etc. That must also become part of good care.

- > Data moves along with the people and can be 'reused'. **Information is exchanged and available independently of time and place**, both for care consumer and informal carers and for care professionals, as long as permission has been given by

the care consumer. People who utilise care services can add informal caregivers and care professionals to their digital networks and can grant them access to their health dossiers (Chapter 5). It is a good idea to formulate the objectives to be achieved along with the person concerned and to set it down in the individual healthcare environment (IHE), so that those providing assistance know what each other is doing to meet those goals.

Reducing institutional care

- > Mental healthcare service providers must keep a certain number of beds available for e.g. crisis situations. The generic module is being introduced for **acute mental healthcare** and regional agreements are being made between carers and insurers.
- > As long as there are **empty beds**, it makes financial sense to use them – keep them occupied. Insurers and healthcare providers can make contractual agreements about this. When the provider needs fewer beds than are available, the provider and the insurer share the revenues from them.
- > Cutting down on clinical care in mental healthcare services requires **sufficient outpatient care** and support. The Monitor Ambulantisering (Monitor for Reducing Institutional Care) and long-term restructuring of mental healthcare shows that this care and support is not getting built up yet. Nationwide interventions are too limited to have an effect down at the regional or local levels. Aanpak Wachttijden (Tackling Waiting Lists) lets care providers develop plans for building up more outpatient care and it also calls on the insurers to finance that care.

- > People who start living in the community again need not only care but also counselling on numerous aspects of life (Dannenberg Commission). Reducing institutional care can only be done properly if these facilities are properly arranged, in addition to the care. Agreements between municipalities and insurers about their input are both needed and helpful when designing a responsible approach to reducing institutionalised care.
- > The care for people must be **scalable up and down**, flexibly and in good time. Continuing treatment for longer than necessary must no longer happen and intensification of the care must be possible quickly when needed. This can be organised for instance by building in fixed reassessment points.
- > To make it possible for people in **vulnerable periods** to avoid institutionalisation or having to undergo treatment, receiving the right care in their own environment instead, a sufficiently accessible care offering is needed.
- > This could for example include **safety net places** where you only spend part of the day, such as an overnight clinic, and places where you can be admitted temporarily when you feel a crisis coming up on you. Redesigning Psychiatry makes the case for forms of care that are located in the middle of society, with accessible places where people can walk in without any perceived barriers. E-health can provide support for possible intermediate forms, as could people with practical experience. (http://www.redesigningpsychiatry.org/wp-content/uploads/RedesigningPsychiatry_uitgave2_mrt2018.pdf)

Where can we see the start of the movement in practice?

- > Networks have been organised that require that specialist knowledge from various groups providing help for a condition. ParkinsonNet (www.parkinsonnet.nl) is a nationwide network of healthcare providers that specialise in treatment and guidance for patients with Parkinson's disease. There are more than 3,000 specialist healthcare providers (including neurologists, physiotherapists, ergotherapists, speech therapists, dieticians and nursing staff) in this network. The aim of ParkinsonNet is to improve the quality of life for patients with parkinsonism by raising the quality of care and enhancing patients' self-management. The vision behind ParkinsonNet is that the quality of care and self-management can be improved by:
 - > Improving the individual expertise and competences of healthcare providers regarding the treatment of parkinsonism.
 - > Improving the cooperation between the various people providing treatment, using regional networks.
 - > Consistently involving the person utilising care as a partner in their own treatment.
 This helps improve the quality of care and results in cost reductions. There are also initiatives for other conditions that have involved setting up networks. Examples are Netwerk Chronische Pijn (the Chronic Pain Network, www.netwerkchronischepijn.nl), Claudicationet (the Claudication Network, <http://www.claudicationet.nl/>), Dementienetwerk (the Dementia Network, www.dementienetwerknederland.nl), district-based mental healthcare services (www.psynet.nl) and regional networks for COPD (www.copdnetwerkutrecht.nl).

- > Two pilots have been set up in the city of Utrecht in which the professionals in specialist mental healthcare services **cooperate** with outpatient sheltered housing supervisors (Social Support Act), people who help patients find work *and* people with practical experience. This cooperation is done in a single integrated team in which the social and medical domains converge around the person utilising the care. This demand can be medical, social or personal in nature, or a combination. This team works intensely with the neighbourhood teams and the district's health centre. A key success factor is that they got started, even when it was not yet clear how it would all be financed. They were therefore taking a risk and placing their trust in each other. Using staff who had practical experience was financed by resources for sheltered/supervised living. In addition, the parties used subsidies from the Ministry of Health, Welfare and Sport to overcome frictions temporarily (<http://ggzindewijk.nl/>) (Volkskrant newspaper article and Google Drive).
- > Deventer town council has made it possible for staff of the Intensive Home Treatment (IHT including the crisis service) to submit a recommendation that care is urgently needed for a Social Support Act indication. When a member of the IHT team providing help assesses that there is an urgent need for care and that there is an **urgent social problem**, they can call in social support staff directly. Depending on the psychiatric problems, the social support staff member will function alongside the help provided by the IHT team; if there are no psychiatric issues, the IHT team will withdraw entirely. Scaling up and down flexibly like this ensures that the patient gets the right care, no more and no less than is required. <https://www.i-ht.nl/presentaties-2017/>
- > The Connect project is an initiative from the Dutch Association for Cardiology. Early detection of heart failure improves the

quality of life of patients, cuts the number of hospital admissions and reduces mortality. “We currently only start treatment towards the end of the spectrum, and we’re too late by then. GPs, together with their support staff in the practice, see most of the patients who are obese, hypertensive or diabetic, or have COPD. You ought to ask those patients if they suffer from fatigue or shortness of breath, because heart failure could then be part of the picture. Then you can really start on prevention.” Connect was started up at the end of 2011 and GPs and cardiologists in Groningen and Noord-Drenthe have for example been working closely together since 2015. This cross-disciplinary cooperation is improving the outcomes of care and patients value the care more. In the meantime, 60% of all GPs are working in the AF care chain project and over 300 patients with previously undetected atrial fibrillation have been found through active case-finding by GPs and then referred to the hospitals. More than 1000 patients have also been referred back to GPs from the hospitals. These results show that cooperation across the lines yields results on many fronts. <http://nvconnect.nl/>

- In Deventer, the community psychiatric nurse works alongside a police officer. This is part of the cooperation relating to problems that the police classify as ‘**confused people**’. This team consisting of police and mental healthcare service staff is referred to as *street triage*. They then think about what process would be most appropriate: Social Support Act care, criminal law, mental healthcare or perhaps somatic care. Proper triage like this at the start avoids people getting shunted back and forth, with multiple assessments by different healthcare providers, unnecessary transport movements, etc. (<https://www.zonmw.nl/nl/over-zonmw/innovatie-in-de-zorg/programmas/project-detail/actieprogramma-lokale-initiatieven-mensen-met-verward-gedrag/street-triage-deventer/>)

- Rehabilitation specialists at the rehabilitation clinic pass part of their work on to **specialist physiotherapists and ergotherapists**. For rehabilitation involving complaints of the hand and wrist, specialist physiotherapists and ergotherapists can take on part of the coordination and execution of the work, instead of the rehabilitation physicians in the specialist secondary care segment. The rehabilitation specialist does the intake and is available for discussions. A customised treatment plan is drawn up together with the patient. This working method makes it possible to deliver good, high-quality and effective care at a lower rate. For more information see <https://kinos.nl/hand-polsrevalidatie/drie-behandelvormen>.

- Setting up and organising regional networks of tailored healthcare provision and assistance around the patient, thereby achieving integrated, multidisciplinary and cross-domain care. A proper chain is being built by the **ALS-expertise centre** (a cooperative venture involving UMC Utrecht and the AMC). The expertise centre controls regional treatment teams that in turn back up the care networks around ALS in the home situation. This model can be made more flexible and patient-specific for a lot more conditions, including rare ones.

- In Gelderland-Zuid, an overall **network approach** is being used to set up district-oriented mental healthcare services and a multidisciplinary approach to people who are confused. There is commitment and active participation by partners in the health, care delivery, welfare, residential and safety sectors. Health insurers are involved and there is also commitment from mayors and the councillors with care portfolios. People with practical experience are working at all levels, including the steering committee. The project is being led by the Municipal Health Services. (<https://ggdgelderlandzuid.nl/239270-2/>)

- In Vught, efforts have been made since 2015 in the area of **overlap between safety and care** with help from district municipal health service staff. They are able to provide help, make links with other partners in the care chain and elsewhere, and to help reduce the burden on the police. Good cooperation at an early stage allows people to work together and determine what approach and what care an individual requires. (<https://www.ggdhvb.nl/nieuws/2016/05/Gemeente-Vught-en-GGD-werken-samen-in-pilot-Wijk-GGDer>)
- The skin medical centre is an example of substitution from the tertiary line back into secondary care. All GPs referred dermatological patients to the AMC and the VUMC. Those patients are now seen in the new medical centre for skin problems, which is a joint venture with a ZBC (independent treatment centre). Only the patients with severe problems are still seen in the academic medical centres. The Skin centre is more accessible for the patients (short waiting times, no barriers to overcome, rapid throughput) and the care is less expensive. <https://huidmedischcentrum.nl/>

10

The transformation has to be viable

The essence of the transformation having to be viable

- The right care in the right place needs to be better rewarded
- Innovative contracts are often possible without modifying the funding rules
- Purchasing backs up the organisational capacity and cooperation in the districts
- More use of bundled care packages, integral rates and fixed sums per client
- Care insurers and municipalities use their purchasing power to push towards a better care landscape
- Concentration of complex care and high-quality care facilities is desirable

Gijs van den Brink talks to us



“Despite my non-congenital brain injury, I want to be as independent as possible. Sometimes I do use a helping hand, but I use technology even more.

For example, I have a head support for in bed. When the motor in this head support broke, I had to wait two months for a mechanic. During that time, I needed help from a carer just to be able to get out of bed. This affects your sense of self-worth; you don't feel quite so 'human'.

The same applies to my shower chair. It was only recently delivered, although I picked it out and ordered it two years ago... There seems to be no rush when it comes to these types of things, so I do them myself.”

What does the movement look like?

The movement towards the right care at the right place is being made possible by taking the way people function as the starting point, by using the intrinsic motivation and expertise of professionals and by utilising the irrevocable commitment of managers. The way care and support are contracted in and financed should support this movement and should be adapted when they get in its way. In addition, not joining the movement should be rewarded less, in both the medical and social domains.

In practice until now, we have seen that in most cases it is not necessary to modify the funding rules to achieve **innovative contract forms**. In fact, there is a broad sense that stability in the costs benefits this development. In a few specific cases, financing will be able to help improve the process of contracting in. Over the coming period, new contract forms will have to be used more widely and on a larger scale. Procurement practices can also be improved, especially in terms of a balanced relationship and better coordination between different buyers, i.e. care insurers, care administration offices and municipalities.

In terms of funding, contracting or financing, the movement must be reinforced:

- > **From supply-oriented to people-oriented and driven by values.** This means more focus on prevention and early detection, more time for people, making decisions together, decision tools and rewarding good care outcomes. There is still too often an indirect volume incentive in the current practice.

- > **From financing monodisciplinary care to rewarding integral care.** It should be about rewarding the added value of every professional involved, of mutual consultation, of collaboration within and beyond their own domain and setting up networks with the person who needs the care. There is too much double diagnosis and stacking up of treatments in current practice, and other cases where people fall between two stools.

- > **From fragmentation to collaboration based on a shared image.** The focus and direction of care and support are determined based on a picture of the health information in a region and the existing supply of healthcare; the procurement policy of care insurers, care administration offices and municipalities are brought in line with this. This applies in particular to vulnerable people who live at home for longer periods and for whom the care can be made more or less intensive as their situation or that of the informal carer requires.

- > **From financing the status quo to financing new forms of care.** It is not about financing the institution but about financing appropriate care. Once there are new forms of care, payments for outdated treatments should be cancelled. If it is possible to give care close to people's homes, the remunerations for hospital care should be cancelled. Some complex forms of care require contracting-in that is aimed at concentration. If this does not happen enough, the authorities should give an impetus to this movement.

- > **Taken as a whole, this can allow a different care landscape to be created.** It is not about financing the institutions or the current organisation of care, but about financing appropriate care, close to home where possible and further away if that is better. It is up to the purchasing parties to push for this

transformation. Long-term contracts can support agreements about desired growth or unavoidable shrinkage.



What do we need to do?

Innovative forms of purchasing are characterised by their link to the context, a process of joint exploration and learning and properly measuring whether it works (business cases). It is certainly not the case that a certain form that works in one place will also work in another place and vice versa. In fact, we all benefit from diversity and a dynamic structure.

Towards people-orientated and value-driven funding

- > Care is still too often focused on illness and treatment instead of improving health. More **time for looking and listening** to clients/patients in the social and medical domains also means more attention to lifestyle advice, prevention and early detection. There is also scope for determining whether people can manage their own limitations or what kind of care and support is most appropriate in which area. More time for discussing decision tools and deciding together also leads to more sensible and economical care in the medical specialist setting, in which referrals back to primary care or non-treatment should also be rewarding options.
- > The initial experiences with longer consultations with the GP are favourable: positive patient experiences and fewer referrals. A step further would be reducing the weighting for consultations in the funding of GP care and increasing the weighting for funding based on the registered population. The ultimate aim should be to reward GPs for realising **care outcomes** that are agreed upon beforehand. This can reduce the variation in practice and it encourages GPs to collaborate with others.
- > With the advent of a **new funding model for district nursing** based on insights into the intensity of care, it should be possible in future to work with fixed sums for distinct client profiles, combined with agreements about quality. The latter is important to prevent selection of patients and avoid too little care being given. This combination also reduces the attractiveness of non-contracted care with respect to the current situation. Non-contracted parties now often compensate low rates with high care volumes. This is undesirable because it raises the costs per client and it does not promote people's ability to take care of themselves.

Towards rewarding integral care

- > Within the medical domain, simple interventions can improve **collaboration** a great deal. Good examples that could be better utilised are sit-in consultations and short consultations between the GP and the specialist. Specialists will also be available on call in more and more places or will hold consulting hours at the general practice unit or in a mixed primary/secondary care centre. Shifting hospital care to locations closer to the patient's home also fits this movement.
- > GPs can also refer people to the social district team through "**prescription welfare**". To promote broad triage and follow-up cooperation, buyers can finance these aspects through one of the parties. The organising capabilities are often still too limited.
- > For elective care, greater use can be made of **DTC bundles** (similar to DRG bundles) that include both pre-care and follow-up care. This could for instance be hip and knee arthrosis, cataracts, rheumatism, wound care or breast cancer. One party is financially responsible for the care supplied and the outcomes. For a given price, the costs in the hospital or independent treatment clinic become lower and shifts to primary care, non-medical care professionals and home situations can be expected.
- > In these examples, costs are declared at the level of the DRGs. An example where the DRG (or DTC in the Dutch situation) as a form of cost declaration has been dropped is the experiment concerning the **integral funding** of clinical natal care. In this, the DRGs plus primary care performance are replaced by a limited number of integral multidisciplinary tasks to be performed. For these tasks, newly formed integral clinical perinatal care

organisations make agreements about rates with care insurers. The initiatives in perinatal clinical care are intended to stimulate collaboration focused on the patient and better quality of care.

- > For **chronic illnesses**, broader experience has been acquired with integral funding for asthma, **COPD** and CVRM where disciplines collaborate. Care insurers can follow one another when buying in these bundles, so there is competition in the price of the bundles. This model can also be developed for e.g. vulnerable people or other chronic illnesses, such as **renal insufficiency**, where associated professions can often also be included. In addition, considerable **efficiency benefits** can be generated for these conditions by moving care outside the hospital setting and organising it closer to people's homes, with digital support.
- > Where chronic illnesses have a social dimension or are correlated with **social problems**, municipalities could also reimburse the involvement of welfare workers as a supplement to a medical bundle. This also promotes the organisation of integral, personalised healthcare.

Towards collaboration based on a shared view


- > Purchasing at care insurers, care administration offices and municipalities should focus on the desired result of healthcare and/or support and on the health or the welfare of people. Duplicate purchasing should be avoided. The parties produce an image of a region, municipality or district in which both the health situation of the population and the healthcare supply can be seen. This gives focus and direction in the procurement policy of care insurers, care administration offices and municipalities. That this should happen is agreed at the national level, but not how it should happen or what the agreements involve.
- > It is desirable that care insurers, care administration offices and municipalities invest in a good **business case** for sensible and economical care and support. The involvement of financial parties such as banks, pension funds and InvestNL can also be useful, as well as experiences with innovative tools and social impact bonds.
- > A stock-taking of all running collaboration projects and initiatives between financers shows that a lot is already happening, but it is mostly small-scale and experimental. It is important to strengthen the **organising capacity** and to scale up successful working methods. Care insurers and care administration offices cannot build collaborations with all municipalities separately, but it is feasible at a regional level. In a region, it seems obvious that the largest health insurer, the care administration office in question and representatives of the local councils concerned should take the lead. Other parties then try to follow them, given their own responsibilities to their residents and the insured parties.

- > The financers can also strengthen the organisational capacity and control *on the ground* by visibly reimbursing **non-client-specific tasks** as part of contracting-in. These are indispensable for connecting the domains and disciplines together, for example tasks involving coordination and switching. A good example of this is the modular care infrastructure of Menzis within the funding of district nursing.
- > Good collaboration is extremely important for **acute care** in particular. The way the ROAZ (Regional Acute Care Forum) works needs strengthening, with purchasers also joining in if necessary. It has been agreed earlier that care insurers, in consultation with healthcare providers, should arrange a regionally available single 'office' that GPs and hospitals can always turn to if they need a bed, both for follow-up care after discharge from hospital or before intake directly from primary care. In many places, they are working hard on setting up such a primary care stay coordination point. It is important that these points are ultimately related not only to primary care stays but also to other forms of follow-up care, such as geriatric rehabilitation care and long-term care.

Collaboration between municipalities, care insurers and care administration offices

- > The more intensive collaboration should also be about **data exchange** and data-orientated working. This is important if proper help and care are to be provided by professionals. What do we as a whole know about the socio-medical situations of people in a district and how can we act on it, each using their own expertise and experience? Good examples are the exchange of information about defaulters in the Health

Insurance Act (Zvw) to municipalities and the Early Detection unit of the Credit Registration Office (BKR) to pay more attention to the relationship between debts and medical problems.

- > Purchasers also benefit from a better exchange and links between data. This applies e.g. to a better picture of the use of the Social Support Act and Health Insurance Act, the inflow into the Long-Term Care Act per municipality and the average weight of the inflow. It is recommended that there should be an exploration of how the Social Support Act budget can move with the number of people who go into the Long-Term Care Act: the fewer vulnerable people go into the Long-Term Care Act, the more people need Social Support Act care. Additionally, it is also possible to see how municipalities can bear part of that extra burden of a higher Long-Term Care Act influx (the **Danish model**).
- > The distinction between social support and health care is by definition arbitrary. At the same time, this means that every boundary is defensible, including in the funding. The current method of funding is not an obstacle in itself. Parties do sometimes disagree about what falls under whose responsibility. This demands clarification of the boundaries of the domains for specific themes (e.g. a helping hand in the assessment function). By temporarily subsidising project costs, municipalities and care insurers can properly coordinate the responsibilities and the procurement, as well as checking whether any tasks and activities are falling between the cracks. The current **prevention coalitions**  are a good example: municipalities and care insurers have joined forces, with a modest governmental subsidy to help them work together.

- > Instead of wanting to breach the bulkheads between funding areas, it seems more productive to promote the formation of **'intelligent interfaces'** that make the client/patient and care professionals forget that there are different domains at all. These are certain types of services that take care of the administrative and bureaucratic burdens created by the 'bulkhead' partitions or even connect and coordinate the different forms of care ('integrators'). Purchasers could jointly finance such initiatives, taking account of where the benefits end up.
- > Additionally, research is needed into the desirability and possibilities for **pooling** budgets from the various domains for integral care. It should be possible for all parties to invest in each other based on a business case, or a programme should be made possible.
- > The experimental article from the Long-Term Care Act could also offer a solution. This offers the option of starting an experiment with the aim of giving the insured party an integral, coordinated package of care and support instead of it all being financed from the various individual domains.

