

Innovation in Health Care for the Elderly in The Netherlands

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INTRODUCTION

In general, care in The Netherlands is provided for elderly people in three types of residence. First, the elderly may live independently. Those who do live independently receive care from primary health care disciplines like general practice and community nursing. Second, when people are not entirely independent, but do not need permanent nursing they are admitted to residential homes. In these residential homes medical care is given by GPs. Third, when permanent nursing is needed, admission to a nursing home is usually arranged with a specialized medical and nursing staff in attendance. The health care system is currently undergoing change. This study gives an overview of the range of experiments being undertaken to try to improve the care of the elderly. The current structure of the Dutch health care system, its problems, and some policy measures designed to solve these problems are described in this introduction in order to provide a fuller understanding of these experiments.

Health care for the elderly in The Netherlands is, like health care for all other people in The Netherlands, financed by insurance. It

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has to be distinguished from the social sector (including many municipal institutions coordinating activities and facilities for the elderly living independently) which is financed by local or regional authorities. Health care costs are mainly covered by two social insurance schemes: the "Sick" Fund Act and the General Medical Expenses Act (AWBZ). Both are run by private not-for-profit organizations, working mainly at a regional level and responsible for paying the health care costs of its members. These organizations are supervised by the Health Insurance Fund Council, in which employers, labor unions, patient organizations, health care providers and the government are represented. This independent body also advises on coverage and premium levels. The health care of the three aforementioned groups is paid from different sources. The costs of the health care for the elderly living independently are mainly covered by the health insurance funds (e.g., GP, physical therapist) and the AWBZ (community nursing). Residential homes are financed from a special budget which is separate from the health care budgets (WBO), whereas nursing homes are paid by the AWBZ.

A central characteristic of the Dutch health care system over the last 20 years is its tripartite stratified structure. The first layer is primary health care. This is the ambulatory, directly accessible, generalist care, situated in the community. Providers of primary health care are GPs, community nurses, home helps, etc. Secondary health care is the second layer and comprises the hospital sector with medical specialists for acute health care. The third layer consists of long-term health care like nursing homes for somatic and psychogeriatric patients. An essential feature of this system is that access to each higher layer is regulated by referrals. This does not mean that one institution in each layer is responsible for all aspects of care. In the first layer, in particular, there are many different institutions and independently established professionals.

Despite the clarity of its structure this system had disadvantages. The first is its lack of flexibility. For example, patients who need more nursing care on a temporary basis than can formally be provided by primary care have to be admitted to a nursing home. They cannot stay at home or in a residential home. The second is that, as providers of care are organized in many different institutions and

financed from different sources, there is no mechanism that guarantees coordination of care. This lack of coordination is a particular problem for those among the elderly who need care from different institutions. It applies especially to people living independently and, to a lesser degree, to people in residential homes. A third problem is that, in comparison with other countries, more patients stay in residential homes and nursing homes and the cost of these facilities, particularly of nursing homes, is very high.

Recognition of these problems coincided with a change of direction in Dutch health care policy in the mid-eighties (Groenewegen and De Bakker, 1993; Lapré, 1988). Until then, structuring the health care system in layers and planning by local and regional authorities were the key elements in government policy. Substituting primary health care for secondary care was seen as an important means of controlling costs. Consequently, primary health care was strengthened, for example, by lowering the patient/GP-ratio, increasing the number of community nurses and subsidizing multidisciplinary collaboration within primary health care.

In 1987, attention shifted from a structural to a functional approach and from planning to the introduction of market forces. The functional approach meant that the provision of insurance was no longer formulated in terms of health care providers (i.e., a community nurse belonging to the regional cross association) but in terms of role or function (i.e., nursing). This means that different health care providers can compete for this 'function' (in nursing, for example: private nursing organizations, nursing homes operating extramurally and the same old regional cross associations). Health care financiers would, it was assumed, contract the cheapest care of high quality.

