

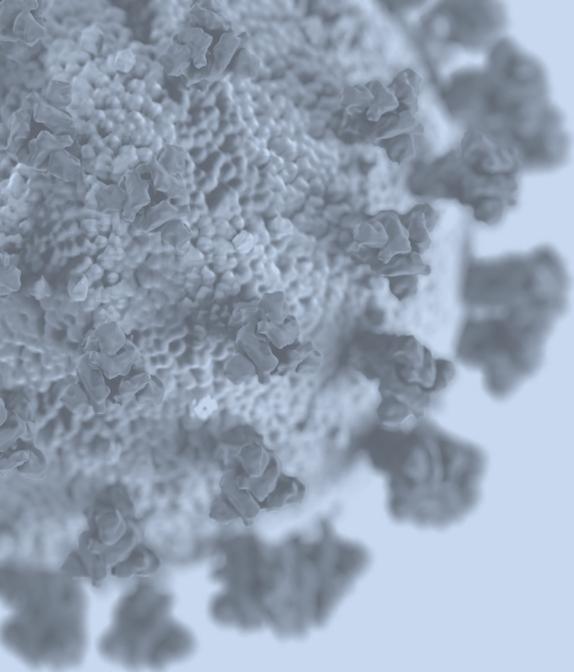
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# MC COVID-19

Governmental response to the COVID-19 pandemic in Long-Term Care residences for older people: preparedness, responses and challenges for the future

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## The Netherlands

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**MC COVID-19**  
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## MC-COVID19

### **Coordination mechanisms in Coronavirus management between different levels of government and public policy sectors in 15 European countries**

The political and administrative management of the healthcare crisis provoked by the COVID 19 is a key issue in preventing the spread of the disease. The Mc-COVID 19 project is set to analyse the socio-sanitary co-ordination procedures in the con-

text of institutionalized older-age care (age group that appears particularly vulnerable in this epidemic context), in Spain as well as in the rest of the EU-15. This study focuses on the articulation of resources between health and social policies, and aim to contribute to improve the effectiveness of the decision-making process and crucial aspects in the fight against the pandemic. Findings also aim to be useful to inform other public policy sectors involved in crisis-related situations.

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## 1. DESCRIPTION AND ANALYSIS OF THE ROLE OF THE RESIDENTIAL CARE SECTOR FOR THE OLDER-AGE POPULATION (PRE-COVID19)<sup>1</sup>

### 1.1. Trajectory of LTC until the most recent model

The Dutch long-term care (LTC) system dates from 1968, when a mandatory social insurance was created to cover all Dutch residents for non-insurable health risks. The Exceptional Medical Expenses Act (AWBZ) meant that people in need of long-term care or ongoing care – related to old-age, chronic illness or disability – no longer depended on the discretion of municipalities, as LTC became an insured right. The system provides in-kind benefits rather than cash-transfers, funded mainly through income-related contributions, and to a lesser extent through taxes. Initially, it entitled to nursing care, personal care and medical help in institutions and hospitals, but in 1970 non-residential care was added and in the following decades the scope of the scheme continued to expand (Mot 2010, Comanje 2015).

Residential care was from the outset an essential part of the system. After the second World War, there was a major housing shortage in the Netherlands. Part of the solution was sought in building old-age homes. Older people had to make homes available for young families. In the 1950s, 50,000 places in retirement homes were created. In the decades that followed, old-age homes developed into care homes. In the 1960s, the first quality legislation was enacted, laying down minimum requirements for care homes. Most of the still existing care homes were built in the 1960s and 1970s. Important impetuses for institutionalization were the introduction of a state old-age pension (AOW, 1956), a national social assistance scheme (ABW, 1965), and the above-mentioned long-term care insurance act AWBZ (1968). These social security schemes made it attractive for investors to build care homes. Under the National Social Assistance Act (ABW), municipalities could be requested to pay the costs of staying in a care home for people who could not pay themselves.

The expansion of the AWBZ triggered increasing concerns with the sustainability of the system. A long process of policy reforms was inaugurated, in an attempt to constrain this extensive LTC system. Deinstitutionalization was actively promoted from the late 1980s, and throughout the 1990s and 2000s legislative changes sought to stimulate the creation of care markets.<sup>2</sup> In the mid 1980s, budgetary restrictions were also implemented, but this led to a deterioration in the quality of care and the restrictions had to be lifted.<sup>3</sup> After two decades of political discussion, the government managed to build a supporting majority to pass a reform of the system in 2015 (Maarse and Jeurissen 2016). The reform aimed at reducing state responsibilities and stimulating the refamilialization and informalization of care (Van den Broek 2016, Grootegoed and Van Dijk 2012). Broadly, it comprised expenditure cuts, a shift from residential to non-residential care, decentralization of non-residential care and a normative reorientation (Van Ginneken et al. 2015). Care at home became an explicit policy goal, understanding that it both coincides with people's preferences and is more

1

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2

To allow for greater competition between care providers, care was split into different 'care functions' (nursing, personal care, domestic care, assistance) which could be purchased separately.

3

A court ruling established that LTC care could not be withheld for budgetary reasons, and the cut-backs were lifted leading to a reduction in waiting lists (Comanje 2015).

efficient than care in institutions (Companje 2015, Da Roit 2012). The new policy promotes ‘self-reliance’<sup>4</sup> and is underpinned by a ‘participation society’ discourse in which citizens are expected to care for each other (Grootegoed and Tonkens 2012).

The scope of the AWBZ was gradually reduced, restricting the access to residential care and excluding lighter forms of home care support from the funded LTC provisions. Understanding that the AWBZ expansion had made people overly dependent on public assistance, the government launched the Social Assistance Act (Wmo, 2007), which made entitlements to social care conditional to the non-availability of informal care (Grootegoed et al. 2015). A new Long-term Act (Wlz, 2014) was passed, limiting entitlement to LTC for those with continuous and severe care needs and tightening eligibility by strict needs-assessment procedures. Most *residential homes* for elderly were closed down, keeping *nursing homes* for people with severe care needs.<sup>5</sup>

There has thus been a shift from a conception of LTC as a social right and a citizenship entitlement in the direction of a perspective that places more emphasis on individual responsibility (Cox 1998, Grootegoed and Van Dijk 2012, Da Roit 2012). The reforms have turned the system into an example of ‘restricted universalism’<sup>6</sup> (Ranci and Pavolini 2015). Access to institutional care is not means-tested but needs-tested. Moreover, user charges have been raised.

## 1.2. Current arrangements in LTC

From its outset the Dutch LTC system has been characterized as a universalist LTC regime, that provides universal access to state-supported services for those in need (Van den Broek 2016, Da Roit 2012, 2013). Against the backdrop of a regular healthcare system where risks are privately insured, the LTC system is based on a logic of universal entitlement to cover large expenses which would not be feasible for private insurances. Nowadays, and despite the reforms, public responsibility is still strong. The system features a strong regulating role of the state, high level of public spending and in-kind services as a major instrument (Maarse and Jeunissen 2016). The system provides an extensive need coverage with a broad range of health and social care services for various categories of clients, including residential and home-based care.<sup>7</sup>

The Dutch public expenditure on LTC as a percentage of GDP (3.7% in 2017) is more than twice the OECD average (1.7%); by contrast, the share of private expenditure (co-payments and out-of-pocket expenses) in total spending on LTC services is relatively low. 75% of public spending is allocated to LTC residential care, as reflected in the still relatively large number of LTC beds in such facilities (OECD 2019).

From 2015 on, the regulation of the services previously under the AWBZ was split between: the Long-term Care Act (Wlz 2014), the Social Support Act (Wmo 2015) and the Health Expenses Act (Zvw 2008). The Wlz replaced the

4  
In Dutch: ‘eigen regie’.

5  
The percentage of people aged 65 and older living in an institutions dropped from 7.2 % in 2004 to 6.5 % in 2010 (Alders et al. 2016). As a consequence, nursing homes concentrate nowadays the most vulnerable old-age population with severe care needs.

6  
Political tensions between different visions of the Welfare State were present from the outset of the AWBZ. Christian Democrats and Conservative parties feared the substitution effect of extensive LTC services; the Left grew critical of institutional settings and professional dominance later on.

7  
Extensive need coverage is coupled with high social contribution (12% of work-related income in 2011).

8

In practice, however, each government makes estimations of the LTC expenses for the coming four years, and the Ministry of Health, Welfare and Sport (VWS) is responsible for making expenditures stay within this budget. Possible instruments to adjust expenses are increases in co-payments, reductions in coverage and tariff cuts for the providers (Mot et al. 2010).

9

Regional assessment boards were replaced by the national assessment center (CIZ), responsible for issuing care assessments for each LTC-applicant.

10

In 2009, standard dependency levels were introduced, entitling to fixed 'care packages' that combined different care functions.

11

<https://opendata.cbs.nl/statline/#/CBS/nl/dataset/82887NED/table?ts=1591109449104>;  
<https://opendata.cbs.nl/statline/#/CBS/nl/dataset/37620/table?ts=1591706529327>

12

Cash benefits are nevertheless relevant for the present study, as they are also used to finance small-scale housing initiatives ('kleinschalige wooninitiatieven') for elderly people (see Section 1.5).

13

The substantial increase of informal caregivers is an explicit policy goal since 2007.

14

'Usual care' refers to 'the normal, daily care that nuclear family members or other people who share a household can be expected to provide to one another' (CIZ 2012: 9).

AWBZ, providing a regulatory framework focused on residential care (Maarse and Jeunissen 2016). Like the AWBZ, it is a mandatory insurance scheme, redistributive and open-ended in nature<sup>8</sup> that ensures care for those who need it regardless of their income level. However, Wlz-applicants are subjected to a tightened needs-assessment procedure<sup>9</sup> according to uniform national standards and only those with severe care needs are entitled to residential care. Already since 2009, institutional care, which used to be financed by fixed budgets (partly based on the occupancy rate and residents' level of dependency), are funded according to their residents' needs assessments.<sup>10</sup> Means-testing in the access to residential care is still rejected (Mot 2010). The view is that anyone requiring intensive and round-the-clock care must be admitted to an institution. However, residents have to contribute to their board and lodging – and following reforms, user charges have been raised considerably for those with higher incomes or wealth.

While residential care is now reserved for people with severe and continuing care needs who need 24/7 care, those with lighter care needs are entitled to home care via either the Social Support Act (Wmo 2015) or the Health Insurance Act (Zvw 2006). The Zvw covers particularly nursing care (e.g. treatment of diabetes, wounds) and personal care (e.g. assistance with bathing, dressing) provided at home ('extramural care'). The Wmo covers the remaining home-based care, comprising what is known as 'social care' (e.g. assistance with daily living activities, maintaining independence, etcetera) and domestic help (cleaning, etcetera). Home care services have considerably expanded since the 1990s. Between 1998 and 2019, the proportion of people aged 80+ living at home has increased from 77% to 88%.<sup>11</sup> Legally, anybody entitled to -care under the Long-term Care Act (Wlz) may choose to receive services at home in the form of a 'full package' (the equivalent of the services delivered in a care home), but in fact this proves to be rather unfeasible.

Cash-for-care schemes were a late addition to the Dutch LTC insurance scheme, responding to LTC clients' demands and the wish to encourage the development of markets in the LTC sector. Open from 2001 for LTC clients of home care, from 2003 onwards it was extended to all kind of LTC clients (Mot et al. 2010). Nevertheless, most LTC (Wlz) insurance beneficiaries still opt for in-kind benefits.<sup>12</sup> In 2016, only 4.7 % of LTC (Wlz) recipients aged 65 and over had a personal care budget (MLZ 2018).