Towards financing new forms of care

- > Care at a specific location should in principle only be financed if it actually has **added value** for the patient. Many diagnoses and treatments are done too often in a hospital setting, while it could be more effective in a different location without compromising the quality. Think of optometrists who do eye checks instead of an ophthalmologist, oral hygienists who take over specific tasks of the dentist and transferring anticoagulation care from the thrombosis service to primary care.

- > It is desirable to select forms of care that – from the viewpoint of quality and efficiency – lend themselves to being transferred to a different place, for example to the home situation, to another domain, or through remote care with the help of e-health. This considers how to reimburse the provision of care closer to home and, in the longer term, only in the desired setting. This can be done for example by including the desired treatment in the quality standards and regulations, or by setting a lower price when contracting in the care.
- > In addition to paying attention to remote care when contracting in, the funding should not become an obstacle. There are already performance descriptions for e-consultations and joint visits to the doctor (involving specialist and GP). Any bottlenecks in the funding must be removed where possible and knowledge about the possibilities for declaring the costs of digitally supported care must be extended.


Towards contracting-in and a different care landscape

- > The design of the care landscape should be based on care demand instead of care supply, as it currently is. The parties that contract care in play a key role in pushing for this transformation by signing **long-term contracts**. Long-term perspectives give healthcare providers greater certainty and the financial consequences of the transaction can be limited or spread over several years. Healthcare providers who do not want to be part of the transformation are offered more sober and shorter contracts than parties who anticipate and participate in the movement for the right care at the right place.

- > One best-practice element is to let healthcare providers share in the savings made via pre-agreed projections of the costs of care (**shared savings**). Additionally, it is important to have more stimuli for delivering contracted-in care and discouraging the opposite. Care that is not contracted in undermines the coordination of a better and more efficient care landscape.
- > The same also applies to **diagnostics**: this must be done at the right place from an integral point of view. Duplicated diagnostics still happen too often during a patient's pathway through the care system. This is not only stressful, but also expensive. The way diagnosis is organised can be improved by buying in fewer providers, by uncoupling the front office and back office for laboratory diagnostics, smarter collaboration, a uniform quality framework for integral diagnostics and by including the diagnostic information in the patient's individual healthcare environment. One example is that the arrival of direct-acting oral anticoagulants (DOACs) means that the current thrombosis services as we know them today have no future. Part of that capacity can be used to provide more hospital care.
- > Providing direction is also necessary for the organisation of **acute care**. In acute mental health care (i.e. triage, assessment and crisis treatment in the first 72 hours), a model like that in ambulance care can be used to guarantee proper organisation of the available care for this specific group. The organisation of A&E (accident and emergency) medical care can also be improved, resulting in denser concentration.
- > With regard to **complex care**, it is desirable that economies of scale should be achieved. Care insurers play a crucial role in this. The Martini-Klinik in Germany, for example, has demonstrated that high volumes of prostate cancer treatments led to

01 decreases in the number of complications and in turn to better
02 care outcomes for the patient. This also means a redistribution
03 between tertiary and secondary care.

- 04 > Concentration of the supply is sometimes also desired in order
05 to achieve a cost-effective introduction of **new healthcare
06 facilities** (medical equipment). Individual care insurers can push
07 for such concentration when contracting their care in. It is
08 important to focus on increasing the transparency of the quality,
09 so that it is easier to see if and when concentration of certain
10 care results in better quality and/or lower costs. This also helps
11 to flesh out collaboration within the framework set by the
Competitive Trading Act.
- > A step that goes yet further is that the governmental authorities, based on objective criteria, can regulate capacity by subjecting certain care facilities to a **licence requirement** (Special Medical Procedures Act, Wbmv). The governmental authorities are exploring to see where this is desirable.

As stated, many forms of innovative contracting are possible given the current funding and there are also various ongoing experiments and pilots, while in specific cases (like the integral clinical perinatal care experiment) funding also helps achieve a better organisation of care. A current example of this is the development of a payment category for **combined lifestyle interventions** . This not only supports purchasing by care insurers but also strengthens the collaboration between the medical and social work sides.

Where can we see the start of the movement in practice?

Innovative contract forms

Care insurers and healthcare providers are signing long-term contracts more and more often. A shared vision for the future makes it easier to make agreements about keeping healthcare available, to improve the quality of care, to manage the costs and to improve the service for insured parties and patients. Additionally, it often gives both parties more financial certainty as well as time and energy, given that there is no need for annual negotiations anymore.

A few of the examples that have occurred in practice:

- > The care insurer CZ and Eindhoven's mental healthcare services have signed a three-year contract. The long-term agreements are based on a **shared goal of a chain of personalised care**, with patients being given as much control of their own care as possible. The two organisations want to use further digitisation of care to provide an impulse towards increasing the general public's autonomy and freedom of choice. The agreement allows Eindhoven's mental healthcare services to expand and accelerate the use of e-health further because CZ is providing financial scope for innovation. The parties trust that clients will be more satisfied with the treatment and support they receive as a result. At the same time, the agreement aims to increase the accessibility and affordability of mental healthcare services. (For more information, visit: <https://www.skipr.nl/actueel/id33516-cz-en-gg-ze-sluiten-meerjarencontract-over-e-health.html>)

- > The care insurer VGZ and the home care organisation Omring Noord-Holland Noord have signed a long-term contract for providing care to the elderly and chronically ill in the north of the province of Noord-Holland. They are also looking to cooperate with hospitals and GPs in the region. The agreements are not only about numbers and prices, but above all about **further developing a healthy region**, improving the quality of the care chain and responding to increasing care demands. Their common ambition is to let people live at home for longer safely and to keep bringing more complex care to the home or closer to home, including in areas where a multidisciplinary approach and the use of high tech are required. Omring and VGZ want to examine, together with hospitals, how hospital admissions can be avoided and how the lengths of hospital stays can be shortened. The same applies to people with an urgent care requirement who come to A&E. (For more information, visit: <https://www.skipr.nl/actueel/id33605-om-ring-en-vgz-gaan-meerjarige-samenwerking-aan.html>)
- > The care insurer Menzis and healthcare provider Livio have signed a contract for three years for district nursing care in Enschede. The aim of these agreements is to improve the quality of home care and to tackle the increasing demand for care resulting from the ageing population in the region, combined with an **increasingly tight labour market**. A fixed sum is paid per client per week. This creates space for the professionals to offer tailored work, using technology if required, and participation by the client and their social circle is encouraged. In addition, these agreements result in less pressure from the regulations. (For more information, visit: <https://www.skipr.nl/actueel/id33010-menzis-maakt-meerjarenafspraken-voor-regelarme-wijkverpleging.html>)

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> The health insurer Zilveren Kruis has signed a contract for three years with the Röpke-Zweers hospital in Hardenberg (part of the Saxenburgh Groep). In the new agreement, Zilveren Kruis makes resources available to enable **care to be shifted to the home environment** of the patient. This allows unnecessary admissions to be avoided. Remote care also means that interventions and adjustments can be done earlier. For the hospital, this means that different requirements are imposed on the organisation and the buildings. Arranging the care better, for instance as with the new care centre in Coevorden, lets people live longer and more independently in their own surroundings. There is close cooperation for this with GPs and their physician assistants. More information on: <https://www.skipt.nl/actueel/id31314-roepke-zweers-en-zilveren-kruis-sluiten-meerjaren-contract.html>

> The care insurer Menzis and the Rijnstate hospital in Arnhem have signed a three-year contract worth €500 million. The hospital gets the scope to **improve its capabilities for a number of target disorders**. There are no turnover thresholds for this. However, efficiency requirements do apply for other conditions. The savings resulting from this shared (*shared savings*). Discussions will continue to take place about changing circumstances that could have an effect on the agreements. In addition, both parties have included a total of eight *value-based healthcare* projects. These will be assessed on the basis of outcome criteria that are defined in advance. In a number of cases, bundling is involved in the agreements: a single amount for the entire pathway through the care system. The hospital also makes agreements with GPs about network care: where is the best place to deliver the care and who does what? There is also financial scope for experimenting with e-health, remote monitoring and home care.

More information on: <https://www.zorgvisie.nl/rijnstate-wil-kli-niek-van-de-toekomst-worden-menzis-helpt>

> **Santeon** (a chain involving seven leading clinical hospitals) has signed contracts for a three-year period with the care insurers Menzis, CZ and Multizorg (a purchasing consortium involving the care insurers Eno, Zorg en Zekerheid and ONVZ) for providing **breast cancer care**. Although the differences between the contracts, they are all based on the principle of *value-based healthcare*. This means that outcomes expressed as health gains or improved quality of life of the patient are leading. Santeon measures the outcomes as the basis of a process of continuous improvement. It has been agreed that the care insurers will be given a clear picture of the quality improvements and will continue to monitor them. The best practices of any one hospital will be taken on board immediately by another Santeon hospital. More information on: www.santeonvoorborstkanker.nl

The experiment called “Ruimte voor resultaat” [Room for Results] carried out by the care organisation Meander (Zuid-Limburg) takes a new approach to providing **long-term care for the elderly** at home based on the Health Insurance Act, the Social Support Act and the Long-Term Care Act. From 2016 onwards, district nursing will be provided on the basis of a single fixed monthly sum of approximately €700. Monitoring hours spent and invoicing on that basis has been stopped, both internally and externally. The principle behind the care provided is improving the ability to cope. To that end, all the staff have been trained in the new way of working via the programme “Blijf actief thuis” [Stay active at home] (a collaboration with Maastricht University). The new way of working has led to fewer hours of care per client (a drop of approximately 20%) and satisfied staff and clients. When care provided at home under the

Social Support Act and the Health Insurance Act leads to unsafe situations, clients can switch to care at home under the Long-Term Care Act. The clients themselves notice very little of this: they keep the same healthcare providers and are not faced with any reduction in hours. Care provided under the Long-Term Care Act is given as a complete home care package. This gives the institution the opportunity to shift away financial resources are apportioned between clients.

> Bernhoven (the general hospital in the region containing Oss, Uden and Meierijstad) has been working together with Synchroon (the regional GP grouping) and CZ and VGZ (the two largest care insurers in the region) since 2015, based on a **strategy** in which the focus is on the quality of **care** rather than on the volume. Bernhoven started over a hundred improvement initiatives for organising the care processes more effectively, based on the principle of sensible care. An essential assumption is acknowledging the role and input of the patient themselves in the care process, for instance in the form of joint decision-making.

In parallel with the improvement initiatives, Bernhoven started a change process for organising their organisation primarily around the patient. Bernhoven set up its organisation to be based on four care models, mainly Acute Care, Diagnosis & Indications, Intervention Care Pathways and Chronic Care. Acute Care is a separate business unit because the dynamic of urgent care is very different to that of elective care.

In order to achieve the strategy, Bernhoven signed long-term contracts with VGZ and CZ (long-term agreements with financial guarantees for the transition period). And as part of the transition, Bernhoven introduced a new governance model in which the medical specialists in all branches of the hospital have leading positions. It meant that the specialists have become

01 employees of the hospital and participate in it financially in the
02 form of a convertible loan, which – if the regulations so permit
03 – will be converted into bonds. The results: the DRG turnover
04 fell by 16% in three years (2015-2017) compared to the baseline
05 year of 2014, whereas the number of unique patients rose in the
06 same period by over 3%. The satisfaction figure on zorgkaart.nl
07 rose during the same period from 8.4 to 8.7 and the proportion
08 of people who would recommend Bernhoven to family or
09 friends rose from 77% to 91%. Bernhoven's baseline costs fell by
10 nearly 4%. An analysis of VEKTIS data for 2015 and 2016 shows
11 that there does not seem to have been any shift during those
years to other hospitals. There was also no structural increase in
waiting times. [https://www.bernhoven.nl/over-bernhoven/
toekomstbestendige-zorg-voor-de-regio/](https://www.bernhoven.nl/over-bernhoven/toekomstbestendige-zorg-voor-de-regio/)

- > The OLVG hospital and Zilveren Kruis signed an agreement about **HIV care**. The OLVG will receive a fixed sum per patient per year for the next three years. The main benefit is that this makes it possible to invest further in an even better quality of HIV care. The treatment team determined the key health outcomes together with its patients and is now monitoring those outcomes. The HIV treatment centre at the OLVG gives its patients and all-round treatment that focuses on more than just the HIV. The patient also gets a picture at an early stage of the additional risks (e.g. mental and cardiovascular health). Led by a team of specialists, the patient then gets custom-designed treatment. This approach reduces the associated risks and the care costs that go hand-in-hand with them. Where the OLVG improves the care through its coordinated approach and the costs fall as a result, the hospital is allowed to retain their proportion of the savings. Investing in quality is therefore rewarded and they manage the costs together. The contract also makes it possible to buy in the care that is provided by multiple

organisations in one go (a care bundle for which no separate description of the tasks performed is therefore required). While retaining the current level of quality, the OLVG is able to invest a substantial proportion of the care cost savings in the further development of HIV care.

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Steering towards transformation

The essence of steering towards transformation

- People must push hard towards transformation (and must be able to do so)
- Administrative commitment is needed at the national level
- Budgetary frameworks are allowed to squeeze and must support the movement
- Move from cutting down care 'within the walls' towards building up care closer by
- This requires temporary transformation resources and investment in cooperation
- Those who pay the premiums must benefit from the right care in the right place
- The right care at the right place must be part of the quality standards

Tim Kroesbergen talks to us



"My name is Tim. I have fragile bones and I use e-health a lot as it gives me a clear picture of how I am doing. My care requirement is that I need help getting up – in other words, getting dressed and washing. And when I go to bed, it's the same thing the other way round. Apart from that, I can do a lot myself."

I have a device that lets me measure my body's various vital signs. Temperature, heart rate and for example the oxygen level in my blood. It has a wireless connection with my iPhone. I'm very pleased that it gives me a relatively easy way of recording the state of affairs inside my body if I'm feeling a little bit less well. If I was worried about something but the result is normal, that's very comforting.

The 'all of me' platform that lets me exchange experiences with other people with similar handicaps has boosted my self-confidence and lets me feel a better person. What I do come up against is that a lot of doctors don't really know how to handle it or do not want to use it at all. They say it's new and scary and everything worked fine the old way, so it's all not really necessary.

I think that the authorities could encourage e-health even better, for instance by training doctors more about what it can bring for patients as well as what it can provide for the doctors. If doctors could use a videophone system, for instance, patients would not have to travel so far. In the end, that would be better for all of us! "

Transition means changing the structures and responsibilities. Transformation is a different way of organising things and a different way of working, based on different principles.

The Right Care in the Right Place. It has been discussed a lot and there are plenty of ideas, and there are already lots of great initiatives at the local and regional levels. This report contains a taster of the many good and inspirational examples that show how the movement is beginning to take shape. But more is needed if a **broad movement** is to be created for preventing care being needed and shifting it and replacing it in people's best interests.

If the movement is to be accelerated and broadened, it is essential that we start looking differently at illness, health and care and then act on those insights. That starts with the **people** themselves. The way people take responsibility for their health, learn to cope with their limitations, the way they use information and advice to try to improve their functioning, the way they look deliberately for support from their surroundings and from professionals. And also the way they are helped if they are less capable of self-management and taking control for themselves. If that is what is expected, we must also make it possible for people to grow in terms of that behaviour, by teaching them about what being healthy is: in education, in information and as details about the choices during a visit to the doctor. We cannot and do not want to wait until the children who receive that new education become elderly utilisers of care. That takes too long. The question for the current generation is what are you doing so that

you can keep functioning well? Did you know that your lifestyle has a major effect on your health and welfare? What can you do yourself and what support and care do you require?

If people are responsible for their own health, they need to know what they're doing. Their own data has to be available to them. They need to know what condition they're in. They have to be able to ask professionals the 'three key questions'. There is not always a medical answer to every human need and the best care is not by definition given in a hospital. Can you accept the limitations and continue with your life despite those limitations? Who and what would help the most?

It is then just as important that **professionals** understand the 'why' of the change and feel that this is aligned to their own professional ambitions. They have to feel there is scope, they have to be given room and they must take it in order to provide integral, individually oriented care. Every professional and every manager too must ask: How am I helping people to function? What can I do better? What can we do better as an organisation? How can we, as organisations together, meaning more for the people in the neighbourhoods, municipalities or regions? This is done on the basis of a clear picture of the tasks within the region.

Asking these questions and tackling them is everybody's responsibility. Aiming for transformation – both from individual responsibilities and jointly – requires **commitment**.

Are we going to give that commitment?

This report has sketched out the preconditions for progressing the movement further that the levels of people, professionals and

managers. Their task is to search for and find added value and co-operation, starting from the right point, with the right commitment and the right instructions. Discussing things with each other, addressing each other and encouraging them to find added value, adding an impulse to the learning environment, exchanging experiences, trying out new initiatives, putting the spotlight on good examples, keeping on learning the lessons, showing courage and leadership. Genuine change is only possible if increasing numbers of people get to grips with the new approach by learning from experience. Practice has the prime role. If necessary, the governmental authorities can support this process and bring parties together to ensure progress. This is the essence of the transformation.

The Taskforce would actually like to draw a line under it here. At the same time, the frameworks within which care is given, organised and funded have to fit in with that transformation and support it. And precisely those frameworks also have to squeeze those parties that do not want to be part of the movement. Away from the comfort of the status quo, no incremental changes, but genuine alterations and investment in the transformation. **The frameworks refer to administrative commitment and financial frameworks, quality frameworks and legislation and regulation.**

Administrative commitment and budgetary frameworks

Administrative commitment is needed at the national level. There are urgent reasons for doing so. If we continue to organise care as we are now doing, the shortage of professionals will only increase, the bill will be unaffordable and we will not be providing enough help for people who are now affected badly by the wrong care being provided at the wrong place. Continuing along the path we are on now is not an option and ducking out of the way is not acceptable.

Commitment is required from the management parties in order to keep this theme progressing over the coming years. The **budgetary frameworks** will need to be defined so that they support the transformation. On the one hand, those frameworks will enforce change, and on the other the transformation must progress in a controlled fashion and that also demands investment. It will have a big impact on professionals and organisations. Being a good employer and the pressures on the labour market demand appropriate rewards for staff, good options for teaching, and that vacancies should be filled as quickly as possible. In addition, they can and must be different and smarter ways of organising and working, making use of technology and boosting productivity.

The Taskforce is providing the **building blocks** for moving the transformation in the right direction. The administrative parties must make room for these building blocks and their associated financial implications at the national level. It is down to the individual organisations to include them in the agreements that they make at the local level. The intention is not to prescribe a blueprint, but to provide direction and support for the initiatives that will take shape regionally and locally, leaving room for diversity and a dynamic approach.

The building blocks must be contrasted against the rising trend in healthcare expenditure. If policies do not change, the volume of care will increase by 2½% per year through to 2022. If we continue that trend to 2025, the volume of care in 2025 will be nearly 20% higher than in 2018. And that is without allowing for developments in the price of care, which are generally significantly above inflation. The **potential for improvement** is enormous.

Building blocks for the transformation

Patients will be the first drivers of transformation. Wanting their help to be different, using modern IT and responding differently as they progress through the support and care that are on offer will give them a powerful tool for ensuring transformation. Their quality of life and how they experience it is the motivation to make professionals provide and organise care differently. It is the touchstone of the movement for organising the right care at the right place, for which the Taskforce is providing the following building blocks.

A. The right care and support in the district network

- > In the Dutch system, the function of gatekeeper – traditionally linked to the role of the GP – is important and proven. Medicalisation and hospitalisation do not necessarily make people get better and sometimes the care is unnecessary and expensive. That gatekeeper function should become a broad responsibility of the GP, community nurse and the social district team, collaborating in a physical or virtual district network. For this, the parties need more time for early detection of vulnerabilities, more time to determine their underlying need together with people and better agreement between professionals. This needs extra funding.
- > The same applies for demonstrably **more time for patients**, the medical specialists and collaboration in the district network. How this will work in practice depends on the situation. There are various options: a smaller number of patients per GP and GP practice; taking away non-patient-specific time from GPs; medical assistants; deployment of physician assistants and nursing specialists; reducing the regulation pressure, etc.