This shift in attention created a climate in which innovation and change flourished, although the actual implementation of the new system had not yet taken place. Health care providers were challenged to renew the care they delivered in order to be prepared for the new market. The government further encouraged this trend by setting up programs in which 'innovation' experiments were supported financially. A characteristic of these programs is the broad differentiation in goals and instruments introduced to achieve these goals.

Measures of special interest were taken within the framework of recent health policy changes specifically for the three groups of elderly people. For example,

1. Funds were made available by the Health Insurance Fund Council to provide intensive home care (e.g., terminal care) during a maximum period of three months.
2. In 1989 the Ministry of Welfare, Health and Cultural Affairs decided to provide extra funds for residential homes, allowing the homes to provide extramural care for those elderly people who had been advised to enter a residential home. This measure was taken to reduce the percentage of the elderly living in residential homes (7.3%; WVC, 1990) and coupled with a stricter admissions policy for residential homes with assessment committees operating at a regional or municipal level.
3. Since 1989, the Health Insurance Fund Council (which is responsible for the General Medical Expenses Act) has also allowed nursing homes to provide extramural nursing care.

These measures provided financial and legal opportunities for innovative experiments in the regions. Many local initiatives were taken and recorded to provide an overview of the experiments. This article describes the nature and extent of the experiments that ensued.

METHOD

The Registration of Innovative Experiments

A secondary analysis was made of the innovative experiments recorded. Registration was supported by the Ministry of Welfare, Health and Cultural Affairs (WVC) and carried out as a joint experiment by The Netherlands Institute of Primary Health Care (NIVEL), The Netherlands Institute of Mental Health (NcGv) and the National Hospital Institute of the Netherlands (NZi). All institutions in the health care system (e.g., home care organizations, ambulatory mental health care, nursing homes, hospitals) were asked to complete a questionnaire about each experiment in which the institution had participated.

When defining an innovative experiment, two elements were distinguished: 'innovation' and 'experiment' (Peters, 1992). Innovation in care was defined as intentional activities aimed at changing the primary process of health care in order to improve the quality of care or the efficiency with which care is given. The primary health care process refers to the health care received directly by the patient. An innovation is perceived as new by an individual institution or other unit and it matters little whether or not an idea is 'objectively' new (Rogers, 1983; Zaltman et al., 1973). 'Experiment' refers to the way the innovation is implemented. An experiment was defined as all activities intended to be carried out within a particular period of time to achieve aims by means formulated beforehand. Furthermore, the activities planned were expected to be put down on paper and had to be evaluated. This evaluation could be carried out by those directly involved in the implementation of the experiment or by independent organizations, such as universities or research institutes.

Selection and Data Analysis

After two years of registration, about 1050 experiments were identified and computerized in a database. In this review, experiments formally targeted the care of the elderly. This resulted in 393 experiments. We excluded experiments for which there was scanty information ($n = 16$), experiments which ceased before implementation ($n = 1$), and experiments which were still in a premature phase ($n = 2$). We further excluded six experiments because on close examination, we found they did not fit our definition of an innovative experiment. Consequently 368 experiments were reviewed.

Following the questionnaire, the experiments were coded in terms of the following characteristics:

- a. *Target Group*. The experiments were divided into groups depending on the residential status of the elderly, i.e.: experiments aimed at changing care for patients living independently, experiments aimed at changing the care for elderly living in a residential home, and experiments aimed at changing the care for patients in nursing homes. Furthermore, some experiments were aimed at changing the care for the elderly in

- hospital, and in other institutions such as psychiatric hospitals. Within these groups, patients were characterized by their care needs: e.g., patients in need of intensive care, patients waiting for a place in a nursing home, psychogeriatric patients.
- b. *The Goals of the Experiment.* The experiments were dichotomized into experiments aimed at substitution of care (i.e., providing extramural care instead of intramural care) combined with a maintenance or improvement of the quality of care and experiments explicitly aimed at the improvement of the quality of care.
 - c. *The Most Important Instruments Introduced to Achieve These Goals.* Instruments were coded in terms of the part of the care process where they entered into: the assessment of the care needed (e.g., how a decision is made on what care is needed), the supply of care (e.g., providing extra care to fill the gap between home care and institutional care, improving the knowledge and skills of professionals), and the coordination of the care provided (e.g., the introduction of a case manager responsible for the coordination). Finally, all instruments designed to improve services to patients were coded (e.g., an information center, introducing a complaints committee). It should be noted that there is only a gradual difference between goals and instruments: the development of an instrument is a goal within an experiment in order to reach higher goals such as substitution of care and improvement of the quality of care.
 - d. *Formal Characteristics of the Experiment.* Such as the length of the experiment, the way the experiment was financed, the supervision, and the evaluation of the results.

