NIHR | National Institute for Health Research

What can the English care sector learn from the NETHERLANDS to recover from the COVID pandemic and become more resilient?

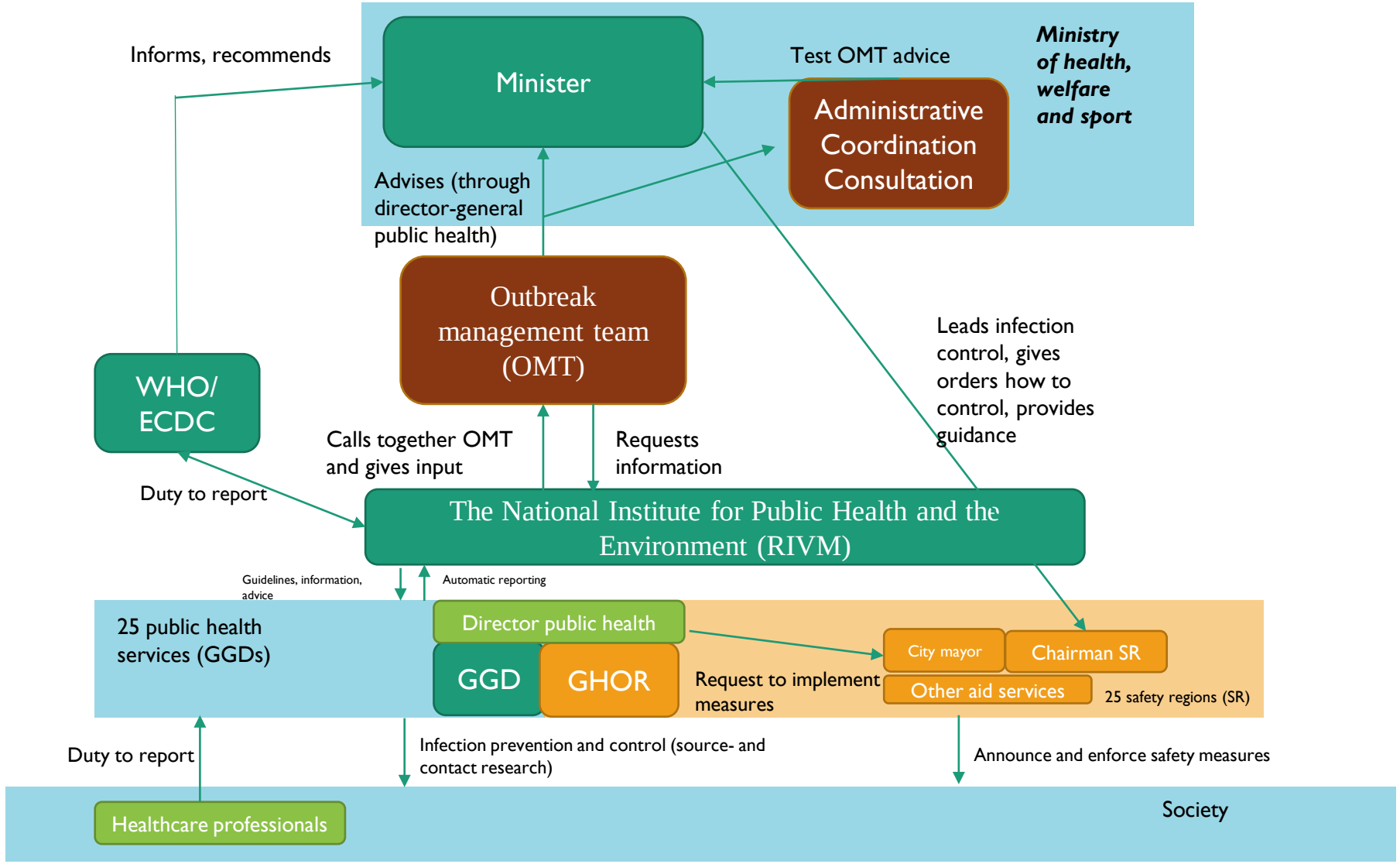
nuffieldtrust

LSE CPEC CARE POLICY AND EVALUATION CENTRE Research at LSE

Methods

- Initial literature review to explore the Dutch long-term care system, and Covid response
- 10 in-depth, semi-structured interviews conducted in Dutch with representatives of people with needs, care organisations, policymakers, service users, experts in LTC
- Initial analysis in Dutch, lessons identified by LSE