- > More funding is also needed for the **other professionals in the district network** so that the additional tasks such as broad triage and more integrated care can be carried out properly. This affects the social work team in the district and the community nursing team. It is also important that mental healthcare service providers and associated non-medical professions are invited and encouraged to be involved in the district network. They carry out essential tasks in realising the right care at the right place, and this requires funding. Deploying professionals together can avoid unnecessary and expensive care and can be a substitute for care elsewhere that is provided too soon or for too long. When extra resources are used, it is important to keep track of whether the intended objectives are being achieved: working together better on improved health for people.

B. The right place for chronic illnesses and elective care

- > People with one or more chronic conditions receive care and support as close as possible to their home situation, or at the place where they themselves prefer to be. For chronic care, the norm is care at home with suitable technical and substantive care support. It is possible to achieve a substantial reduction in the **overall costs for care of the chronically ill**. In the first instance, we are talking about COPD/asthma, chronic heart disease and diabetes mellitus, renal sufficiency and arthrosis.
- > This is made possible by more **integrated provision of care**, e.g. by organising care effectively and without red tape, replacing specialist care with general care (with rapid consultations with specialists where necessary); by replacing institutional care and condition-oriented care with district-based and individualised care; by replacing care given by medical staff with care given by nursing staff and/or associated professions;

by replacing the physical care with e-health and/or blended care; and through self-management and informal care instead of care provided by professionals.

- > More care is being moved from 'within the walls' of hospitals to other places. We are seeing the traditional hospitals (including outpatient clinics) developing into centres for complex care, with major concentration and high volumes ensuring quality and efficiency. One of the ways to do this is buying in **low-complexity elective** procedures such as orthopaedic, dermatological and ophthalmological procedures in specialist centres with a strong focus on quality and service.

C. The right place for the vulnerable elderly

- > People want to live at home for longer and receive as much care as possible at home. This demands a broadly-based early detection system, joint triage and effective cooperation between GPs, community nursing teams and the social work district team within the district network.
- > Those responsible for case management in dementia and those in the non-medical care professions can also be involved. What shape it all actually takes in practice depends on the local situation. The fact remains that this cooperation takes time and money.
- > In the case of urgent situations, cooperation is important between the professionals in the district network, the duty GPs, the accident and emergency department (A&E) and those providing intramural follow-up care. This also results in fewer admissions to hospital.

D. The right hospital care and right mental healthcare services

- > The key determining factors for delivering care are people's functioning, their care needs and their environment. A better focus on professional added value and proven efficacy, collaboration in consultations, working in delivery chains and networks and less variation between practices can help reduce the amount of care provided within hospitals and mental healthcare institutions. That will in turn reduce the need for infrastructure and facility services, enabling savings.
- > The implementation of Samen Beslissen with choice aids, better care evaluations and the implementation of this, peer reviews, the 'Better Not Done' list, scaling up and implementing *Leading the Change*, combatting duplicate diagnosis and avoidable damage and sharper procurement are all examples of activities that can help this reduction. That does not mean people receive less help, but it does mean that care is organised differently and delivered in a different manner. This can reverse the rise in the volume of hospital care.
- > Substantial reductions have already been achieved in recent years in mental healthcare services in the number of beds. Looking at the broad-based clinical capacity in the mental healthcare services (i.e. including long-term care and care under the Social Support Act), there is potential for further reduction in intramural capacity. This is certainly possible in long-term clinical mental healthcare if longer-term tailored outpatient care can be provided along with housing facilities organised through the Social Support Act.

E. Investing the money that becomes available

- > The first few years will see an end to the upward trend in hospital care expenditure and money is needed to reward institutions that cooperate in the process of transformation or contraction. Long-term contracts that include **temporary funds for transformation** can facilitate this process. These funds are significant but also temporary and must deliver genuine results. The aim is not to finance the postponement of the transformation but to invest in a new care process and a new form of care delivery, including the deployment of e-health applications and digitally supported care. Parties that do not get involved will be offered a more basic contract, often just for one year. There should be clear benefits to having a contract (rather than not). After all, proper agreements about quality and effectiveness can only be made within a contractual relationship.
- > Some of the money that becomes available will need to be used to allow for the fact that a reduction in hospital care will mean some tasks shifting to the professionals in the **district network**. That requires funding for the additional capacity. In the case of the vulnerable elderly, this means investment in collaboration between the relevant parties and using additional funds for elderly patients with acute care needs such as primary-care stays and emergency care. More generally, coordination and cooperation require investment.
- > As regards the reduction in intramural mental healthcare capacity, it is crucial to have money available for the proper intensification of outpatient care. **Reducing institutional care** is about more than just turning beds into outpatient capacity. Outpatient care needs to be aligned with or to become part of the district network. This demands broad, multidimensional

expertise (in psychiatry, addiction care, the problems of people with an intellectual disability, labour participation, social welfare issues etc.) that enables broad-based triage and integrated care delivery. Mental healthcare pilots in the districts have for example shown that accommodating professionals together encourages cooperative processes. Municipalities play an important role in the success of the mental healthcare services' goal of a comprehensive transfer from institutional care to outpatient care.

- > Some of the money that becomes available will need to be used to control the **rise in insurance premiums**. Healthcare expenditure is forecast to increase faster than economic growth over the next few years. That difference will have to be reduced to make healthcare affordable in the longer term and to maintain solidarity in the healthcare sector.

Based on the proposals in this report, the Task Force is providing **specific goals** that can guide administrators' commitment to the necessary transformation.

Towards the right care in the right place with the following results by 2025

- > In 2025, the national volume of care delivered in hospitals should be on a par with 2018. This would break the trend given that (extrapolating the estimates given by the Netherlands Bureau for Economic Policy Analysis) would give growth in the volume of care of around twenty per cent over this period. The aim is therefore to gradually turn that growth in volume into a decline.

- > A similar reduction of twenty per cent in the intramural mental healthcare capacity, including the clinical/intramural capacity in long-term care and care under the Social Support Act.
- > A substantial reduction in the costs of non-complex elective care, starting with disciplines such as ophthalmology and orthopaedics.
- > A reduction of 25% on average in the comprehensive costs for the chronically ill, starting with COPD/asthma, chronic heart diseases and diabetes mellitus, renal insufficiency and arthrosis.
- > Inextricably linked with these goals is the investment of a substantial portion of the money that becomes available in reinforcing the broad gatekeeper function, the district network with the addition of mental healthcare service professionals and non-medical health professionals, a strong agenda for the reduction of institutional mental healthcare and temporary funds for the transformation of hospital care.
- > The rest of the systematic savings will be used to combat the upward pressure on premiums and alleviate the impact on the economy and solidarity.

These goals let people benefit from the right care in the right place in their role as patients and from affordable insurance premiums in their role as premium payers.

The right image of the common task

- > To translate administrators' commitment at the national level into action at the local level, a shared picture is needed of the

social and health situation in a given region, municipality or district. Together with healthcare providers, professionals, patients and their environments, the health insurers, health offices and local councils ensure that this happens. What overarching tasks are we facing across the domains in this region: what needs to happen if the right care at the right place is to be organised and supplied in this region? Given that picture, each of the parties – given their various responsibilities – makes agreements about care organisation and healthcare procurement. That task thus helps guide the purchasing by local councils, insurers and care offices and helps guide the way that providers organise care and professionals provide care. Professionals in the social and medical domains must have the right tools to be able to get down to business with this task.

- > **At the national level**, it is important to have commitment among administrators for such an approach in that region. This allows parties at the national level to provide an impetus for their own rank and file as well. Exactly what agreements are made in the regions are not defined at the national level; neither is the form the process takes. If there is reason to do so, the progress can be discussed at the national level.

Quality frameworks

- > The responsible parties will promote the inclusion of the various **dimensions of the right care in the right place in the quality standards**, with the support of the National Healthcare Institute. E-health applications, digitally supported care and the electronic exchange of patient data are crucial for achieving the right care in the right place and consequently for the (perceived) quality of the care, but such topics are currently barely

addressed at all in the standards. The same applies to Samen Beslissen, the focus on outcomes and collaboration across domains.

- > A **specific quality framework for the secure electronic exchange** of patient data is needed. This is an indispensable aspect of quality. Professionals apply the standard, administrators target the results and the Health and Youth Care Inspectorate monitors compliance. Health insurers then purchase only that care that satisfies the standards. The funding rules of the NZa (Dutch Healthcare Authority) incorporate incentives for providers to actually use the information standards.
- > These frameworks are drawn up by professionals, patients and procurement officers; if there is not enough progress, the government will step in to drive the process forward via the National Healthcare Institute. The financial implications need to be identified and they need to be affordable.
- > The government also uses targeted (financial) interventions to encourage improvements in information management and the sharing of information between providers. An impetus needs to be given to the enforcement of **open standards** among IT vendors. The government is also reviewing the **privacy legislation** to see whether it is impeding the transformation, and helping as much as it can to resolve any issues that have been identified.

Funding, regulation and supervision

- > Many **innovative forms of contracts** are possible within the existing funding rules to facilitate and encourage the transformation. One example is the use of fixed amounts per patient or

group of patients in combination with measurements of healthcare outcomes. Another example is more financial leeway for Samen Beslissen to avoid unnecessary follow-up care. A review of the funding system would be time-consuming and expensive, and would only be justified if considered necessary based on experiences in the field. That is why the Task Force is suggesting that if parties run into actual or perceived obstacles in the funding of the right care in the right place, they should inform a team at the Ministry of Health, Welfare and Sport and the Dutch Healthcare Authority (NZa) with the aim of quickly clarifying whether a particular option is allowed or of obtaining the best possible solution.

- > The Task Force feels that if certain diagnoses and treatments can be provided or moved closer to patients' homes, they should in principle no longer be carried out in the hospital setting. It recommends having a tripartite working group examine what care – in terms of diagnosis-treatment combinations (i.e. DRGs) – can be considered for procurement mainly outside the hospital setting, as the final element of the vision on care of the professionals, insurers and patients.
- > Where e-health applications and digitally supported care become the norm, this will be funded instead of, or in combination with, traditional forms of care. Purchasers of care and support and care providers pay attention to the innovative possibilities as standard when **contracting care in**.

- > **Diagnostics** (in the broad sense of the word) need to be assessed specifically. A lot of duplicate diagnosis takes place at present. This can be reduced by focusing more on the proper exchange of information. Furthermore, price differences are not transparent even though there are signs of substantial

differences in prices. There is also considerable potential for improvements in efficiency. The NZa's rates currently apply for primary care while the diagnostics in secondary care are part of the DRGs. If the diagnostics were to be taken out of the DRGs, this would improve transparency and as a result offer possibilities for cost savings. Ultimately, a uniform rate could apply for the procurement of the diagnosis, regardless of where it takes place: the right diagnosis in the right place.

- > Concentration of care delivery may be preferred for some forms of healthcare and new care facilities (medical equipment). If that cannot be achieved through the insurers' steering options, the government could regulate capacity, based on independent advice, by imposing a **licence requirement** on certain kinds of healthcare and care facilities (the Special Medical Procedures Act). The government will arrange an exploratory study to see where this intervention is desirable.
- > The Health and Youth Care Inspectorate will also assess its **regulatory activities** from the perspective of encouraging the right care in the right place (including across the domains governed by different laws, and with a focus on networks). The National Healthcare Institute will do the same for its quality regulation.²⁰ Ultimately, the key question here is how day-to-day practice is changing and whether people will really notice the effect of the right care in the right place.

²⁰ The National Healthcare Institute will amend the Assessment Framework in 2018-2019. The National Healthcare Institute is also advised to change the existing wording on both the content and organisation of healthcare, and the information on the outcomes of the care provided. Then the quality standards and their associated measuring instruments can be assessed in terms of the extent to which they help deliver the right care in the right place.

01 Achieving these goals will require efforts from patients, care professionals and managers. That needs courage. At the same time, this report shows that the requisite courage is already being shown at various places – successfully too. The Taskforce calls on all parties to pull together and help speed the transformation up and make sure it succeeds.

02
03 **Who wants to join in?**

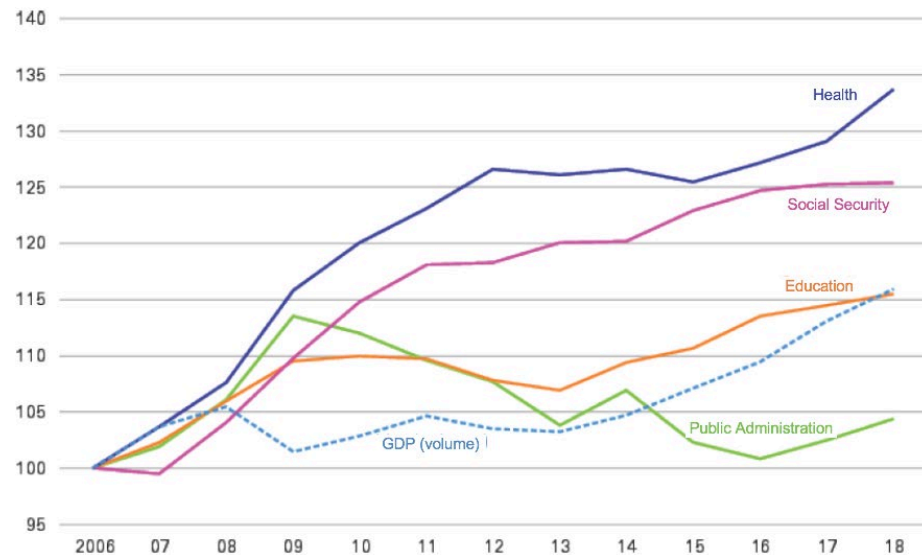
04 **The right care in the right place.**
05 **Who dares?**
06
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Healthcare expenditure

Overall healthcare costs are already high. In the period 2017 to 2021, they will grow by €18 billion to €83 billion. At present, every adult already pays an average of €5,721 per annum on healthcare and care (long term and curative), and this will grow by around €1,250 during the current cabinet's term of office, despite the planned savings.

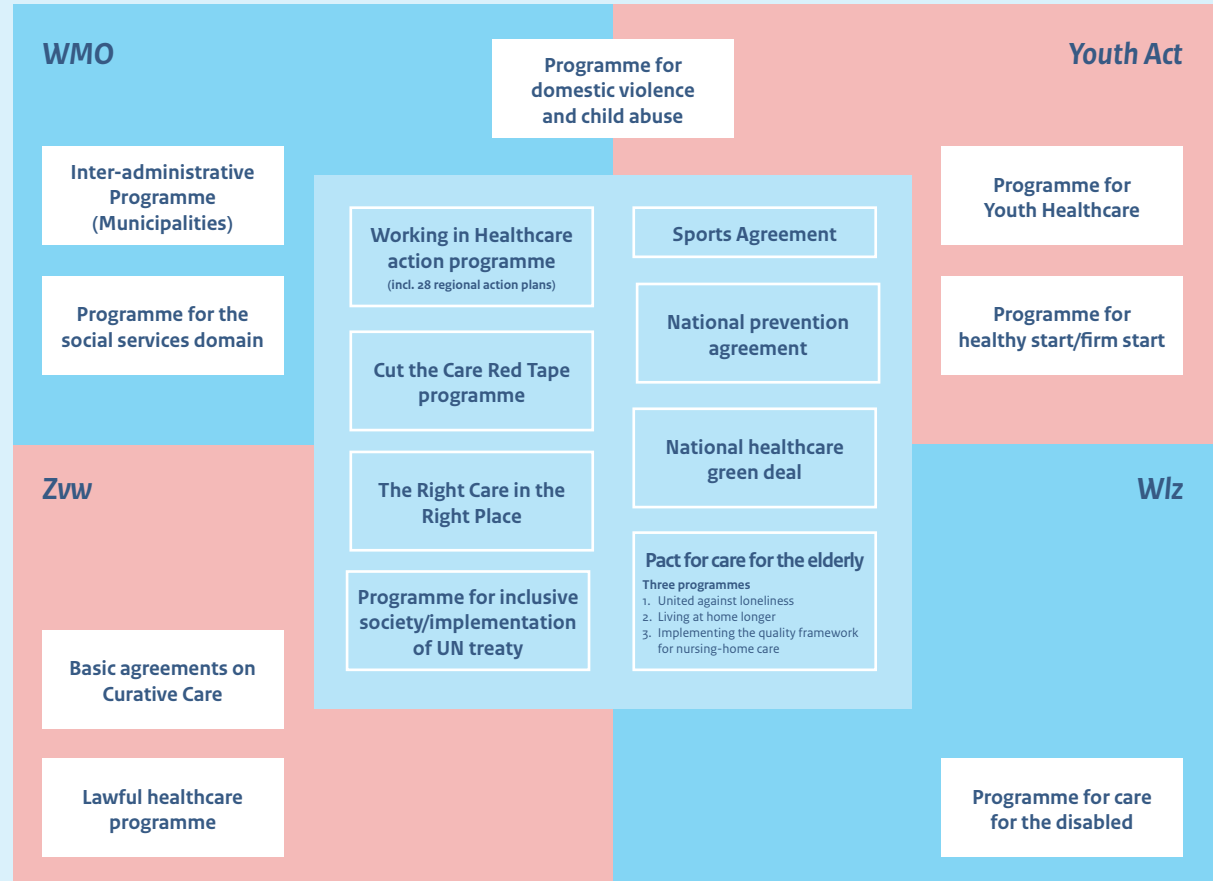
This growing expenditure could lead to difficult situations in the long term. A few years ago, the Netherlands Bureau for Economic Policy Analysis calculated that healthcare costs could rise to 30% of GDP by 2040 if growth continued at this rate.

Figure 2 Changes in expenditure (index, 2006=100)



Source Netherlands Bureau for Economic Policy Analysis, Ministry of Finance (State budget for 2018)

Other initiatives

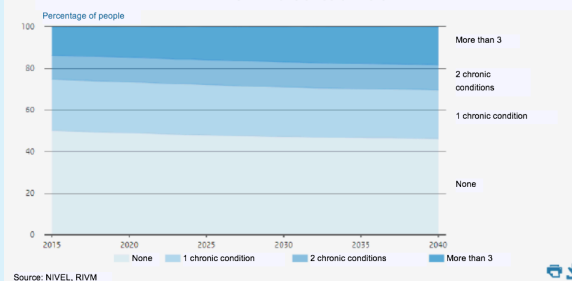


Chronic conditions

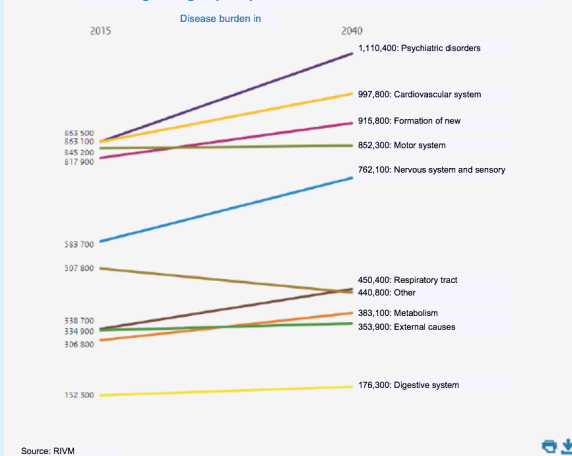
The growing and ageing population will lead to a rise in the number and proportion of people recorded by their GP as having one or more chronic conditions; this is forecast in the Trend Scenario to grow from 50% (8.5 million people) in 2015 to 54% (9.8 million) by 2040. By then, one in three Dutch people will have two or more chronic conditions and nearly one in five will have three or more. The proportion of people who have a single chronic condition will fall slightly from 25% in 2015 to over 23% in 2040. The proportion of people with more than one chronic condition will increase. The ageing population is leading to an increase in the proportion with more than one condition (multiple morbidity), as the elderly are more likely to have several conditions at the same time than the young.

The increase is mainly due to an increase in the group with three or more chronic conditions. The percentages in this group are 14% (2.4 million people) in 2015 and 18% (3.3 million people) in 2040. In 2015, 50% of Dutch people had no chronic conditions at all. This percentage is forecast to fall to 46% in 2040. In absolute numbers, this corresponds to 8.4 million people in both 2015 and 2040: the absolute numbers will remain the same despite the falling percentage as the population will grow.