Currently, all these LTC services are expected to be complemented with informal care.<sup>13</sup> In order to establish which costs in home care are eligible for public funding, the Dutch government codified an explicit 'customary care principle'<sup>14</sup> in 2005 (Duyvendak et al 2006). Care deemed as 'usual' must be performed by relatives and friends and is therefore not eligible for public funding.

### 1.3. LTC Governance

In the Netherlands, the state plays a central role in the regulation and funding of LTC, but private actors and subnational administrations are also

prominent actors. Public regulation and financing is combined with private service delivery – either non-profit or for-profit. In fact, in the Netherlands there are no government-owned care providers; rather, all providers are private, although the large majority are not-for-profit (Mot 2010). For-profit providers are allowed to operate in the home-based care sector, while in the LTC regulated sector only non-profit providers are permitted.

LTC responsibilities fall within one single ministry (Healthcare) with different departments dealing with institutional care (LTC), social care (WMO) and nursing treatments provided at home (ZVW). As a result, intersectoral coordination is not an issue in the Dutch LTC system.

Policy reforms have entailed important changes in the governance pattern of the system, particularly in terms of marketization and decentralization. Since 2015, the LTC system has been partially deregulated. The non-residential care has been devolved either to private insurers or to municipalities, while residential care remains more strictly controlled. Reforms have tended to gradually give health insurers more responsibility in LTC provision. The implementation of the Long-term Care Act (Wlz) is delegated to care offices run by a single care insurer, as the representative of all insurers in a region (normally, the market leader in the region). These care offices are legally responsible to guarantee sufficient Wlz care for the population in the region by contracting care services from competing private providers.<sup>15</sup> (The borders of these LTC regions have been drawn ad hoc; they do not coincide with provincial borders. As a matter of fact, provinces do not play a role in the governance of the care system.) Since 2015, insurers are also responsible for contracting nursing care and personal care (e.g. assistance with washing, dressing) at home under the Health Insurance Act (Zvw 2006).

The remaining home-based care has been decentralized to local authorities<sup>16</sup>, including what is known as ‘social care’, managed and financed by municipalities under the Social Support Act (Wmo 2015). Municipalities are now responsible for providing a wide range of services and receive a non-earmarked budget, so they have an incentive in limiting spending (Mot et al. 2010). Underlying the policy reform is the idea that private insurers and municipalities are able to organize LTC more efficiently than the care offices which organized LTC under the previous AWBZ.<sup>17</sup> However, cut-backs have had major consequences for the price and availability of services, leading municipalities to negotiate lower tariffs or contract lower volume of care, what on its part has triggered deficit among many care providers (Maarse and Jeunissen 2016).<sup>18</sup> Particularly, many providers for house-keeping have stopped their activities.

This fragmented governance pattern has brought about tensions and inconsistencies among the different actors involved in the implementation. Particularly, coordination problems arise from the fact that the LTC system comprises now three different financial regimes, each with its own implementing agencies, budgets and incentives (Non et al. 2015, Maarse and Jeunissen 2016). In other words, in order to save money municipalities

15  
Care offices and care providers, in cooperation with municipalities, must ensure that there is enough capacity. They make estimations based on the development of the demand (Kamerstukken 2019/20, 31765, nr. 453).

16  
This includes services for older persons, persons with disabilities, drug addicts and persons with psychiatric problems.

17  
The expenditure cuts in the Wmo and Zvw were politically sold as ‘efficiency cuts’, and amounted to 0.7 and 0.4 billion euro respectively (Maarse and Jeunissen 2016).

18  
Home care has been deregulated; providers are free to compete on tariffs and decide on capacity. The functioning and competition of the LTC markets is monitored by the Dutch Healthcare Authority (NZa); only in the part that is still regulated (residential care) the NZa makes rules and supervises providers’ compliance.

may have an interest to refer a client to the Zvw-regime (health insurance) or Wlz-regime (LTC insurance) or vice versa. For the users, the extreme complexity of the system also entails difficulties as to distinguish which scheme or instance must be held responsible for their different needs.

### *Types of residential care*

Traditionally, long-term care institutions were classified according to their functions into nursing homes, residential homes, and rehabilitation centers for temporary stay. Presently, the main criteria for distinction is the intensity of care needs, certified by an accreditation for delivering care under the Long-term Care Act (Wlz).<sup>19</sup> Institutions with Wlz accreditation are mainly nursing homes and some of the former residence homes for elderly that had a nursing department. Institutions without Wlz accreditation comprise residential homes for elderly that provide no medical treatments, small-scale elderly housing and apartments linked to nursing homes in which elderly people live independently and receive targeted services from the nursing home when necessary.

Besides that, there are private care homes for more affluent elderly people who are able to pay for good housing and facilities (concerts etcetera), while their care costs (if they qualify for care under the Wlz) are covered by the Wlz (through cash benefits).<sup>20</sup> Likewise, there exist small-scale housing initiatives for elderly, initiated by entrepreneurs or by residents themselves; recipients pool their LTC (Wlz) cash benefits to buy the necessary care services. Finally, other care homes target specific groups within the population. Traditionally, these were based on religious denominations, following the pillarization tradition, but nowadays they mostly target older people with migratory background.

#### **1.4. Debates around the development of a LTC systemy**

Recent debates in the Netherlands confront advocates and detractors of the LTC reforms. Since the 1970s, residential care became the 'default option' for older Dutch people in need of long-term care. Old-age people expected to move to a residence home as they became less able to live a total autonomous life, and as their health deteriorated they could eventually move to a nursing home. In the 1990s, this started gradually changing, following changes in normative expectations, particularly as older people were expected to live at home as long as possible. Policies actively stimulating 'ageing in place' and de-institutionalization were justified as measures that better matched the wish of many older people themselves to live at home.

19  
www.lhv.nl/service/huisartsenzorg-voor-ouderen-woonsituatie

20  
Since the Balkenende II government (2003-2006), housing and living expenses are separated from care expenses. Residents have to pay their board and lodging, while care expenses are covered by the AWBZ, now the Wlz.

Patient and client organizations played a crucial role in the justification of these reforms. Over the years, they held demands of more autonomy and freedom of choice, arguing that the LTC system constrained LTC patients' ability to be in control of their lives (NPCF 1998, Visset et al. 2002, Per Saldo 2005). From this perspective, living at home contributes to a sense of wellbeing and autonomy. The discourse of older and disabled people's

right to live autonomously and to decide over their own lives has permeated public opinion, being incorporated by the public administration as the new catchphrase. According to the federation of LTC organizations ACTIZ, it signals a radical shift in the approach to LTC care, from a focus on illness and disability from a professional perspective, to a client-centered orientation:

The focus shifts from quality of care to quality of life for the client. (...) Good care is care that contributes to quality of life from the perspective of the people themselves. And that is: being able to lead a valuable life – even with defects – from one’s own views on what that ‘valuable’ means. (ACTIZ 2014: 1)

However, the concept of ‘self-reliance’ has been contested by many, for relying on false assumptions. As Grootegoed and Tonken (2016) rightly say, for persons depending on others for care, speaking of the ability to control one’s life actually means speaking about their informal carers being in control. Likewise, the Wmo policy of conditioned support is based on the assumptions that everybody has a social network and is able to arrange for assistance, something refuted by research (Grootegoed and Knijn 2012).

In recent years, the desirability of de-institutionalization has been strongly debated, and observers ask whether some of the elderly who now live at home would not be better off in nursing homes. Alarming reports have been released about elderly people with severe care needs living at home without sufficient care.<sup>21</sup> According to healthcare professionals (Gijzel et al. 2017), keeping people with LTC needs longer at home can lead to increased safety risks, as indicated by the increasing numbers of hospital and crisis admissions. Many professionals do not consider it a responsible option, particularly for people needing around the clock supervision and care.

Other undesired side-effects concern the overburdening of informal carers, particularly women.<sup>22</sup>

As policies put an increased pressure on families to provide care to dependent relatives, a related debate has emerged about the refamilialization of care. Overall, people in the Netherlands considers that the LTC should be a state’s responsibility. Dutch users show a stronger preference for formal care services, as reflected in opinion surveys and the in high levels of use of in-kind LTC benefits and other publicly funded care services. In the SHARE survey, for example, more than 60% of Dutch people aged 50 and older thought that the state should be responsible for personal care, such as nursing or help with bathing or dressing for older persons who are in need of such care (Börsch-Supan 2019). In the early 21<sup>st</sup> century a shift took place towards a ‘cold-modern’ care ideal (Hochschild 1995), which considers caregiving primarily a state responsibility (Van den Broek 2016). In this sense, the shift to refamilialization of LTC actually clashes with contemporary care ideals and preferences endorsed by the majority of population (Van Den Broek 2016). However, the same study suggests that

21  
Sometimes, this is the result of waiting lists at nursing homes (of their preference).

22  
As Van den Broek (2016: 84) pointed out: ‘Given that family caregivers tend to be women, the LTC policy arrangements work out differently by gender [...]. Policy makers encouraging family members to take on a caring role are effectively addressing women.’

public opinion tends to support more individual responsibility when care for the ‘deserving’ is guaranteed by the state. Particularly, older people with light care needs are more expected to organize themselves the provision for their care needs, while those with more severe care needs are more likely to be perceived as ‘deserving’ than the former.

### 1.5. General functioning of the residential care system

The Dutch government bears overall responsibility for the LTC system and must create the conditions for a correct functioning of the system. Nevertheless, specific responsibilities are laid down on private care providers. Quality of care is regulated by law, and all care providers must meet certain quality requirements, as laid down in the Healthcare Quality, Complaints and Disputes Act (WKKGZ) and various other laws.<sup>23</sup> They also need an accreditation to offer care that is reimbursed via the Healthcare Insurance Act or the Long-term Care Act (Care Providers (Accreditation) Act, WTZI). There are also various quality assurance schemes for care providers. Care providers that meet a scheme’s specific quality requirements may carry its quality mark.<sup>24</sup>

Compliance with quality requirements is supervised by the Dutch Healthcare Inspectorate (IGJ). Periodically, the inspectorate monitors nursing homes to assess in how far they comply with quality and safety goals.<sup>25</sup> In addition, care providers have been measuring these indicators from 2007 onwards.<sup>26</sup> In the home-based care sector, the results of a IGJ study in 2009 on the quality of care delivered by new care providers of home care revealed serious problems (IGZ 2009). Above all, the study found deficits in the qualification of the staff and substantial shortcomings in the medication policy. As for residential care, clients gave 7.8 (out of 10) to old-age residential homes and care for people with disabilities, while nursing homes received an average score of 7.4 (westert et al. 2008).<sup>27</sup> As for the residential system, a number of quality problems have been also identified, particularly concerning the availability of sufficient personnel with adequate qualification, and waiting lists (Westert et al. 2008).<sup>28</sup> Other points of improvement are the communication/ participation of residents, and the excess of paperwork (Mot et al. 2010).

