Learning integrated care from the Dutch

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Purpose

This article aims to gather lessons from a research interchange between England and The Netherlands, reflecting on the countries' delivery of integrated care across adult and elderly long-term care, and how to transfer learning across contexts.

Approach

The paper describes the Dutch health and care system, using four key components of integrated care described in the literature: person-centred, expert knowledge, continuity and coordination.

Findings

The Dutch deliver integrated care expertise in each component assessed. The weakest integrated care characteristics in England are multi-sectoral coordination and person-centred care.

Originality

This article develops an overview of integrated care delivery in The Netherlands and puts a spotlight on the importance of exchanging real-world experiences, not just evidenced-based, to collaboratively improve integrated care in England. There is no need to reinvent the all-wheel, a lot of good is already done, tested and proved.

Keywords: integrated care; multi-sectoral; person-centred care; The Netherlands; England; clinical-academic.

Introduction

In March 2024 I undertook a research visit in The Netherlands, specifically interacting with people and Institutions in Leiden, Katwijk and Sassenheim. The Dutch are recognised by their work in integrated care and also have the biggest facility worldwide caring for people with Huntington's Disease (a rare neurodegenerative condition usually affecting people in adulthood), both my areas of interest, and so I wanted to expand my English horizons.

In generic terms, Dutch healthcare is provided by the government, through an insurance system of reimbursement schemes; everyone is mandated to have insurance. People that do not have enough financial capacity to get insurance, have the government supporting them with benefits, a part of which needs to mandatorily go to insurance. Therefore, all people in The Netherlands, regardless of economic status, have access to healthcare. The government also supports research in their settings including long-term care. In a comprehensive analysis of a comparative dataset on health policies and health system characteristics, the authors (Joumard *et al.*, 2010) place The Netherlands and the United Kingdom (UK) in opposite sides of the spectrum, based on one being abundantly reliant on private provision of healthcare (The Netherlands), while the other is heavily reliant on the public system (UK), highlighting that The Netherlands have reduced health inequalities thanks to their insurance coverage. Conversely, when comparing the UK's healthcare system with other countries over the occasion of the National Health Insurance (NHS) 75th birthday, the NHS is described as being in 'perma-crisis' and 'perma-reform' (Anandaciva, 2023, p. 6).

In The Netherlands, care is prioritised at home, with people being admitted to long-term care settings at a much older age and/or advanced stages of disease, when managing at home becomes too complex. To facilitate the growing population of frail elderly patients, The Netherlands created the role of the elderly care physician; this medical practitioner specializes as a primary care expert in geriatric medicine and qualifies as a basic specialist with expertise in geriatric medicine (Koopmans *et al.*, 2010). Clinical and social care teams see people at home, clinics, outpatients, day centres, etc. Admissions to inpatient settings happen when other options have been explored and discarded. Indeed, the statistics featured in an European Parliament report (Agnieszka Sowa-Kofta *et al.*, 2021) show that in the Netherlands, from 1995 to 2019, the share of people living in care institutions decreased from 16 % to 5.6 %. While in England, data (Office for National Statistics, 2023) shows that the proportion of people aged 85 years and over, living in care homes, decreased from 14% in 2011 to 11% in 2021. From all the teams I spoke to during my visit, it was clear that it is in everyone's interest that people are cared for at home when possible: this is a friendly environment to patients, it is usually the carers' preference, and it often is cheaper for society. When comparing older people's care in both countries, Conroy and colleagues conclude that, despite the differences, both countries are following the pattern to move away from institutionalised care to more integrated community care (Conroy *et al.*, 2009).

There was a sense of proactiveness in Dutch care, particularly thanks to the role of case managers. This role was performed either by specialist nurses or social care workers, depending on the organizations' needs. For example, Topaz Overduin, managing adult and elderly patients with Huntington's Disease (HD), preferred to have social care workers as case managers. Topaz had a caseload of approximately 25 patients per social worker. While Marente, caring for people with dementia, preferred to have dementia specialist nurses as case managers. Marente had a caseload of 42 patients per nurse. These ratios are astonishingly lower in England (The Neurological Alliance, 2019; Willock *et al.*, 2023).