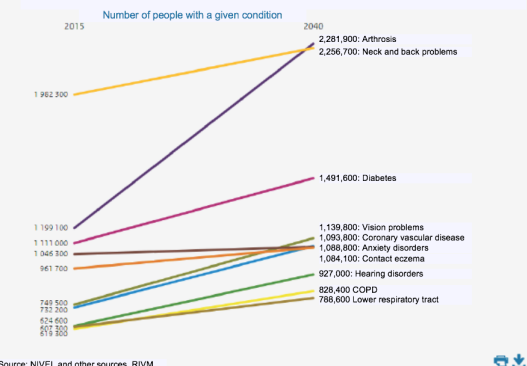
One in three Dutch people will have two or more chronic conditions and nearly one in five will have three or more



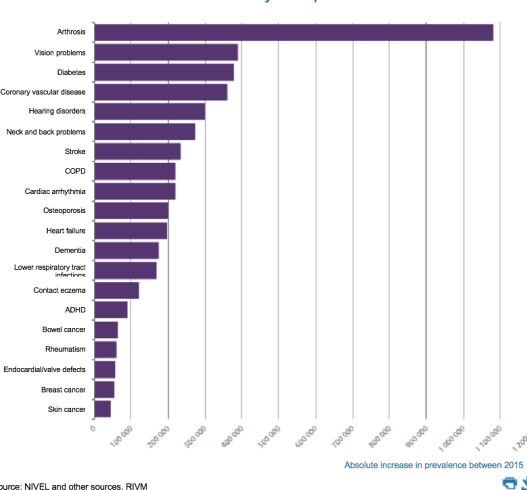
As in 2015, psychiatric disorders and cardiovascular diseases are the diagnosis groups expected to cause the most burden in 2040



In both 2015 and 2040, the most common conditions are neck and back problems, arthrosis and diabetes



Arthrosis and diabetes are also among the biggest climbers in terms of numbers; the number of people with vision disorders and coronary vascular diseases will increase substantially in the period to 2040



RIVM on changing healthcare requirements

RIVM illustrates this with the example of cancer. “The focus in the treatment during the ‘acute’ phase of the disease is usually on cure and/or survival. As time passes and the treatment works, the focus shifts to living with the condition or after the disease. Other aspects become more important then, such as the effects that the condition and treatment have on the quality of life. Many current and former cancer patients struggle with loss of concentration and chronic fatigue, nerve pain (neuropathy), hand-and-foot syndrome (‘chemo feet’) or having difficulty or being unable to perform daily activities such as washing and getting dressed.

Anxiety and depression are also commoner among current and former cancer patients than among other people. Adults in this group are relatively more likely to have relationship problems, permanent occupational disability and be unemployed. People who are treated for cancer when young are more likely to lag behind at school, and be unemployed, unmarried, and still living with their parents as an adult. The impact of cancer on the patient’s immediate circle is also large.”

Source: <https://www.vtv2018.nl/andere-zorgvraag>



Health skills

http://www.pharos.nl/documents/doc/factsheet_beperkte%20gezondheidsvaardigheden_en_laaggeletterdheid.pdf

Samen Beslissen

- > Samen Beslissen means that the healthcare provider and the patient take decisions together on health and treatment goals, in a joint process in which they are equals. The risks, benefits and downsides of various options and the patient's personal values and preferences are shared.
- > After all, preferences can differ from one person to another. A musician will go to great lengths to maintain their ability to hear. Someone who feels they have done all they want in life may no longer want burdensome chemotherapy. On the other hand, a father or mother with young children may be prepared to do anything to have more time alive.
- > Samen Beslissen is not just something the patient has a right to, it also turns out to be an effective form of communication: patients are better informed and experience fewer doubts and regrets about the decision afterwards. Samen Beslissen is not yet standard practice.
- > The Ministry of Health, Welfare and Sport is currently working on an action plan to broaden and reinforce the movement towards Samen Beslissen and information about the outcomes. That plan will be sent to the Lower House of the Dutch parliament in the spring of 2018.

RIVM: Pilots for a population- oriented approach – A brief synopsis¹

Collaboration, links and coordination between prevention, healthcare and welfare are required if a future-proof healthcare system is to be achieved. Experiments have started in various regions in the Netherlands with a population-oriented approach, also known as ‘population management’. What this approach means is that providers of prevention, care and welfare, health insurers, municipalities and the general public make efforts to improve the health of the population and the quality of care, as well as controlling the costs (the ‘Triple Aim’).

In 2013, the Ministry of Health, Welfare and Sport designated nine such regional collaborative ventures, based on nominations by the healthcare insurers, as pilots for ‘better healthcare for lower costs’. New developments and experiences in these pilots will be presented by RIVM (National Institute for Public Health and the Environment) in the Landelijke Monitor Proeftuinen (LMP, National Pilot Monitor). But the pilots are not isolated examples; similar initiatives can be found both at the regional level and beyond, which means that increasing numbers of primary care and secondary care providers will come into contact with this population-oriented approach. The initiatives vary in focus and size, from an initiative at the urban district level, for example, to a population-oriented approach for a municipality. Developments in these initiatives seem largely similar to the developments in the pilot projects.

Pilots are adaptive networks

The pilots are regional networks that were formed in 2013 mainly around healthcare providers, healthcare insurers and representatives of people who currently or potentially have a care need. In most regions, these networks have since been extended to include parties in the social domain, such as municipalities and welfare organisations. For example, the *Gezonde Zorg, Gezonde Regio* [Healthy Care, Healthy Region, GZGR] pilot is exploring how they can partner up with the municipality, a joint district initiative is being introduced in the *Blauwe Zorg* pilot by the municipality, healthcare providers and health insurer, and the *MijnZorg* pilot is implementing a number of interventions for vulnerable elderly people in cooperation with the municipalities and welfare organisations. Employers and schools are also involved in the *Vitaal Vechtdal* pilot. In the pilot projects, various structures have been used over time to guide the process of achieving the triple aim. In 2013, all pilots had a steering group that formulated goals and made agreements about each other’s activities in the interests of the triple aim. At the start of 2017, changes were made to the steering group’s role in a number of pilot projects because of the large number of actors, the different interests of competing healthcare providers and/or the lack of a mandate for the managers who had been delegated for this task.

Increasingly broad scope of interventions

In 2013, the pilots started with healthcare interventions, most of which were aimed at the curative domain. The first interventions ranged from efficient prescribing behaviour and mixed primary and secondary care processes to raising awareness about formulating (care) preferences for the final phase of life in good time. The pilot interventions were typically developed and implemented by three

or more parties. In addition to the substantive healthcare projects, interventions/projects aimed at creating the right conditions have also been started since 2013. They focus for example on new forms of funding, joint data infrastructures and the development of a shared vision of the future. The pilots are increasingly being used to design and implement interventions that cross domains, such as experiments with district social work teams and a prevention programme involving a municipality and health insurer.

Financing and funding

So far, the pilots have used volume-driven funding for the interventions. In a number of pilots, agreements have been made about shared savings in a specific project involving pharmacy. The implementation of this and other funding mechanisms in line with the triple aim is a long-term endeavour, and a close watch will need to be kept on the pros and cons to enable corrective measures where necessary. Although the new funding mechanisms require expertise and data, it is also important to invest in trust and leadership if progress is to be made.

¹ The synopsis is based on:
> RIVM, 2017. Factsheet ‘Pilots for a population-oriented approach: now and in the future’
> RIVM, 2017. Factsheet ‘Collaboration between municipalities and health insurers’
> RIVM, 2018. Factsheet ‘Evaluation of prevention in the healthcare system: collaboration between municipalities and healthcare insurers in 2017’

Visible results are the tip of the iceberg

So far, the specific interventions that have been deployed in the pilots have a limited scope (projects for prescribing medication efficiently) and small target groups (for example, diabetes patients). Accordingly, most managers do not expect a visible improvement in the triple aim by 2018 when the entire regional population is analysed (five years after the start of the pilots). They do expect positive effects for the triple aim for specific interventions and subpopulations. What is more, a great deal has been achieved under the surface and managers say a basis has been created for a new collaborative culture based on shared goals and visions, new structures and agreements (for example on shared savings) and a real new approach to delivering prevention, healthcare and welfare. They therefore expect it will be easier to extend the interventions that have already been implemented to cover a broader target group and more healthcare providers. They also expect the collaborative venture will facilitate communication between organisations, so that new project ideas can be developed and implemented more quickly.

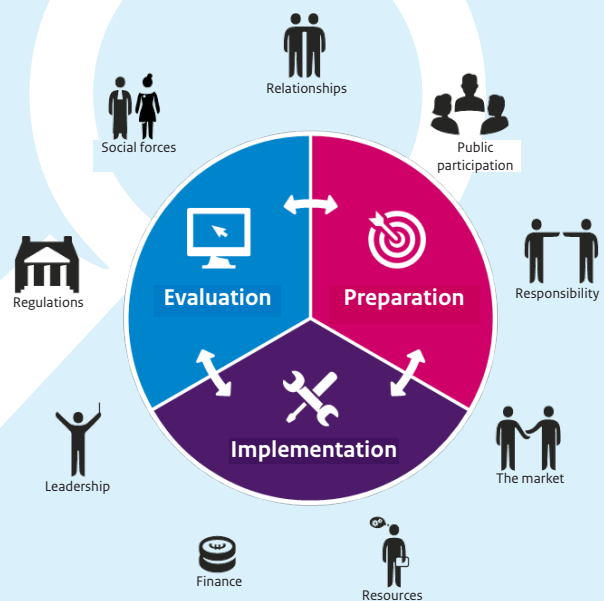
To date, the pilots have used various strategies relating to the nine components (see Figure 1) to develop a population-oriented approach, increase collaboration and achieve the initial results on a small scale on the assumption that this will provide the necessary basis for the eventual implementation of interventions and changes for the entire population and consequently for the achievement of the triple aim. Leading guidelines for how strategies can best be used and which ones should be used (taking account of the specific context) will follow in mid-2018, thanks to the experience gained in the pilots. At the same time, people also expect that more will be needed for further scaling up and for progressing towards the Triple Aim, given the various interests that are involved. The pilots envisage a number of important handles for doing this.

- > **Positive health:** The positive health philosophy can be used as a tool for making the integrated vision more concrete and raising the awareness that health is affected by more than mere care. In addition to achieving greater awareness, positive health can also be used to give the general public the opportunity to take control for themselves.
- > **Public participation:** In addition to an increase in self-management and the general public taking responsibility for their own health, care and support, people also expect that the public ought to get more influence at the administrative level. The best ways to involve the general public are still being investigated.
- > **New governance structures:** Although managers unanimously acknowledge the temporary nature of the current care structures, there are various visions about what it is going to look like in the future. A number of primary care managers and care insurers expect that hospital care will partly be shifted to multidisciplinary centres for complex care, where specialists will have a supporting or consultative function, and partly to institutes for extremely complex care. Conversely, the majority of hospital managers expect on the one hand that hospital care will focus yet more on highly complex care and on the other that there will be hospitals that will expand the generalised care they offer. In these new structures for organising care, account must also be taken of the fact that cooperation with other policy domains, such as helping with debts and other actors (e.g. employers and companies), will be needed if the Triple Aim is to be realised. It is also anticipated that there will be a larger and more closely involved role for the private sector, including an increasing number of public-private partnerships. It is also expected that a regional (integrated) health policy will be created in the longer term, with appropriate funding that

supports this integrated, regional policy. The way in which this will be funded has not yet been defined, but people do see that there has to be a single party that takes on the coordinating role. People disagree about the best candidate for the role.

- > **Knowledge infrastructure:** Managers say that it is important to have a clear picture of the supply and demand (need), the quality and the effectiveness and cost-effectiveness of prevention, care and welfare. They anticipate that this will let them help improve awareness and readiness for cooperating so that the care on offer can be changed, so that the requisite improvements can be designed better and to improve the accountability for the investments required. It is thought that this could be assisted by the increasing range of technological options for making use of existing information systems belonging not only to professionals but also to the general public.
- > **Nationwide support:** In order to speed the process up, the majority of managers states that amendments to legislation and regulations are not currently required, but that there is a need for support from the national authorities. Managers therefore anticipate that a change to budgets and limits will be required in order to make working towards the Triple Aim more obligatory and for example to accelerate substitution. Support from the Ministry of Health, Welfare and Sport is also expected by managers in the form of e.g. trust, clarity about what is permitted within the current system or financial support for the requisite umbrella investments such as those needed for coordination.

Figure Visualisation of the nine components that could be used for improving the healthcare system.



Encouraging care innovation among care insurers for the right care in the right place

“What should care insurers pay attention to if they want their healthcare procurement policy to make the optimum contribution to innovation of care underpinned by technology?” That is the research question of the PwC report called “Care purchasing innovation: Success and failure factors”.

PwC explored factors affecting the success and failure in the procurement of innovative care with the aim of giving innovation the greatest possible chance and applying it as widely as possible when proven successful. They spoke with almost all care insurers based on the sample projects supplied by them.

The following conclusion can be drawn from this.

Algemeen

- > There are no factors that apply specifically to the innovative purchase of e-health. Almost all the factors identified apply to other innovations as well;
- > Every care insurer uses different definitions of innovation;
- > All insurers are contracting in innovative organised care;
- > Care insurers have to look at which contribution is the most effective. Sometimes a guiding hand is necessary for a project, while other innovators need no help;

- > Competition between care insurers can be a problem. Sometimes projects never get off the ground because insurers do not want to follow each other;
- > Care insurers are recommended to build links between innovation teams and healthcare procurement within their organisations.

Success and failure factors and recommendations:

- > Mutual trust is essential. Realising new to replace the old is not easy. Long-term contracts and financial resources are the most important tools;
- > Promote trust and arrange collaboration between municipalities and care insurers in regional platforms where these parties can make concrete agreements with providers.
- > The use of top talent and more capacity at care insurers is needed for realising innovative healthcare procurement to be able to scale up innovation in care.”

An example of the latter is that when primary care providers can help more patients in primary care, hospital capacity can be reduced. If that is not possible, for example because the insurer who wants to sign contracts for primary care is not the insurer with the largest market share, the project fails. It is recommended that highly talented people should be used who can implement innovation with courage, tact and persuasion. Healthcare purchasers said that they wanted more coaching in this.

For the optimum collaboration between municipalities and care insurers, you have to pay attention to the approach of parties, language, culture and tempo. Once they have found each other, the collaboration is generally successful. Another problem is the field of work: insurers say that they sometimes want to work with hundreds of municipalities but that it simply is not feasible. Conversely, municipalities say that it is hard to talk to all the insurers at once. The solution was found in some regions by collaborating on a regional platform in which insurers and municipalities are represented and where concrete agreements about innovation projects can be made with these financiers and providers.

District scan

District scan district team area X



Population characteristics

- Total size of district team area: X km²
- Number of residents: X residents
 - Percentage 65+: X% (Enschede: 17%)
 - Percentage married or divorced: X% (Enschede: 59%)
 - Percentage widowed: X% (Enschede: 5%)
 - Percentage single-person households: X% (Enschede: 21%)
 - Percentage non-Western origin: X% (Enschede: 15%)
- Socioeconomic status*: very low (lowest 10% of the Netherlands)
- Properties from the health monitor**:
 - X % with restricted mobility
 - X % with sufficient control over your own life
 - X % with moderate to (very) severe loneliness

* This is based on a weighted average of the postcode areas.

** The health monitor (organised by municipal public health services, Statistics Netherlands and the RIVM) offers an overview of the health, social situation and lifestyle of residents aged over 19. Every four years the municipal public health services collect information on behalf of municipalities about the health of residents using questionnaires. Results can be used for planning, research and policy.



District map



District infrastructure

District team

- Total number of general staff: approximately X FTE.
- The district team was originally created from multiple organisations*. Social work consultants have also been part of the district teams from September 2017 onwards. The team targets the ages 0 to 100 and focuses on combined problems.
- The district team has designated contacts for the district nurses and for general practitioners.

General practitioners

- Total number of GP practices in the district: X practices
- Percentage of district residents who are represented by the GPs: X%
- X out of X general practitioners (practices) have the care for the elderly module: GPs with this module map out their 75+ target group preventively and make a more detailed problem inventory.
- The average distance from residents to the GP practice: X km (Enschede: 0.80 km)
- Number of doctor's medical assistants in elderly care: X FTE contracted in the district

Note: supply may be greater when there are seconded doctor's medical assistants working in the practice.

Suppliers of household support, day activities and district nursing

	Household support	Daytime activities	District nursing Tender	Social infrastructure module?
Total number of active suppliers	X	X	X	
Number 1.				
Number 2.				
Number 3.				



Use of beds in Enschede

- Primary-care stay (Health Insurance Act): X declared number of days (average of 26 beds in use throughout the year)
- Nursing home (Long-Term Care Act): X beds declared
- Care home (Long-Term Care Act): X beds declared

Note: the supply of beds is shown at a municipal level instead of at a district level because the use of beds is not necessarily district-based.



Provisions and transport in the district

Generally accessible social facilities:

- The district has a public library and a community centre.
- The average distance to a large supermarket is X km (average in Enschede is 0.70 km)

Using transport services:

- Social participation in transport: X
- Social participation in transportation by wheelchair: X
- Collective supply of local transport: X



Other activities in the district for seniors

Pilot X (2015): using training courses to reduce the number of accidents involving falls in the elderly and increasing their vitality.

Knowledge Centre for the Healthcare Chain – Regional Care Alliance

What does the Knowledge Centre have to offer with regard to continuity of the care chain?

The knowledge centre for continuity of care is currently positioned as an expertise centre for chronic care. It has been supplying benchmark and care reports for affiliated care groups since 1998, which helps monitor and improve the quality of care and with which the criteria set by care insurers or quality authorities are met. The core competency of the knowledge centre is bringing together relevant care information and making it available from the various sources that the clients themselves need and use in their primary tasks and processes.

Since 2005, the knowledge centre has been supporting GPs in their mutual cooperation with specialists in the hospital based on an infrastructure that bundles data from GPs and hospital, carries out research and gives feedback. This feedback takes place at the level of healthcare providers, healthcare organisations, care research and care education under the direction of Prof. Henk Bilo. The centre gives information about the effects that changes in the regional care landscape have on the effectiveness and quality of patient care. In addition, the Knowledge Centre can detect high-risk groups that need special attention and have their own action plans. Reports also show differences within patient groups.

From 2015, onwards the Knowledge Centre has been offering real-time reports with data extraction from the GP information system or healthcare chain information system (KIS), the 'KcK

Dataservice'. This allows relevant data to be extracted from the source systems and processed into reports, without the need for extra effort on the part of the individual help provider. This new method of extraction and processing is available for diabetes, COPD, asthma and CVRM. Reports for new patient groups such as the vulnerable elderly are in a pilot phase.

Privacy guaranteed

The Knowledge Centre was classified by InEen as a Regional Data Centre (RDC), meeting the nationally defined specifications for data management; the current NEN standards are met and this data is delivered to InEen in good time, in full and using the correct formats. All the links in the process of data collection, processing and storage meet the legislation and regulations concerning privacy and information security.¹ The Knowledge Centre collects and delivers primary anonymous care data for population management to care groups and individual care providers. The data of individuals is collected without the Knowledge Centre knowing who the person is. This also makes the data suitable for scientific research. Data storage is organised in collaboration with Isala so that security is maximised.

From GP to multidisciplinary, transmural and cross-sector care data

In the Regional Zorgalliantie Zwolle (RZA), GPs, hospitals, home care, district nursing, pharmacists, municipal public health services, municipalities, mental healthcare services and care insurers work together. The alliance has the Triple Aim as its vision and mission for the residents of the Zwolle region (over 500,000 residents). It

has better horizontal collaboration between care providers and helps providers in the district and transmural between care in the district and care in the hospital as the most important strategies.

Experience has been acquired in recent years of linking data files together. In May 2016, the Knowledge Centre demonstrated the factual substitution of diabetes care to primary care based on DTC codes (similar to a DRG) of internal medicine and ophthalmology. The centre also identified that costs of care for men and women with type 2 diabetes who are treated in primary care are 38% and 43% higher respectively in comparison with men and women without diabetes, after linking clinical data to VEKTIS data. Since the beginning of 2017, a number of cardiovascular risk management (CVRM) patients have been examined who are known within the region in both primary and secondary care in order to create a picture of duplicate declarations and the effects on policies used in the shift from CVRM care to primary care.