The government has been working on these problems for years, combining ongoing policy efforts and policy changes. Recently, action has been taken to improve the quality in nursing homes. In 2016, a program of quality improvement was launched. Based on the results of a research and a consultation process among stakeholders, the Ministry of Health (VWS) elaborated a framework for quality standards in nursing homes (Kwaliteitskader Verpleeghuiszorg 2017)<sup>29</sup>, backed up by substantial funding (2,1 milliard euro investment in nursing homes in 2018). In 2018, following a national Pact for Eldercare signed by more than 40 different actors, the Ministry of Health launched the program ‘At home in nursing homes, dignity and pride in every location’, that proposes a shift towards more time and attention for clients, sufficient (qualified) and satisfied care workers, training and innovation and changes in management.<sup>30</sup>

23

www.government.nl/topics/quality-of-healthcare/quality-requirements-for-care-providers

24

www.kiesbeter.nl/artikelen/zorgthemas/keurmerken-in-de-zorg/index

25

For each care organization, the inspectors visit one of the care homes (2-3, for large organizations). They observe daily activities, visit facilities and speak with residents and personnel, www.igj.nl/zorgsectoren/verpleeghuiszorg/verpleeghuiszorg-in-beeld

26

In 2007, the main actors in the LTC sector cooperated in the elaboration of a set of performance indicators for good care, including technical quality of care and clients’ experiences (Stuurgroep Kwaliteitskader Verantwoorde Zorg 2008).

27

Nursing homes score particularly low in provision of information (5), participation (6) and availability of sufficient personnel. Less than 4 out of 10 clients said that a member of the staff ‘sometimes stuck up a conversation in passing’.

28

Waiting lists were seen as problematic particularly at the beginning of the century (Mot et al. 2010).

29

Care providers are responsible for the application of these standards, under the advice of the Zorginstituut Nederland and monitored by the Healthcare Inspectorate.

30

The research included the experiences and opinions of different parties concerning nursing homes, including care professionals, managers, care recipients and relatives, etcetera.

Nevertheless, despite all these efforts, the most recent report of the Health Inspectorate (first trimester of 2020) shows mixed results.<sup>31</sup> While the majority of the 516 organizations visited comply with quality and safety rules (56%), still a considerable 44% doesn't comply or not completely. The same applies for personnel qualification standards: the majority of organizations (61,7%) have enough qualified care workers matching clients' needs, but still 38% don't. Further, in 63,5% of the organizations, care workers don't work methodically, according to their function, and this process is not clearly described in the client's dossier. Comparatively, however, Dutch care homes perform relatively well in cross-national opinion polls (Mot et al. 2012); for example, they stand in the third place in the 2007 Eurobarometer 67.3 after France and Sweden.<sup>32</sup>

## 2. DESCRIPTION OF THE EVOLUTION OF THE PANDEMIC IN SOCIETY AT LARGE, AND IN THE RESIDENTIAL CARE AND HEALTHCARE SECTORS MORE SPECIFICALLY

### 2.1. General description of epidemic: detection, scope and some data

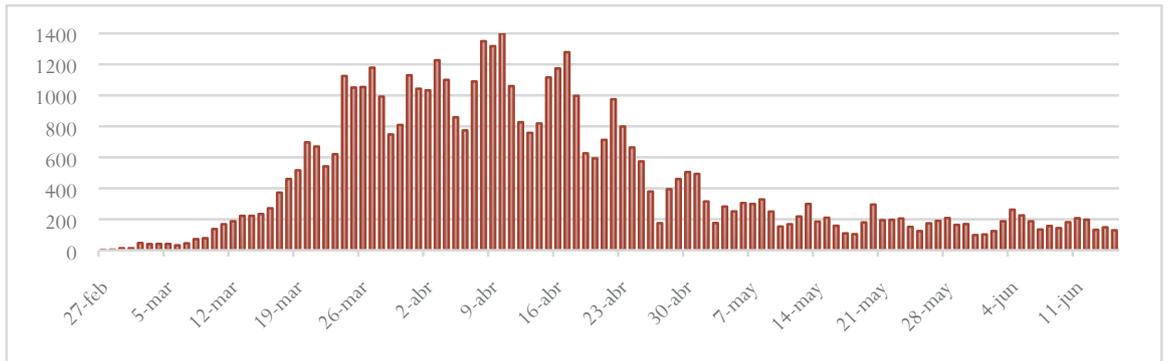
On January 28, the Dutch minister of Health classified COVID-19 as a so-called 'A-disease' to enable the government to take drastic measures (e.g., mandatory quarantine) to prevent the spread of the disease. Health professionals are obliged to report cases of COVID-19 to the regional public health services (GGDs). However, until February 25, only people who had been in Wuhan and who had fever and at least two other symptoms were tested. As from February 25, the testing policy was extended to people who had been in northern Italy. The first confirmed COVID-19 case was reported on February 27 and involved someone from the south of the Netherlands who had been in Lombardy and had celebrated carnival after returning home. Two weeks later, the daily number of new confirmed cases had risen to around 200, and it was decided to not conduct contact tracing anymore for all identified cases. Over the month of March, the number of new cases continued to rise and so did the numbers of hospital admissions and deaths.

Graphs 1 to 3 show the daily numbers of confirmed COVID-19 cases, hospital admissions and deaths respectively. It should be noted, however, that only the figures on hospital admissions are accurate. The figures on new cases and deaths are underestimates because most people with symptoms were not tested due to limited testing capacity. For example, people with mild symptoms, household members of confirmed patients and nursing homes residents were generally not tested. Only patients who were admitted to hospitals and hospital staff were systematically tested. It was not until the beginning of June that all persons with symptoms could be tested.

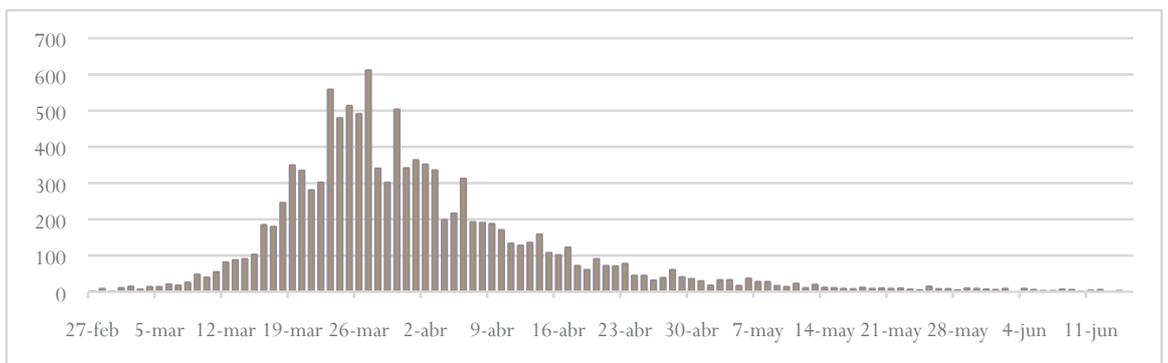
Graph 2 shows that the number of new hospital admissions of confirmed COVID-19 patients peaked in the week of March 23, when nearly 4,400 COVID-19 patients were hospitalized. Graph 4 shows that the influx of COVID-19 patients to intensive care units (ICUs) of hospitals

31  
[www.igj.nl/zorgsectoren/verpleeghuiszorg/verpleeghuiszorg-in-beeld](http://www.igj.nl/zorgsectoren/verpleeghuiszorg/verpleeghuiszorg-in-beeld)

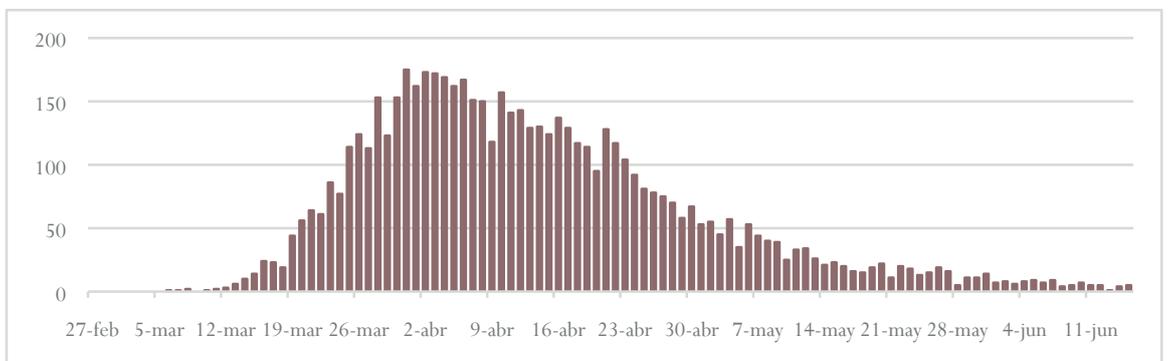
32  
 Also, the quality of evaluation structures in Dutch LTC policy, as measured in the ANCIEN project (Dandi et al. 2012), scores relatively well -sixth position, after Sweden, France, UK, LV, and Spain.



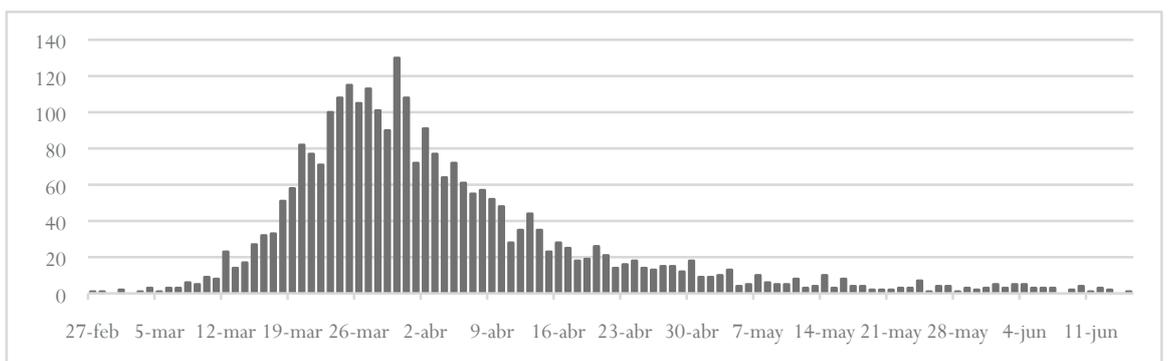
**Graph 1:** Daily new confirmed COVID-19 cases, February 27 – June 15



**Graph 2:** Daily new hospital admissions, February 27 – June 15



**Graph 3:** Daily deaths (confirmed COVID-19 patients), February 27 – June 15



**Graph 4:** Daily new intensive care admissions, February 27 – June 15

**Table 1: Overview of lockdown and social distancing measures**

March 9	People are advised not to shake hands and to ensure good hand hygiene.
March 12	Meetings of more than 100 persons are banned. People are asked to remain at home as much as possible. (The hard-hit province of North-Brabant asked people to stay at home already on March 6, and large public events were prohibited in this province as from March 10.) People are urged to limit visits to people aged 70+ and (other) vulnerable people.
March 15	People are asked to keep 1.5 meter distance from each other. Bars, cafés and restaurants, gyms, saunas and sex clubs have to shut down.
March 16	Schools and universities have to shut down as well. An exception is made for children of parents with 'essential jobs' (such as medical personnel), so that their parents can continue to work.
March 20	Nursing homes and care homes across the country have to close their doors for all visitors. (Some homes took this measure already a few days earlier.)
March 24	All public events are banned and so are meetings of more than two persons in public space. An exception is made for funerals and religious gatherings, they may be attended by 30 people. All professions involving physical contact (such as hair dressers) have to shut down. Dentists and paramedical care providers decide themselves to postpone all regular care and perform emergency care only. Shops are allowed to remain open provided that they take hygiene measures and enforce the 1.5 meter rule.

peaked in the same week (732 admissions). The total number of patients being treated in ICUs peaked two weeks later (more than 1,300 patients). The number of deaths of confirmed COVID-19 patients reached its peak in the week of April 6, when 1,166 deaths were recorded.

