Ministry of Health, Welfare and Sports

The President of
the House of Representatives
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Multimorbidity and care for the elderly			

Introduction

The nature of health care is changing. Medical progress has provided us with increasingly effective treatments for many incurable diseases. So we are living longer, and that is wonderful news. But it also means a rise in the number of (older) people suffering from chronic diseases, and increasingly more than one at a time. Care is becoming more complex, and it is therefore important for care providers to work together effectively. We achieve this by consistently placing the client at centre stage; this must be the ultimate perspective for all the players in the care sector. Timely integral diagnostics on the one hand and an appropriate care offer on the other. But we have not got there yet.

The *Themacommissie Ouderenbeleid* [Special Committee on Policy for the Elderly] made recommendations on dealing with the expected increasing demand for care in its report, "*Lang zullen we leven*" [Long may we live][1]. In its response to this report the Cabinet[2] announced the establishment of a position on the medical geriatric function. In order to obtain greater insight into the medical geriatric function, the Minister for Health, Welfare and Sport asked the Advisory Council on Health Research to advise on what research is needed on geriatric care provision and how its use could be encouraged. The Minister also asked the Health Council to advise on co- and multimorbidity in the elderly and on the development of a strong geriatric service provision in the Netherlands for elderly people with multiple illnesses. In my letter of 31 May 2007[3] I announced a Care for the Elderly programme. In this letter I will keep my promise and respond to the abovementioned reports.

Firstly I will explain the reason for starting the programme and will provide a profile of the geriatric patient and the specific demands they make on care. I will then respond to the Health Research Council's recommendation entitled '*Onderzoek medische zorg voor Ouderen'* [Survey of medical care for the elderly] and the advisory report entitled '*Multimorbiditeit bij Ouderen'* [Multimorbidity in the elderly][4]. I received the latter recommendation from the Health Council ahead of the advisory report of the same name,

[1] TK 2005-2006, 29 549, nos. 4-5
[2] TK 2005-2006, 29 549, no. 8
[3] TK 2006-2007, 30 800 XVI, no. 146
[4] 11 September 2007, reference U-1098/RvdS/tvdk/782-I

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which is to be published later this year. Finally, I will discuss my policy intentions regarding the care of geriatric patients and clients and the activities resulting from them: The Care for the Elderly programme

Background

The number of elderly people in our society will increase dramatically in the coming years. Currently 14% of the Dutch population are aged 65 or over. This is set to rise to more than 20% by 2025 and will peak at about 25% in 2040. Not only will there be more old people, we are also living longer. The life expectancy of men born in 2007 is 77.8 years, and women 81.7 years. They will therefore live 7.4 and 9 years longer respectively than people born in 1950. The number of people aged 100 or over rose by 40% over a 10-year period to almost 1,400 on 1 January 2007. Statistics Netherlands expects the life expectancy of men in particular to increase even further in the coming decades.

Increasing age often also brings with it a combination of diseases and conditions such as osteoarthritis, heart disease, high blood pressure, dementia and depression. More disorders affecting day-to-day activities such as mobility problems, incontinence and sensory disorders also develop.

Frailty is also a problem for many elderly people. This causes such a loss of both physical and mental vitality that incidents that are minor in themselves can quickly lead to multiple complaints and a further impairment of their ability to live independently. Frailty also results in rapid decline, more frequent complications and slower recovery. This group of elderly people usually has a great need for support and care. Various reports and signals from the field have shown that frail elderly people in particular often do not get the care they need. They therefore lose functions and need long-term care at an earlier stage. There are estimated to be 247,000 frail people in the Netherlands. This figure will increase dramatically in the near future.

	Number of people aged over 65	of which suffering from comorbidity problems	of which frail
2006	2.2 million	1.4 million	247,000
2025	3.6 million	2.4 million	415,000
2040	4.2 million	2.9 million	505,000

The rise in the number of elderly people and therefore also the number of people with diseases and disorders is resulting in a greater need for care. This applies in particular to elderly people who are especially vulnerable, whom I will refer to as ‘geriatric patients’.