The alliance intends to develop the Knowledge Centre into one that works on the instructions of municipalities and healthcare providers from informal care, primary care and secondary care. That means that data from home-based care, welfare agencies, nursing homes, municipal public health services and mental healthcare services are being added. The aim is to develop a format that can be used nationally as a reference point for regional support.

As a test, the Knowledge Centre carried out an analysis in 2016 of data files from primary care, secondary care, home care and municipalities, leading to a so-called '**risk model**' that can be used to predict the likelihood of unexpected readmissions. More medi-

¹ Work is currently being done on checking against the context of the GDPR

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cines, more chronic conditions and having (indirect) home care and/or informal care and a lower SES are factors that contribute to a higher risk of falls. Cognitive impairment further increases these risks. Complications occur more often and with that the risk of an unexpected readmission.

Does the region need a Knowledge Centre?

The region increasingly needs a core competency to collect relevant information from various sources and systems to make it possible for clients to realise the Triple Aim for their populations. The next new lifecycle for multidisciplinary, transmural and cross-sector care data is coming.

Projects that were carried out under the alliance are interrelated and improve the health of the residents. This is how the project 'Vital and Safe at Home' started – preventive home visits among all over-67s in Zwolle, where safety in and around the house and the health of the district residents is central. This is to enable them to live independently as long as possible. Another project is 'Early detection of the elderly with a risk of vulnerability' where the doctor's medical assistant for somatic care, the community nurse and social district team member set up a care plan together and take preventive actions. Finally, a pilot was started very recently in which a community nurse is on call for the GP unit and Isala's A&E for additional care during evening, night and weekend shifts, preventing unnecessary admissions of elderly people (without medical indications). The result of the efforts is cohesive good quality care, focused on health gains for residents of the region, at the same or at lower costs (Triple Aim). Research from the Knowledge Centre contributes to knowledge development of the region and strengthens the cooperation.

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The Knowledge Centre supports the promotion of care in the right place through detection of problem areas and prioritisation of actions, as well as monitoring and effect evaluation (connecting public health with curative and long-term care). This presents a major opportunity for the vulnerable elderly in particular. The Knowledge Centre can act as a catalyst for regional developments.

Healthcare organisations will need the data for implementing new contract forms with care financiers. For example, the largest regional care insurer, Zilveren Kruis, is working on developing value-based healthcare purchasing contracts and tools. Municipalities are also making changes in their policy and purchasing: from facilities to outcomes for specific groups of residents.

The knowledge centre focuses on the following themes:

Implementation of the regional vision:

- > Offering (vulnerable) people a good life together
- > Positive health, prevention
- > Risk-driven (population) approach

Transmural programmes:

- > Integral approach for the vulnerable elderly
- > Value-based healthcare

Care in the right place: monitoring effects of the shift of care from secondary care to primary care and informal care (including the VRM programme).

At the moment, the expenses of the Knowledge Centre are currently covered by the income from the services paid by the

participating care groups; in addition, there is project-based income from specific tasks, in particular from Isala and care group Medrie. The other members of the Care Alliance see the added value of further developing the Knowledge Centre, but do not want the current expenditure to be structurally financed. The municipality of Zwolle has indicated that it can provide services; Zilveren Kruis wants to facilitate the development costs through a subsidy.

Additional funding is needed for the ambition of creating a regional data centre with a broader scope (combining data related to "health services" with data from "social services"), at least at the start.

Securing structural funding in time is important to make it possible to keep supporting the right care in the right place with all care partners in the region. Regional parties can obtain valuable information from the Knowledge Centre through specific assignments, as is the case now for Isala and Medrie, where the activity has to be self-financing for the Knowledge Centre.

Increase medication safety throughout the healthcare sector

The medication safety follow-up study from January 2017 shows that tens of thousands of avoidable medication-related hospital admissions and deaths still take place every year. The problems mainly affect vulnerable and often elderly patients, who use many medicines because of comorbidity (polypharmacy) and go to many care providers, and of whom the majority live at home.

One of the key points is that all those involved in the healthcare chain have a good picture of the medications used and that **transfer of data** between various players very important in being able to provide the right care in the right place. Not only is safe use of medications important, but also attention for stopping medication responsibly.

In 2021, the number of avoidable medication-related admissions will be reduced by 50% in comparison to 2017. Prescribers, suppliers and those administering medication must take professional responsibility together for greatly improving medication safety in pharmaceutical patient care. In 2018, the umbrella organisations of prescribers, suppliers and those administering medication¹ set up an ambitious and concrete healthcare sector action plan under the management of the Ministry of Health, Welfare and Sport. Those administering medication are often the most directly in contact with the patient, for example district nurses or nursing home nurses.

It includes at least the following **measures**:

- > Implementing **good transfer of medication and electronic exchange of medication data** between care providers, using the basic medication transfer and the information standard for the medication process.
- > Optimising the use of medication among vulnerable groups with polypharmacy by responsibly **stopping medication and using a tailored medication assessment**.
- > Clear agreements about the **division of responsibilities** for healthcare providers cooperating in the chain.
- > **Improving the collaboration and communication** about medication among care providers and encouraging the consultation with the patient to prevent medication errors and to improve therapy compliance.

¹ Care sector-wide parties of prescribers, suppliers and those administering medication (including in primary care, network care, district nursing, home care, hospitals, nursing homes, mental healthcare services)

Self-management

An example of the right tool in the right place:

When choosing a suitable blood glucose meter, the wishes of the patient are taken into account with regard to:

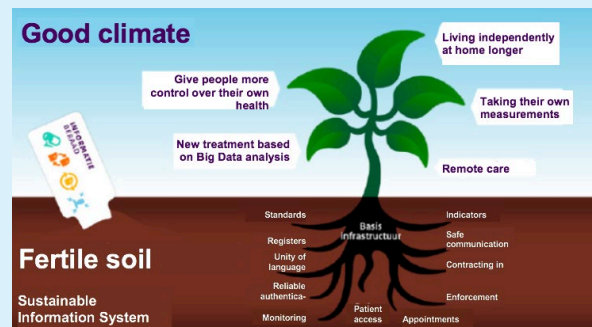
- > Bolus administration calculator
- > Input option for carbohydrates
- > Setting the target range of analysis options per measurement
- > Insulin dosage via smartphone
- > Meal marking
- > To be able to read data and share it with the care provider
- > Connection to computer/laptop/tablet/smartphone

<https://www.zorginzicht.nl/bibliotheek/hulpmiddelen-diabetes/Paginas/Home.aspx>

The Informatieberaad Zorg

The Informatieberaad Zorg (IB - Care Information Forum) consists of managers from the healthcare umbrella organisations and the Ministry of Health, Welfare and Sport. Together, the members¹ of the IB work on a sustainable information system based on the idea of “the whole system in the room” with enough administrative support for making decisions. The parties in the IB have committed to the following outcome goals:

1. **Medication safety:** From 1 January 2019, medication prescriptions are given in accordance with the current medication transfer guidelines, where in some cases a current medication overview (Medication Transfer Basic Set) is available that has been verified by the patient.
2. **The ‘Patient at the Centre’ (MedMij):** the set of requirements, standards and agreements that individual healthcare environments should meet: All healthcare providers support more equal collaboration between patients and healthcare providers,



which is why from 1 January 2020 onwards they will be offering the public the option of viewing their medical data digitally and in a structured way and making that data available for their individual healthcare environments, to which they can add their own data.

3. **Digital transfer:** From 1 January 2020 onwards, healthcare providers always pass on the data needed for proper care and treatment of a patient to other healthcare providers involved with the patient’s care process digitally, in a standardised and secure format and (unless this is impossible) with the patient’s permission.
4. **Recording and reusing only once:** From 1 January 2021 onwards, the primary care process becomes the basis for data recording in care and recorded data is reused for declaration, research, quality transparency and governance.

A precondition for the realisation of all goals is that agreements are made about the exchange of data (interoperability) at different levels; organisation, care process, information, application and IT infrastructure.

Development of standards

One component in the development of a sustainable information system is that standards are set that allow for efficient and reliable exchange of data by digital means. The IB decides which standards are set, who are involved and which parties will pay the bill for the implementation. The first standards have been set by the IB, including partial use of Basisgegevens Zorg (Basic Care Data) and care information building blocks for exchange. Multiple standards are

on the list and are assessed according to a process of ‘admission to the basic infrastructure’, e.g. through open consultation. After decision-making in the IB, the implementation in the field for healthcare should start, i.e. within the IB members’ organisations.

Privacy

In healthcare, a lot of data is exchanged using digital systems. Legislation and regulations must be complied with in order to protect privacy. An important legal framework for this is the General Data Protection Regulation² (GDPR), which came into effect on 25 May 2018. To a significant extent, the GDPR is similar to the existing legislation and regulations, such as the Personal Data Protection Act. A few new elements of the GDPR do have a major impact on the field, however. The GDPR ensures among other things:

- > strengthening and extending the client’s privacy rights;
- > more responsibilities for organisations

Under the GDPR, there are new information obligations and regulations about working with the client’s permission and new rights such as the right to data portability, whereby the client has the right to request and have their digital data removed and to receive it in an easy way, such as in their individual healthcare environment. Care institutions are responsible for complying with the GDPR in time.

- 1 Participants who take part in IB chaired by the Ministry of Health, Welfare and Sport: Actiz, FMS, GGZ Nederland, InEen, KNMP, KNGF, LHV, NFU, NHG, NVZ, NPF, VGN, VNG, ZN.
- 2 The General Data Protection Regulation (GDPR) is a European privacy law that transcends national legislation. The Client Rights in Electronic Processing of Data Act <https://www.rijksoverheid.nl/documenten/brochures/2017/06/01/elektronische-gegevensuitwisseling-in-de-zorg> applies in addition to the GDPR. That means that where the GDPR gives clients greater protection, the GDPR takes precedence.

'Better not done' and 'Better left out'

Mirroring information for professionals gives insights into the actions of others and puts your own actions in perspective. The 'Better not done' and 'Better left out' initiatives of various parties support this. These are lists of medical procedures that have not been proved to be effective, such as the use of a pulmonary arterial catheter in acute heart failure. It also includes procedures that can be done by others, such as making beds, mowing grass, administration. The programme called 'Verstandig Kiezen' [Choosing Wisely] examines when it is sensible to be cautious with certain procedures. For example, there is a study evaluating the choice between a cast and an operation for elderly patients with wrist fractures.

<http://www.nfu.nl/actueel/beter-niet-doenlijst-met-niet-effectieve-medische-handelingen-gepresenteerd>, <https://www.venvn.nl/Portals/1/Nieuws/2017%20Documenten/Beter%20laten%20Aanbevelingen%20.pdf>

Functionally oriented approach

The quality standard here is getting the right healthcare provider in the right place.

Brand and type can be determined based on the link between functional requirements and the functional characteristics of the tool. Who and how this is done can vary in each case. This distribution of roles is developed in a specific module for each category. The basic principle is that a tool is prescribed by competent care professionals who put the patient at the centre and work according to this standard.

<https://www.zorginzicht.nl/bibliotheek/generiek-kwaliteitskader-hulpmiddelenzorg/Paginas/Home.aspx>

Encouraging research into the added value of new care

Before new care can be put into effect responsibly, the key question is whether a new treatment, tool, medical technique or medication has added value compared to the existing treatments. The requirements for admission to the basic health insurance package are high because it is important that high-quality, responsible care can be given. Answering the question requires data to be collected about the effectiveness and cost-effectiveness of the new care.

It is not obvious that everyone with an innovative plan can take this often complex research step independently. Knowledge and experience of carrying out good research are important, just like being able to fund the necessary studies. The downside is that many parties – particularly the smaller ones – fail to get their promising ideas to the patient, or that innovations are used at too early a stage without the added value being well-founded.

The governmental authorities want to encourage a **culture of evaluation of cost-effectiveness**, so that potentially promising care reaches patients as quickly and as well as possible. The goal is that non-academic parties such as SMEs, start-ups and small hospitals will also contribute structurally to this evaluation culture in the future.

This movement is backed up by transforming the regulations for conditional licensing of care packages, which are currently too complex, into an **accessible, simple subsidy scheme with low barriers**. It provides financial and research support for studies into the added value of promising care ideas.

This fits a movement that is already being used:

- > **Development knowledge agendas:** for the last few years, the Federation of Medical Specialists has been proactively encouraging the development of knowledge agendas for evaluation of existing care. Scientific institutes of professional groups put agendas together for the key knowledge gaps in their fields, in order to do better research faster and to improve this care.
- > Evaluation of innovative care through current regulations for the conditional licensing of care packages. Better care in cases of **cerebral infarction**: last year a new treatment for acute cerebral infarctions was admitted into the insured package after research that was made possible by conditional admission. Almost 40,000 people annually have a cerebral infarction, of which about 10,000 can now get better help thanks to a new treatment for more focused cerebral angioplasty. A team with a neurosurgeon and cardiologist is present 24/7, so patients can be treated faster and better using the new technique. This gives them a much greater chance of survival and of recovering from the cerebral infarction relatively well.
- > Another recent example is a new treatment for women who underwent a **mastectomy** for breast cancer. Currently, research is being done through conditional admission into a technique for breast reconstruction with the body's own material.
- > The expectation is that – if the study is completed successfully – the quality of life will improve for the approximately 14,000 women each year who would be eligible for it. For the patient, this treatment is a qualitatively better alternative for the existing treatment with silicone implants that have to be replaced every few years.

The transition to the care landscape of 2030 Royal HaskoningDHV

- > The hospital as we know it will disappear. That statement comes from the dialogue initiated by Royal HaskoningDHV with eighteen experts about the healthcare landscape in 2030.
- > Good care begins and ends with putting people first: healthcare consumers. The values that play or are going to play a role in this are health, taking control for yourself, ease, trust, personalisation, humanity and solidarity.
- > These values impose conditions for the structure of the care landscape in 2030.
 - > Integration of care and health in one chain and into daily life;
 - > Embracing technology;
 - > Using demand-driven funding;
 - > Legislation and regulations as the levers;
 - > Doctors evolve from an authority figure to being the adviser and partner of the healthcare consumer.
- > The change has three phases:
 1. Transparency and integration of knowledge. Digitisation makes knowledge available everywhere and for everybody.
 2. Quality and effectiveness of care. Availability and bundling of data make the quality of care clear and comparable. This ensures greater control and freedom of choice for the healthcare consumer.

3. The central role of the healthcare consumer is strengthened even more. Care networks are created to support people. This will result in a differentiated care landscape based on the needs of the healthcare consumer.

- > The transition has consequences for all parties in the care landscape. Parties that do not adapt quickly will risk going bankrupt. Hospitals should reflect on their role in the care network and on what buildings they need.

https://www.royalhaskoningdhv.com/nl-nl/nederland/specials/zorglandschap2030?utm_source=Website&utm_medium=-News%20article&utm_campaign=Delphi%20Zorglandschap%202030

Thinking and acting sustainably in healthcare: 'care without doing harm'

Why should we have to tackle this?

- > *Improving care:* A pilot in the Slingeland hospital for better monitoring of COPD patients shows a decrease of 25% for both admissions and outpatient visits. In other words, not only is the care improving, but the patients are affected less and the burden on the environment is reduced due to the decrease in transport kilometres.
- > *Combating wastage:* The healthcare sector is a major consumer of energy and raw materials. There is still a lot of potential in healthcare for cost savings and environmental benefits. Research shows that it is possible for any care institution to save an average of 12% on its energy bills.
- > *A health-promoting environment:* Sustainability and health go hand in hand. For example by encouraging exercising and by creating green areas. This assists quick patient recovery and provides a healthy working environment for employees.

Prevent damage to health: The consequences of human actions on the environment ultimately influence humans. **Fine particulates can lead to COPD, for example**, as well as to reduced brain development in unborn children (according to recent research at the Erasmus MC). According to the World Health Organization, 16% of all deaths are attributable to environmental factors that could be avoided or eliminated.

The OR is a major consumer and at the same time also one of the biggest polluters. An OR complex uses up to 35% or more of all medical supplies provided; it is an energy-intensive department and it generates large quantities of specific hospital waste. The OR environment is also not always too kind on patients and employees. Patients are often administered an unnecessary amount of antibiotics and medication, not all surgical procedures are proven to be effective and implants are not designed for recycling. Long working hours in sometimes poor ergonomic working conditions and exposure of employees to inhalable vapours from anaesthesia mean that the OR's environment is not conducive to long-term deployment of personnel.

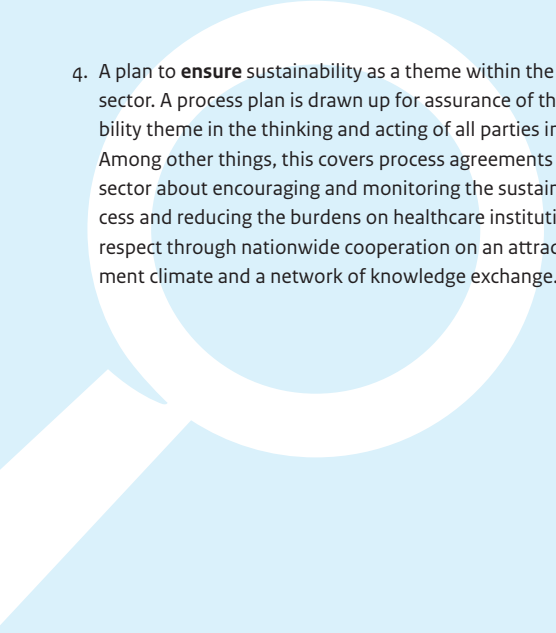
How can this be achieved?

The healthcare sector faces a significant challenge in the coming years. There is a threat that making it more sustainable will slide down the agenda, largely because there are not only few positive stimuli to investing in sustainability but also few negative stimuli against it. Innovation and cultural change are needed for structurally working on making all organisations and all places more sustainable. This includes themes such as making healthcare more sustainable, monitoring the OR, less medicine residues in water, reduction/better handling of waste, chemical safety, saving on energy or generating it sustainably, etc. Green healthcare and business operations require awareness, a good infrastructure for exchanging knowledge and investment opportunities.

The "Ostrava Declaration" was signed by the Netherlands and 51 other member states in June 2017. This declaration covers the healthcare priorities in relation to the environment for the European region for the coming six years. The member states have committed to submitting a national action plan by the end of 2018. One of the top priorities is "care without doing harm".

What does it take?

1. Administrative awareness and agreements. On 10 October 2017, healthcare managers agreed on working towards a roadmap for care and cure, and a **national Green Deal on care** for 2019-2021 (to be signed in October 2018). In the spring of 2018, an administrative knowledge forum was organised for each sector to eliminate information asymmetry, to let front-runners inspire others and to cultivate administrative commitment. Themes: energy, circular purchasing, medicine residue in water and a healthy environment.
2. **A kick-start for energy.** The Ministry of Health, Welfare and Sport has made a claim on the 2018 climate budget for €5 million. This money is being used for (1) a subsidy scheme to encourage energy-saving measures and the generation of sustainable energy at care institutions in 2018; and (2) insights from the land registry into the current real estate portfolio of healthcare.
3. Tailor-made handles for each sector on how to become sustainable.

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4. A plan to **ensure** sustainability as a theme within the healthcare sector. A process plan is drawn up for assurance of the sustainability theme in the thinking and acting of all parties involved. Among other things, this covers process agreements with the sector about encouraging and monitoring the sustainability process and reducing the burdens on healthcare institutions in this respect through nationwide cooperation on an attractive investment climate and a network of knowledge exchange.