All figures decreased in April and May, which was attributed to the effectiveness of lockdown and physical and social distancing measures, and later on, after the relaxation of the lockdown measures, also to a seasonal effect. Table 1 provides an overview of the measures introduced in March to slow down the spread of the virus.

By June 15, the cumulative number of confirmed cases amounted to 48,948 (281 per 100,000 population); the cumulative number of hospital admissions amounted to 11,831 (68 per 100,000 population); and the cumulative number of deaths of confirmed COVID-19 patients amounted to 6,065 (35 per 100,000 population). However, Statistics Netherlands calculated that in weeks 11 through 19 (March 9 – May 10), there were almost 9,000 more deaths than normal, representing 32% excess mortality. As of week 20, mortality was below the level considered normal for this time of year.

### *Impact of the epidemic by region, age, sex, social groups*

**Region:** The southern part of the Netherlands was hit hardest by the epidemic. Carnival, which is celebrated in the (catholic) south of the Netherlands, turned out to have been a superspreading event (February 23-25). Statistics Netherlands calculated that excess mortality was highest in the southern provinces of Noord-Brabant (55%) and Limburg (62%). There were (smaller) municipalities with three times more deaths as normal during weeks 11-19. By contrast, the northern part of the country experienced almost no excess mortality; excess mortality in the province of Groningen was less than 1%.

**Age:** Statistics Netherlands calculated that excess mortality was relatively high among the elderly and (especially) among people receiving long-term care in care homes and nursing homes. In weeks 11-19, relatively the highest excess mortality was recorded among the population aged 75-89 years (42%). Among people receiving long-term care, there were an estimated 5,000 more deaths than normal for this time of year.

**Sex:** Across all age groups, excess mortality was higher among men (on average 37%) than among women (on average 28%).

**Social groups:** Statistics Netherlands calculated that excess mortality was not higher among people with a lower income than among higher income groups. It should be noted that in normal times, people with a lower income have a significantly higher level of mortality. In weeks 11 to 16, excess mortality was relatively higher among people with a non-western migration background (47%) than among people with a Dutch background (38%). In absolute terms, however, the number of deaths with a non-Western migration background was limited, which can be attributed to the relatively young age structure of this group.

## **2.2. The effects of the epidemic on the healthcare system**

The first point of contact for suspected COVID-19 patients was the GP or the GP out-of-hours service. Patients with symptoms were asked to contact their GP by phone. The GP would then decide whether the patient should be admitted to hospital. GPs were advised to organize separate office hours for patients with respiratory complaints, abolish walk-in office hours, and use video instead of face-to-face consultations whenever possible. The waiting room should be reorganized to facilitate the 1.5 meter rule.

Already on March 13, two weeks after the first confirmed COVID-19 case, 'code red' was promulgated for all hospitals in the province of Noord-Brabant. This implied that all non-emergency surgeries were postponed and the leaves of care workers could be revoked. Hospitals in this province were thus preparing for a large influx of COVID-19 patients. Many hospitals in other parts of the country (also in provinces with relatively few COVID-19 patients) took the same measures. They postponed all non-urgent

treatment appointments and surgeries and cleared nursing departments to make space for COVID-19 patients.

Despite these measures, many ICUs (intensive care units) in Noord-Brabant soon reached their maximum capacity. New COVID-19 patients had to be transferred to hospitals in other parts of the country. The Ministry of Health asked the national acute care network (LNAZ, [www.lnaz.nl](http://www.lnaz.nl)) to establish a national coordination center for the distribution of patients (LCPS, [www.lcps.nu](http://www.lcps.nu)). The transportation of patients was organized by a special unit of the army. Hundreds of patients, particularly from Noord-Brabant and Limburg, were transferred to hospitals in other regions. At the beginning of April, when ICUs all over the country were reaching their maximum capacity, a few dozens of patients were transferred to ICUs in Germany. The health minister of North Rhine-Westphalia had offered to take in 600 ICU patients from the Netherlands.

In those days, many GPs called their older patients – either because they were asked to so by hospitals or on their own initiative – to talk with them about whether they wanted to be treated in an ICU if they contracted COVID-19. People often turned out to have already thought about this question themselves. Elderly residents of nursing homes were not taken to hospital either. In other situations this also happens only rarely, as it is assumed that a stay in a hospital would do these patients more harm than good. As explained above, nursing home residents are people with severe care needs, e.g. because of advanced dementia. Hospitals are not equipped to deal with such patients.

The Netherlands have a relatively small number of ICU beds. When the epidemic begun, there were about 1,150 ICU beds (6.6 per 100,000 population), including 250 insulating beds. Normally, about 70% of these beds are occupied. In the second week of April, more than 1,300 COVID-19 patients were treated in ICUs. During the epidemic, about 650 temporary extra ICU beds were created. The health minister and politicians wanted more extra beds, but that was not possible. The main bottleneck was the number of ICU nurses. At the peak of the epidemic, there was also an impending shortage of ICU equipment (private hospitals and the army provided respirators to hospitals where COVID-19 patients were treated, and the Ministry of Health ordered 2,000 extra respirators – which, however, had a long delivery time) and a shortage of anesthetics (the Healthcare inspectorate temporarily approved a veterinary anesthetic for use in humans to help solve this shortage).

ICUs were thus put under extreme strain. However, over time, the priority given to COVID-19 patients was criticized by medical specialists such as cardiologists and oncologists, who noted that it was detrimental to the interests of patients with other life-threatening diseases. Suspending the regular care might cause casualties as well. This risk was exacerbated because many people hesitated to contact emergency services for other emergencies, such as pain in the chest, because they assumed that the emergency department was too busy with COVID-19 patients and/or because they feared contracting COVID-19 in the hospital.

Non-hospital care sectors (home care and nursing homes) were also put under enormous strain. There was a scarcity of personal protection equipment, such as face masks. A central allocation model was developed to assess the availability of protective garments and manage distribution. Initially, this model focused on supplying hospitals as a first priority, as it was assumed that they would receive most COVID-19 patients. What may also have played a role is that the long-term care sector was not hardly represented in the outbreak management team (OMT), the team of experts, chaired by the director of the Center for infectious disease control of the national institute for public health (RIVM, [www.rivm.nl](http://www.rivm.nl)), which advises the government on how to tackle the corona virus. As a consequence of the scarcity of supplies, many care workers outside hospitals had to work without protection equipment. Moreover, if they had only mild symptoms, they could not be tested (because of the limited test capacity), and they had to continue working (so as to prevent staff shortages due to high absenteeism). These were guidelines of the RIVM applicable at the time.

These circumstances and policy decisions clearly paved the way for the spread of the virus in nursing homes. It only became clear in early April that nursing homes were dramatically affected by the virus and that their residents were not taken to hospital when they fell ill with COVID-19.<sup>33</sup> The RIVM revealed on April 6 that there were (or had been) outbreaks in about 40% of all nursing homes, and that in some of these homes there had been many deaths. On April 12, the minister of Health announced that care personnel in nursing homes and home-care nurses would from now on also have access to high-quality protective masks when treating COVID-19 patients. However, this did not solve the problem of scarcity. In the first half of May, there were still nursing homes where care personnel had to work without personal protection equipment. Moreover, although they could be tested as from April 6, in practice, home-care and nursing home personnel with mild symptoms were still refused at various GGDs.

On June 9, the RIVM reported that 16,973 healthcare workers had been diagnosed with COVID-19 since the outbreak began; 529 healthcare workers had been hospitalized and eleven had died. It was not possible to determine whether they contracted the virus during their work or outside of it. The RIVM did not provide a breakdown by profession or sector.

### 2.3. The epidemic in the public and political debate

In March and April, the situation in ICUs (in particular the impending shortage of ICU beds) dominated the public and political debate. This lasted until it became clear that the risk of ‘code black’ – which would mean that ICUs could not treat all patients needing intensive care – had passed. Other (impending) shortages in hospitals (protective equipment for medical personnel; respirators and anesthetics for ICU patients) and the shortage of testing capacity also attracted a lot of attention, both in the media and in parliament. MPs of all parties put a lot of pressure on the government to solve these shortages.

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Nursing homes residents are only rarely transferred to hospitals, also outside pandemic situations, as it is assumed that a stay in hospital in most cases will do them more harm than good. Our interviews also reveal that the extraordinary rapidity by which elderly people deteriorate and die hindered eventual decisions to move them to hospitals.

An issue that came up somewhat later was the usefulness of face masks for the general public. Initially, the OMT advised against it, because it feared that people would no longer adhere to the 1.5 meter rule – which was considered to be much more effective in preventing the spread of the virus – but also because it would exacerbate the existing shortage of masks for medical personnel. Later on, non-medical masks were made compulsory in public transport, because the 1.5 meter rule was not tenable there. As the lockdown measures became more and more relaxed, discussion arose again about whether masks should be made compulsory in public space.

As the numbers of new infections, ICU patients and deaths dropped, the economic impact of the pandemic became a more important issue in the public political debate.

Two vulnerable populations that received quite a lot of media and political attention from April onwards were migrant workers and nursing home residents. After a series of outbreaks among migrant workers in the meat industry, the government set up a ‘booster team’ (Aanjaagteam bescherming arbeidsmigranten) to develop proposals to improve the working and living conditions and reduce the risk of infection with COVID-19 for migrant workers.

When it became clear in April that despite the visitation ban, there had been many COVID-19 outbreaks in nursing homes, resulting in many deaths, this led to some debate and parliamentary questions about the apparent lack of attention for this vulnerable population. From May onwards, the negative side effects of the visiting ban attracted attention. The media and senior citizens’ organizations reported about nursing home residents who suffered or even died from loneliness; there were protests at some nursing homes from relatives of residents against the continuation of the visiting ban; there even were reports about residents going on hunger strike because they could no longer stand the visiting ban.

### *Has ageism played a role?*

Early April, opinion maker Jort Kelder received more disapproval than acclaim when he criticized the lockdown measures, stating that ‘the economy is at a standstill because we are rescuing over-80s who are overweight and have smoked.’

When ICUs were in danger of reaching ‘code black’, some doctors asked for a political decision on whether they should or should not use age as a criterion if there would not be sufficient ICU beds to treat all COVID-19 patients. Some doctors thought age could be a criterion if they would have to choose between a younger and an older patient with similar chances of survival; they argued that in such a situation the younger patient should get the chance to reach a similar age as the older one. However, the minister of Health and politicians categorically rejected using age as a criterion.

Over time, as the numbers of new infections and ICU patients declined, concerns about the impact of the corona crisis on young people came more to the fore. Some people, including social scientists and philosophers, proposed to relax all measures for younger people and/or to replace the '1.5 meter society' by a '60- society'. These proposals received little support.

All in all, it can be concluded that 'ageism' has not played a role, at least not in the sense that it led to COVID-19 being perceived as a problem of the elderly, or to the elderly being blamed for the economic impact of the lockdown measures.