The geriatric patient

> *Mr van Zaanen (80) is suffering from shortness of breath and fatigue and visits the cardiologist. He prescribes him ACE inhibitors. That is a protocol heart failure treatment. But he is not getting better; Mr van Zaanen is increasingly feeling listless and tired. The GP contacts the homecare service. They now come more often. Despite the help, his tiredness continues. One evening Mr van Zaanen falls when he gets out of his chair and is taken to hospital with a broken hip. There they notice that his blood pressure is very low and his kidneys are not functioning properly. He is taken off the ACE inhibitors immediately. His blood pressure and kidney function recover and he is given a new hip. After three months of convalescence in a nursing home Mr van Zaanen goes home, but he still finds walking difficult. So someone from the homecare service will need to do his shopping from now on.*

Because of their special characteristics, elderly patients have specific requirements in terms of the skills of the medical care providers. Many elderly people are struggling with age-specific diseases and disorders. Very common - and therefore also known as the 'geriatric giants' - are forgetfulness, dementia, deafness, poor vision, incontinence and mobility problems. The 'geriatric giants' are accompanied by several medical problems which require diagnosis and possible intervention. And there is the issue of the care needed on account of the limitations resulting from these medical problems. This is the care that compensates for ADL and HDL activities provided by homecare organisations and organisations providing social support. These issues are complex because they involve many care providers; the care recipient manages his or her care but is not always in a position or able to make decisions that result in the best possible solutions.

First of all we need to take a close look at the diagnosis. Some diseases manifest themselves differently in the elderly than in the young, which brings with it the risk of underdiagnosis. For example, if chronic heart failure is not noticed or identified as such, this can ultimately result in a heart attack with all the consequences that brings. Changes in metabolism can make elderly people react differently or more acutely to medication. As a result, general medical guidelines for the treatment of certain illnesses, especially among the very old, are not always effective. This can result in loss of function and admission to hospital.

Another way to do it:
Using the geriatric filter Mr van Zaanen's GP identified Mr van Zaanen as being in the vulnerable group. Mr van Zaanen therefore sees the nurse regularly. She ascertains that his condition is deteriorating. The GP then decides to consult the geriatric advice centre at the town's hospital. They establish that Mr van Zaanen is developing heart failure and advise him to start taking a low dose of ACE inhibitors whilst strictly monitoring his blood pressure. He is also advised to start exercise therapy to improve his stamina and the coordination of his movements. The GP implements both recommendations. While visiting the nurse, Mr van Zaanen complains of feeling dizzy when he stands up, and his blood pressure is found to be extremely low. The GP decides to take him off the ACE inhibitors. Meanwhile, an exercise and rehabilitation programme is started, partly on the insistence of his son, who has obtained municipal advice saying that this is important for elderly people. He also knows that this exercise programme is available from the homecare service and the nursing home round the corner from his father's house. Mr van Zaanen starts to improve and after six months he is once again able to walk to his wife's grave.

It is not uncommon for different specialists to prescribe medicines that are incompatible with each other, so they either do not work or they cause serious side-effects. This is because every specialist treats a patient's disorders from the point of view of their own area of expertise. They often do not have the multidisciplinary knowledge they need to enable them to treat patients with several different diagnoses effectively.

If intervention is delayed or treatment is ineffective, the patient may need to be admitted to hospital. Research[5] has shown that in 2003 approximately 36,000 people, mainly elderly, ended up in hospital as a result of drug use (incompatibility, side-effects, overdoses). The medication file can play an important role in reducing such admissions. However, it cannot prevent the drug poisoning caused by the changing metabolism of the elderly. Although the medication file is a very useful tool, it is not in itself sufficient to prevent many elderly people from ending up in hospital because of their drug use. This requires a knowledge of pharmacokinetics in elderly people and is also related to the organisation of the care. The cost of these hospital admissions is estimated at roughly €225 million.

Another way to do it:
In the Farmacotherapeutisch Transmuraal Overleg *[Pharmacotherapeutic Transmural Meeting], representatives of care providers coordinate the choice of medication and prescription behaviour. Once every six months Mr van Zaanen's GP discusses half of his vulnerable patients at this meeting. This enables geriatric knowledge relating to drug use to be disseminated and established more effectively. The quality of the geriatric patient's treatment improves. The meeting also contributes to the multidisciplinarity of drug use.*

[5] Van der Hooft, Adverse Consequences of Drug Use in the Elderly, 2006

Sometimes the consequences of drug use are so serious that the patient dies in hospital. But even if the patient is admitted to hospital promptly, the consequences can be far-reaching. We know from practical experience that 50% of elderly patients are less able to lead an independent life after being admitted to a geriatric ward in a hospital. These patients will initially need (extra) home care. But some of these patients will no longer be able to live independently and will go to a nursing home or care home. About 10% of hospital admissions result in the elderly patient landing up in a nursing home. We spend an estimated €108 million on nursing home costs for the 36,000 people who land up in hospital on account of their medication and the resultant temporary or permanent loss of function. The cost of home care following such admissions is €20 million. The costs are therefore not limited to curative care.

