Positioning the individual in health care

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MADELEINE J.N. RIJCKMANS

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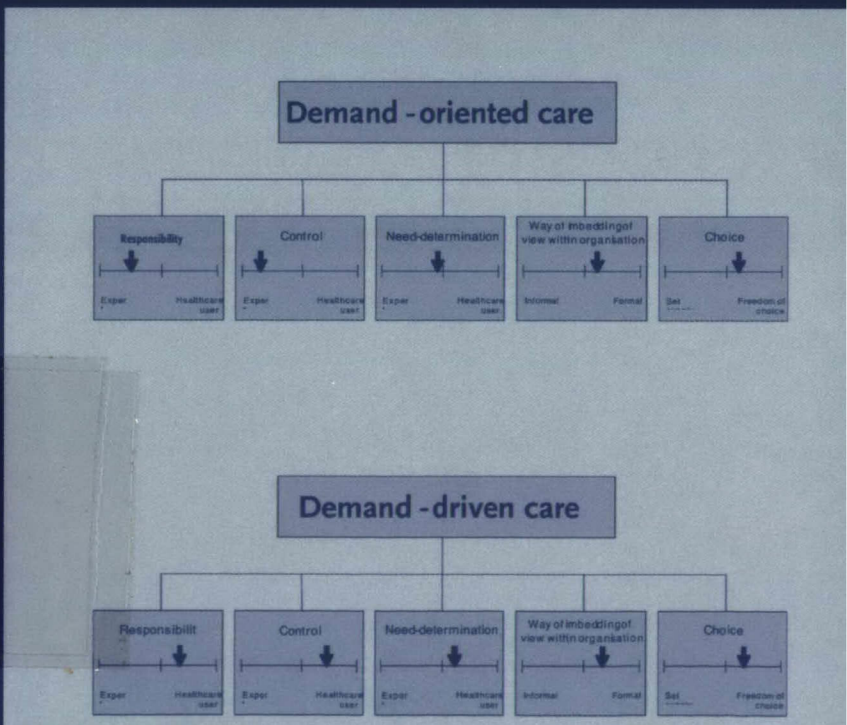
A typology of the demand-oriented and demand-driven approaches



Erratum

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A typology of the demand-oriented and demand-driven approaches

Positionering van het individu in de gezondheidszorg
Een typologie van de vraaggerichte en vraaggestuurde benaderingen

PROEFSCHRIFT

ter verkrijging van de graad van doctor aan de Universiteit van Tilburg op gezag van rector magnificus, prof.dr. F.A. van der Duyn Schouten, in het openbaar te verdedigen ten overstaan van een door het college voor promoties aangewezen commissie in de aula van de Universiteit op vrijdag 2 december 2005 om 14.15 uur

door

MADELEINE JEANNE NOËLLE RIJCKMANS

geboren op 27 december 1973 te Goirle

PROMOTOR:
Prof. dr. H.F.L. Garretsen

COPROMOTORES:
Dr. L.A.M. van de Goor
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Tranzo, Faculty of Social and Behavioural Sciences; Tilburg University, the Netherlands

Key words: Demand-orientation, demand-driven care, typology

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Chapter 1

General introduction

> 'According to a survey of twelve European countries, Dutch medical care meets the expectations of consumers the best... followed by Switzerland and Germany. Minister Hoogervorst [of the department of Health, Welfare and Sports] is pleased with the results of the study. He considers the index a positive contribution as it emphasizes the importance of transparency in health care. According to Hoogervorst, the index focuses on issues which citizens consider important, such as the results of care' (Ministerie van VWS, 2005).

1.1 INTRODUCTION

Health care in the Netherlands is currently undergoing a radical transformation (Merks-van Brunschot, 2004). In the Netherlands, as in most European countries, we are witnessing a swing from supply-driven to demand-driven approaches in health care. Many see demand-orientation and demand-driven care as the key-concepts in innovative thinking about health care and welfare (Van Diest, Van Wijngaarden & Wijngaarden, 2002). These concepts are seen as the answer to many of the problems confronting us today in this area. But what exactly is meant by demand-oriented or demand-driven care? And before we can address these questions, we must determine: what is demand, and what is need? In terms of content, the concepts demand-oriented and demand-driven health care are not clearly distinct, and are often not defined at all (Rijckmans et al, 2003).

