Exploring the impact of austerity-driven policy reforms on the quality of the long-term care provision for older people in Belgium and the Netherlands

Publication of remaining quality principles

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Prologue

To finalize my master programme in European Public Health at the University of Maastricht in 2015, I wrote a thesis on the quality of the long-term care provision in Belgium and the Netherlands after structural long-term care policy reforms had been implemented in both countries. This master thesis was submitted to the Journal of Aging Studies and accepted for publication, although in a revised and downsized form. While the master thesis focused on the 11 different quality principles for long-term care as defined by the European Partnership for the Wellbeing and Dignity of Older People (2012), the article that was eventually published in the Journal of Aging Studies only focused on 3 key quality principles. During the peer review phase the original master thesis was deemed too lengthy and its contents too abundant for publication in a scientific journal, and compromises were made regarding length and scope of the article.

As to ensure that valuable information is preserved and potentially valorised, the current article describes the findings pertaining to the 8 remaining quality principles that were not included in the official publication. The current article is therefore merely meant to complement the findings of the official publication.

For further information on the background and methodology of the study, we refer to the official publication in the Journal of Aging Studies.

What follows is a description of the 8 quality principles and how these quality principles are reflected in the contemporary long-term care provision in the Belgian region of Flanders and the Netherlands.

Description of quality principles

Quality principle	Explanation
Respect for human rights and dignity	The fundamental rights and liberties of older people, their caregivers and their families should be respected in accordance with national, European and international human rights frameworks. A long-term care service should acknowledge the rights of the elderly as being equal to those of other age groups, and should steer clear from any form of discrimination based on age, national or social origin, race, skin colour, financial situation, beliefs, religion, gender, sexual orientation and identity.
Prevention and rehabilitation	Long-term care services should seek to prevent deterioration – and facilitate rehabilitation – of an older person's mental and physical health, wellbeing and capacity to live independently. Autonomy should be supported through home adaptations, assistive devices or rehabilitative nursing. Social isolation should be adequately addressed and prevented.
Accessibility	Services for people in need of care and assistance should be easily accessible to everyone who needs these services, regardless of physical or cognitive limitations. When a person cannot access the service, for instance due to limited mobility, adequate and affordable transportation to the service should be provided, or amenities should be available to bring the service to the person in need. Older people, their families and informal caregivers should similarly have easy access to objective information and advice on the different services and provider options available to them.
Comprehensiveness	A long-term care service should be comprehensive in the sense that it provides support for all types of care a recipient needs. Most recipients have multiple and diverse needs and expectations when it comes to long-term care. Comprehensiveness also encompasses collaboration between care providers working with each individual care recipient, and a proper integration of their provided services.
Continuity	Continuity means that a long-term care service is reliable, uninterrupted and delivered on time, but also flexible in the sense that it is responsive to a person's changing needs. Furthermore is the quality of long-term care reflected in the synergy between care providers in facilitating a smooth transition when care tasks for a recipient are transferred. An older person should also be able to ask one dedicated service to coordinate and cover his or her diverse care needs.
Outcome-oriented and evidence-based practices	The main purpose of a long-term care service should be reaching beneficial outcomes regarding a recipient's wellbeing, health and independence. Furthermore, where possible and appropriate, beneficial outcomes for informal caregivers, family members and society should be pursued. Regular critical evaluation of the care provision should be common practice, incorporating the opinions and feedback of all relevant stakeholders. Measures to improve the efficiency of the care provision should be based on scientifically supported evidence.
Transparency	There has to be clear and extensive information and advice available regarding the availability of long-term care services, the exact costs of these services, how to obtain access to these services and how to stop using these services. This information should be reliable, up-to-date, easily publicly accessible and also available on request. Changes regarding the long-term care provision which will affect a recipient should be communicated to that recipient far in advance and should be accompanied by information about alternative options when relevant. Transparency furthermore applies to the public accessibility of quality evaluations and to the decision making progress within a care service.
Gender and cultural sensitivity	Long-term care services should acknowledge the cultural diversity and specific needs of men and women among both staff members and care recipients. Culturally sensitive care respects the biographical, linguistic, cultural, religious and sexual diversity in both patients and personnel.

Respect for human rights and dignity

The Dutch and Belgian respondents stated that agreements from human rights conventions are generally effectively translated into national legislation and clinical practice guidelines. One Dutch participant did indicate that while there is sufficient attention for certain human rights – for instance with regard to physical integrity, confidentiality and privacy –, other human rights are sometimes overlooked, an example being the right to work, especially when it concerns the elderly population. Furthermore, it was not before January 2016 that the Netherlands ratified the Convention on the Rights of Persons with Disabilities (United Nations 2006), whereas Belgium already ratified this same treaty in 2009. In practice this means that in coming years great efforts will be required in the Netherlands to honour and effectuate the Convention's aims for strengthening the position of citizens with physical or cognitive disabilities, including older people with functional limitations.