01 Organisation & Infrastructure 02 tools for strengthening primary 03 care

- 04 > On request by the National Association of General Practitioners, InEen and Zorgverzekeraars Nederland, the Dutch Healthcare Authority (NZA) introduced a number of items from 1 January 2018 onwards within the secondary segment under the banner 'organisation and infrastructure'.
- 05 > These elements offer the possibility of agreeing on additional compensation for each registered insured party based on agreements between healthcare providers and care insurers.
- 06 > The goal of these additional remunerations is to encourage (multidisciplinary) cooperation between healthcare providers so that the patient experiences the benefits of continuous improvement in quality and/or costs of care.
- 07 > In all cases, it involves reimbursement for each registered insured party for general practitioners affiliated with the multidisciplinary partnership. The remuneration is then agreed upon with the partnership in question.
- 08 > All these items have a freely definable rate and may only be charged if there is a contract for it with the care insurer. The care insurer should ensure that the agreements about compensation via these classes of care given do not have overlapping cost components that lead to double funding. The agreements within this 'organisation and infrastructure' field are always linked to agreements about compensation, contents and results.

- 09 > We distinguish **four elements** under organisation and infrastructure:
 - 10 > **O&I for District Management:** This field of care offers the opportunity to make agreements about investment in multidisciplinary partnerships with associated support structures with the aim of optimising the collaboration between primary healthcare providers at the district level;
 - 11 > **O&I for Continuous Care Chains:** This field of care offers the opportunity to make agreements about the funding of the organisation and infrastructure associated with setting up and implementing the national continuous healthcare chain programme;
 - > **O&I for Regional Management:** This field of care offers the opportunity to make agreements about additional investment in multidisciplinary partnerships with associated support structures with the aim of optimising the collaboration between primary healthcare providers at the regional level;
 - > **O&I for Other Integrated Primary Care:** If care insurers and healthcare providers want existing agreements about remunerations and investments for multidisciplinary collaboration between care providers to continue, and cannot or will not use the O&I classes as described above, agreements about them can be made within this class.

Value-based healthcare Towards value-driven care (outcome information)

- > The right care in the right place should be about the best outcome for the individual patient compared to the costs (care value). The right care goes much further than simply following quality standards, regulations and protocols.
- > The patient's freedom of choice is an important key to continuous improvement of the outcome of care. **Shared decision-making** should therefore be the starting point: patients must be able to choose which consulting room they want and get the right treatment in that consulting room, where justice is done to the expertise of healthcare providers and the right of patients to complete information about the care and treatment possibilities and about the pros and cons and the corresponding outcomes.
- > A crucial precondition is that considerable efforts are made to develop the outcome information. The goal is that in four years' time, outcome information will be available for Samen Beslissen for **50% of the overall burden of illnesses**. To achieve this, it is possible to affiliate to existing international sets, such as the International Consortium for Health Outcome Measurement (ICHOM). This covers more than just medical outcomes: it is about relevant outcomes that are relevant to the patient such as will they be able to walk again or hold a conversation. Is there pain? Or how is their mental well-being?
- > A focus on care outcomes should lead to a **different organisation** of the care process, with more focus on prevention, more cooperation across compartments or in networks around the patient. The care sector is now mainly organised from the healthcare provider's perspective and pigeon-holed into different compartments.
- > Care insurers should also make outcomes much more the leading criterion in their **healthcare procurement**: encourage providers to collect outcome data, base contracts on that and support a renewal of the care landscape. In turn, care insurers can inform their insured parties about the outcomes of the contracted-in healthcare providers, allowing insured parties to use that information when choosing a care insurer and (if necessary) a healthcare provider.
- > Much greater use can be made of a bundled price for the entire care process, for example including diagnosis, treatment and follow-up care, or for certain groups of patients, instead of payment per intervention. In other words, a shift **from volume to value**. The current funding system does not have to change. In fact, healthcare providers and care insurers say that changes are not desirable now for the movement towards paying for outcomes.
- > Outcome information can also be used in **e-health** apps and in electronic data exchange. This facilitates self-management on the part of patients and can also improve the consulting room conversations as people progress towards Samen Beslissen. This also lets it help provide the right care in the right place.

Appropriate utilisation of care

Current policy for encouraging appropriate utilisation

There are already various policy tools in place that promote appropriate utilisation of care. Some of these tools are linked to the management of the basic benefits package and others are there to improve the quality. The tools listed below are an addition to the regular package management as set by the minister, health-care procurement by care insurers and professional development by professional groups.

Package management

- > **Risk-focused package management:** The National Healthcare Institute manages the Health Insurance Act package using a risk-focused approach. This means that it gives advice about the package based on signals, its own research or on request by the minister.
- > **Sensible Care:** In the Zinnige Zorg ("Sensible Care") programme, Zorginstituut Nederland systematically researches the ICD-10 areas to see whether diagnostics and therapeutic and other interventions are used in a patient-oriented, effective and efficient way, and what is necessary to improve care for the patient further and avoid unnecessary costs.
- > **Conditional reimbursement:** Conditional reimbursement is a tool that allows the final research to be done to determine the effectiveness of interventions.

- > **Horizon scan for pharmaceutical products:** The goal of the Horizon Scan is to increase knowledge about upcoming new medication. This is for various purposes such as the safe or 'lock' for expensive medication, purchasing by care insurers and informing interested parties.
- > **Efficiency studies by ZonMw (the Netherlands Organisation for Health Research and Development):** Two research projects at ZonMw into the efficiency, quality and effectiveness of interventions and medication.

Quality

- > **Quality and Efficiency Agenda (Q&E agenda):** The Q&E-agenda was started under the responsibility of the partners in the Coalition Agreement and contains a planned improvement cycle consisting of guideline development, implementation of guidelines, quality registration, healthcare procurement and care evaluation.
- > **Quality institute long-term agenda (LTA):** Zorginstituut Nederland encourages the improvement of the quality of care in the Netherlands, for instance by promoting the development of quality products. The LTA contains the upcoming quality products, including their planning.
- > **Outcome indicators & Samen Beslissen:** The Zorginstituut is implementing the "Outcome information for shared decision-making" programme. The aim of this is to structure work that is a precondition for Samen Beslissen, such as quality registration, reporting on outcomes and international cooperation.

Debts

Working integrally in the social domain (and the relationship between debt and health)

Restricted access and serious shortcomings in the people's means to fend for themselves lead to unnecessary care costs in the care domain, which is unlimited (i.e. in principle accessible to everyone).

Various studies¹ show that there is a **correlation** between debt and e.g. mental health (depression), alcohol and drug problems, high blood pressure, etc. For example, all people claiming benefits together account for 58.2 per cent of the costs for mental health-care. People with debts face stress and problems that make them less susceptible to interventions from the care domain or social domain that would improve their health. These complaints are greater in cases of long-term debt and seem to disappear when the debts decrease. Investments relating to housing, income support, support for nutrition and in care *coordination & community outreach* have a positive effect on health outcomes and expenditure on healthcare and support.

Professionals in the social domain have to deal with members of the public who have both health problems and financial problems. The task for municipalities is to offer these people integrated, tailored solutions from the social domain (see also Article 2.1.2 of the 2015 Social Support Act). Integrated help for the general public – particularly when given early – prevents greater demand for care and lowers the costs, making it a sub-theme of “care in the right place”.

DO IT! In a governmental Letter to Parliament entitled “A broad approach to debt” of 18 December 2018, the State Secretary of Social

Affairs and Employment (together with the most closely involved cabinet colleagues) will be announcing a broad, overarching approach to debt for this Cabinet period. In terms of the VWS terrain, it specifically covers:

- > encouraging and helping to set up innovative local approaches aimed at multiple related issues (debts and health);
- > creating a clear picture of successful integrated local approaches (working principles, business cases and the obstacles) for other municipalities and for governmental policy;
- > drawing up an action plan for vulnerable younger people (18+).

We have partitions that keep policy and finances orderly and manageable. But those very divisions can cause some groups to fall between two stools. These are often vulnerable individuals with multiple care requirements and high costs of care (for example the overlaps between mental healthcare services, district nursing, social support and debt assistance). Although possibilities are created within the “system” for working across domains, cross-domain working is in practice hard to get off the ground. In conversations with municipalities, the causes are often low-level: care professionals and care insurers not speaking the same language, the titles of experiments in regulations are complicated, experiments are very rarely followed up.

DO IT! Together with the municipalities, it would be possible to look into these kinds of obstacles in practice and see how they can be resolved.

¹ Among others, a meta-analysis by Richardson et al. (2013)

Acute care: prevention, coordination and follow-up care

Good care at home

It is important that initiatives are rolled out at many more places by parties who take that extra small step in care delivery and support for vulnerable elderly people who live at home, so that it can be noted in good time that vulnerability is an issue among these elderly people and targeted actions can be started for tackling that vulnerability (prevention, early detection and early intervention). There are existing projects that deserve follow-up in which people providing care and help can get a picture at an earlier stage of how elderly people are doing in physical, mental and/or social terms. Examples are the cooperation between cure and care and between living and welfare according to what is referred to as the 'butterfly model' in Zwolle and the early detection project involving GPs, hospitals and the care sector working together in Drenthe. This can prevent the situation for these elderly people escalating unnecessarily so that they end up in A&E. Intensive forms of respite care, extending the availability of urgent care under the Social Support Act and strengthening the deployment of district nursing during evenings, nights and weekends can all help vulnerable elderly people live at home for longer. Proper coordination and cooperation are crucial between all the professionals (GPs, district nursing, social district teams) *and* between health insurers and municipalities. That commitment is also defined in the **Pact for Elderly Care**.

Care coordination

For patients who nevertheless need acute care, it is important to organise and coordinate it better so that they end up at the right link in the care chain. Not all patients who urgently need care also need acute care (e.g. from the GP unit or A&E). InEen and Ambulancezorg Nederland have started six **springboard projects** relating to care coordination. In one of those projects, the GP unit, ambulance service and district nursing in Overijssel co-located their telephone emergency lines, for instance, so that they could switch between them more quickly, deploy the appropriate care together immediately and avoid double deployment of professionals. Initiatives such as these in care coordination deserve a broader follow-up.

Good acute care

It is also important that sufficient staff with the correct qualifications, skills and competencies are available for those patients who need care, in particular for especially vulnerable patients. This allows a correct assessment of the patients and appropriate care (see also the quality framework for the emergency care chain). This applies among other things to the increasing number of elderly people with complex problems who end up in the accident and emergency department. The availability of the correct clinical expertise does not only help improve care at the A&E unit: it can also help prevent patients from having to stay at the A&E unit for so long and they may also need fewer repeat visits to A&E. Those hospitals that do not yet have the correct clinical expertise for treating these vulnerable groups properly as well should arrange to be able to do so as soon as possible. This can be done in a variety of ways: through training and improved geriatric expertise among A&E staff

(a development that is already underway; for instance there are currently scientific studies in Leiden looking at how the quality of care for the elderly at A&E can be improved) and/or through structural deployment of medical specialists at the A&E unit (as is done at the A&E unit of the Westeinde site of HMC).

Furthermore, if possible even more so in acute care than in other sectors, it is extremely important that the correct patient information is made available at the correct time for proper triage and further provision of care. In acute care, the transfer or medical data in particular between GPs, GP units and A&E is seen as a bottleneck because the records of patient data do not fit together properly, according to the NZa and others in the acute care market scan. Information about e.g. the patient's previous hospital admissions and information exchange between ambulance facilities and the GP is also important for ambulance care. It is important that the IB focuses on better exchange of digital patient data between health-care providers (not only the use of medication and GP information). The patients' privacy and their consent must be assured here. It is also important that the progress of the actions of the IB (Care Information Forum) should be encouraged.

Flexible access to follow-up care

People who are unable to stay at home (temporarily or otherwise) must end up in the right place as soon as possible. It must not be impossible for healthcare providers to find a place for anyone. This can be a primary-sector stay or geriatric revalidation care if it is expected that people will be able to go back home, or a place in a nursing home if that is no longer possible. For that reason, it is extremely important that access to the Long-Term Care Act is organised as flexibly as possible for people (the red carpet treatment

01 plus avoiding any care trap). This also prevents people from having
02 to wait for a long time for an indication under the Long-Term Care
03 Act, resulting in their situation escalating and then ending up in the
04 crisis care under that act via A&E or a hospital. It has been agreed
05 in the 2018 Outline Agreement for Medical Specialist Care that the
06 care insurers, in consultation with healthcare providers, should ar-
07 range a regionally available single 'office' (coordination point) that
08 healthcare providers can always turn to if they need a bed, both for
09 follow-up care after discharge from hospital and before intake di-
10 rectly from primary care (such as e.g. ZorgnaZorg in Noord-
11 Nederland). People are working hard at numerous places in the
Netherlands on setting up these front desks for primary-sector
stays. It is furthermore important that these front desks are ulti-
mately related not only to primary care stays but also to other
forms of care and follow-up care, such as geriatric rehabilitation
care, long-term care and (soon) extramural treatment as well.

Elderly people living at home and A&E

Between now and 2035, the country will gain a million people aged 75 and over (Figure 1), which is an increase of 70%. Some 90% of that group currently live at home. This growth in the number of people aged 75-plus over the coming years means that more than 2 million people aged 75 or older will be living at home by 2035 (Figure 2). As their age increases, more elderly people experience limitations in the way they function in their daily lives. Of those aged 65 to 74, 79% currently have no limitations; among those aged 75 and above, that figure is only 51%. The SCP report 'Vulnerable elderly' reveals that the number of vulnerable elderly will rise from 700,000 people to 1,000,000 by 2030¹. They will go to the A&E department more readily and more frequently than younger people (see Figure 3 for current A&E visits by age group in 2016). It is estimated that if we continue doing what we are doing now, the number of A&E visits by people aged 75 and above per year will increase by 3.5%. That means more than 800,000 people visiting A&E in 2030 and 1.129 million in 2040 (the current figure is 489,000). And 42% of that group are currently admitted to hospital (Figure 4). The burden on hospitals due to acute patients is growing (source: NZa).

¹ SCP, Kwetsbare Ouderen 2011 [Vulnerable elderly]; the measuring instrument used for vulnerability is the Tilburg Frailty Indicator (TFI). Please refer to the report for a further explanation. It should be noted that three quarters of the population of institutions are also vulnerable elderly.

Figure 1

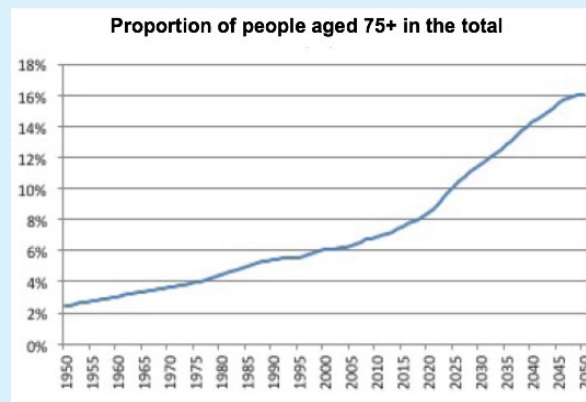


Figure 2 Proportion of institutional residents compared to the total number of people aged 80+ (source: Long-Term Care Monitor)

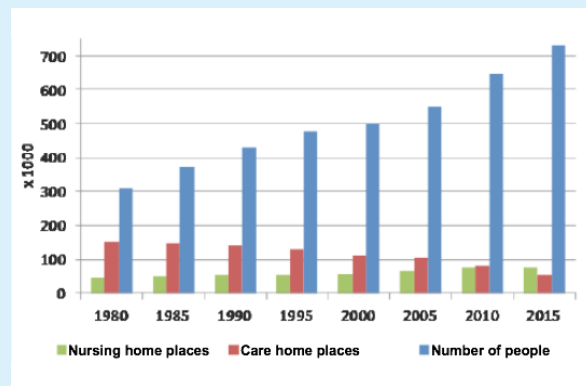


Figure 3 Number of A&E visits per 1000 residents broken down by age group in 2016 (source: VEKTIS)

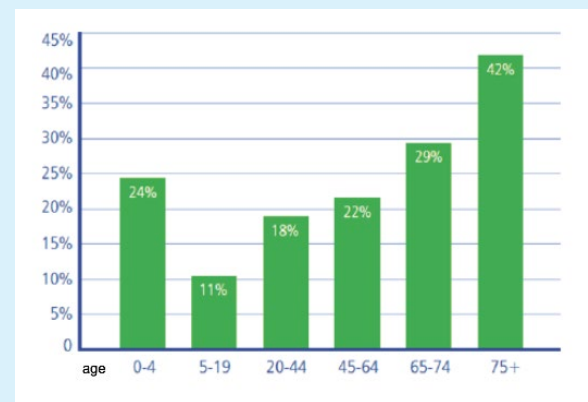
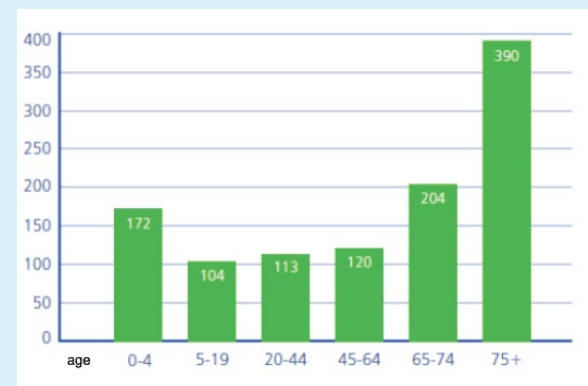


Figure 4 Percentage of clinical admissions after A&E visits broken down by age category in the first half of 2016 (source: VEKTIS)



Elderly people needing care and support in the right place (care trap)

The majority of elderly people who require care or support want to keep living in their own homes for as long as possible. This is the area where people have their social networks and where they know the facilities. Care and support at home can be provided via the Health Insurance Act and/or the Social Support Act and Long-Term Care Act. As a result, people with a care need may have to deal with differences between the systems and may as a result suffer a drop in the number of hours of care they receive and a change in the financial contribution they have to make.

- > It is important that people receive the care that they need and that they feel safe in their own environments. Care at home must fit in as much as possible with what the person with the care need wants, with care and support being tuned to match each other as well as possible. This means for instance that if the bedlinen has to be changed after an accident, the care provider who arrives first is able to do so. There is no way you can say to the client that they will have to wait until the next day because somebody from the home help department can only come then.
- > Prevention and early detection play an important role in the contacts between the person with a care need and the professional. Many vulnerable people go through a lengthy period of deterioration. There comes a moment when it is no longer responsible for care can be provided for them at home and the need for intramural admission appears on the horizon. Action must be taken if things do not feel right.

- > Care at home is provided via the Long-Term Care Act if clients meet the accessibility criteria for the act and have requested an indication. When there is a transition from the Health Insurance Act/Social Support Act, clients who do not wish to be admitted are faced with a reduction in the number of hours. This is caused by the fact that the Long-Term Care Act uses an efficiency threshold, derived from the costs in an institution. This means that there are clients who would like to live at home but are no longer able to stay at home because there are limits on the care that can be provided at home.
- > Clients ask for an indication under the Long-Term Care Act because they may possibly want to be admitted to an institution in future. The assumption is that asking for an indication early on will ultimately allow the client to be admitted to their institution of preference. This is often not the case. The client only goes on to a waiting list if there is a genuine wish to be admitted. It is then often the case that a crisis situation arises, resulting in the client having to be admitted urgently to an institution that happens to have a place free.

Options for preventing a decline in necessary care

- > Municipalities and health insurers make agreements to deliver the care in as integrated a form as possible. This can for example be done by making procurement agreements together with a healthcare provider that is able to deliver both the care and support. Depending on the care and support that is provided, this may be claimed from the insurer and/or the municipality.
- > Municipalities and health care providers make agreements so that the care can be offered at home via the Health Insurance

Act and Social Support Act of 2015 and as long as the client is satisfied with the care and support provided. This continues to apply for as long as the care can still be delivered at home.

- > Municipalities, community nurses and the social district team make agreements about who is in charge for signalling any feeling that things are not quite right and making agreements about how to deal with this.
- > Municipalities, the community nursing team and the social district team agree who is in charge of the preparation and provision of information about an indication under the Long-Term Care Act. Informing the client better about the consequences of an indication under the Long-Term Care Act can avoid having people asking for such an indication either spontaneously or on the advice of a third party while they still do not wish to be admitted and are satisfied with the care that is on offer.
- > VWS is currently investigating what is possible in terms of expanding the boundaries of the Long-Term Care Act so that clients who want to be cared for at home can receive more hours of care. In addition, studies are being done into how far it is desirable to limit the care of the elderly that is given at home to care and support via the Health Insurance Act and Social Support Act.