RESULTS

Formal Characteristics of the Experiments

As can be seen in Table 1, most experiments were documented (89%) and were subject to evaluation (89%). Innovations were often not entirely new: almost two out of every three experiments referred to the existence of similar experiments (not on the table), whereas 38% of the experiments were in cooperation with similar

TABLE 1. Some formal characteristics of innovative experiments.

written plan (N = 349) ^a	89%
cooperation with similar experiments (N = 361)	38%
formal experiment manager (N = 368)	47%
written estimation of the costs (N = 368)	71%
extraordinary financing (e.g., by the Ministry of Health) (N = 368)	41%
evaluation of the experiment (N = 354)	
• no explicit evaluation	11%
• procedure is not yet laid down	56%
• established procedure	33%
evaluation by an external person or institution (N = 354)	39%
duration of the experiment (N = 337)	
• two years or less	17%
• two to four years	16%
• more than four years	2%
• end of experiment is unknown	64%
number of professionals involved (N = 335)	
• 1-10	53%
• 11-20	13%
• > 20	33%
number of different disciplines involved (N = 331)	
• 1	5%
• 2 or 3	32%
• 4 or 5	32%
• 6 or more	31%

a. Due to missing values the total number of experiments included varies.

experiments. At the onset of an experiment, the duration of the experiment was often unknown (64%): this depended on the progress of the experiment, on the outcome of the evaluations and, last but not least, on the financial options for continuing the experiment. A considerable part (41%) had extra budgetary aids from external institutions such as the Ministry of Health, the Health Insurance Fund Council and municipalities. In most experiments (95%), care was provided by two or more different disciplines.

Target Groups

Looking at the three main types of residential status for the elderly, Table 2 shows that most experiments were aimed at elderly people living independently (70%) or living in a residential home

TABLE 2. Target groups of the innovative experiments (N = 368).

Target group	abs	% ^a
A. Elderly people living independently and:	256	70%
- having moderate (primarily somatic) care needs	36% ^b	
- having intensive (somatic) care needs	21%	
- having psychosocial problems	4%	
- having psychogeriatric problems (not screened for a nursing home)	19%	
- having psychogeriatric problems and recommended for a nursing home	8%	
- recommended for a nursing home (irrespective of type of problem) ^c	16%	
- recommended for a residential home	11%	
B. Elderly people living in a residential home and:	97	26%
- having moderate (primarily somatic) care needs	32%	
- having intensive (somatic) care needs	3%	
- having psychosocial problems	1%	
- having psychogeriatric problems (not screened for a nursing home)	24%	
- having psychogeriatric problems and recommended for a nursing home	16%	
- recommended for a nursing home (irrespective of type of problem) ^d	29%	
C. Patients in a nursing home	22	6%
D. Elderly people in a hospital	7	2%
E. Elderly people in a psychiatric hospital	5	1%
F. Elderly mentally disabled living in institutions	1	1%
G. Other target groups	2	1%

- The sum of the percentages exceeds 100% because some experiments had several target groups.
- The denominator is the number of experiments of the main target group (e.g., in this case the denominator is 256). The sum of the percentages exceeds 100% because some experiments are aimed at several groups.
- Experiments aimed at somatic as well as psychogeriatric patients. Three experiments only aimed at somatic patients with a positive advice for a nursing home are included in this target group.
- Two experiments only aiming at somatic patients recommended for a nursing home are included in this target group.