Respect for human dignity is generally regarded as being very important amongst long-term care organisations and healthcare professionals in both the Netherlands and Belgium. The prevailing ethical and moral principles in society are aligned with the notion that a human being deserves the best care possible. Despite this general philosophy, in both intramural and extramural long-term care settings there are occasional reports of theft and elder abuse by healthcare personnel. These are regarded as unforgivable indiscretions, inevitably leading to termination of employment and legal action. However, in most cases of elder abuse the perpetrators are one's children or one's spouse. As informal caregivers in the Netherlands and Belgium are confronted with increasing care demands, some respondents fear that this will contribute to an increasing prevalence of elder abuse in both countries.

Prevention and rehabilitation

The Belgian and Dutch participants indicated that there is not enough emphasis on measures stimulating healthy ageing; especially in times of economic crisis, initiatives with a preventive focus often perish due to decreasing financial resources. The respondents also stated that in both Belgium and the Netherlands, the efforts to stimulate reablement (i.e. helping people to regain their independence) are generally insufficient in the long-term care provision, a phenomenon which is being facilitated by the financing mechanisms behind long-term care. In both countries the financial allocations from the government are directly linked to the level of disability of a care recipient; the higher one's functional limitations, the more money is allocated to meet one's care demands. Furthermore, there are no financial incentives encouraging and supporting long-term care organisations to reduce the level of care dependency of a care recipient or to prevent further deterioration of an older person's health status. One Belgian respondent talked about a 'perversity in the system', in which long-term care organisations that prove highly successful in rehabilitating the capacities of older persons are being penalised financially in the form of decreased funding, sometimes even necessitating termination of employment of healthcare staff.

The Dutch respondents indicated that while the Dutch government is decreasing the intramural long-term care capacity, there is simultaneously a substantial shortage of specially adjusted houses to facilitate the needs of tens of thousands of older people in extramural settings. Consequently, many older people live in homes that could be seen as unsuitable for them, for instance due to having to use the stairs while functional limitations make this a dangerous endeavour. This exposes older people to unnecessary risks of falling and potentially becoming more care dependent.

Accessibility

According to the Dutch participants, there are currently quite distinct differences between the various municipalities in the Netherlands in terms of ensuring adequate accessibility to services for older people. Since the recent reforms, the municipalities are responsible for supporting the social participation and self-reliance of older people. Particular groups of vulnerable older people – such as those in the early stages of dementia – are entitled to participate in daytime activities under the supervision of social workers. These activities are provided to foster the wellbeing of these older people while simultaneously reducing the strain on informal caregivers. And while some municipalities provide adequate transportation to ensure the accessibility of the aforementioned daytime activities, there are also municipalities that do not provide similar transportation services due to budgetary constraints. Multiple Dutch experts argue that some municipalities could show more creativity and determination in ensuring adequate accessibility of services for dependent older people. In Belgium, concerns regarding the physical accessibility of services were less pronounced, although one respondent did indicate that the Flemish government has stopped funding certain provisions in the public domain, such as public libraries. Consequently, in various smaller municipalities across Flanders, libraries have been closing. Public places such as libraries often facilitate social interaction and cohesion within a community, and although there are often still libraries in adjacent, larger municipalities, these are often not adequately accessible for older people due to limited mobility and frailty.

While information on the long-term care provision is generally available in abundance in both Belgium and the Netherlands, this does not automatically imply sufficient accessibility of this information for all relevant stakeholders. Especially in the Netherlands, accessibility of information on the long-term care provision was seen as problematic, for various reasons. Firstly, computer literacy is often a prerequisite for adequate access to relevant information, but a substantial number of older persons – especially those from lower socioeconomic backgrounds – still lack the required skills and knowledge to adequately utilise the internet's potential. Secondly, the written correspondence on the long-term care provision from the national government and the municipalities towards older people is regarded as often being too complex for the specific target group to sufficiently comprehend. The phenomenon of independent client support – which was introduced with the recent reforms – is however expected to progressively address some of these issues. Independent client support is available free of charge to anyone in need of long-term care and assistance, and offers people the opportunity to receive

objective information and advice on the care provision in the Netherlands, by a personal advisor who takes into account people's wishes and capacities. While in general the Belgian respondents deemed the accessibility of information on long-term care to be adequate, one respondent did express concerns somewhat similar to those in the Netherlands; accessibility of relevant information was sometimes seen as problematic for people from lower educational and socioeconomic backgrounds.