According to Verkooijen et al. (2003), the demand-oriented and the demand-driven approach are both counterparts of the strongly institutional supply-driven approach. In the supply-driven approach, the existing supply is the point of departure, while in the demand-oriented and demand-driven approaches, the focus in on the individual health care user's wants and needs. Because of this development, more and more

attention is paid to how content clients are with their treatment, what their specific needs and wants concerning their treatment may be (Veeninga & Hafkenscheid, 2002), as well as what their goals are (Anthony, Cohen & Cohen, 2000). The demand-oriented and demand-driven health care approaches are believed to be key-concepts in the increasing focus on health care users. It is claimed (Tranzo, 2001) that both approaches put more emphasis on the client's wants and needs and that, in this way, health care helps enhance the client's experienced quality of life (Häyry, 1999).

Demand-orientation and demand-driven care are concepts used by many when formulating mission statements, policy goals, organisational visions, and advertisements. However, different actors define the two concepts in different ways, and the definitions vary from 'taking the client into account', on the one hand, to 'actual steering by the demand', on the other hand, with the client having the means to influence the service (Rijckmans et al., 2003). Agreement about the meaning of both concepts is necessary from a scientific point of view, but also for a correct evaluation of the implications for policy and practice. In scientific debates, as well as in policy and societal debates concerning whether or not a strongly institutionalized supply-oriented approach should be transformed into a more demand-oriented or demand-driven approach, it is essential that the different parties agree on how the concepts are defined. This requires good communication, especially between different parties, as the expectations that are raised, can lead to miscommunication through confusion of concepts. Little literature has dealt with this issue, and there does not seem to be enough insight into the content and the consequences of the concepts of demand-orientation and demand-driven care in the sector of health care and welfare. Though the concepts are used in practice on a large scale, originating from practice, and concerning various aspects of health care, there is no unambiguous conceptual framework that can be applied.

1.2 RESEARCH QUESTIONS

Because of the lack in scientific knowledge about the meaning of the concepts, the topicality of the subject, and the great interest from the field, a PhD study was initiated in May 2001. The aim of this study was to gain insight into the concepts of demand-oriented and demand-driven health care, and fill them in. The main goal was the development of a model for scientific use that could also serve as a tool for policy and practice in the field. It should serve as a means for the government and health care organisations to shape their vision with respect to the health care user and acquire insight into the consequences of different ways of organizing their services.

When dealing with goals and means, one must consider their meaning to those who are affected by them. For such a way of sorting, the term 'typology' is used (Luiten, 1987). A typology is a model that identifies multiple ideal types, each of which con-

sists of a unique combination of elements (Doty and Glick, 1994). This study aims to develop two ideal types with respect to the filling-in and execution of health care. Furthermore, since both demand-orientation and demand-driven care aim to give health care users a more central role to meet their needs and wants more thoroughly, this study also aims to develop a concept-instrument with which to evaluate the degree health care users value the concepts.

By reviewing the problems defined and the goals set in this study, the following questions were addressed[1]:

- What is meant by the concepts demand-orientation and demand-driven care?
- To what extent are the abstract dimensions present in the current supply of care?
- How do health care users value the concepts?
- How do the approaches match with current societal rules and legislation and ways of financing the health care system?

1.3 STRUCTURE OF THE THESIS

As stated above, the meaning of the concepts demand-oriented and demand-driven health care seems to be unclear. There is little literature clarifying these concepts, and the definitions of the concepts seem to vary a lot. In Chapter 2, the different definitions in the scientific and professional literature will be compared and considered, with a special focus on their common and distinctive elements.

The swing from supply-driven care to demand-driven care is fuelled by the current trend to put the individual in the foreground, considering his or her quality of life and associated individual wishes and needs. In Chapter 3, a conceptual framework for research will be sketched that takes quality of life as its starting-point. The concepts of 'need' and 'demand' will be explored, and all the factors that may influence these concepts.