### *Support for and compliance with the corona measures*

In March, when the lockdown measures were announced, there was widespread public support for these measures and a very strong willingness to comply with them. The decision to close schools was even taken under pressure from public opinion; the OMT had advised against it. At the end of April, when the number of patients treated in ICUs had dropped, opinion polls showed that the Dutch were getting less concerned about the health risks of the virus, while concerns about the economy were increasing. Later polls confirmed this trend, particularly among people aged 55 and younger.

Paradoxically, protests against the corona measures increased just as the lockdown measures were relaxed. In June, action group 'Virus Madness' filed a lawsuit against the government (which they lost), and starting in July, they organized a series of demonstrations against the 1.5 meter rule. These actions and demonstrations have attracted a lot of media attention. However, large-scale surveys show that the government's approach is still supported by a large majority of the population.

The Ministry of Health commissioned the 'Corona behavioral study' to monitor the well-being of the population and support for and compliance with the measures. The first five survey rounds took place between April and July 2020, with between 50,000 and 90,000 people taking part in each round. The results of the last round show that support for most of the measures has remained high (80-93%). Only the support for working-at-home-as-much-as-possible rule has decreased significantly (62%). There also still seems to be great confidence in the government's approach: 72% have (a lot of) confidence, 5% have no confidence at all. According to 70%, the Dutch government does (much) better than other countries, while 4% scores the Dutch policy as (much) worse. At the same time, many people find it increasingly difficult to comply with the rules regarding social life. Fewer people stay 1.5 meter apart in many places, and fewer people avoid busy places. Moreover, fewer people who have COVID-19 symptoms stay at home, and most people with only mild symptoms are not getting tested. Other polls found that, though support for the 1.5 meter rule is still strong, about half of the population has doubts about its feasibility.

Voter polls show that prime minister Mark Rutte and his conservative-liberal party (VVD) gained popularity during the corona crisis. Left-wing and

populist opposition parties did not profit from the crisis. Although nearly all parties asked critical questions in parliamentary debates with the government, there was no fundamental disagreement with the government's approach.

### 3. DESCRIPTION AND ANALYSIS OF THE MEASURES ADOPTED TO ADDRESS THE IMPACT OF THE PANDEMIC ON THE RESIDENTIAL CARE SECTOR FOR THE OLDER-AGE POPULATION

#### 3.1. Background of preparedness for the Crisis

The Netherlands had a national pandemic action plan in place before the COVID-19 outbreak.<sup>34</sup> The plan was drawn up in 2014 by the national council for infectious disease control (LOI). The LOI was established in 1995 by the minister of Health with the task of realising national uniform agreements on the control of infectious diseases. It is composed of representatives of the regional public health services (GGDs), the four major cities, the healthcare inspectorate, the national coordination center for travel advice (LCR) and other organizations.

The pandemic action plan is aimed at the public health services and describes the actions to be taken in case of an infectious disease crisis. It describes which measures should be taken in which phase of the crisis and who is responsible for determining the phase of the crisis. The phases are: (1) after the first case has been reported: direct measures, including treatment of the patient, testing, contact tracing, and lab diagnostics; (2) scaling up, including cooperation with other parties, information provision, type of measures for scaling up, ensuring continuation of usual care; further measures, including social distancing, refining contact tracing and diagnostics, hygiene measures, medical supervision, isolation and quarantine, vaccination and prophylaxis; (3) downscaling, including cancelling the crisis organization, after care, evaluation, reporting.<sup>35</sup>

During a crisis, there must be regional and, if necessary, national coordination.<sup>36</sup> There are 11 regional acute care councils (ROAZ) and 25 regional medical assistance organizations (GHOR) in which measures to be taken in response to a disaster or crisis or pandemic can be discussed and coordinated with all those involved.<sup>37</sup> The ROAZ organizations have drawn up an escalation model in which the required cooperation and coordination of care is described for various situations or phases: from green (mapping potential bottlenecks, e.g. at the start of the flu season) to yellow to orange to red to black (supra-regional coordination required).

Measures in response to the corona outbreak were at first coordinated at the regional level in the province of Noord-Brabant. As the outbreak became more widespread, coordination was taken over by the national institute for public health (RIVM), and an outbreak management team (OMT) was set up to advise the government on how to tackle the outbreak.<sup>38</sup>

34  
<https://lci.rivm.nl/draaiboeken/generiek-draaiboek>

35  
[www.covid19healthsystem.org/countries/netherlands/livinghit.aspx](http://www.covid19healthsystem.org/countries/netherlands/livinghit.aspx)

36  
<https://nvc.nl/sites/nvc.nl/files/Draaiboek%20Pandemie%20deel%201%20versie2.0%20-%20160620%2012.pdf>

37  
<https://richtlijndatabase.nl/covid-19.html>

38  
[www.covid19healthsystem.org/countries/netherlands/livinghit.aspx](http://www.covid19healthsystem.org/countries/netherlands/livinghit.aspx)

All hospitals in the Netherlands are obliged to prepare for disasters and for crises such as influenza pandemics by drawing up a ‘hospital disaster relief plan’ (ZiROP), which describes the measures the hospital will take in the event of a large influx of victims or patients.<sup>39</sup> Every ICU is obliged to have a care policy plan, which states with which hospitals in the region it has agreements and what they entail. The national association of ICU physicians (NVIC) developed its own specific pandemic action plan for ICUs. This plan uses colour codes from green (standard care) to orange (upscaling) to red (crisis care). As of March 30, ‘code red’ applied (see section 2.2 above).<sup>40</sup>

Despite all these plans and organizations, several experts noted that the Netherlands was badly prepared for a pandemic. They pointed out that since the Ebola outbreak in West Africa in 2014, the Dutch government had been advised several times to pool knowledge and expertise about pandemics, to seek international cooperation, and to create buffers for ICU capacity, respirators and medicines. However, little had been done with these recommendations.<sup>41</sup> A crisis expert pointed out that disaster exercises and the 2018 influenza epidemic had shown that in the event of a pandemic, the available capacities would quickly fall short. However, solving these capacity problems would be extremely costly.<sup>42</sup> Another expert characterized the Dutch preparations for a pandemic as ‘mainly symbolic’, pointing out that national risk analyses had been made and all kinds of plans had been written, ‘but materially, we were not prepared.’ According to this expert, the costs involved were the main factor:

It’s a cost-benefit consideration. That is why those national risk analyses that predicted a pandemic were decoupled from policy a few years ago. This prevented the departments from having to do anything with the results of those analyses.<sup>43</sup>

A journalistic investigation based on interviews with dozens of stakeholders and public and internal documents concluded that the illusion that the Netherlands was well prepared for an outbreak led to an underestimation of the corona virus. For example, in the worst-case scenario of the GGDs, there would be a ‘large’ introduction of up to twenty patients at the same time – a scenario which proved to be untenable within two weeks after the first known infection. According to this journalistic investigation, the shortages were the logical consequence of decades of pursuit of economy and efficiency in Dutch health care:

This is called ‘sensible care’ in policy language. Empty IC rooms, large stocks, overly extensive diagnostics, these must all be avoided. This has resulted in a system that in normal times offers just enough care for everyone.<sup>44</sup>

The corona crisis made it clear that such a system also comes at a price.

On a more positive note, it can be concluded that the Dutch health care sector had learned lessons from previous epidemics, in particular the 2009 Mexican flu and the 2018 influenza pandemic. Cooperation between hospitals went more smoothly.<sup>45</sup>

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www.ggdghorkennisnet.nl

40  
<https://nvic.nl/sites/nvic.nl/files/Draaiboek%20Pandemie%20deel%201%20versie2.0%20-%20160620%2012.pdf>

41  
Kabinet negeerde adviezen over pandemie-aanpak, Trouw, 15 April 2020

42  
Onze voorbereidingen op een pandemie waren symbolisch, NRC, 27 March 2020

43  
Onze voorbereidingen op een pandemie waren symbolisch, NRC, 27 March 2020

44  
Hoe Nederland de controle verloor, NRC, 20 June 2020

45  
Hoe Nederland de controle verloor, NRC, 20 June 2020

### Specific provisions for nursing homes

The national pandemic action plan is a generic plan, but it contains a number of appendices that are specifically relevant to care homes and nursing homes. These appendices provide detailed guidelines for how nursing homes and other institutions should deal with outbreaks of gastroenteritis,<sup>46</sup> the norovirus,<sup>47</sup> and scabies,<sup>48</sup> and with respiratory infections.<sup>49</sup>

It is difficult to say to what extent and which of these pre-existing guidelines were useful for responding to COVID-19 outbreaks in nursing homes, and whether and to what extent they were consulted and followed by nursing homes during the first weeks of the corona epidemic, when there were not yet specific COVID-19 guidelines for nursing homes. However, the circumstances were unfavourable: there was limited testing capacity and limited knowledge about symptoms that could indicate a COVID-19 infection and the modes of transmission of the virus.

On March 20, the minister of Health decided that all care homes and nursing homes had to close their doors to all visitors. The decision was taken on the advice of the OMT and Verenso, the association of specialists in geriatric medicine, and after consultation with the RIVM and Actiz, the umbrella organization of long-term care providers.<sup>50</sup> As far as we have been able to ascertain, nursing homes across the country have implemented this measure with immediate effect.

During the pandemic, the RIVM developed a series of national COVID-19 guidelines, some of which were aimed at the long-term care sector. On March 20, the first guidelines on the use of personal protection equipment by care personnel outside hospitals were published,<sup>51</sup> and on March 24, the first guidelines for deploying and testing non-hospital care workers with symptoms or with family members with symptoms.<sup>52</sup> According to these first versions, the use of personal protection equipment by non-hospital care workers caring for patients who were not infected was not necessary and (given the scarcity of this equipment) was also not desirable. Non-hospital care workers who had only mild symptoms could not be tested (because of the limited test capacity), and they had to continue working (so as to prevent staff shortages due to high absenteeism). In the following months, these guidelines were revised repeatedly. However, it took longer to solve the shortages of personal protection equipment (see section 2.2 above). Nursing homes with an urgent shortage of protective equipment and (possibly) infected residents were advised to contact the ROAZ in their region.

Again, it is difficult to say to what extent these RIVM COVID-19 guidelines were followed. What is clear, however, is that they were not easy to follow for many nursing homes, for a number of reasons, which were to a large extent beyond the control of the homes. The latter is clearly the case for the limited testing capacity and limited availability of personal protection equipment, and the strong focus of policymakers and policy advisers on supplying hospitals as a first priority (see section 2.2 above). The repeated adjustments to the guidelines also made it difficult to keep an overview

46  
<https://lci.rivm.nl/draaiboeken/gastroenteritis-en-voedselvergiftigingen>

47  
<https://lci.rivm.nl/richtlijnen/norovirus>

48  
<https://lci.rivm.nl/richtlijnen/scabies>

49  
<https://lci.rivm.nl/draaiboeken/generiek-draaiboek>

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[www.rijksoverheid.nl/documenten/mediatekst/2020/03/19/persconferentie-minister-president-rutte-en-minister-de-jonge-over-aftreden-minister-bruins-en-het-bezoek-aan-verpleeghuizen](http://www.rijksoverheid.nl/documenten/mediatekst/2020/03/19/persconferentie-minister-president-rutte-en-minister-de-jonge-over-aftreden-minister-bruins-en-het-bezoek-aan-verpleeghuizen)

51  
<https://lci.rivm.nl/covid-19/PBMbuitenziekenhuis>

52  
<https://lci.rivm.nl/lci.rivm.nl/covid-19/bijlage/zorgmedewerkersinzetentestbeleid>

and it was only in a version published on May 1, that the RIVM acknowledged that

these guidelines [...] require further elaboration per sector, taking into account context and target group. If the specific situation requires it, healthcare workers can deviate from these principles based on their professional insights and experience.<sup>53</sup>

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<https://lci.rivm.nl/covid-19/PBMbuitenziekenhuis>

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Bijna 8000 coronagevallen in verpleeghuizen, ruim 2500 doden, Telegraaf, 20 mei 2020.