Comprehensiveness

The Dutch respondents mentioned a vastly increasing number of people with mild to moderate functional limitations, who not yet meet the admission criteria for intramural long-term care, but whose (social) care demands are at the same time not adequately met within the extramural long-term care provision. Since the reforms, some uncertainty prevails regarding who should feel responsible for meeting certain care needs of this group. Consequently, many older people – a good example being those in the early stages of dementia – remain deprived of adequate care and support. While the Dutch government is transferring responsibilities to the local level, many municipalities in the Netherlands lack the professional expertise, capacity and financial means to act on their expanded competencies and responsibilities in the field of long-term care. One positive development in the Netherlands according to the respondents however, is that there seems to be a strongly increasing emphasis on neighbourhood care, with small self-managing teams of nurses and other care professionals closely collaborating to provide extramural long-term care within a demarcated geographic area. While these neighbourhood care teams do regularly encounter professional barriers (e.g. lacking competencies for providing certain types of care), financial barriers (e.g. receiving no reimbursement for certain care proceedings) and the aforementioned obscurities regarding who is responsible for certain care tasks, the respondents do think that small self-managing teams can contribute to a more comprehensive and efficient long-term care provision.

In Belgium, some respondents state that the decentralisation of long-term care responsibilities to the regional level has been characterised by poor collaboration between the different actors in the field of long-term care (e.g. the national and regional governments and long-term care service providers). Consequently there have been significant problems with transferring relevant administrative and medical data on the long-term care provision from the federal level to the regional level. The Belgian regulatory framework is furthermore seen by the Belgian respondents as too complex, rigid and bureaucratic to facilitate a smooth transition of the long-term care system. As the Flemish government is expected to obtain additional competences in extramural long-term care in 2018, while simultaneously pursuing a new system of person-tailored financing, respondents feel that the current regulatory framework in Flanders needs to be substantially revamped and simplified. Especially the person-tailored financing system will require a very flexible regulatory framework to prevent older people from running into bureaucratic barriers when seeking the care and assistance they need.

Continuity

A flexible and vigilant approach is needed to ensure that the evolving care needs of older people are adequately addressed in a timely manner. The experts stated that in both Belgium and the Netherlands, the changing care needs of elderly people are generally addressed fast and efficiently. This applies to both extramural and intramural care settings. In the Netherlands, if an older person's care needs (suddenly) change, residential care organisations are free to instantly intensify the level of care provided, corresponding to the care recipient's needs. Justification of this intensified level of care towards the government – which is paying for this care – can then be provided ex post. This is seen by Dutch respondents as a substantial improvement compared to the situation a couple of years ago, where prior approval by a government official was always required when adjusting the level of care provided.

In Belgium, general practitioners fulfil a key role in coordinating the care delivery for the majority of dependent older people, and a referral from a general practitioner is needed for almost all medical services, including long-term care services. As the long-term care demands of a person progressively increase, and more healthcare professionals get involved in the care process, a coordinating role is often adopted by the healthcare professional most actively involved in the care process. The Dutch system works quite similar, although the recent introduction of independent client support provides patients with additional options of potentially outsourcing the coordination of the care services they need. One Belgian respondent expressed concerns about the health insurance funds actively trying to adopt a coordinating role within the long-term care provision by assigning dedicated 'care brokers'. These care brokers act as personal care advisors for dependent older people, but this respondent argued that these care brokers are generally too far removed from the care process to adequately assess the exact needs of the clients seeking their assistance.

Outcome-oriented and evidence-based practices

As brought to our attention by a Belgian respondent, nursing homes and care homes in Flanders are obliged to monitor a set of 16 indicators related to the quality of the organisation, its personnel and the provided care (see annex 1). This respondent argued that the chosen indicators depict a distorted and insufficient picture of long-term care quality; the Flemish government is criticised for including mere objective, administrative indicators, while not including any subjective perceptions and experiences of elderly people when assessing long-term care quality. The Flemish government bases its policy in the field of long-term care on a study by Van den Bosch et al. (2011). Van den Bosch et al. (2011) estimated in what manner the long-term care demands in Flanders would develop between 2011 and 2025. One of the respondents expressed concerns about the Flemish government relying too heavily on the primary projections of this study, while not giving sufficient consideration to alternative projections and scenarios that were developed both within the same study and in other studies. Indeed, as emphasised by Senge et al. (1994), it is important not to dismiss alternative scenarios, and to develop effective strategies for various scenarios that might come to pass. Furthermore, this particular Belgian respondent

felt that a re-evaluation and possible readjustment of the projections from 2011 would be appropriate to ensure inclusion of the latest insights, developments and contextual influences and to effectively guide the further transition of the Belgian long-term care system.