(26%). A small number of experiments in the database were aimed at patients in nursing homes (6%). Few experiments were aimed at elderly people living in other intramural institutions. There were more experiments in the original database aimed at patients in other intramural settings such as hospitals, but these experiments were mostly directed at the entire population of the institution and not at elderly patients in particular. Most experiments were aimed at people with moderate health care needs. There were also many experiments aimed at people who needed more intensive care than the primary health care professionals were usually able to provide: people needing intensive care and those advised to enter a residential home or a nursing home. Substitution of care might be possible for such people.

In the following parts of this paper, the range of the experiments within each target group will be described. The goals (whether or not substitution of care) and the instruments used to obtain these goals were considered. We also looked at the cooperation between extramural and intramural institutions filling the gap between these forms of care. For each target group, these characteristics are shown in a table and have served as guidelines for the description of the experiments.

Innovative Experiments for Elderly People Living Independently (256 experiments)

Elderly People with Moderate Care Needs (92 Experiments)

When one looks at the descriptions of each experiment targeting this group, the differentiation among them is remarkable. Table 3 offers some global figures about the goals and instruments used in the experiments and the number of experiments in which health care was provided by intramural as well as extramural health care institutions. Most experiments were aimed at substituting health care, usually trying to prevent admission and encouraging the elderly to be self-reliant for as long as possible. There were only twenty experiments in which no reference was made to any form of substitution. Most of these experiments were primarily aimed at organizing the existing care better or providing a new care facility, such as incontinence consultations, organized by community nurses,

TABLE 3. Experiments aimed at elderly people living independently.

	elderly people with moderate care needs	elderly people needing intensive care	people with psycho- social problems	psycho- geriatric patients	psycho- geriatric patients recom- mended for a nursing home	patients recom- mended for a nursing home	people waiting for admission in a residential home
	(N = 92)	(N = 53)	(N = 11)	(N = 49)	(N = 20)	(N = 42)	(N = 28)
Primary goal							
Substitution + care quality	78%	91%	82%	57%	100%	98%	89%
Improving care quality	22%	9%	18%	43%	0%	2%	11%
Most important instruments							
assessment of care	21%	15%	0%	25%	15%	17%	25%
supply of care	75%	87%	91%	84%	75%	81%	64%
coordination of care	71%	77%	36%	55%	70%	62%	82%
extra patient services (e.g., information)	11%	4%	9%	4%	5%	0%	11%
Cooperation between extramural and intramural institutions	54%	53%	46%	43%	45%	60%	39%

having a maker of orthopedic footwear visit people at home (in the past, patients had to go to the orthopedic institution), or a memory course for elderly people. One out of every five experiments started with a coordinated assessment of the patients. The full range of care-needs was assessed by a single person or group. Consequently, there should be an increased guarantee that the patient will ultimately receive the care needed. The care needed was usually formulated in terms of functions (instead of disciplines or institutions). After diagnosis, the decision on who would provide the care had to be made. Institutions for secondary and tertiary health care like nursing homes, also offered their expertise to the professionals in primary health care: for example, by introducing a geriatric outpatient clinic where patients were examined to obtain a more adequate diagnosis.

Most experiments changed the supply of care and provided improved coordination of care. Several means were used to improve coordination of health care, such as the introduction of a case manager, intensive multidisciplinary consultations, the formation of health care teams for the individual patient, formulation of plans for each individual patient, and the use of standards to describe what care was needed for particular categories of patient.

One example of a new care facility was new accommodation with differentiated amounts of care given to each person. People in these homes lived on their own in a formal sense. The houses often had communal rooms for recreational activities or joint meals. Admission to an institution might be prevented, the elderly person could remain as self-reliant as he wished, and it was possible for partners to live together. Occupants could use regular primary health care facilities and, if they were recommended for residential care or nursing care, they received additional care.

In other experiments people stayed in their own homes, but received part-time health care in a residential home or nursing home. Relatives were relieved of their tasks, so that the elderly person could stay at home longer. Some experiments offered admission for a shorter period of time.

There were also many experiments experimenting with less drastic new care supplies for elderly people to promote self-reliance. For example, the supply of hot meals at home ('meals on wheels'),

the introduction of alarm systems, or occupational therapy at home (occupational therapy is usually only available in intramural settings).