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Moreover, different actors warned about the wrong assumptions underlying the Dutch approach (in the first two months). Among other, the association of microbiologist doctors warned that because of the restrictive test policy, the RIVM data gave an inaccurate view of the spreading of the virus in the country.

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RIVM guidelines. In fact, the Outbreak Management Team emphatically advised to people with symptoms but falling outside the definition not to get a test. Otherwise 'we could end up testing everybody with a cold' (Hoe Nederland de controle verloor, NRC, 19 June 2020).

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Later on, it was known that the test capacity was actually pretty high, and had been unused (NRC, 23 June 2020).

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These coordinating bodies prioritized the needs of hospitals and IC departments; often, nursing homes were not even members of the network.

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According to RIVM, since the outbreak began 16,973 healthcare workers have been diagnosed with Covid-19, 529 healthcare workers have been hospitalised and eleven have died (data by 6 June).

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Interviewee 3, from an organization that suffered a dramatic corona outbreak, reports that during the whole period (March-June) 119 employees were tested positive.

### 3.2. General Impact of the Epidemic on the Residential Care Sector and Policy Responses

The COVID-19 epidemic has had a dramatic impact in the Dutch residential care sector. By early April it became public that nursing homes were severely hit by the virus. At that point the RIVM estimated that in about 40% of all nursing homes there were (or had been) outbreaks, with high mortality figures in some of these homes. By 15 May there had been 7,900 verified COVID-19 cases among residents of nursing homes, plus 4,550 unverified cases. About 7% of the residents of nursing homes had been infected, 2% had died.<sup>54</sup>

The government's approach in the corona crisis clearly paved the way for the spread of the virus in care homes.<sup>55</sup> Particularly, two early policy choices can be associated with high infections and mortality rates in the sector: namely, the test policy and the distribution of protective material. Access to corona tests was subjected to very restrictive conditions from the offset; only persons who had been in Wuhan (China), presented fever (above 38 degrees Celsius), and two other symptoms of the illness were entitled to be tested.<sup>56</sup> This very restrictive test policy was held until June, on grounds of shortage of test capacity.<sup>57</sup> In addition, care homes were at the end of the cue for receiving protective equipment, since its distribution was administrated by the regional networks of emergency care (ROAZ), dominated by hospitals.<sup>58</sup> The ROAZ focussed on scaling up hospitals and the ICU. Although nursing homes had more infected people, the masks were divided between the hospitals and nursing homes in a ratio of 90% to 10%, with nursing homes only getting 10% of the masks. Interviewee 1 described that, instead of providing them with protective equipment, the ROAZ went so far as to ask them to 'make our protective equipment available to the hospitals.'

The scarcity of protective material for personnel in nursing homes was a clear spreading factor, aggravated by RIVM guidelines establishing that those professionals with mild symptoms had to continue working. Paradoxically, this rule established so as to prevent staff shortages, contributed to high incidence of infection and absenteeism among personnel. While official figures of COVID-19 incidence among healthcare professionals are not disaggregated by sector<sup>59</sup>, our interviewees report high levels of sickness leave among staff (10-12%), well above regular rates.<sup>60</sup> As a consequence, nursing homes struggled with labor shortages, which in many cases were covered by hiring temporary personnel (Interview 3) or by intensifying the working hours of regular employees - e.g. asking them to work more days or not to take days off (Interview 1). Likewise, nursing homes with many

infected care workers got assistance from nurses from the Dutch army; in some homes the army must actually take (over) the reins of the institution. No emergency legislation related to the health system has been issued, other than relaxing to some extent the registration requirements for health-care personnel involved in COVID-19 care.<sup>61</sup>

Nevertheless, the situation in the residential sector did not aggravate the overburdening of hospitals and ICUs, it was rather the other way around. As interviewee 4 put it: 'Because (many) people died in the nursing home, the IC capacity was not under too much pressure. Unfortunately, because so many people are dying, we don't have to consider our capacity of beds as such a concern' (Interview 4).

As a matter of fact, the coordination or lack of thereof between the health-care and the long-term care systems has not been an issue in the Netherlands. According to a representative of the association of residential care organizations (Interview 4), nursing homes and hospitals have collaborated particularly for purposes of testing and for the transfer of clients. As to reinforce personnel shortages, there have been some regional exchanges, e.g. of nurses from nursing homes to hospitals or geriatric doctors supporting each other across regions. But such initiatives have been occasional and not been at a large scale, because at a general level 'there has not been a need', and 'in terms of staff, we in the Netherlands have managed well. We do not see what we have seen in Italy or Spain' (Interview 4).

The (lack of) collaboration between the public and private organizations of residential care has not been an issue either, despite the latter being better resourced and equipped. Somehow, not much interaction was deemed necessary with the healthcare system, considering that nursing homes are well equipped by themselves to provide medical care for COVID-19 patients, as they count with their own personnel<sup>62</sup> - besides nurses and care assistants, also GPs, geriatric doctors and other specialists.<sup>63</sup> Customarily, elderly residents who get ill are treated within the nursing home, only exceptionally being transferred to a hospital. The same was applied to COVID-19 patients, most of whom were treated within their own nursing homes, in their own rooms or in special sections specifically arranged. Only a minority of the residents severely affected by the virus were actually transferred to hospitals, following a path-dependent practice. According the interviewees, as a result of the fast tempo how the disease unfolds, there was virtually no time to transfer ill people, as most all of a sudden deteriorated and died. Apparently, many elderly patients showed no symptoms or only light ones and then suddenly died.

Policy measures to tackle this situation were scarce and adopted late. Following the advice of the national association of geriatric doctors Verenso, a ban for visits in nursing homes was imposed on March 19. The measure aimed at protecting vulnerable old-age residents against the corona virus. As the minister of Health explained in a letter to the Parliament, the experience in the strongly affected regions of Noord-Brabant and Limburg taught the necessity to reduce the visits to nursing homes in order to curtail the

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[www.covid19healthsystem.org/countries/netherlands/livinghit.aspx?Section=5.1%20Governance&Type=Section](http://www.covid19healthsystem.org/countries/netherlands/livinghit.aspx?Section=5.1%20Governance&Type=Section)

62  
 In the Netherlands, care homes with accreditation for Wlz care are responsible for the organization of the medical care of their residents, what includes both general medical care or specific long-term care (W LZ).

63  
 Interviews showed that nursing homes even count with specialists in other areas, such as infectious diseases (Interview 1) or lungs (Interview 3).

spread of the infection. Families would be only be allowed to visit their old-age relatives when they are dying. Old people living at home received a different treatment by the government, understanding that they are ‘less vulnerable’ and that ‘there [at home] the concentration of vulnerable people is not an issue’.

Anticipating that this measure would be met with considerable reluctance by relatives of nursing homes’ residents, the government took efforts to communicate the importance of restricting visits to ‘vulnerable people’ as to protect them. Nevertheless, the measure created significant social resistance, for its emotional implications. To prevent relatives from visiting elderly residents, some nursing homes must implement harsh enforcement measures, such as hiring surveillance services (Interview 3) or fencing buildings to keep relatives away from residents (e.g. nursing home in Dieren).<sup>64</sup> The legality of the ban was also contested, on grounds of vulnerating the privacy and integrity of nursing homes’ residents, and the case was even taken to court.<sup>65</sup> Critics of the measure argued that the measure takes a position in a difficult dilemma, choosing for *keeping people alive*, while neglecting their *quality of life* (Interview 1). Nursing homes found tough that they must implement this contended measure. In the words of interviewee 3:

[The ban on visitors] meant that everybody, also those who didn’t have COVID, were detached from their family. Actually, it was a too harsh, disproportional measure that we had to apply in nursing homes. (Interview 3)

Critics of the measure argued that the measure takes a position in a difficult dilemma, choosing for keeping people alive, while compromising their quality of life:

For us it is really different from the ICUs, because it is not about saving lives. For us it is about adding quality of life. And it’s not about saving life or stretching life because we know that residents don’t like that at all. (...) They want to have as good a quality of life as possible. But actually what you see is that, the policy measures that have been taken, have not been taken with that objective, but with the same objective as the ICUs. (Interview 4)

64

[www.rtlnieuws.nl/nieuws/nederland/artikel/5117036/verpleeghuis-hekken-corona-covid-19](http://www.rtlnieuws.nl/nieuws/nederland/artikel/5117036/verpleeghuis-hekken-corona-covid-19)

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The federation of clients of nursing homes of the Amsterdam area demanded the public authorities and the case was taken to court. According to Interview 3, the case was probably closed with negotiations among the parties.

66

FAQ coronavirus and nursing homes, [www.rijksoverheid.nl/onderwerpen/coronavirus-covid-19/zorg/verpleegtehuizen](http://www.rijksoverheid.nl/onderwerpen/coronavirus-covid-19/zorg/verpleegtehuizen)

People very often die at our institution. People live in a nursing home for an average of two years and then they die. Of course it’s not nice if they die with corona, but the impact of the measures for other residents who also live there has also been very big. (Interview 1)

A side-effect of the ban on visitors has been the growing reluctance for older people in need of intensive LTC to move in nursing homes, fearing that if a second corona wave strikes they would be isolated from their families (Interview 3). Public authorities recommended families not to take their old-age relatives home with them during the lock down, warning about practical difficulties and negative implications<sup>66</sup> that it may entail (‘What if you get sick yourself? Who will take care of your elder relative?’). In spite of the waiting lists, nursing homes are facing difficulties at the moment to fill in their vacant places from COVID-19 deceased.

A related problem faced by nursing homes has been the unprecedented financial impact of the corona crisis. In particular, the death of many residents affects the occupancy rate of many nursing homes, with high numbers of empty beds and little prospects to fill them in in the short or medium term.<sup>67</sup> This affects unevenly care organizations, constituting a real problem for those hit the hardest by the pandemic. Other aspects implying extraordinary expenses in a short period, relate to additional personnel costs in order to cover sick leaves and the purchase of protective material. Public authorities have launched compensation schemes for extraordinary expenses in medical stock and for empty beds in underoccupied nursing homes. However, nursing homes are worried about the time constraints of public help, as schemes grant financial compensations just until early September.

Throughout the lockdown months, several stakeholders have advocated for more attention to nursing homes. They saw that long-term care services were taking a hit and did not immediately have the tools to respond effectively. Although many were voicing this concern, it took too long for policymakers to come to the same page (Interview 1, 2, 3, 4). Particularly, the federation of long-term care providers ACTIZ has been actively lobbying from the beginning of the crisis (Interviews 1, 2, 3, 4). Also the Dutch association of geriatric doctors Verenso played a prominent role, as for example pushing for the introduction of the ban for visitors, and also starting an initiative with the registration systems of nursing homes as to produce more accurate statistical figures on COVID-19 related incidence and mortality. Moreover, on May 8<sup>th</sup>, a common protocol for the gradual reopening of nursing homes for visits was agreed among a number of key actors of the care sector; it proposes to apply a 'controlled approach to visits'. This bottom-up initiative, endorsed by the Minister of Health, will be first applied on 25 institutions, gradually including other as they are free of infection. Additionally, a pilot research will be carried out in three locations to monitor the spread of the virus once this new regulation for visits is in force.