How the Dutch deliver integrated care

Previous research identified four key characteristics of integrated care (Bartolomeu Pires *et al.*, 2024): person-centred approach, expert knowledge, continuity of care and coordination. I have compared The Netherlands system against these.

Person-centred

There was a person-centred approach in the care settings I visited. The professionals were strong minded about identifying what matters to the patient and do a balanced risk assessment. In the behavioural HD unit (Topaz Overduin) for example, they had people with challenging behaviour. The clinical team was trying very hard so that a patient can visit his friend, who lives 1-hour distance. They are assessing risks (for the patient and for the friend) considering the satisfaction and quality of life that spending time together may provide. Another patient really liked chocolate, but he had dysphagia and there was a risk of choking; the medical team suggested to melt the chocolate in the microwave, which should make it less of a hazard.

There was a constant intention of finding out what quality meant to people. At the dementia nursing home in Zuydtwijck, patients had a "me" board. A collage/painting done with the resident about what matters to them; this way different paid carers could see the resident for the whole person they are, and talk about their specific interests, instead of making chit-chat. I saw a "me" board for one of the first policewoman in Holland and how much she enjoyed jazz. These enhanced the therapeutic relationship between staff and residents.

In Topaz Overduin most staff did not wear a uniform. They found this to be a negative trigger, since Topaz was, for many people, their home. They believed there was a calmer setting if everyone behaved as normal as possible; sort of normality generates normality. In addition, the team was testing the Triple-C approach (client, coach, competence), to do with coaching to find out what matters to patients (Tournier, 2021). There was an organizational concern to provide quality care to patients. Through research, the results could then be cascaded to other Topaz institutions. This keenness to improve was very present in the settings I visited, having research as promoter, funded and encouraged by the government. Excellence generating excellence, thanks to intertwined links with research centres/universities.

Expert knowledge

Staff recruitment and retention is a current problem in many countries. But in The Netherlands, I spoke to colleagues that have worked in those institutions for years. At Topaz Overduin, several colleagues had worked there for decades. Some came as students to do a placement, enjoyed the environment, and returned as undergrads to continue working there as practitioners. After working with HD patients for three decades, my nurse colleagues are experts, and teach the new cohort of nursing students. The students have a good experience, in a mature team, and as they finish their degree some will come back as employees. At Marente, the case manager has been the same familiar face for four years, looking after families living with dementia. Staff turnover rates in long-term care in the Netherlands for 2016-2018 was calculated at 10.5%, while in the UK turnover rates were at 34% (nurses) to 44%(care workers) (Eurofound, 2020).

It is worthwhile reflecting on other aspects that affect retention. People are entitled to progress in their career and as a society that is how we evolve. But the Dutch promote that growth with institutional support. Doctors at Topaz had dedicated contracted hours to do their research, alongside their clinical practice, feeding their updated and developing knowledge back into their organization. Many of the professionals I encountered were also connected to Leiden University Medical Center (LUMC), doing their postgraduate research and teaching at different levels; these 'Linking Pins', played a key integrated role, holding joint appointments at the university and at long-term care institutions (Verbeek *et al.*, 2020). The link between practice and academia, through a 'living lab' model, was normalised (Verbeek *et al.*, 2023). We know research active institutions generate better outcomes for patients, and that clinical-academics present many benefits. But the fact is, although increasingly common, these roles are far from standardized in England (Council of Deans of Health, 2020).