Next, in order to identify the different views that the various relevant parties hold, and to examine to what extent there is consensus in the Netherlands about the concepts of demand-orientation and demand-driven care, the results of a Delphi-study will be given, as done among twenty-six experts, based on the Grounded Theory (Glaser & Strauss, 1967). The experts were representatives of the relevant actors in the field: scientists, health care insurance companies, health care suppliers, the government, independent advisory bodies, and client interest groups. The study resulted in a typology of the two concepts, presented in Chapter 4, demonstrating the

1. Research questions are elaborated in chapters 2 to 7. Since these chapters include manuscripts that have been published or submitted for publication to (inter)national scientific journals, there is some overlap in the introductions of the chapters.

similarities and differences between the concepts in five dimensions: 1) Responsibility, 2) Control, 3) Need-determination, 4) Way of imbedding of the view within the organisation, and 5) Choice.

Then, since the emphasis in the demand-oriented and demand-driven approaches is on the health care user's perspective, in the final phase of the study (Chapters 5 and 6), the health care user's views of the importance of the elements in the typology, and their experiences with the various elements in practice. The research population, in which the importance of the elements in the typology was explored, was clients from the ambulatory mental health care. The goal was to explore which elements met the health care users' wishes and needs. For this purpose, a questionnaire was developed, based on the typology. Chapter 5 focuses on the health care users' appreciation of the elements in the typology. Chapter 6 explores the experiences of health care users concerning the presence of the different elements of either approach in the health care they received.

In Chapter 7, the possibilities of the new approaches and the developed typology will be considered given the current legal and financial situation. The main question addressed is 'given the current legal and financial situation, what are the possibilities and limitations for the demand-oriented and demand-driven approaches within the Dutch health care system?'

Finally, in Chapter 8, the results of this dissertation are summarized and some implications for policy and practice and future research will be discussed.

Chapter 2

Demand-orientation and demand-driven care: Conceptual confusion in health care

The concepts demand-orientation and demand-driven care are seen by many as the key words in innovative thinking about health care and welfare. These concepts are seen as the answer to the problems confronting us today. But what do these concepts mean? Literature on clarification of the concepts is scarce and when they are defined, the definitions seem to vary a lot between the different parties. For this article the different kinds of definitions in literature were studied and compared on the basis of common and distinctive elements. In the current literature there seems to be a fundamental difference between the concept of demand-orientation on the one side and the concept demand-driven care on the other. In the case of demand-orientation, supply steers the demand, while in putting together and shaping the supply the demand will be considered. In the case of demand-driven care, supply is being steered by the demand, and freedom of choice for the user is a central element. Additionally, in the case of demand-driven care the user even has the financial means to effectuate this freedom.

2.1 INTRODUCTION

Health care is an almost permanent subject of public debate. Aspects of discussions are broad and of a moral, ethical, economical, legal, organisational and administrative nature. This makes the field of health care extremely interesting but at the same time very complex.

Patient choice has become an important touchstone of health care reform across northern Europe. This search for a new role for patients reflects the current period

of what might be called a 'paradigm flux', now affecting health service delivery in nearly every advanced industrialised country (Saltman, 1994). In developing health care policy and the organisation of health care services, more and more pleas are being made to introduce demand-orientation and demand-driven care as counterparts to a strongly institutional, supply-oriented approach. This movement can be viewed across all aspects of society, for instance in public housing, education, social services and social security (Roo, 1995). Janssen speaks of a trend over the next decade, in which client demands will become the departure point, i.e. 'demand-driven' health care (Janssen, 1997). The Ministry of Public Health, Welfare and Sports has a somewhat similar point of view that states that 'demand-driven care' has become a policy aim (Terpstra, 1997).

The turning point in the health service, from a supply-driven to demand-driven approach, took place in the Netherlands in the late 1980s, beginning with the recommendations of the Dekker Committee. The conceptual cornerstone of this approach is consumer sovereignty, which assumes that it is possible and useful to let supply be steered autonomously by the demand for care (Grinten, 2000). It assumes that consumers are capable of making choices in relation to the use of services, and are highly motivated; they want to choose. The reforms Dekker envisaged have hardly materialised. The possibility of personal budget financing arose only in 1995, largely because of lobbying by the Disability Board.