Finally, some experiments concerned individual financial budgets. Instead of receiving a standard package of care, the elderly person received money to buy the care. Essentially, the elderly person could decide what care was needed and could also choose who was to provide it. The client was often helped by a care-mediator.

Only 11% of the experiments also offered extra patient services such as an information desk, clear procedures concerning complaints about the care, and participation of elderly people in the policy concerning experiments.

Elderly People Needing Intensive Care (53 Experiments)

The present organization of primary health care is equipped to meet moderate care needs. The organization cannot generally meet long-term help requirements on a 7-day 24-hour basis. Round-the-clock nursing for patients who required intensive care was introduced in various experiments. Thus, most experiments were aimed at substituting care and provided extra care. Again, coordination of care was an important instrument for intensive care provision.

The Health Insurance Fund Council initiated experiments in three regions offering patients intensive care at home for a period of up to three months. A coordinating center allocated extra care for individual patients and dealt with administrative tasks. Patient care was organized by a case manager, who was usually one of the professionals involved. As a result of the positive evaluation of these experiments, the Health Insurance Fund Council decided to provide funds for intensive home care.

Some experiments offered special accommodation with communal rooms and care in accordance with the needs of each individual. There was also special accommodation for the terminally ill and their relatives. This accommodation, for at most five patients and their relatives, was staffed by volunteers. Medical care was provided by general practitioners and community nurses.

Volunteers were also engaged in experiments that were set up to make it possible for the terminally ill to die in their own homes.

Volunteers gave additional help, such as household and patient care, family support, and stayed with the patient overnight.

Nursing homes and residential homes also participated in experiments offering patients the option of living at home. The patients could receive part-time care in a nursing home or residential home. Part-time care could consist of day care as well as admission during the nights. This was often organized in cooperation with primary health care organizations. These examples show that the boundaries between institutions and layers are becoming less rigid.

Elderly People with Psychosocial Needs (11 Experiments)

Few experiments were targeted at elderly people with psychosocial problems (often isolated elderly people). This is not surprising because the registration of innovative experiments was confined to the health care system, whereas, in The Netherlands, institutions outside this system promote the general well-being of elderly people. Experiments were only registered when health care organizations were involved. The aim of almost all experiments was to encourage those isolated socially to remain self-reliant for as long as possible. This aim was often achieved by offering recreational activities, day care, or organizing conversational groups.

Psychogeriatric Patients (49 Experiments)

These experiments differed from other experiments to the extent that substitution of care was an explicit aim in only 57% of the cases. Experiments exclusively aimed at improving the quality of care included, for example, those developing procedures to improve the diagnosis of psychogeriatric patients in order to provide more adequate care, and experiments primarily aimed at developing a coordinated care circuit and encouraging professionals to get to know this expanding group of elderly people better. Substitution of care was often pursued by a better coordination of care combined with extra care supplies such as memory training and part-time care in a nursing home to relieve the family. Sometimes nursing homes reserved one or two extra beds for emergency situations. This flexibility of care offered the patient the opportunity to stay at home longer.

As far as other target groups were concerned, new housing was

set up for psychogeriatric patients in particular. One experiment, for example, offered psychogeriatric patients and their partners accommodation to enable them to remain together. The partner is the first carer and, if necessary, additional care is given by primary health care professionals (e.g., home helps). In other experiments a small group of psychogeriatric patients lived together in one house. Some of these houses were connected with nursing homes or residential homes, others were autonomous.

Again, several experiments were primarily aimed at mobilizing and guiding volunteers. Volunteers visited the patient at home to help the family or act as a host family for a psychogeriatric patient.

Psychogeriatric Patients Recommended for Nursing Home Care (20 Experiments)

Since it had been made possible for nursing homes to provide nursing care outside the nursing home, many experiments were initiated. A number of these experiments aimed at giving nursing care to people living at home. The aim of all experiments was care substitution. As in the experiments aimed at other target groups, the most important instruments were extra care supplies and coordination of care. Many of the processes of change within nursing homes were guided by the Innovation Project on Elderly care ('PIO-project') in order to implement this new coordination of supply care. This experiment is being carried out by the National Hospital Institute of The Netherlands and a private consulting firm.