GOVERNANCE: pandemic



Lessons from the Netherlands

1. Embedding in legislature **clients' involvement** in decision making can lead to improved outcomes and enhanced wellbeing
2. Measures to recruit **workforce**, may have limited long-term effects in the context of uncompetitive salaries and lack of whole system reforms
3. **Reduction of legal and organisational complexities** is vital for effective accountability and collaboration
4. Right incentives vital for **collaboration and integration**
5. **Technology** may work better for some clients, right incentives are crucial

Embedding in legislature clients' involvement in decision making can lead to improved outcomes and enhanced wellbeing

- In most cases, client councils were not involved in decision making, especially during the beginning of the pandemic, however their involvement depended on the philosophy of the care organization. Some were directly included in the newly formed 'crisis teams'; in other cases, client councils were asked for advice and others were never consulted.
- During the pandemic, family members and client councils became unhappy with the lack of input in the decision making. This combined with national guidelines for their involvement in decision making, led to their increasing involvement by care organisations in decision making.
- Although initially, the focus of care organisations was solely on infection prevention, later, as families and services users became more involved in decision making, the care organisations realized that infection prevention might not be the most important goal for the clients.
- After lockdown Dutch Ministry of Health invited the national federation for people with intellectual disabilities to help them in decision making. The ministry used the insights from the meetings to develop new policies and would let the federation check these newly developed policies and the communication strategy

Measures to recruit workforce, may have limited long-term effects in the context of uncompetitive salaries and lack of whole system reforms

- Despite the numerous measures to retain and recruit workforce, staff shortages worsened during Covid
- Staff exodus for several reason, low pay reported as key relative to other sectors
- low salaries in the sector have partly contributed to the declining social status of the social care professions, combined with existing predominance of short -term contracts, contribute to staff exodus
- Lack of government subsidies for LTC staff wages, makes it harder to pay staff more
- Just shifting the burden to care organisations (e.g. recent Dutch policy emphasis on work flexibility and permanent contract) makes it harder for private providers to recruit staff, without whole system reforms, government support
- Workforce creativity and ingenuity was crucial in coping with the COVID-19 crisis as professionals developed innovative initiatives (e.g. the distribution of infected and non-infected residents across institutions; the coordination of family visits)

Reduction of legal and organisational complexities is vital for effective accountability and collaboration

- Highly fragmented system, differentiation of responsibilities across different laws, governmental levels and public and private organisation with new organisations emerging during Covid: Communication among and across national, regional and local government, other governmental organisations and providers was organised through different structures, meetings and consultations.
- Although boundaries are supposed to be described clearly, lots of grey areas exist. “The COVID19 crisis exposed these shortcomings of the system ruthlessly.”
- Tensions based on different policy views and interests often arose between different levels of governance and different organisations:
    - ✓E.g. there were frictions between national government COVID policies and the lack of support for these policies - and lack of willingness to carry them out – among many decisionmakers on a local level.

Right incentives vital for collaboration and integration

- Pandemic brought the health and social care sector closer together, and increased collaboration between them (e.g. sharing PPE, managing capacity), partly due to shared enemy, partly due to better financial resources
- Post Covid, collaboration is limited, partly due to limited financial recourses and competition for both resources and staff
- GPs coordination of care of frail elderly still far from optimally focusing on providing holistic, preventative care across system, partly due to limited GP time

Technology may work better for some clients, right incentives are crucial

- Covid-19 has sped up the use of technology in the long-term care sector (e.g. Videocalling, teleconsultations etc).
- Not all digital options were successful, especially in dementia care e.g. Videcalling, WhatsApp messeges confused people), some respondents noted that they do not envision for the development of technological solutions to be continuing in dementia care
- It is vital that the system creates right incentives to use technology (e.g. payment for online as well as face to face consultations) as in Netherlands, hospital consultants receive payments only for face to face consultation
- Interviews highlighted that not only skills and knowledge need to be considered, but also culture change is needed to embed technological solutions as people (users and professionals) may be fearful of new technologies

Thank you!

ltccovid.org