Much has been written about the dilemmas of demand driven care, organisational difficulties in the execution of demand-orientation and the financial consequences of the introduction of care based on demand. In contrast, the literature on the clarification of these concepts is quite scarce. Furthermore, the terms have been defined in various ways, ranging from mere client-orientation, to actual influence on supply by client driven demand (Garretsen, 2001). To prevent miscommunication, clarification of the different concepts is highly desirable. Definitions are discussed below.

In comparing the various definitions, there seem to be some distinctive and common elements:

- Focus: what is the main concern
- Power: who has final control
- Perspective: professional, individualistic, administrative, economic perspective or combination of these.

2.2 DEMAND-ORIENTATION

Definitions of demand-orientation focus on supply and thus on the actions of care providers. Demand-orientation refers to a procedure that care providers (ought to) use while developing services. One government advisory body report defined it as 'A

mutual effort of patient and provider that leads to the patient receiving help that fulfils his wishes and expectations and at the same time complies with professional standards' (RVZ, 2000). The provider has knowledge of these so-called professional standards, (often in contrast to the client), who therefore tend to control the content and shape of services.

Another definition of demand-orientation is 'Policy and practice that aims at fulfilling the need for public health interventions based on: data concerning the size and severity of population health problems and the needs, wishes and expectations of client organisations as well as individual clients' (Dekker, 2000). This definition balances individual subjective wants and the objective needs of the whole population. Control rests with policymakers and providers, as they decide on the weight of individual versus collective needs and are responsible for financing.

In contrast to these two definitions the Dutch Patient/Consumer Federation uses a more general definition: 'Demand-oriented supply is that, which on a collective and individual level, according to the opinion of the user or their representative, contributes optimally towards the problems he encounters' (Goudriaan & Vaalburg, 1998). However, further explanation of this definition reveals that it is similar to that of the RVZ, as health care suppliers with professional knowledge take account of the needs and wants of users through a process of demand clarification.

In defining demand-orientation, the focus of all the different definitions seems to lie in the process of generating a service that (to a certain extent) contributes towards the needs and wants of users. Final control is in the hands of policymakers and health care suppliers. Suppliers decide to what extent they are willing to accede to the demands and wishes of their clients. All of this largely occurs from a professional perspective, and because of information-asymmetry health care suppliers retain their status as experts. From an administrative perspective, the deliberations of policy-makers on individual versus collective population needs help play a role in demand orientation.

2.3 DEMAND-DRIVEN CARE

Most definitions about demand-driven care, as well as demand-orientation, indicate a process, but in this case the focus is not so much on the actions of the suppliers or providers but much more on the possibility of choice for users, and thus demand itself. The interdepartmental commission Etty describes this as: 'The essence of driving demand is that the insured himself can determine his care. The main concern here is the possibility of choice. The goal of introducing the concept of demand-driven care is to put clients in a more equal position in relation to suppliers, so that suppliers will work more efficiently and meet more user demands. Clients will have more influence on care received because they themselves, as much as possible and as far as

they desire, can make choices from the available supply, given of course that a choice of care option exists' (Etty, 2000). The focus here is on the process that service users will go through. A somewhat similar definition of demand-driven care is used by the Ministry of Public Health, Welfare and Sports. 'Indicated demand guides the quantity and quality of the required supply' (Ministerie van VWS, 2001). Both of these definitions contain restrictions: choice is limited to available supply and a formal indication for care is required.

In contrast to the above, some definitions do not restrict user control: 'The patient/consumer needs to be in control, for he is 'the client' and also has experiential expertise. Patients and consumers decide on care options. Demand-driven care must be accompanied by solidarity, freedom of choice and preservation of personal autonomy' (NPCF, 2001), and 'Steering demand is translated as the ideal of the free market, in which the supply of care is determined by autonomous and responsible consumers/patients making self assured choices on the use of health care services' (Grinten, 2000). The Board for Public Health Care defines the concept somewhat similarly as 'implying that market demand determines the supply of care' (RVZ, 2000). Crucial to all of these definitions is the dependency of supply on demand and thus the dependency of suppliers on patients. This can be further emphasised: 'Having supply guided by demand, with demand actually having the means to guide supply' (Goudriaan & Vaalburg, 1998).