Chronic diseases and disorders often result in limitations. If a patient or client requires attention in this regard, we often respond by offering compensatory care. For example, if someone is no longer able to cook, meals are being brought to their homes, or if someone finds it more difficult to move around because of their limitations, a minibus will be sent to bring them where they need to go. This is not always in the client's best interest. However, this may be beneficial if they are being encouraged to use their remaining capacity. They can then retain their remaining functions for longer and are less dependent on help.
A client often delays asking for help for as long as possible. They will tend to only seek medical help as a very last resort. With chronic illness the added value of medical intervention is often, but by no means always, limited. As a result, the solutions for the consequences of medical problems, especially in the area of living and welfare, remain somewhat neglected.

Conclusion
Care providers have insufficient knowledge to enable them to effectively provide the help that elderly patients need, particularly if their problems are complex. The provision of care operates reactively; intervention only takes place when problems get out of hand. Care providers operate in an organisational context, and only look at a particular part of the patients' problems with no coordination between one another. This gives patients the feeling that they are not getting sufficient help and are being sent from pillar to post. No-one is making a decision as to what combination of care from the cure, care and social services would provide the best outcome for them. It is in everyone's interests that we improve the quality of care for the elderly in these areas.

Recommendation of the Advisory Council on Health Research (RGO) and the Health Council (GR)

The RGO presented its '*Advies Onderzoek medische zorg voor Ouderen'* [Recommendation on research into medical care for the elderly] to the Minister of Health, Welfare and Sport in August 2006. The starting point for the RGO was the question as to how scientific research can contribute to safeguarding the quality of medical care for the elderly. The RGO recommends focusing research on frailty, comorbidity and limitations, the scientific basis of guidelines for doctors and nurses and the organisation of geriatric care. According to the Council, it is also important to include elderly people in 'regular' clinical studies, because much of our current knowledge of health care has been evaluated experimentally in younger populations with single problems. Comorbidity and age are often used as reasons to exclude people from studies. The RGO particularly recommends using existing networks and

encouraging research groups to be a mixture of practice and research. Finally, it recommends focusing research on a limited number of subjects.

The GR has issued an advisory report on multimorbidity which you have also received. The GR's definitive recommendation on '*Multimorbiditeit bij ouderen'* [Multimorbidity in the elderly] will be published this year. In its advisory report the GR observes that healthcare in the Netherlands inadequately targets medical and nursing care for the elderly with complex multimorbidity. There are at least four indispensable functions involved in the care of these elderly people:
1. Prompt identification of imminent risks of complex multimorbidity;
2. Client-managed treatment and care for these elderly people
3. Specialist second-line advice;
4. Application of geriatric knowledge in the clinic.