Many nursing homes adopted individual measures, which may have been associated with successful outcomes (lower incidence and mortality rates), as suggested in our interviews (see 3.4). Some of them applied a ban for visitors from the first moment of the outbreak, one month earlier than the government issued it (Interview 1), or set up to purchase their own supplies for protective equipment (Interviews 1 and 3). A nursing home in Friesland established a quarantine for their workers and their families. Employees must refrain from social contacts and from working elsewhere and accommodation in the facilities was provided for them.

### 3.3. Case Analysis

In the Netherlands, the overall (corona) crisis management has been criticized for its lack of leadership, inconsistency and untransparent decision-making. The reactive attitude that the government has adopted reflects the role that the Ministry of Health has within the semi-privatized and regionalized healthcare system. Subsidiarity prevails (regional and private stakeholders must face the problem), while the Ministry of Health has a mere coordinating, supervising

67  
After a resident's death, care homes continue to receive payment for the unoccupied room for only 13 days.

function.<sup>68</sup> In our view, the dominant governance pattern in the healthcare, with a subsidiary role of the state, has resulted into a ‘soft’ crisis management: characterized by a shifting strategy, untransparent decision-making, and absence of strong leadership. In this context, client politics under the influence of pressure groups and different actors of the healthcare scene have played a prominent role.

Against this backdrop, several factors are crucial for explaining the strong impact of the epidemic in the residential care sector. Some of them are related to this overall management of the crisis, thus rather unrelated to the type of LTC system, while other are linked to institutional aspects of the LTC system and to the policy reforms of the last decades.

First, in the management of the corona crisis, cure has been put before care and before prevention, focusing all attention on the hospitals and (especially) their ICU stations. As interviewee 3 says,

the position of the nursing homes was not acknowledged for a long time, despite the drama that was taking place there. (...) Most of the dead didn’t fall in the hospitals but in the nursing homes; and they got no masks, no attention. (Interview 3)

The LTC system, and the residential care sector in particular, was not represented at all in the group of experts that advised the government during the first phase of the crisis. Conversely, the influential part that the strong Dutch hospital lobby has played has been highlighted in all the interviews.

The fact that the Dutch healthcare sector (hospitals) is better organized as a lobby than the long-term care sector (nursing homes), has been determinant in channeling a specific framing of the issue and related policy responses. The perspective of medical and emergency care has dominated in the construction of the problem, contributing to a view of the corona crisis as an ‘emergency’ and a ‘health-care issue’, specifically affecting hospitals and ICU stations.<sup>69</sup> Such policy frame has been promoted by the hospital lobby through their role as policy advisors (top-down) and via their influence on the media. Interviewee 1, for instance, recalls:

They [hospitals] try to get the public attention and then you get all the images of all those nurses in full packaging protection and that looks very serious, and all the doctors who were interviewed over how terrible it all was. (...) And The Hague politicians have somehow bought this image of the issue. (Interview 1)

As this narrative of the issue effectively permeated Dutch society, the hospital lobby got to ‘own the issue’ (Petrocik 1996). The COVID-19 issue became a ‘hospital issue’, while in the reality of figures and death tolls it was as much a ‘nursing homes’ issue.

Second, the scarcity of protective material in nursing homes is another crucial element in the explanation for the high mortality rate. As we saw, care

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For instance, talking about the possible shortage of protective material, the Minister of Health said that it was not necessary to purchase large stocks of masks. In his own words, he must limit itself to follow the developments and call the attention of care providers and private insurances in case that there are incidental shortages (Hoe Nederland de controle verloor, NRC, 19 June 2020). This is also consistent with the general approach of the government’s coalition.

69

Following McBeth et al. (2010), we can analyze the narrative behind many of these public discourses in terms of a story with actors, victims, and villains. This construction of the issue depicts IC’s personnel as the ‘health heroes’ struggling against the corona virus (the villain), to save Covid-19 patients (the victims). Nursing homes are absent from this narrative.

homes (and other parts of the LTC sector) were at the back end of the queue for the distribution of protective equipment. As the care workers in the care homes had to work without protection, the ban on care home visits was useless in its effort to curb corona infections within homes.

Third, the lack of support that nursing homes received in the first months of the crisis was exacerbated by the sharp increase in workload in nursing homes affected by the epidemic. The overload of the regular channels required improvisation and quick reactions, making professionals face difficult practical dilemmas. Often, this entailed to choose between bad and worse. For example, in many homes, sick staff were asked to keep working, because they were indispensable due to personnel's shortages. This coping strategy with adverse effects in further facilitating the spread of the virus could have been tempered with explicit guidelines requiring sick personnel to keep quarantine.

Fourth, institutional factors also played a role. While the overload of the system (esp. nursing homes) was certainly not specific to the Netherlands, institutional variation most likely played a role in the degree of preparedness of different health systems for this kind of emergency. Especially, scarcity of protective material is not only the result of the distribution policy and the politics underlying the specific decision-making structures created to manage the corona crisis. It is also related to structural factors, such as the general facilities, cut backs in personnel in nursing homes or availability of medical stocks. Following the cost-efficiency reforms of the healthcare and the long-term care systems, drastic cutbacks were implemented in the first decades of the 21<sup>st</sup> century. As a consequence, the Dutch healthcare and long-term care systems were not prepared for a crisis of this caliber. The availability of resources was planned for regular healthcare needs (not counting with a sudden increase), as shown by the relative low number of ICU-beds and insufficient stocks of protective equipment. Holding empty beds in hospitals to tackle eventual growing demand by an epidemic is not efficient.<sup>70</sup>

Likewise, the relatively high degree of institutionalization of eldercare, typical of the Dutch system, has probably been influential as well. In spite of process of deinstitutionalization, the Netherlands still has a large population of old people living in care homes (nearly 114,000 persons aged 65+ in 2020).<sup>71</sup> While the propensity of virus spread in institutional settings due to spatial concentration is not specific of the Dutch case, some particularities of the Dutch context could be relevant.<sup>72</sup> Particularly, the concentration of vulnerability in nursing homes, as a result of the reforms of the LTC system, could have facilitated the spread of the virus within homes, and led to higher incidence of death per infected people.<sup>73</sup> This suggests that institutional choices matter, and that the high incidence of COVID-19 in nursing homes was reinforced by policy reforms, which limits access to homes to the most vulnerable clients.

Fifth, in many cases, the implementation of the corona measures has probably added insult to injury. On the one hand, because practitioners lacked

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Cf. section 3.1: this is called 'sensible care' in policy language.

71  
<https://opendata.cbs.nl/#/CBS/nl/dataset/82887NED/table?ts=1608639982499>

72  
Further comparative research should be done about availability and use of common facilities such as eating rooms. For example, how widespread are common eating rooms in care homes in different countries, and what has been the role of this in spreading transmission.

73  
Not only multimorbidity patients are more prone to contagion and death; but also older people with cognitive disorders as dementia who are hard to instruct in protective measures. In many nursing homes, the department for people with dementia have been the most hardly hit by the virus.

clear and consistent guidelines to tackle the crisis. The guidelines and health recommendations issued by the central government and its scientific advisors changed day by day:

So, with every announcement, you get in a very short time, you had to make a complete turn around in your organization and before you had already done it, there was another. And we had that in the beginning with all restrictions, including with RIVM guidelines. We found that very difficult. You come first to say how to do that, and then you come the next day and say: Oh no, it has to be different. And sometimes it is just too high to just be very practical in the practical situation. (Interview 1)

In addition, guidelines often promoted unrealistic or unfeasible requirements (Interviews 1 and 2). All of this created increasing uncertainty among nursing homes' managers and personnel.

Differences across regions and nursing homes, in terms of relative success in containment of the virus spread, were also remarkable. Care homes in the southern part of the country were affected more severely, most likely because corona in general hit that region harder. Conversely, nursing homes in the northern part of the country were hardly affected. Also social and cultural factors help making sense of variation. Particularly, the Carnival, mostly celebrated in the southern part of the country, was a strong infection-vector. The weeks after the Carnival parades and parties took place, hospitals in the areas where overflowed with COVID-19 cases. The higher incidence of the epidemic in these regions, also prompted more proactive initiatives and stronger coordination and collaboration among stakeholders. In Brabant, a specific structure was created agglutinating LTC actors (RONAZ), in parallel to the network for emergency care (ROAZ), which was later extended to other regions.

Moreover, our study of two nursing homes in the Utrecht region suggest that different approaches to the epidemic also make a difference. We will deal with this in the next section.

### 3.4. Examples of developments in specific care homes

Our interviews indicate that practitioners were also caught by surprise by the pandemic, just like policymakers. In one swoop the understanding of the problem changed from one day to the other. 'So first we thought it was a flu out of control from our experience, and that was on March 8, and on March 13 it was a huge dramatic situation with far-reaching consequences' (Interview 2). However, some organizations adapted very quickly to the new challenge, while other took a reactive response, essentially following top-down directions by the Public Administration.

Individual initiatives were taken in the context of a widespread disappointment with the Public Administration. The interviews reflect a feeling of the residential care sector of being left alone, under-resourced and unrepresented in the decision-making venues. Some respondents make not only

demands for more attention and support for the LTC sector, but also plea for a conceptual shift from understanding the corona crisis purely as an emergency crisis to seeing it as a ‘long-term care crisis’ (Interview 1). In this context, the diverging reactions of nursing homes seem to have made a significant difference in terms of outcomes.

Case 1 (Interview 1) is a large organization comprising 10 nursing homes as well as home-based care services. They are specialized in vulnerable elderly (psychogeriatric care). At the beginning of the COVID-19 pandemic in the Netherlands, this organization completely closed their homes to visitors on its own initiative. They also managed to get themselves sufficient supplies of protective equipment for their staff. In addition, they established an internal policy that if residents were showing coronavirus symptoms, they were immediately tested and put in isolation in their room awaiting the test results. They have also made sure that the movements of suppliers and treatment providers at their locations have drastically decreased<sup>74</sup>. Organization 1 was hardly affected by the virus, with a total of 15 deaths among their patients.

Case 2 (Interview 3) is the largest elderly care institution the Utrecht area, with 15 different nursing homes. They have 960 nursing home beds and 350 places in sheltered housing where people reasonable healthy live. Almost 100 people have died at their locations due to the COVID-19 virus since it broke out, which is an unprecedented level of mortality. In terms of staff, above 12% (around 119 people) have been infected. Moreover, case 2 is facing financial issues, with about 100 empty beds which they believe will remain empty for the foreseeable future. The government will only compensate them until September 1st, after which they have to figure out how to make up for the lost revenue.

In their management of the crisis, organization 2 followed to the letter the measures from the Public Authorities. They complied to the RIVM guidelines, although these guidelines initially kept changing every few days. For example, initially employees were supposed to keep working even if they had light symptoms; later on, the advice was updated to more accurately decide when a staff member should work or stay at home. Organization 2 has been following all these RIVM guidelines.