Two examples

A cooperation agreement for cross-domain working

The cooperation agreement for cross-domain working is a collaboration agreement between the municipality of Ede, the health insurer Menzis and the healthcare provider Opella. This cooperation

01 agreement puts the client at the centre. Vulnerable elderly people
02 (and their relatives) are assisted in a way that lets them live for lon-
03 ger (and at an acceptable level of quality) as they want, i.e. in their
04 own, trusted environment. Agreements have been made between
05 municipalities and healthcare providers for supplying the care at
06 home for as long as possible via the Health Insurance Act and
07 Social Support Act.

The Elderly Care Boundaries Project

04 This is a project in which the VNG, municipalities, a healthcare in-
05 surer/Long-Term Care Act provider and healthcare provider discuss
06 what issues there are at the intersecting areas of the Health Insu-
07 rance Act/Social Support Act and the Long-Term Care Act and how
08 those can be resolved as well as possible in practice.

The chronically ill (starting with COPD)

The preconditions that are needed for a genuinely different organisation affect preliminary care, care and support across the board. They are particularly important for specific groups for whom the right care is certainly not being provided in the right place at the moment. One such group is people with chronic conditions, especially COPD, diabetes, heart failure, renal insufficiency and dementia.

A working method for the **COPD target group** is sketched out below. If we are able to identify a number of general features of this subgroup, then draw up objectives and preconditions and sketch out an alternative, it may then be possible to extrapolate this to other groups. One precondition is that scaling up to the national level must be started for a limited number of target groups (fewer than four). For the group who are chronically ill, COPD seems to be the most interesting case and the most clearly defined.

People with COPD are registered as such in the various GP information systems, and the DRGs in the hospital are categorised based on COPD. This means that the group as a whole, estimated at 600,000 people, could be clearly defined and the overall annual burden could be mapped out via VEKTIS. For this group, there are 30,000 admissions to hospital annually (estimate: Longallantie Nederland - LAN).

People continue to come to the hospital because they are anxious and uncertain (perceived lack of safety) and they want to take their questions to a specialist person so that their urgent questions can

be answered. Any exacerbations can be prevented if people and their environment (partner, family or informal caregivers) feel sufficiently safe in the home situation.

Problem definition

- > Studies by LAN (seven pilots) have shown that a reduction of 60% in hospital admissions for COPD patients is possible, as long as professionals cooperate (district nurses, pulmonary and other nurses, any case managers, the pulmonologist – with a directing role and diagnostic role; the GP only has a limited role).
- > However, there is no financial stimulus for hospitals, either in care for COPD patients or in a general sense, to cooperate when this results in fewer admissions. It results directly in less turnover, while many of the fixed costs remain the same. That is not good for the continuity of the hospital. This does not fit in with the philosophy of the right care in the right place.
- > A certain percentage of people with COPD visit an outpatient clinic every year, often several times. This is extremely burdensome for them and costs a lot of time (mobility). It is desirable that this group does continue to get answers to their questions, but this should ideally be done in the home situation, and is driven by the philosophy of the right care in the right place.

Objective

- > **No longer physically treating people with COPD (read: chronic ill people) in the hospital, unless...**

Starting point

- > COPD (why: a clearly identifiable group with a clear result profile; care that can be delimited regionally).
- > Regional: so that the 'close by' function can still be fulfilled, and to allow new connections to be made for and by the professionals in the simplest way.

Example step-by-step plan

- > Obtain a picture of the overall costs (primary, secondary and tertiary) for the COPD population as a whole in the Netherlands (via VEKTIS – see also below).
- > Place these overall costs outside the existing framework and earmark them.
- > Start up in a procurement (or other) tendering procedure in a number of regions for delivering care to the COPD population in question.
- > Base the tendering procedure on a package of requirements, including:
 - > **Anyone can apply.**
 - > Focus on prevention (preventing anxiety and uncertainty).
 - > Reduction of the mobility of patients to hospitals (i.e. down by 25% or -x% by 20xx).
 - > Care delivery based on results (to be defined) that matter to the patient, for example improving the individual's well-being.
 - > Cooperation between community nurses, GPs, hospital (pulmonologists and nursing staff).
 - > Appropriate structure of services, including any shrinkage (while ensuring services in the evenings and at weekends).

- > Financial tasks relating to efficiency, e.g. total costs for this population in the current situation are 10 million and could be 7 million.
- > The output of the tendering procedure is provided by the parties is a protocol for care delivery; the tendering party selects the best one, given the requirements imposed.
- > Tendering for a period of 3 years:
- > Additional precondition: scientific associations make sure that suitable guidelines are available (or at any rate nothing that is contradictory).

To be discussed

- > Delimiting of the regions and the appropriate number of regions. Options to weigh up: provinces (12); care administration office regions (32); number of COPD patients¹; number of hospitals.
- > Decide who will have the role of tendering party. It would seem obvious to give this to the market-leading health insurer in the region.

Information about COPD patients and costs

<https://statline.rivm.nl/#/RIVM/nl/dataset/50040NED/table?graph-type=Table&ts=1512975518824>

Generic figures from 2011: <https://www.volksgezondheidenzorg.info/onderwerp/copd>

Figures for the hospital sector: DRG (or “DTC” in the Dutch setting) and number each year for pulmonary conditions: http://www.doktersrekening.nl/zoek/top_behandelingen.php#Longziekten

The development of treatment of respiratory diseases in hospitals from 2012 to 2014 (VEKTIS): <https://www.zorgprismaopenbaar.nl/producten/ziekenhuiszorg/ontwikkeling-medisch-specialistische-zorg-2015/monitor/volumemonitor-msz/>

SiRM in their report <http://www.sirm.nl/docs/Publicaties/Rapportage-SiRM-Next-level-gezondheidszorg.pdf> about the possibilities for substitution: page 85 about readmissions (Flevoland project) and above all pages 169 ff. that list a lot of costs.

¹ TO BE DETERMINED: the desired value for N (scale for the tender) should be discussed with Long Alliantie Nederland

Renal impairment – more dialysis in hospitals instead of at home?

The facts

- > The number of people with renal failure has increased between 2001 and 2016. This was caused in particular by an increase in the number of patients aged above 45, most probably because people are living for longer with kidney replacement therapies (dialysis).
- > The number of transplants (donor kidneys) is increasing for all age categories.
- > The number of dialysis patients is decreasing for younger age categories (up to 45 years), stable for the middle age categories (ages 45 to 74) and increasing for the oldest age category (75+).
- > The number of dialysis patients who are treated at home has been decreasing until recently.
- > This movement is strongest in the youngest age categories (from 2001 to 2016, this figure dropped from 53% to 41% up to age 45, from 47% to 24% between the ages of 45 and 74, and from 40% to 22% for people aged older than 75).

The trend: less dialysis at home – more dialysis in the hospital.

A drop can be seen in the number of dialyses at home for patients with renal impairment. More patients are being dialysed in the hospital or dialysis centre. This could be seen as undesirable, because:

- > having to go to the hospital every time is a burden on people, and because certain hospitals no longer have their dialysis units available full time – some hospitals may only offer dialysis in the mornings – so that the patient has to travel further.
- > the costs of dialysis at home are much lower¹.

Is it because of a greater need for care?

It seems reasonable to assume that patients who previously received dialysis are now eligible more often for transplants, and that this means that the patients who are now receiving dialysis are in essence in greater need of care than was previously the case. Where patients have a greater care need, there are more facilities in a centre.

Or are there other causes?

- > There has been a growing number of independent treatment centres offering dialysis since 2000.
- > Are doctors cautious about home dialysis and/or unfamiliar with it? Insufficient attention seems to be paid to peritoneal dialysis in the training.
- > There seem to be differences in the rates (average price differences) for home dialysis and dialysis at a centre.
- > There seemed to be financial stimuli for dialysis in centres (empty places in these centres are expensive and remunerations are higher).
- > There is variation in the practice of home dialysis.

It is however not easy to determine the size of the objective potential for more home dialysis. We can assume that this potential definitely exists, though.

Transplants are the best treatment – with a positive relationship with home dialysis

It should be noted that transplants (with living or dead donor kidneys) are always the most effective and cost-effective form of

treatment by far. More transplants result in better quality of life and much more favourable cost-effectiveness among people with renal failure.

If a transplant is not possible, the choice of treatment with dialysis at home or in a centre must then be discussed with the patient.

An undesirable trend – actions by healthcare providers and research centres²

Parties in the field and research institutions are seeing the added value of home dialysis and taking action. They are trying to encourage home dialysis and make it a top of mind³:

What else is needed?

- > A good funding infrastructure that facilitates cooperation between the care chains and across organisations. A single rate for performing all dialyses could be considered.
- > Improving the way data is shared between specialists, i.e. integrating data creation/a network in registers that cover more than a single disease and resolving the privacy issues involved in them.

¹ The rates for haemodialysis vary widely, particularly for dialysis at home. It is estimated that dialysis at home is about €100 a week cheaper. This estimate is however based on data from a single health insurer and does not therefore necessarily give a nationwide picture.

² The falling trend in the number of home dialyses seems to be flattening out. Since 2016, we have seen a slight increase once again in the number of home dialyses.

³ This is only an indicative overview and is therefore not exhaustive.

Choice Assistant & Deciding Together (improving the freedom of choice for the patient)

Netherlands Kidney Patients' Association	Developing the Kidney Info Sheet, and online choice assistant and consultation card
Patient+	Tool for choosing dialysis treatments
Zorgverzekeraars Nederland and the Nierstichting (Kidney Foundation)	Renal Team at Home, a nationwide project involving four academic hospitals and for general hospitals. Information is given at kidney patients' homes to their families, friends and acquaintances about the impact and ways of treating renal disease.
De Nierstichting (Kidney Foundation)	The portable artificial kidney that the Kidney Foundation is developing is a compact haemodialysis device. It offers an alternative to the current, large haemodialysis device that is primarily suitable for use in a hospital or dialysis centre.
Nederlandse Internisten Vereniging (Dutch Internists Association)	Developing a guideline on whether kidney replacement therapy should or should not be started
Nephrology Department of the Academisch Centrum Amsterdam	Organising a peritoneal dialysis university course (PD University). This addresses the theoretical and practical aspects of peritoneal dialysis (where there are shortcomings in the training).

Research (improve the insights into the costs and outcomes of kidney replacement therapies)

Taskforce including representatives of the Dutch Federation for Nephrology, the Dutch Kidney Patients Association and the Kidney Foundation	Studies into the obstacles to expanding home dialysis, both peritoneal dialysis at home and haemodialysis at home.
DOMESTICO	Research pathway that obtains a picture of the effects of home dialysis on the quality of life and clinical outcomes, related to the actual costs of care. This is being done both retrospectively and prospectively.
Dutch nOcturnal and hoME dialysis Study To Improve Clinical Outcomes	
ICHOM International working group led by the internal medicine specialist and nephrologist Willem Jan Bos ⁵ , VWS	The rollout of PROMS/ICHOM, in which a set of indicators for nephrology is defined that can be benchmarked internationally (specifically PROMS).
AMC, the Onderzoekscentrum Keten zorg (Healthcare Chain Research Centre) for chronic diseases at Isala and Nefrovisie (funder inter alia by the Kidney Foundation)	Development of the Nieratlas (the Dutch 'Kidney Atlas' will yield nationwide figures that make international comparisons possible as well as revealing any regional differences in the care and the associated costs of care for renal diseases).
RIVM (National Institute for Public Health and the Environment) in cooperation with the Nierstichting (Kidney Foundation)	Research into renal diseases ⁶ and declaring the costs of various therapies.
Vita Valley	Vitaal Thuis. Vitaal Thuis was started in 2014 and it is a field-based initiative of VitaValley that aims to allow people to receive the care that they need at home. Digital innovations and use of technology for care (at home or otherwise) is an important cornerstone of this. Their focal points include home dialysis.
Insurers	
Zilveren Kruis Achmea	Zilveren Kruis Achmea and others are encouraging home dialysis in their healthcare procurement.

⁵ <https://www.nefrovisie.nl/nieuws/ichom-luistert-naar-nierpatient/>

⁶ For example: <https://www.nierstichting.nl/nieuws/2018/01/minder-patienten-met-chronische-nierschade-door-verlaging-zoutconsumptie/>

Prevention coalitions

The subsidy arrangements for prevention coalitions have been running since last year. This is one of the measures that the Dutch Ministry of Health, Welfare and Sport has introduced in order to encourage prevention for high-risk groups within the care system. The underlying thought here is that health insurers and municipalities are the funding parties and clients for the implementation of five laws in which prevention plays a role: Public Health Act (Wpg), Health Insurance Act (Zw), Long-Term Care Act (Wlz), Social Support Act (Wmo) and the Youth Act. They are focusing here on the same health issues and the same target groups.

Features of the regulations

- > The subsidy is a contribution to the costs of cooperating incurred by municipalities and health insurers in setting up prevention activities for high-risk groups;
- > A maximum of one third of such costs for process coordination will be subsidised;
- > The health insurer is the requesting party and should carry out the process coordination work together with one or more municipalities;
- > The subsidy will be granted for a maximum of three years (and can be applied for and until October 2021);
- > A total amount of €15 million is available; there is no maximum amount per application.

Type of activities

The objective of the subsidy arrangements has been formulated in broad terms. It could instance cover activities that are needed for coordinating setting up the coalition, for coordinating its imple-

mentation, for further development of the cooperation and for structural assurance of the working methods that are developed. Activities that support the implementation could also be covered. An example of this could be involving new or existing parties that are not yet properly affiliated to an existing prevention coalition.

The actual implementation of the preventive activities is therefore not covered by these arrangements because the regular funding methods can be used for this.

Two examples

The care insurer Menzis and various municipalities in the Twente region work together in the prevention coalition called Vitaal Twente. Its aim is to improve the vitality of residents for whom it is most under pressure as a result of health risks. These could for example be the elderly, vulnerable groups and obese children.

The prevention coalition called **Wijkgerichte Aanpak Oss** (District-Based Approach in Oss) is a cooperative venture involving the health insurers VGZ and CZ and the municipality of Oss. In the district of Ruwaard they are focusing jointly on supporting the residents in improving their health at lower costs. The district's residents are closely involved in this as it is their own living environment and responsibility.

Vitaal Vechtdal is making efforts to create a healthy, active region. The partners in Vitaal Vechtdal are working together on linking the social domain, healthcare providers and health insurers through communal projects. <https://www.vitaalvechtdal.nl/>

The prevention team of VWS (the Dutch Ministry of Health, Welfare and Sport) will be pleased to help you prepare an application: preventieteam@minvws.nl.

For more information about the subsidy arrangements: <https://www.loketgezondleven.nl/preventie-het-zorgstelsel/alles-over-preventie-het-zorgstelsel/subsidieregeling-preventiecoalities>

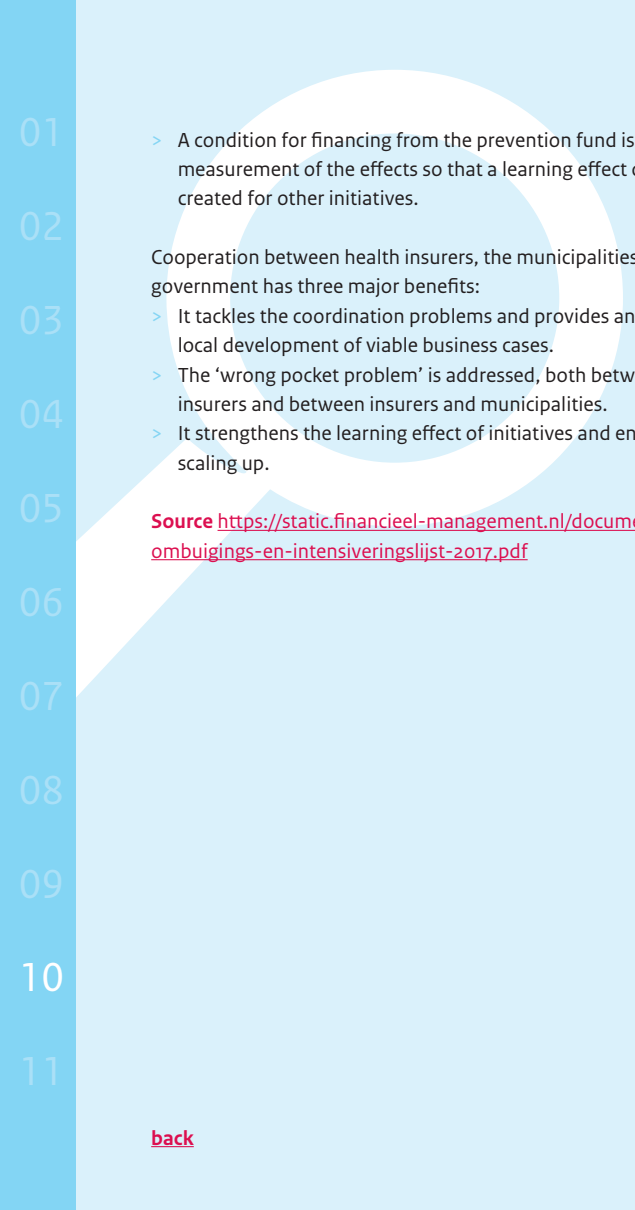
Prevention facility

Insurers cannot be obliged to make contributions to a prevention facility, although this can be an administrative agreement. This can stand alone or it can be an extension of the prevention coalitions. The insurers undertake to make one euro per insured party available annually for a period of five years for selective prevention (i.e. prevention focusing on specific high-risk groups). That will yield €85 million over a period of five years.

This money comes from the health insurers' own resources and can be topped up with resources from the municipalities. If a municipality and an insurer (or a group of both) agree on the joint activities, they can draw upon this facility after a simple check by their representatives. No legal amendments are needed.

The facility has the following features:

- > Resources are available for supporting local initiatives by municipalities, healthcare providers and other stakeholders (the resources are non-governmental);
- > Scaling up feasible business cases by exchanging knowledge and information about the possibilities for regular funding;

- 
- > A condition for financing from the prevention fund is thorough measurement of the effects so that a learning effect can be created for other initiatives.

Cooperation between health insurers, the municipalities and the government has three major benefits:

- > It tackles the coordination problems and provides an impulse to local development of viable business cases.
- > The 'wrong pocket problem' is addressed, both between insurers and between insurers and municipalities.
- > It strengthens the learning effect of initiatives and encourages scaling up.

Source <https://static.financieel-management.nl/documents/15724/ombuigings-en-intensiveringslijst-2017.pdf>

The Combined Lifestyle Intervention

A Combined Lifestyle Intervention (hereinafter also “CLI”) is an intervention in cases of obesity that focuses on encouraging people to eat more healthily, exercise more and change their behaviour, such as relaxing more and sleeping better. In 2009, the National Healthcare Institute noted that a CLI is an effective intervention in cases of overweight and obesity.

The contours that a CLI needs to comply with in order to be paid for from the basic benefits package are now starting to become clearer. This is because the National Healthcare Institute has drawn up an addendum to its statement of 2009 and the NZa has progressed a long way in drawing up a description of what needs to be achieved and a rate. These are based inter alia on the Cool programme (Coaching on Lifestyle) from the care insurer CZ in a number of regions; this has been funded by the innovation policy rules of the NZa over recent years.

The intention is that the CLIs on offer will be available via the regular care performance route and that care insurers will start contracting in this care as of this year. The rate for a CLI will be based on a group program, but numerous variants are possible in terms of the content in order for it to be paid from the basic benefits package. What is important is that the programme focuses on the said three aspects (eating, exercise, behaviour), that it is effective and that it fits in with the preconditions in the description of what is to be achieved given by the NZa.

Aligning it with the opportunities to exercise offered by the municipality can increase the effectiveness of a CLI programme.

Cooperation with the social domain and funding by municipalities is essential for this. The costs of coordinating this alignment with the social domain and with the GPs are included in the rates for the operator of a CLI programme and are therefore paid from the basic health insurance package.

More information is available on the website of the National Healthcare Institute. <https://www.zorginstituutnederland.nl/actueel/nieuws/2018/03/12/zorginstituut-geeft-meer-duidelijkheid-over-gecombineerde-leefstijlinterventies>

There are also other programmes that are funded by other health insurers, such as “Keer Diabetesz Om” (Turn Type 2 Diabetes Around) by Stichting Voeding Leeft and the health insurer VGZ. The participants work in a group led by doctors, dieticians, cooks and coaches to change their lifestyles. They do things together for five days and also receive support via the Internet. The focus is on nutrition, exercise, relaxation and sleep.