The experiments for this target group resembled the experiments targeting psychogeriatric patients who had not been referred to nursing homes. Different sorts of new housing and part-time care facilities were provided in both groups. However, in contrast to the experiments for psychogeriatric patients in general, none of the experiments for psychogeriatric patients referred to nursing homes aimed at mobilizing voluntary aid. Another difference between these groups of experiments concerned the institutions involved in organizing the care. In experiments where the patient was referred to nursing home care, nursing homes were often involved in the provision of care. Ambulatory mental health care institutions (RIAGG) were more involved in care provision in experiments where the patients had received no such advice on nursing care.

Patients Referred to Nursing Homes (42 Experiments)

As with psychogeriatric patients, nursing homes were experimenting with other types of provision of care for all (somatic as well as psychogeriatric) patients. Most experiments offered extra care supplies, such as part-time treatment, beds for emergency care, consultation or training for primary health care professionals, and special accommodation for both psychogeriatric and somatic patients; for example, a guest-house where patients could stay during a part of the day, up to one week (7×24 hours). Some nursing homes offered special accommodation for people recommended for nursing homes, where patients could use the facilities, while keeping their own privacy. If nursing home care was given to patients living at home, this was via community nurses or nursing-home nurses. Often extramural professionals were involved as well as intramural health care institutions (60%).

People Referred to Residential Homes (28 Experiments)

In all experiments targeting this group, health care was given by primary health care professionals, sometimes in cooperation with professionals from residential homes. Nursing homes only played a minor role in the care for this target group. Substituting improved coordination for care was a goal of the majority of the experiments. Examples of extra care provisions that were organized were the provision of hot meals at home, extra day care facilities and short-stay facilities. New housing accommodation was also set up. People could be fully self-reliant but could obtain extra facilities (such as hot meals, home help) if necessary. These houses offered a flexible care arrangement in accordance with the needs of each individual person. The elderly could live in their own homes, despite an increasing need for care.

People Living in Residential Homes (97 Experiments)

As shown in the preceding paragraph, residential homes also have extramural tasks. Elderly people now remain self-reliant for as long as possible. Consequently, new residents experience more difficulty in performing daily activities and need more care. Greater

demands are made on the professionals in residential homes. In addition, the opportunity to remain in a residential home for as long as possible, produces a population needing an increasing amount of care. Now the boundaries between residential homes and nursing homes are fading. This is illustrated by the many experiments aimed at giving nursing home care in residential homes (Table 4). The experiments within each target group considerably resembled each other so that the target groups were linked. Nursing home professionals were almost always involved in the care. Residential home professionals were often trained to work with patients demanding more care. Primary health care disciplines such as community nursing only played a role in a small number of the experiments. Nursing care could be provided for individual residents of the residential home or for groups of patients.

TABLE 4. Experiments aimed at people in residential homes.

	people with moderate care needs (N = 32)	people needing intensive care (also recom- mended for a nursing home) (N = 30)	psycho- geriatric patients (N = 23)	psychogeriatric patients recommended for a nursing home (N = 16)
Primary goal				
substitution + care quality	88%	97%	100%	100%
improving care quality	12%	3%	0%	0%
Most important instruments				
assessment of care	9%	10%	13%	0%
supply of care	100%	97%	100%	100%
coordination of care	78%	97%	96%	81%
extra patient services (e.g., information)	0%	0%	0%	0%
cooperation between extra- mural and intramural institutions	34%	37%	9%	13%

Some experiments for people with moderate care needs did not aim at expanding nursing care in residential homes. For example, nursing homes offered occupational therapy or physical therapy to patients in residential homes and experiments in starting a conversational group for isolated people or a memory course. There were also experiments aimed at organizing volunteers, e.g., for the transport of people in wheelchairs. In comparison with the experiments targeting the elderly at home, less attention was paid to improving the assignment of care and improving the services to patients.