The focus of different definitions for demand driven care seems to be freedom of choice for users, i.e. the process by which individuals select services that best address their needs and wants. Control ultimately rests with users (demand). The emphasis in this case is on the individual nature of the demand (individualistic perspective). Individuals determine both the type and provider of care. As every individual has different experiences, each demand can be different. The policy for and nature of supply are thus tuned to demand. Demand affects the nature, quality and quantity of supply. Furthermore, demand-driven care is seen from an administrative perspective, in which hierarchical budget-driven approaches are replaced by more decentralized consumer-oriented perspectives. Ultimately, when users also have the financial resources to ensure that suppliers acquiesce to their demands, the concept can also be viewed from an economic perspective.

2.4 DIFFERENCES IN DEFINITIONS BETWEEN KEY-PLAYERS

Definitions in the literature originate from five different key-players: science and knowledge institutes, government and advisory bodies, care suppliers, client interest groups and others such as commercial organisations. In comparing the various definitions from key players, several differences can be identified.

Firstly, the extent to which restrictions are built into definitions varies. In contrast to others, the government and advisory bodies include restrictions on the complying with client needs and wants, freedom of choice and final control. This raises the question as to what extent there is actually a focus on demand. Within the concept of demand-orientation, these restrictions need not be a contradiction. After all, final control rests with suppliers, who ought to attend to clients' needs and wants (demand), but who also from a professional perspective can ascertain what is best for the patient.

However, when control rests with users, as in the case of demand-driven care, these restrictions seem to somewhat contradictory to the meaning of this concept. According to a number of governmental definitions, individuals ought to have some choice over services and suppliers, but constrained by available supply and need for appropriate indication for care. To some extent we can speak of freedom of choice, but this is only the case when an individual agrees with the formal indication for care and available supply meets needs and wants. For example if a child is identified as being suitable for 'special education' because of a behavioural disorder, he and his parents would then be able to choose between special schools in the area (available supply). However if the child (and his parents) would prefer to go to a normal school and see a psychologist once a week, demand-driven care would imply that the type of services provided would be dependent on demand and thus the needs and wants of service users. In this case however the needs and wants of the child and his parents would not be met, given restrictions which limit choice to existing supply. There lies the contradiction in recommending demand-driven care.

Another noticeable difference is that many care suppliers do not distinguish between the terms demand-orientation and demand-driven care. When they speak of demand-orientation, the elements found in their definitions are similar to those for the general concept of demand-driven care, and vice versa. Care suppliers define both demand-orientation and demand-driven care as: 'Making the client and his needs and wants the centre of attention' (ZMOK, 2001). In the explanation of each given definition, sometimes the definition leans more towards the generalized concept of demand-orientation (focusing on the actions of suppliers who maintain control), and in other cases towards demand-driven care (focusing on freedom of choice with patient control). Examples of such nuances include: 'addressing more clients' needs' and 'individualisation of care' on one side and 'service provision tailored to demand' or 'more authority for the client' on the other. In all cases definitions provided by the government and associated advisory bodies are the most restrictive in nature, while those of client interest groups maximise the level of control exercised by individuals. This of course is consistent with the nature and aims of these groups.

2.5 CONCLUSION

Although there is some confusion about demand-orientation and demand-driven care, we can identify some common themes. We can conclude that there seems to be a fundamental difference between the two concepts. Regarding demand-orientation, the focus is on the extent to which those who provide services, take the needs of individual patients into account. Largely this is a matter of professional perspective. In demand-orientation, those supplying services still guide demand.

In the case of demand-driven care, the focus is on freedom of choice, with the individual patient having the final say on the type of care received. Demand-driven care is seen more from an administrative perspective, in which hierarchical budget-driven approaches are replaced by more decentralised consumer-oriented perspectives. The emphasis is on the individual nature of demand. It assumes that only individual patients have the necessary experiential expertise to make informed choices. In some instances patient influence over demand can be extended even further, giving individuals the necessary financial resources to ensure that desired services are provided. Demand-driven care can thus be viewed from an economic perspective. Supply can actually be influenced by demand. We can conclude that in the case of demand-orientation supply guides demand, while in the case of demand-driven care, demand guides supply.