Existing studies about the potential for savings from Care in the Right Place

It is obvious that savings can be achieved by providing the right care in the right place. But what kind of sums should we be thinking of? It is not simple to tie that to a macro figure because it covers so many different forms of reorganisation of care delivery. There are however a number of studies that offer interesting insights into elements of the right care in the right place. These studies are based on assumptions with a high degree of uncertainty. This does not detract from the fact that substantial opportunities for savings can be envisaged and that the expenditure over the coming years should at least fall.

SiRM: potential savings of €1.5 billion by decompartmentalisation in the Health Insurance Act

In 2016, SiRM carried out a study of decompartmentalisation in care delivery.¹ SiRM states that the Dutch care sector can improve further in terms of quality and efficiency by compartmentalising care less. Because of the existing pigeonholes – whereby SiRM makes a distinction between financial partitioning, regulatory partitioning and partitioning in practice resulting from the strength of habits and cultural differences between organisations – the care that is delivered is not always the care that would be best for the patient. SiRM has analysed 60 successful projects, extrapolating their results to the national level and including prognoses based on the various studies. SiRM estimates that the growth of expenditure under the Health Insurance Act could be reduced by 0.6% per year by shifting care from hospitals and mental healthcare institu-

tions to GPs, primary care facilities and the patients themselves at home (i.e. a slice amounting to €0.25 billion per year). This results in a potential saving of €1.5 billion by 2020. Extending this decompartmentalisation and a shift to the Long-Term Care Act and Social Support Act could of course result in larger savings, but SiRM has not given any figures for that.

Gupta: 46% of hospital care could also be provided at home

In 2017, Gupta released a revised version of his earlier study *No place like home*². The main message is that 46% of the care that is currently provided in hospitals in the Netherlands could also be given at home, using remote monitoring and data analysis. For 70% of all ‘patient journeys’ and 60% of all patients, it turns out that the care could partially be given at home. According to Gupta, 40% of hospital buildings will become redundant, which could result in a reduction in hospital budgets of 1 to 2.5%. Given a total of almost €22 billion³ in 2018, that would boil down to a sum of between quarter and half a billion euros, structurally. This saving can of course only be achieved in the longer term. Gupta does not examine the broader context of savings that could be made by providing more hospital care at home. The techniques that are needed for this are already available. Good examples of care being shifted to the home environment are popping up like mushrooms everywhere, according to Gupta, but this does involve a lot of reinventing the wheel. Because the patient journeys for 90% of patients are possible in (virtually) any hospital, the hospitals could learn a great deal from each other or make joint efforts to shift the care towards the home. The key obstacle to this not happening is the people themselves, in Gupta’s opinion. It requires a different way of thinking from both the professionals and the patients.

Gupta: individual healthcare environments can yield €4.6 billion

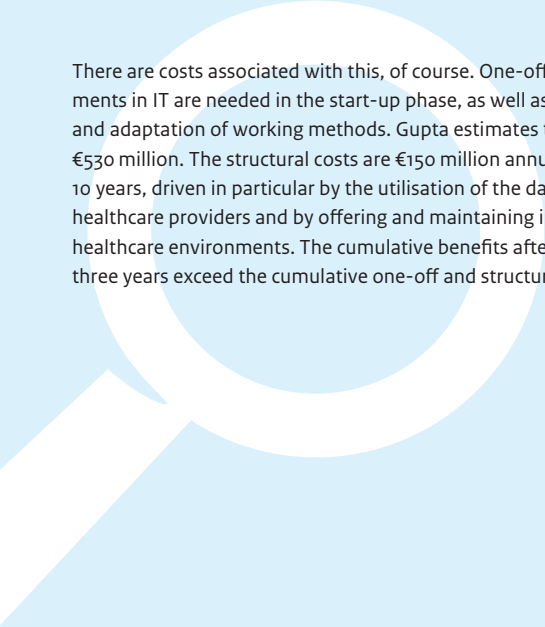
Last year, Gupta also published a report on the costs and benefits of individual healthcare environments⁴. This refers to a secure online environment in which people who so desire can gather, use and share all their health information from the GP, dentist, hospital, child health clinic, sports school, etc. Based on existing studies and the validation of assumptions by various experts, Gupta comes to the conclusion that the potential benefits outweigh the costs. If everyone is using an individual healthcare environment like this in ten years’ time, the benefits could be as much as €4.6 billion, driven primarily by a reduction in long-term sickness absences and incapacity for work (€2 billion), a reduction in referrals to secondary care as a result of self-management (€1 billion), prevention of unnecessary medical examinations (€365 million), prevention of medication-related hospital admissions, improved therapy compliance (€275 million) and the prevention of exacerbation of diseases and long-term complications by using remote monitoring (€220 million).

1 SiRM (2016), Next-level healthcare: how it can be made better and more efficient. <http://www.sirm.nl/publicaties/next-level-gezondheidszorg-hoe-het-beter-en-efficiënter-kan>

2 Gupta (2017), No place like home. An analysis of medical care at home – revised edition. <https://www.gupta-strategists.nl/storage-files/Gupta%20Strategists%20-%20No%20Place%20Like%20Home%20-%202017.pdf>

3 This figure does not come from Gupta but from the VWS budget for 2018. This is the sum for specialist medical care, not including geriatric rehabilitation care, primary-care stays and availability contributions.

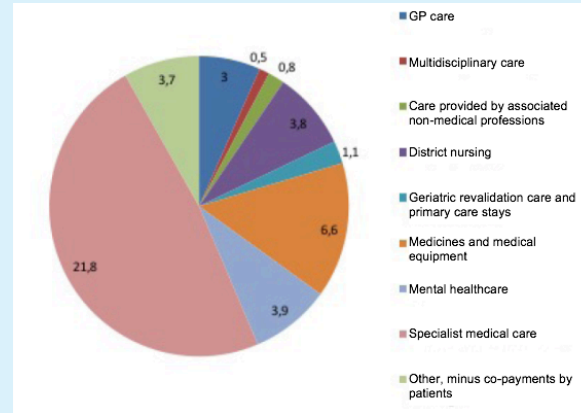
4 Gupta (2017), Kosten-batenanalyse persoonlijke gezondheidsomgeving [Cost-benefit analysis of the individual healthcare environment], <https://www.medmij.nl/wp-content/uploads/2017/07/Rapport-Gupta-Kosten-batenanalyse-persoonlijke-gezondheidsomgevingen.pdf>



01 There are costs associated with this, of course. One-off invest-
02 ments in IT are needed in the start-up phase, as well as training
03 and adaptation of working methods. Gupta estimates these at
04 €530 million. The structural costs are €150 million annually after
05 10 years, driven in particular by the utilisation of the data by
06 healthcare providers and by offering and maintaining individual
07 healthcare environments. The cumulative benefits after about
08 three years exceed the cumulative one-off and structural costs.
09
10
11

Total Health Insurance Act expenditure

Total Health Insurance Act expenditure	billions, 2018
GP care	3.0
Multidisciplinary care	0.5
Care provided by associated non-medical professions	0.8
District nursing	3.8
Geriatric revalidation care and primary care stays	1.1
Medicines and medical equipment	6.6
Mental healthcare	3.9
Specialist medical care	21.8
Other, minus co-payments by patients	3.7
Net Health Insurance Act expenditure	45.2



Source Net Health Insurance Act expenditure (estimated) – Draft budget for 2018, amount x €1 billion

Appendix 1 The task of the ZOJP Taskforce (The right care in the right place)

“The principle is providing good care for everyone in the right place and at the right time” (coalition agreement).

What is it about?

The Dutch care system is good, but it is facing a number of challenges over the coming years in terms of both the content and the funding. More scope for people to take control themselves and more care that is tailored to fit, close by for the patient if possible but further away if necessary, working in networks and breaking through the compartmentalisation where necessary. Not asking people what the matter is with them, but instead asking what matters to them. Not only whether the surgery was successful, but also whether the intervention is beneficial to the quality of life. Keeping a sharp eye open for the fact that the origins of medical problems can often be found in other domains. We often say that we want a more integrated way of looking at care, so it is important that we actually do that.

‘The Right Care in the Right Place’ can involve different ways of restructuring the delivery of care:

- > Prevention: preventing people from becoming ill (or more ill);
- > Offering sufficient care where the patient is (at home, e-health);
- > Promoting self-management by patients (including via e-health);
- > Proper transition between care covered by the Health Insurance Act/Social Support Act and that covered by the Long-Term Care Act;

- > Shifting care from the secondary care sector to the primary care sector and the social domain;
- > Proper collaboration between municipalities and health insurers as sources of funding;
- > Shifting care from the tertiary care sector to the secondary care sector and within the secondary care sector;
- > Realigning tasks within various sectors and encouraging appropriate utilisation;
- > Forming networks (or collaborating) around patients.

Transparency/value-based healthcare is important as a limiting condition: clarity about what care is necessary and appropriate, what helps most, which healthcare provider can best offer this etc., transparent information about the quality and outcomes of care for joint decision-making.

Accessible care in the right place at the right time, meeting the requirements of people, should lead to: (i) improvements in the experienced quality of appropriate care; (ii) improvements in health and the quality of life; (iii) keeping costs under control.

What are we going to do?

The key element is that all the sector partners involved in healthcare and support should take responsibility for the Triple Aim, support the guiding principles and translate them into specific objectives and working agreements. Much has been said and written on this subject. Now is the time to spur on and support the **movement**, learn with and from daily practice, make better use of the opportunities and remove obstacles, with room for diversity and experiments.

This topic has been on the agenda of the various policy consultation bodies for some time and some work has already been done as part of the bridging accords in 2018. Further research is also being done in this context. We want to inject some more dynamism into this movement. In addition to the labour market agenda and tackling the regulatory burden, the intention is that this becomes a key, foundational theme in the various outline accords that are due to be concluded (but elaboration on the theme is still valuable even if unfortunately no accords are concluded).

The practical aim is to offer the sector **persuasive prospects with specific building blocks**. Those building blocks should help improve the organisation of support and care. This is therefore about both “what” and “how”: what needs to be arranged to achieve the goal, how can we manage this and what do we need for this? The aim is not to create a blueprint, but to offer specific models, approaches and examples that are inspiring and are copied in practice. After all, there are examples at the local and regional levels of successful shifts and innovations in the delivery of care, but we are not yet seeing a broad-based movement.

All the work that has already been done and is still being done will be incorporated as an integrated whole in the Taskforce’s work as part of the 2018 outline accords. This is therefore how we create cohesion between the initiatives of the various consultative forums. This must result in a product that enjoys broad support.

What needs to happen over the next four years so that we can say in ten years’ time that we have initiated and implemented a broad movement with tangible outcomes? That requires changes that affect positions and interests, perseverance and endurance, expertise and leadership.

In addition to this product, the Taskforce will then be able to take on a role monitoring the actual movement from what is planned on paper to what is done in practice, and making recommendations.

Who will be doing this?

A strong team of authoritative experts from a range of domains are tackling the task in a private capacity. They are doing so in a Taskforce with a specific assignment: creating a basis across the whole care sector for the sectoral accords, that enjoys the support and the confidence of the parties in the sector organisations, and inspired by ongoing work on this topic and a working conference with professionals from the field and experts and administrators from the umbrella organisations. This lets us keep the initiative compact while still ensuring contact with all the existing policy governance forums.

The Taskforce members have the following expertise and background:

- > The patient's perspective
- > Municipalities
- > District nursing
- > Multidisciplinary care
- > Care provided by associated non-medical professions
- > General practitioners
- > Hospital
- > Medical Specialist
- > Independent treatment clinics
- > Nursing home sector (with hospital connections)
- > Contracting-in director at an insurance company
- > Mental healthcare

- > Quality of Care and academic hospitals
- > Chair and Secretarial Office (Ministry of Health, Welfare and Sport)

We expect the Taskforce will be able to make a valuable contribution to the substantive aspects of the various sectoral accords that will have the support of the various parties. Of course the parties involved in the policy forums will ultimately decide whether they consent to the input from the Taskforce for the sectoral accords and whether agreement can be reached on an accord. An initial product was delivered on 1 April 2018 plus a plan for a follow-up process.

Appendix 2 Broad conference on 'The Right Care in the Right Place'

In the afternoon of Wednesday 7 February, 112 people from the sector came together at the Ministry of Health, Welfare and Sport in The Hague to discuss Care in the Right Place. The afternoon was all about coming up with innovative concepts and concrete building blocks, swapping ideas and discussing trends in the healthcare sector relating to Care in the Right Place.

Francis Horst-Lotterman, who has a visual disability and is a diabetes patient, shared her own experience of the healthcare sector with the participants. She told them that she had to visit the internal medicine specialist and the diabetes nurse every month for her diabetes, for example. She had to note down her blood values in a notebook for this, but she can't do that because of her poor eye-

sight. She would much rather connect up the digital pump system that she wears to her PC and then e-mail the data to her internal medicine specialist and nurse practitioner. But she said that unfortunately the digital transfer of data was not yet possible at her hospital.

Afterwards, the participants split into different working groups to discuss where there were opportunities for the taskforce and how these opportunities could be fleshed out.

Sophia de Rooij talked to the participants about the 'Hospital at Home' project, where the specialist visits the patient at home with a specialist nurse and where use is made of digital remote care. After this talk, the participants once again split into working groups, this time to discuss how to make use of the opportunities. At the end of the conference, a delegation from the various working groups that ranged from cardiologists to nursing staff presented their findings and the results of the afternoon to Ms Francis

Horst-Lotterman (as an expert based on her own experience) and Mr Bruno Bruins, the minister.

The Taskforce took these points into account in the assessments made in the present report.



Appendix 3 Composition Care in the Right Place Taskforce

Chair

B.E. (Bas) van den Dungen
Director-General for Curative Care, Ministry of Health, Welfare and Sport

Members

Prof. P.J.E. (Patrick) Bindels
Professor of Family Medicine, Erasmus MC

W.F.H. (Willem) de Boer
Managing Director, MC Groep

J.P.J. (Joris) van Eijck
Director of Carer, Menzis

J.H. (Jak) Dekker
General Manager of Equipe Zorgbedrijven

Prof. J. (Joost) Dekker
Professor of Paramedical Care, VUmc, Amsterdam

O. (Olivier) Gerrits
Director of Care Procurement, Zilverenkruis

J. (John) Kauffeld
Board member at Espria

Prof. J.(Job) Kievit
surgeon (n.p.), emeritus professor of care quality

H. (Heleen) Post, LLM
Manager of the Dutch Patients' Federation

E.J.D. (Elnathan) Prinsen
Psychiatrist, Dimence

H. (Hilde) Reints
Manager, Municipality of Enschede

Dr. G. (Guy) Schulpen
Medical Director, Zio Foundation

Prof. M.J. (Marieke) Schuurmans
Professor of Nursing Science, Utrecht University

M.F.T. (Marcel) Timmen
Director at Vereniging Spierziekten Nederland

Dr. S.C. (Selma) Tromp
Neurologist, St Antonius Hospital Nieuwegein/Utrecht, former chair of the Netherlands Neurology Association

G. (Gerard) de Valk
Project Leader for Mental Health First Aid and Destigmatisation, Altrecht

Official Secretary

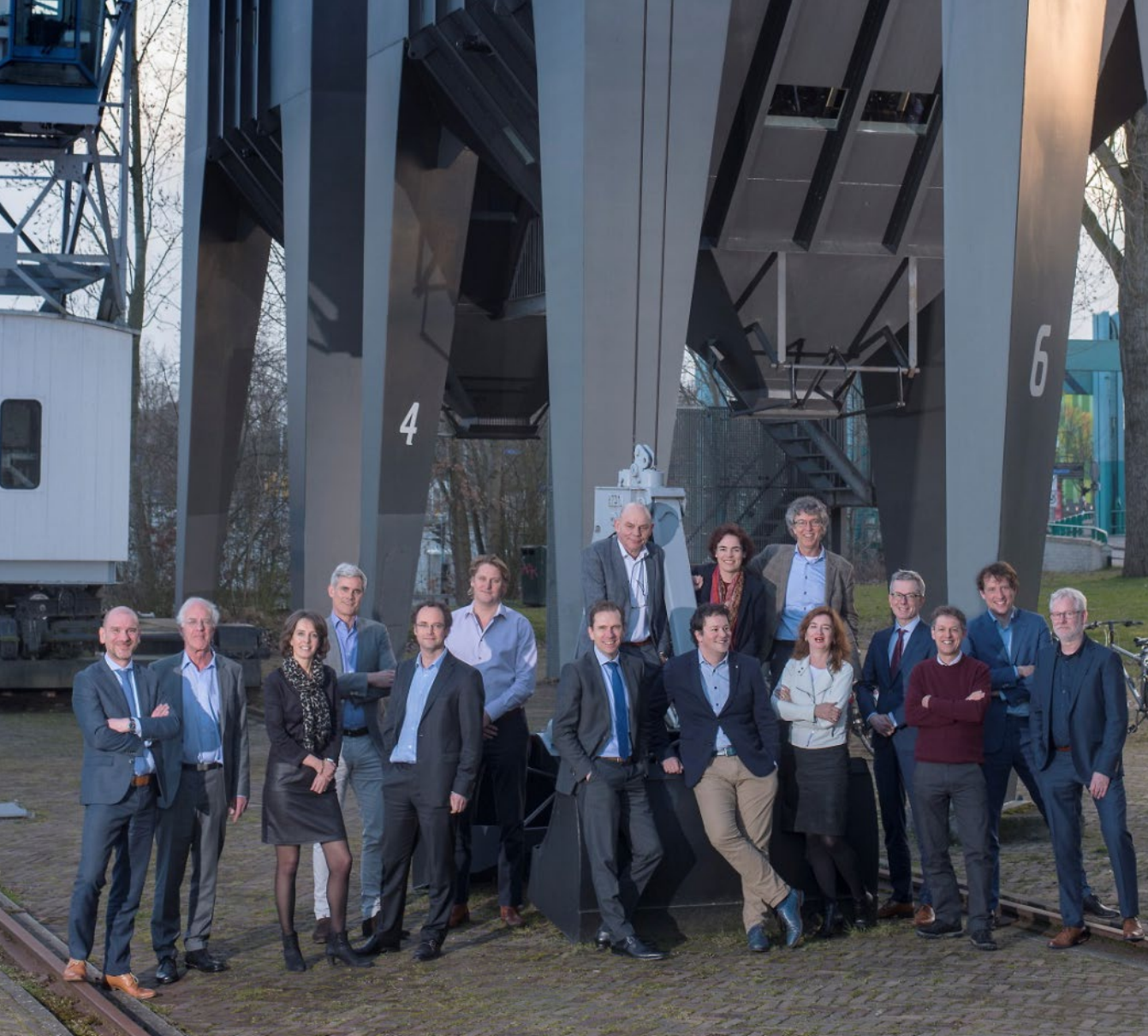
E.B.K. (Ernst) van Koesveld
*Director for Health Insurance
deputy Director-General for Long-Term Care
Ministry of Health, Welfare and Sport*

Secretarial office

The secretarial office was staffed by Ingeborg Been, Hattem van der Burg, Roland Beukers, Chris Flim, Marijke van der Heijden, Gerlinde Holweg, Jana van Kuringen, Caspar Lombaers, Jacqueline van der Marel, Georgette Mentink-Kleiss, Mirrin Middelhuis, Tessy Nelissen, Karen van Ruiten and Yvette de Jong.

Word of thanks

The chair of the Taskforce would like to thank everyone who was involved in producing this report and was consulted for input. In addition, the chair would like to thank the 112 people who took part in the broad 'Care in the Right Place' conference on 7 February 2018 for their involvement and input. Special thanks are due to Francis Ter Horst-Lotterman (Ikone) and Sophia de Rooij (UMCG). A particular thank-you is extended too to the secretarial office of the Health Insurance Department for their work in arranging the logistical, purchasing and organisational aspects for producing this report. Finally, he would like to thank the report's graphic designer.



Care in the Right Place **Taskforce**