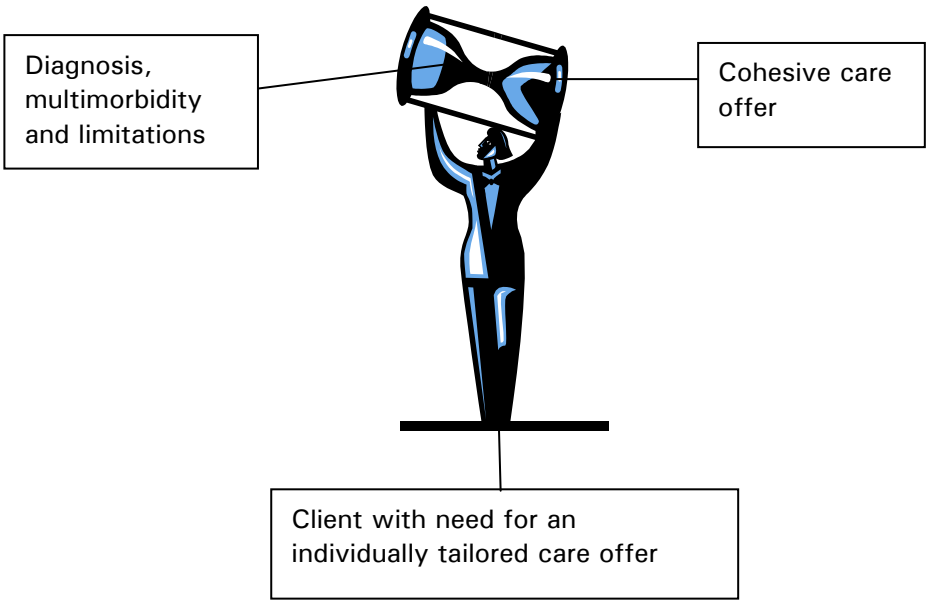
The GR would like to see the creation of regional agreements on a cohesive geriatric function. These agreements should be established administratively in order to put in place mutually binding agreements on access to and the content of care, the required opportunities for consultation, and communication between the various care providers. The GR is of the opinion that, after the investment needed to set it up, the geriatric function will result in cost savings.
The GR recommends taking or reinforcing initiatives in four areas in order to ensure an effective geriatric function. These are its organisation and financing, the information infrastructure, training and refresher courses, and research. It sets the following research priorities:
- knowledge of the scope, nature and starting points for the prevention of complex multimorbidity;
- effective opportunities for early identification of complex multimorbidity;
- research into improving diagnosis and developing better treatment and care strategies for complex multimorbidity.

I acknowledge and appreciate the contents of the recommendations issued by the RGO and the GR. The findings of both councils agree with the signals I am getting from the field, namely that we need to expand our knowledge of the geriatric patient and complex co-morbidity and that this care needs to be organised in such a way that we can create the geriatric function. The recommendations provide me with some important starting points for my policy and the activities that will flow from it. It is clear that we still need to gather a lot of knowledge about geriatrics and the geriatric function. By creating a strong link between research and practice we will be able to disseminate the knowledge we acquire very quickly. The recommendations on collaboration between the various care providers confirm my conviction that the Care for the Elderly programme is a means of achieving better care.

The Care for the Elderly programme

My ambition for care is to achieve a situation in which the client is actually at centre stage. This also applies to the elderly client with more than one illness. This does justice to the complexity of their illnesses and, in my opinion, is also the best incentive for achieving good quality, effective care. After all, the client him or herself is the interface between diagnosis and the care offer. The client needs a care offer that is tailored to his or her specific needs ('what do I need with my problems?') and wishes ('what form do I want my care to take?'). This is often dependent not on one diagnosis with one specific care offer but on an integral

consideration of the different diagnoses and the possible treatments or approaches, and the patient's preferences.
This can be illustrated as follows:



There are three key points in a coordinated care offer:
- How do we arrive at the correct diagnosis in these complex situations in good time;
- How do we arrive at an effective care offer;
- How do we coordinate it properly from the client's point of view (or how do we achieve coordinated care or integrated care)?

These three points are therefore key in my approach. First of all it is important that care providers have sufficient knowledge, are flexible and work together. The care provider being consulted examines a request for care with a multidisciplinary eye and where necessary involves other care providers in order to achieve an integrated diagnosis (medical and social). It is also important that the client receives precisely the information he or she needs in order to be able to make a well-considered decision about the next steps. With regard to the curative aspect, this decision covers the treatment options and their consequences, and with regard to the care aspect, the options for providing the necessary care also include the opportunities for support at a local level (living and welfare).

By producing this picture and thus realising the geriatric function, I expect value-added to be created for the client, for the care provider and ultimately for society as a whole. For the client because he or she will be able to lead a more independent life, retain his or her functions longer and have a lower treatment burden. For the care providers because by working together they will extend their knowledge and expertise and become more effective. This will strengthen their position. For society because an effective geriatric function should save money in relative terms.
Approach

I have commissioned the Netherlands Organisation for Health Research and Development (ZonMw) to set up a Care for the Elderly programme and to implement it in conjunction with the relevant parties in the field over the next four years. The objective of the Care for the Elderly programme is to improve the outcomes of care for older people so they can access a care offer that is tailored to their needs and wishes, whilst keeping costs at a manageable level. The programme has three core elements:

1. More effective diagnosis for elderly people with multiple illnesses;
2. Experiments aimed at shaping geriatric care;
3. Development of knowledge and the wide dissemination of this knowledge.