People in Nursing Homes (22 Experiments)

As shown in Table 5, most experiments for people in nursing homes aimed at improving the quality of the health care provided. In contrast to experiments aimed at the elderly at home or in residential homes, few experiments aimed at substituting nursing home care. In addition, there was little cooperation with primary care professionals. Two nursing home experiments substituted extramural nursing care for intramural. Another experiment introduced a special program to reactivate psychogeriatric patients so that they

TABLE 5. Experiments aimed at people in nursing homes.

	patients in nursing homes (N = 22)
Primary goal	
substitution + care quality	27%
improving care quality	73%
Most important instruments	
assessment of care	0%
supply of care	73%
coordination of care	64%
extra patient services (e.g., information)	9%
Cooperation between extramural and intramural institutions	9%

could go home again. One experiment transferred some domestic tasks, usually done by nurses (such as changing beds) to the house-keeping services, so that nurses had more time for the patients.

However, most experiments were primarily concerned with improving care quality. Often multidisciplinary coordination was formalized, e.g., by experimenting with individual care plans or with care protocols. Some of these experiments also explicitly involved the patient and family in making care plans. Examples of new care supplies are a new ward for people needing more than medical and nursing care (e.g., people with behavioral problems) and experiments with new treatment programs (e.g., for psychogeriatric patients and patients with Korsakow syndrome). Another new facility was accommodation for relatives of patients near the nursing home. Relatives could then remain close to the patient.

Experiments Aimed at Other Target Groups (15 Experiments)

Seven experiments aimed at changing the care of the elderly in hospitals. Most experiments concerned the care of patients who did not need hospital care anymore but could not (yet) go home. These patients ought to have gone to a nursing home but had to stay in hospital because nursing homes had no room for them. One hospital tried to reactivate psychogeriatric surgery patients with a special program in order to make it possible for them to go home again instead of being admitted to a nursing home. Another experiment offered some recreational activities to patients who were waiting for a place in a nursing home to prevent hospitalization. Other experiments tried to reduce hospital and nursing home waiting lists by transferring patients from hospitals to nursing homes and from nursing homes to homes as soon as possible, e.g., by offering an intensive reactivation program and by close cooperation between the hospital and nursing home. Finally, one experiment offered new accommodation between hospital and home. This small-scale accommodation for sixteen somatic patients offered nursing and medical care as well as psychosocial care and homeopathic treatment.

Five experiments aimed at improving the care of chronically sick elderly people living in psychiatric hospitals. Experiments were carried out with new treatment or training programs (e.g., reality orientation training) and with small-scaled sheltered accommodation.

DISCUSSION

In the introduction to this article, it was argued that a climate for change had been created in the second half of the eighties. The government promoted renewal in the health care system and supported all kinds of experiments financially. At the same time legal and financial barriers were removed to provide opportunities to flexibilize the health care system.

This review shows that under this climate a wealth of experiments were initiated. The simple situation with the elderly living independently relying on primary health care, people in residential homes and in nursing homes, had been replaced by a situation in which all kinds of hybrid forms developed, in which care was provided to the elderly living independently and people in residential homes, that in the past had only been possible for people in nursing homes, etc. Many experiments aimed at changing health care for people living independently. The fragmented primary health care layer and the general aim of reducing intramural health care contributed to this dominance.

Most experiments aimed at both substituting health care and improving the quality of health care. Intramural institutions often cooperated with primary health care professionals to provide health care outside the institutional walls. Movement in the opposite direction with primary health care professionals, such as community nurses, giving care in an institution occurred less often. Substitution was found to be a less prominent goal in experiments for psychogeriatric patients living independently and for patients in nursing homes. The relative lack of knowledge about psychogeriatric problems and the lack of facilities for psychogeriatric patients and their families in primary health care may require experiments on improving the quality of health care for this group. Experiments in nursing homes also primarily aimed at improving the quality of health care. Patients in nursing homes usually need intensive health care and, for a lot of patients, the nursing home is a final residence. Substitution of care is not a desirable attainable objective for these patients.