Chapter 3

Key-concepts of demand-driven health care: An approach based on client's needs

Objective: In most European countries we are witnessing a shift from supply-driven to demand-driven approaches in health care. According to these approaches, health care should contribute to the fulfilment of health-care-related needs of individuals and, therefore, to their perceived quality of life. The purpose of this study is to develop a conceptual framework for research in this new view of health care.
Findings: The authors conclude that the 'felt need' should be the foundation of demand-driven care. The second part of the study is based on a widely used Behavioural Model to which the authors make an additional distinction, resulting in a conceptual framework for research, policy and practice
Conclusions: This study makes a start at providing information about fundamental concepts that are at the heart of the demand-driven approach. In order to contribute to quality of life, health care providers should explore the underlying needs while developing services in order to fit the demand-driven approach.

3.1 INTRODUCTION

In several European countries we are witnessing a shift in health care from supply-driven to demand-driven approaches, in which freedom of choice for patients is an important starting-point. Patient choice is usually associated with the idea of 'consumer sovereignty' and the importance of tailoring health care systems to meet the individual demands of its users (Calnan, Halik & Sabbat, 1998). This reflects the current search for a new definition of the patients' role, which could also be called a paradigm shift that affects the supply of health care services in virtually every progressive Northern European country (Saltman, 1994). The swing from supply-driven

care to demand-driven care is fuelled by the current trend to foreground the individual and his wishes and needs. This trend is part of the wider trend towards individualization, which has been an ongoing historical, social, and cultural process in Western societies for centuries and that has by no means fully run its course. As a social process, individualization manifests itself as people's emancipation vis-à-vis each other. This implies that, in more and more areas of life, people make choices that are relatively dissociated from other people's choices, even their near and dear, and from their own choices made earlier or elsewhere. There is less coercion than there used to be, but there is also less resignation to one's destiny (Schnabel, 1999).

The increase in patients' assertiveness dates back to the mid-sixties, when social upheavals occurred in many countries the world over. Many intellectuals rebelled against the established power relations and demanded increased-participation policies. Public health care also received its share of the mounting social discontent. The term 'patient' was outlawed as a misjudgement of fellow human beings and their existential problems, and the new term 'client' became fashionable (Geelen, 2000). In such an individual-oriented culture, which considers 'autonomy' of paramount importance, people are determined to be the captains of their own souls and the masters of their own lives (Schippers & Gennep, 1999). In other words, they attempt to arrange their lives in such a way that they manage to fulfil their needs as much as possible and take responsibility for their quality of life. The phrase 'quality of life' made its way into the Netherlands from the United States, where it has been very prominent in health care debates for several years (Achterhuis, 1988). When the quality of human life is defined in order to assist patients towards informed, rational and autonomous decision making, quality of life is good if and only if it is good according to the criteria they themselves have chosen to employ (Häyry, 1999). Thus, if one conceives of the individual as an autonomous being - a self-reliant and independent individual - with authority over his own life, then his perception of quality of life is at the centre of things. This study uses the definitions of 'health' and 'quality of life' as these have been formulated by the World Health Organization (WHO). Health is 'A state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity' (WHOQOL group, 1994) and quality of life is 'Persons' perception of their position in life and in relation to their goals, expectations, standards, and concerns. It is a broad-ranging concept incorporating, in a complex way, the person's physical health, psychological state, level of independence, social relationships, personal beliefs, and relationship to salient features of the environment' (WHOQOL group, 1994).