Continuity

With professionals remaining in their organizations for longer, there are stronger bonds built with the service users; staff knows how to sooth patients and avoid triggers. Research (Bartolomeu Pires *et al.,* 2024) indicates that in England 56% of people with HD repeat information most of the time/always. One of the issues highlighted is the lack of continuity with social care workers. But at Topaz Overduin, social workers are integrated in the team. There is a colleague retiring in about 2 years' time, so Topaz hired a new social worker, that is currently being inducted for a smooth caseload transition. Even with staff changes, there is a thoughtfulness and readiness to create a familiar environment for patients and families.

In addition, I was pleased to see family carers tightly involved in developing and delivering the care plan in Zuydtwijck; in here, family could stay with the residents for as long as they wished to, even overnight. Carers could help with activities of daily life (e.g., assisting with meals). But I also

observed this at the rehabilitation unit Topaz Revitel, a facility under my hotel room. I saw families visiting people in the rehabilitation unit at 9pm. This is so different from the reality I know, with rigid visiting times, and an observer position, instead of a participative one.

Coordination

As stated, at Topaz Overduin the multi-disciplinary team (MDT) is also multi-sectoral, including a group of social workers that bridge the institution to the community, and health and social care. This seems to promote integration *versus* fragmentation, which we experience between health and care in England, where social care stands alongside health, not within health, and funding streams differ. But also, I saw the MDT meet before and after the clinic, discussing each case and care plan. At the clinic, professionals moved between rooms, while clients stayed in the same room. Professionals communicated with each other during and between appointments, since we were all physically enclosed in the same U-shaped space. After the clinic, the MDT re-joined to discuss difficulties and solutions, actions and responsibilities, and who was following-up the patients in the community. Service users knew who their point of contact was and could access them if needed.

The case managers, pillars of multi-sectoral coordination, were the glue that kept all pawns in the game, with patients at the centre. But I found that it was crucial for the case managers to truly know their clients, their networks, and the resources on the ground. In England, I get reports from people with HD saying their case manager keeps changing, an obstacle to care needs being met. We need competent resourceful case managers that stay. We need to figure how to cultivate and retain this staff.

What was so special about The Netherlands? Lessons for England

Above all:

- The committed workforce, committed to the teams, to the organization, to the individuals, because their commitment was reciprocal. This created trust, continuity, multi-sectoral collaboration, and therefore person-centred care.
- Person-centred culture. Looking after individuals from what matters to them, and professionals navigating the system to meet those needs. Much of the personalised care I spotted had no direct spend (staff wearing their own clothes, meals cooked in the common areas, residents wearing their own clothes, the “me”-boards, bedbound patients included in the common areas, etc.).

Now, looking at England’s care, how can we take the leap to integrated care? With this new experience and with this year’s 24th International Conference on Integrated Care still fresh on my mind, I believe the weakest characteristics of integrated care, in England, are currently:

- Coordination of care, particularly between sectors. The division between health and social care is harming people to their core.
- Person-centred care, people are not partners in care. And by people, I mean not only our service users but our providers. I feel people are speaking but not listened to, and we have entered a snowball of each looking at our bellybuttons with disasters consequences at workforce- and person- levels.

Conclusions

We do not need to reinvent the all-wheel, a lot of good is already done, tested and proved. But I wonder, have I been served the *crème de la crème* at my research visit? Nevertheless, this snapshot

represents a different reality from the England I know. There are important lessons to be drawn from the Dutch about the success of integrating health and care systems, well-financed long-term care settings and strong clinical-academic collaborations. The investment on professionals, developing their research interests, feeds the person-centred approach, that enhances patients' and families' experience of better living with their disease and, in its turn, keeps service users and providers engaged, making the system sustainable.

The population in England is getting older and lonelier ("Census - Office for National Statistics", 2021) and currently we do not have the resources to meet their complex needs. But countries like The Netherlands are better at providing integrated care, so it is not Utopia. Let's move past the denial stage and accept that if we cannot take care of our vulnerable people, we are failing miserably, as a government and as a society. In Lee Clayton's words (1979):

"You've got some things to do,

If I just had the strength

And the nerve to take it on

If I can do it (…) so can you."

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