The overwhelming majority of the experiments provided extra health care facilities in combination with better coordination. This flexibility as such can be seen as the added value in the wave of

experiments: it is possible for people to die at home if they so wish. With growing care needs, admission to nursing homes is not the only alternative, etc. In contradistinction to this emphasis on changing the provision of care, few experiments gave special attention to the assessment of care needs and to patient-oriented services such as information about care facilities and accessibility of care. Primary health care in particular with its many different institutions and independently established professionals can be rather complex for the patient. Most experiments integrating different kinds of care by introducing multidisciplinary assessment procedures for health care needs and offering extra services for the patient (such as an information desk) were found within primary health care.

In the introduction, three problems of the traditional health care system were mentioned: a rather inflexible structure (few standard packages of care), with fragmented care (difficulties with coordination), and a great deal of intramural health care (high costs). The many experiments offering new care supplies that better meet the needs of the individual, introducing new ways of coordinating care, and trying to prevent intramural care show that, in general, finding of solutions for these problems played an important role. However, the question arises as to whether these problems have really been solved. In order to discuss this, the most logical thing to do is to look at the evaluation of innovative experiments. Most experiments reviewed in this article planned an evaluation procedure and a considerable number of these experiments were evaluated by an external institute. Some experiments planned an extensive evaluation procedure, including evaluations of the processes as well as the effects. Most experiments reviewed had not yet been evaluated. An example of a group of well-evaluated experiments were the seven demonstration experiments. Substitution was achieved in five of the seven experiments (Romijn, 1991). The quality of care did not decrease and even increased slightly. Substitution often implied cheaper care. However, substitution of care did not automatically result in less expensive care. It was concluded that the care of badly disabled people needing intensive home care might be cheaper if provided intramurally. In general, discussions arose about the costs of attempting to provide as much extramural care as possible.

Despite the importance of evaluative research, it is difficult to

design. In practice, the traditional designs used in social sciences, including pre- and posttests and comparable (control) groups, were scarcely used. This limits cause-and-effect conclusions. One of the problems is that researchers were sometimes not involved in the planning of the experiment and, as a result, it might be too late to have a pretest. Furthermore, adequate control groups were not easily found. As we have shown, many experiments did not yet have an evaluation procedure at the onset of the experiment. A rather late involvement may also conceal possible conflicting interests and hidden policies of the parties from the researcher (Van den Heuvel, 1986). A process evaluation helps to find an explanation of the effects obtained. This is an essential part of the evaluation of the experiment because often aspects of the experiment had already been changed during the experiment or the instruments had not been implemented, or not completely.

Apart from the experiment evaluations some other issues can be raised. The first concerns the continuity of the experiment. What happens if the subsidy for the experiment ends? Subsidies were often of a temporary nature and four out of every ten experiments had extra budgetary aids from external sources. When the subsidy ends, is the extra care facility only open to people who can afford an out-of-pocket payment?

The second issue is the pluriformity in health care provision which is the result of the experiments. In a way, pluriformity can be positive as long as it is tuned to the specific needs in the region. But if it means intensive home care is available to people with the same insurance policy in region A and not in region B, it may be asked as to whether this is desirable.

A third issue is the effect on professionals in primary health care, in residential and nursing homes. For example, as a result of the extra care facilities for those living independently and the stricter assessment criteria, the health status of people remaining in the homes shows a downward trend. For the personnel in these institutions this means that the workload per patient increases, in addition to a possibly negative impact on the quality of work. This, in a period, where there are already shortages in nursing staff.

Finally, some comments can be made about the role of the patients themselves in the experiments. Only occasionally did

elderly people play an active role in planning and implementation of the experiment. Participation would be preferable because most experiments aimed at providing care which corresponds better with the care needs of the individual. Participation could be achieved by the involvement of patient organizations, by having patients in the management-team, or by structural consultations with elderly people (e.g., discussion groups). Patients could also be part of the evaluation of the experiment. Because innovative experiments aim to change the primary health care process, evaluative research should include patient measures such as satisfaction, functional status, well-being, complaints and other judgments about care.

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