The Dutch government was criticised by some respondents for not integrally monitoring the effects of the reforms within the long-term care sector. Furthermore, the Dutch respondents argued that the various long-term care policy changes that have been implemented in the Netherlands over the past years hardly have an evidence-based foundation. The government's idealistic and ideological reasoning behind the reforms – to ensure tailor-made care, delivered closer to home, with the support of a caring and involved society – is mainly seen as rhetoric, with the real driving force behind the reforms being the need for austerity measures. While on a governance and policy level a scientific basis seems to be missing, the Dutch respondents did indicate that most practices relating to the actual individual care delivery process are generally reasonably supported by scientific evidence. Still, some respondents indicated that within many long-term care organisations there still is a lack of awareness of the importance of sound scientific research amongst healthcare professionals, managers and directors.

Transparency

In both Belgium and the Netherlands, the governments structurally evaluate the quality and safety within long-term care institutions. The outcomes of these evaluations can be accessed via the respective government websites. Furthermore, care homes and nursing homes are obliged to periodically provide reports in which they elaborate on various predetermined quality indicators within their organisation; these reports are also to be made publicly accessible. According to the respondents, long-term care organisations in both countries are generally very accommodating in providing (potential) care recipients with reliable and comprehensive information about the services they provide.

In the Netherlands, substantial efforts are currently being channelled into further developing 'Zorgkaart Nederland', an online platform where end users can share their experiences by writing reviews of healthcare professionals and healthcare institutions, including long-term care organisations. This is seen by some respondents as a promising initiative to further increase the transparency within the long-term care sector, especially since opinions of end users – while valuable – are generally not adequately incorporated in quality evaluations.

In Belgium, the Flemish government has recently implemented additional measures to increase the transparency and to counter fraud within the long-term care sector. Previously, long-term care service providers generally declared the costs of the provided care directly to a care recipient's healthcare insurer, without the care recipient having insights in these costs. Since 2015, care recipients receive an exact overview of the declared proceedings and their costs, to ensure that the costs that are being declared actually correspond to the care that has been provided. Belgian respondents however did mention a perceived lack of transparency regarding long-term care governance; uncertainty prevails regarding the implications for long-term care organisations and care recipients of additional fundamental

changes of the long-term care system (e.g. the transition of extramural nursing care from the federal level to the regional level) that are scheduled to be implemented over the course of the coming years.

Gender and cultural sensitivity

The specific cultural and religious needs and preferences of older people are generally respected and met according to both the Dutch and Belgian respondents. While the number of long-term care organisations with a religious identity has greatly decreased in the Netherlands over the past decades, in Flanders there still seem to be a substantial number of long-term care organisations that have maintained a Christian identity. Still, these organisations generally tailor to the needs of Christians and non-Christians alike. In the Netherlands, nursing homes and care homes are free to allocate part of the governmental budget to assign a pastor, reverend, imam or other religious key figure if they deem this is aligned with the needs of their residents.

Sexuality and gender sensitivity are still regarded as issues that need to be further addressed according to the Dutch respondents. One issue relating to gender sensitivity is the fact that transgenderism and transsexuality are frequently met with ignorance and stigmatisation within long-term care settings. Similarly, homosexual residents regularly experience discrimination and stigmatisation in intramural care settings, by fellow residents and to a lesser extent by staff members. Multiple nursing and retirement homes in the Netherlands have created special residential wings within their institutions exclusively for homosexual residents. This does not imply homosexual residents are not welcome in the other residential wings; it merely provides an alternative for the group of homosexuals who prefer such a living arrangement. Dutch long-term care organisations can furthermore obtain the 'Pink Carpet' ('Roze Loper') quality label, which indicates a high level of tolerance and respect towards homosexual residents. The existence of similar initiatives in Belgium was not mentioned by the respondents, possibly related to the fact that the Belgian respondents generally did not see sexual sensitivity as being an issue within the long-term care provision in their country.

References

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Annex 1. Quality indicators for Flemish residential care facilities

Indicators on the quality of care and safety	1. Decubitus
	2. Unintended weight loss
	3. Falling incidents
	4. Daily physical movement restrictions
	5. Daily physical movement restrictions limited to the use of side rails
	6. Incidents with medication
	7. Vaccination against influenza amongst staff members
	8. Medication usage (5 till 9 different types)
	9. Medication usage (>10 different types)
	10. Mortality rates
	11. Palliative care plan for end of life
Indicators on the quality of the care professionals and the institution	12. Absenteeism of healthcare staff due to sickness (short term per employee)
	13. Absenteeism of healthcare staff due to sickness (globally per employee)
	14. Healthcare staff leaving the organisation
	15. Shaping and investing in education of staff members
	16. Contributions of volunteers in the care process

Note: As brought to our attention by one of the Belgian respondents. This respondent furthermore referred us to the corresponding publication by Agentschap Zorg en Gezondheid (2015)*.

* Reference: Agentschap Zorg en Gezondheid. 2015. *Vlaams indicatorenproject woonzorgcentra: handleiding 1.6* [Flemish Indicator Project Residential Care Facilities: Manual 1.6]. Brussels: Agentschap Zorg en Gezondheid.