Case 1 may be seen as a ‘best practice’. Our cases suggest that this is essentially related to the strategic choice of taking an own initiative, emphasizing a preventive and integral approach. In some cases, initiatives can be even labelled as ‘disobedient’, explicitly denying government’s guidelines (Interview 1). The positive outcomes of different actors following this ‘loner strategy’ have been highlighted by other observers.<sup>75</sup> In case 1, the combination of early closure, sufficient protective equipment and application of tests led to a practical absence of infection and death in most of their homes. There was only one exception, which however confirms the rule. They didn’t immediately close down a small sheltered apartment complex with 22 residents who rent their own apartment but receive LTC services at home. Because they closed a week later than the other locations, the

74

They have implemented additional measures. For instance, they have opened a 7am-7pm phone line to provide advice and psychological support to employees and family members of residents.

75

‘Warnings from experts who ignored RIVM rules, improvisations from civil servants and hospitals who set aside a straitjacket of rules and protocols helped prevent a larger disaster’ (Hoe Nederland de controle verloor, NRC, 19 June 2020).

incidence of infections was also much higher, reaching a total of 15 victims, and many patients infected.

Because they rent themselves, we initially did not close the location. We felt that we could not forbid people to receive visitors in their own homes. After a week, we decided, given the circumstances, to do so. Legally, that was difficult, but it turned out to be very sensible in the end. (Interview 1)

Accordingly, those nursing homes that adopted an early lockdown seem to have been the most successful in curbing the virus. However, we must acknowledge that this was not always the case. Some organizations taking a proactive approach were also badly hit by the epidemic. The association of residential care organizations ACTIZ is more cautious about the positive results of strict measures in order to contain infection:

We simply know that infection prevention in location is essential. But the question is: how far is it preventable by having directive protocols very strict, and how far is it [a question of] good or bad luck? It depends on so many factors! (Interview 4)

Those nursing homes that adopted an early lockdown seem to have been the most successful in curbing the virus. However, we must acknowledge that this was not always the case. Some organizations taking a proactive approach were also badly hit by the epidemic.

Conversely, case 2 can illustrate a ‘worse practice’ case. Bad practice is related to follow more to the letter public authorities in their guidance of the crisis. The director of organization 2 explained that they observed the RIVM guidelines, and consequently did not apply tests until they were permitted. Also, they did not implement a ban on visitors till the government introduced it, and they followed a lenient implementation with exclusions on two more grounds than what was allowed by the general rule. Likewise, their personnel must work without protective equipment, and sick people with light symptoms kept working.

Case 2 also shows that LTC organizations experiencing a serious COVID-19 outbreak have drawn important lessons from their experience. Interviewee 2 expresses his satisfaction for being granted more autonomy in the management of an epidemic from now on. In the face of an eventual second corona wave, they intend to apply an active test policy, and preventive measures. The same lesson is highlighted by many other nursing homes, who intend to test all personal, residents and visitors by the first sign of infections in the area. As we read in an interview with the (representative of the board of) directors of a nursing home in the south of the Netherlands: ‘We are not going to wait until somebody shows cold symptoms neither will wait for the (advice of the) GGD (public health offices).’<sup>76</sup>

Some demands for more subsidiarity and autonomy of nursing homes’ organizations have been immediately granted. As a result of the bottom up initiative of LTC stakeholders to agree on a controlled approach to visits

76  
Veel personeel in verpleeghuis Budel  
besmet zonder het te merken, NRC, 23  
August 2020.

(see 3.2), a devolution of responsibilities has been made to nursing homes. Although this explicitly relates to visits management, indirectly it seems to open the way for the application of tailor-made measures in general in the struggle against epidemics.

In addition, another lesson emphasized by the respondents was the need to increase coordination, across sectors and levels. Particularly, more local and regional coordination (Interview 3), better collaboration between interest groups (esp. ACTIZ and VERENSO), and more coordinated work between hospitals and nursing homes' geriatric doctors and more support for the last ones (Interview 2).

## REFERENCES

ACTIZ (2014), *Eigen regie, een sociaal begrip*. Position paper, Utrecht: ACTIZ.

Börsch-Supan, A. (2019), *Survey of Health, Ageing and Retirement in Europe (SHARE) Wave 2*. Release version: 7.1.0. SHARE-ERIC. Data set. DOI: 10.6103/SHARE.w2.710

Companje, K.P. (2015), 'Financing high medical risks in the Netherlands: Healthcare, social insurance and political compromises', in: Companje, K.P. (Ed.), *Financing high medical risks. Discussions, developments, problems and solutions on the coverage of the risk of long-term care in Norway, Germany and the Netherlands since 1945 in European perspective*, Amsterdam: Amsterdam University Press, pp. 101-176.

Cox, R.H. (1998), 'From safety net to trampoline: labor market activation in the Netherlands and Denmark', *Governance*, Vol. 11, No. 4, pp. 397-414.

Dandi, R., Casanova, G., Lillini, R., Volpe, M., De Belvis, A., Avolio, M. and Pelone, F. (2012), *Long-term care quality assurance policies in the European Union*. ENEPRI Research Report No. 111, Brussels: Centre for European Policy Studies.

Da Roit, B. (2012), 'The Netherlands: The struggle between universalism and cost containment', *Health and Social Care in the Community*, Vol. 20, No. 3, pp. 228-237.

Da Roit, B. (2013), 'Long-term care reforms in the Netherlands', in: Ranci, C. and Pavolini, E. (Eds.), *Reforms in long-term care policies in Europe: Investigating institutional change and social impacts*, New York: Springer, pp. 97-115.

Duyvendak, J.W., Knijn, T. and Kremer, M. (2006), *Policy, people, and the new professional: De-professionalisation and re-professionalisation in care and welfare*, Amsterdam: Amsterdam University Press.

Gijzel, H. et al. (2017), *De wet langdurige zorg in de verzorging, verpleging en gehandicaptzorg. Ervaring uit de praktijk*, Amstelveen: KPMG and Vilans.

Goudriaan, G. and Vaalburg, A.M. (1998), *De vraag als maat: vraaggerichtheid vanuit gebruikersperspectief*, Utrecht: NP/CF and NIZW.

Grootegoed, E., Knijn, T. and Da Roit, B. (2010). 'Relatives as paid care-givers: How family carers experience payments for care', *Ageing and Society*, Vol. 30, No. 3, pp. 467.

Grootegoed, E. and Van Dijk, D. (2012), 'The return of the family? welfare state retrenchment and client autonomy in long-term care', *Journal of Social Policy*, Vol. 41, pp. 677-694.

Grootegoed, E. and Knijn, T. (2012), Minder dankbaarheid, hogere eisen. Betaling voor mantelzorg veroorzaakt nieuw 'emotiewerk', available at [www.nemokennislink.nl/publicaties/minder-dankbaarheid-hogere-eisen/](http://www.nemokennislink.nl/publicaties/minder-dankbaarheid-hogere-eisen/)

Grootegoed, E., Van Barneveld, E. and Duyvedak, J.W. (2015), 'What is customary about customary care? How Dutch welfare policy defines what citizens have to consider "normal" care at home', *Critical Social Policy*, Vol. 35, No. 1, pp. 110-131.

Grootegoed, E and Tonkens, E. (2016), 'Voluntary care: a deficient alternative', *Nederlands tijdschrift voor Geneeskunde*, Vol. 160, D243-D243.

Hochschild, A. (1995). 'The culture of politics: Traditional, postmodern, cold modern, and warm modern ideals of care'. *Social Politics* 2 (3), pp. 331-346.

Hochschild, A. (1995), 'The culture of politics: Traditional, postmodern, cold modern, and warm modern ideals of care', *Social Politics*, Vol. 2, No. 3, pp. 331-346.

IGZ (2009), *Grote zorgen over 'nieuwe' toetreders op de thuiszorgmarkt*, Den Haag: IGJ.

Zorginstituut Nederland (2017), *Kwaliteitskader Verpleeghuiszorg. Samen leren en verbeteren*, Den Haag: Zorginstituut Nederland.

Maarse, J.A.M. and Jeurissen, P.P. (2016), 'The politics and policies of the 2015 long-term care reform in the Netherlands', *Health Policy*, Vol. 120, No. 3, pp. 241-245.

Meerman, W., Castelijns, E., Heesbeen, S. and Vreeswijk, F. (2015). *Particuliere en reguliere verpleeghuizen. Een vergelijking om van te leren*, Utrecht: Berenschot.

MLZ (2018), *Gebruik bijdrageplichtige Wlz-zorg*, available at <http://mlzstatline.cbs.nl/Statweb/publication/?DM=SLNL&PA=40055NED>

Morée, M., Van der Zee, B. and Struijs, A.J. (2007), *Formalisering van informele zorg. Over de rol van 'gebruikelijke zorg' bij toekenning van professionele zorg*, Den Haag: Centrum voor Ethiek en Gezondheid.

Mot, E. (2010), *CPB document no. 204: The Dutch system of long-term care*, The Hague: CPB.

Mot, E. et al. (2010), *The Long-Term Care System for the Elderly in the Netherlands*. ENEPRI Research Report No. 90, Brussels: Centre for European Policy Studies.

Mot, E. et al (2012), *Performance of long-term care systems in Europe*. ENEPRI Research Report No. 117, Brussels: Centre for European Policy Studies.

Non, M. et al. (2015), *Keuzeruimte in de Langdurige zorg*, The Hague: CPB and SCP.

Maarse, H. and Paulus, A. (2003), 'Has solidarity survived? A comparative analysis of the effect of social health insurance reform in four European countries', *Journal of Health Politics, Policy and Law*, Vol. 28, No. 4, pp. 585-614.

McBeth, L. et al. (2010), 'Buffalo tales: interest groups policy stories in Greater Yellowstone', *Policy Sciences*, Vol. 43, No. 4, pp. 391-409.

OECD (2019), *Health at a Glance 2019: OECD Indicators*, Paris: OECD Publishing.

Ranci, C. and Pavolini, E. (2015), 'Not all that glitters is gold: Long-term care reforms in the last two decades in Europe', *Journal of European Social Policy*, Vol. 25, No. 3, pp. 270-285.

Saers-Molenaar, A.W.D. (2005), 'De vraag van de klant zou echt uitgangspunt moeten zijn', in: *Caleidoscoop van de thuiszorg. Wenken en wensen voor de toekomst*, Bunnik: STOOM, pp. 101-103.

Stuurgroep Kwaliteitskader Verantwoorde Zorg (2008), *De toon gezet: één taal voor kwaliteit*, available at <https://zoek.officielebekendmakingen.nl/kst-31200-XVI-186-b1.pdf>

Van den Broek, T. (2013), 'The formalization of informal care in the Netherlands: Cost containment or gendered cost redistribution?', *International Journal of Feminist Approaches to Bioethics*, Vol. 6, No. 2, pp. 185-193.

Van den Broek, T. (2016), *Supporting Ageing Parents: Comparative Analyses of Upward Generational Support*, Rotterdam: Erasmus University Rotterdam, available at <https://repub.eur.nl/pub/93509/>

Van Ginneken, E. and Kroneman, M. (2015), 'Long-term care reform in the Netherlands: too large to handle', *Eurohealth*, Vol. 21, No. 3, pp. 47–50.

Visser J., den Brok, Y. and Van Charante, M. (2002), *Op maat regelen: ervaringen van mensen die hulp vragen*, Utrecht: CG-raad

Westert G.P., Van den Berg M.J., Koolman X. and Verkleij, H. (2008), *Zorgbalans 2008. De prestatie van de Nederlandse gezondheidszorg*. RIVM: Bilthoven.

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