Re: 1
Not every elderly person who visits a GP or consultant is a geriatric patient. In order to be able to implement geriatric care effectively, they need to be able to 'filter out' the geriatric patients. Such a filter can be developed by mapping the risks involved with various diseases, limitations and other signals in specific age groups and other groups in the population. The right medical and care diagnosis for the geriatric patient can be made much more quickly in regional collaboration networks. Referrals can then be better targeted and treatment or care that meets the client's needs can be started earlier.
In order to improve the diagnosis and produce a broad analysis of the client's needs, it is essential that the care providers have sufficient knowledge, are flexible and work together. I want to encourage this collaboration by setting up an organisational infrastructure which should lead to the formation of collaboration networks that bring together regional organisations at an administrative level with the aim of delivering better geriatric care. The university medical centres and universities need to take the lead in setting up this infrastructure in accordance with the RGO's recommendation. Such networks are already active in some regions, and I want to build on them. Ultimately I would like these collaboration networks to cover the entire country. When it comes to the size of the regions I am thinking about the regions of the GPs' surgeries. In addition to a medical faculty with research capabilities and geriatric knowledge, these collaboration networks will also include general hospitals, nursing homes, homecare organisations, client organisations, municipal services and companies that operate in the field of social support. I believe that this broad scope is essential. The parties will play an equal role in the network. The network will be set up in such a way that it can take decisions on the necessary collaboration, the chains surrounding certain problems, as well as the experiments they intend to perform.

Re: 2
It is not only important to identify vulnerable elderly people, but it is also important to work together to meet their need for care and support in an integrated way. The regional infrastructure is the vehicle for developing better geriatric care in the region. By geriatric care I mean the structurally organised actions of professionals and organisations around common geriatric problems. This will enable us to shape the integration of the care offer for elderly people with multiple illnesses. This will be done with experiments that will be assessed in terms of the value-added they offer clients. By value-added I am thinking about the ability to live a more independent life, less function loss, less care consumption and a lower treatment burden.
Integrated first line care plays a key role in this. I would like to achieve integration of the care offer by equipping and supporting the GP, home care and social or first line care

providers with the help of the collaboration network in such a way that it can manage the treatment of geriatric patients. A precondition of the ZONmw assignment was that the experiments must include curative care, long-term care and social support. Without this broad approach, it is impossible to make an integral decision about the 'treatment' of geriatric patients in a broad sense. The activities and experiments to be carried out within the scope of the ZON programme must demonstrate what value-added a certain organisational approach offers. Once the programme is completed I would like to have a better understanding of the benefit for the client of an integrated care offer and the way in which this can best be achieved, or what preconditions play a key role in it.

Re: 3
Successful geriatric care depends on the development and use of the necessary knowledge about the geriatric patient. I would like to invite the collaboration networks to make suggestions in the programme concerning how to further develop geriatric care through research and experiments. Following on from the recommendations from the RGO and the GR, I am thinking about activities in the following areas:
- Gathering knowledge on the size and nature of complex multimorbidity;
- Obtaining starting points for preventing complex multimorbidity;
- Early identification of complex multimorbidity;
- Improving diagnosis and the development of treatment strategies for complex multimorbidity, including in relation to existing general guidelines;
- Research into the effectiveness of the geriatric function and its organisation.

Collaboration networks can play an important role in further disseminating the accumulated knowledge and the results of the experiments.
I would therefore like to receive suggestions in the programme for disseminating this knowledge and these results among the other collaboration networks.

Between 2008 and 2012 we will make a total of €80 million available for the Care for the Elderly programme to improve cohesion in care.

When the Care for the Elderly programme is implemented it will dovetail with current activities in the context of *Zorg voor Beter* [Providing better care], two of which I would specifically like to mention: *Landelijk Dementie Programma* [National Dementia Programme] and *Innovatie in de care* [Innovation in Care].
ZonMW will carry out an interim assessment after two years, in which they will evaluate the effectiveness of the geriatric networks and the potential of the experiments being performed at that time.

The State Secretary of Health,
Welfare and Sport

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