Each individual may have different needs in realizing his life; different needs in the areas of work, social relations, and material matters, but also in the areas of health care, well-being, and housing conditions and the health care services they require in fulfilling these needs (Sartorius, 2000; Skevington, Sartorius & Amir, 2004). A de-

mand-driven approach in health care implies that the individual's demands and needs must be met. Ultimately, the individual's wishes and needs are the core issues (Rijckmans et al., 2002). However, can an expressed demand be equated with a felt need and thus serve as a reliable foundation for health care supply that contributes to fulfilling care needs? Are the care needs felt by the individual actually and accurately translated into care demands formulated by that individual? In this article, which is part of a study concerning the development of a typology for demand-oriented and demand-driven care, the authors sketch a conceptual framework for research that has quality of life as its starting-point. This study's main focus is on long-term care, as the demand-driven approach is obviously more amenable to chronic mental and or physical conditions than to incidental acute care. The authors will be dealing with the process from 'need' to 'expressed demand' and with all factors (Goodwin & Andersen, 2002) that may have an impact on this process, in order to explore the different variables and give insight to all different parties in the field and into the ways individuals come to their expressed demands.

3.2 RESEARCH METHODS

To gain a better understanding of the process of how an expressed demand for care is realized and in order to fully interpret the concept of demand-driven care, the literature was reviewed to define answers to the following questions:

- What does the concept 'demand' stand for in demand-orientation and demand-driven care?
- What factors have an influence on the expression of a demand?
- Which theoretical issues should health care providers consider in their search to offer demand-driven health care services?

The first step in this study was a complete literature search (Psych.lit., Medline, OCLC Pica) for the concepts 'need', 'demand' or 'want' in relation to the concepts 'demand-orientation' or 'demand-driven care'. This search gained very little useful references. Next a series of interviews with experts in the field of 'quality of life' and 'health care policy' followed. Information from these interviews lead the authors in their search for relevant articles. The references used in those articles were then used to find new relevant literature (snowball method). Many of the relevant articles concerning need and demand pointed towards Bradshaw's Classification (Bradshaw, 1977) and literature concerning health care use pointed toward Anderson's Socio-Behavioural Model (Andersen, 1995). Both models were then taken as starting points.

3.3 DEFINITIONS OF NEED AND DEMAND IN DEMAND-DRIVEN CARE

What is need? What is demand? How are we to take these terms? These are crucial questions for any study dealing with the topic of demand-driven care, since those

concepts determine the content of health care that is based on client's wants (Rijckmans et al., 2003). Both concepts have been extensively considered in the field of epidemiological needs research (Goudriaan & Vaalburg, 1998). Recurring points of debate concern what real needs are and how they can be measured. In the Oxford Advanced Learner's Dictionary (OALD, 1995), 'need' is defined as a 'basic necessity or requirement'. However, establishing a particular need is not an unambiguous matter. The concept of 'care needs' is sometimes called a container concept, in the sense that needs research can be done from a great many perspectives (Bijsterveld, 2001). It is clear that care needs are relative to time, place, and culture, but there are also different definitions of needs. In sum, the concept of 'need' is not an autonomous fact. The determination of what a need is and what kind of care would be required is subject to norms, values, and experiences, which may differ over time. Not every kind of 'neediness' will actually result in a demand for care (Moons, Kerkstra & Picauly, 1989); people with the same degree of 'neediness' may formulate different demands for care and may receive varying degrees of actual care and the presence of health problems is a very poor predictor of the presence of need for professional care (Romme, 1979). People are different, in sickness and in health. Aside from demographic differences such as age and gender, people also belong to different cultures and have different personalities, psychological constitutions, and life experiences which all impact the ways in which they interpret their 'diseases'. They have different ways of dealing with the consequences of their ailments and, hence, require different kinds of care. In needs assessment, therefore, it has meanwhile become an accepted fact that the use of averages is deceptive. Average (demographic) citizens, average responses to treatments, and average outcomes are usually inapplicable to individual cases (Moatti, 2003, Sartorius, 2000). 'The' need for care, consequently, is an elusive phenomenon, which is related to demands for care and the availability and quality of actual facilities in a complex way. How, then, can we define the concept of need in more precise terms?

In psychology, the concept of 'need' is one of the central themes in explaining human behaviour. A well-known example of a need-oriented approach to human behaviour is Murray's need theory, in which he defines the concept of need as a construct which stands for a force in the brain region, a force which organizes perception, apperception, intellection, conation and action in such a way as to transform in a certain direction an existing, unsatisfying situation (Murray, 1938). Needs refer to organisational tendencies, which appear to give unity and direction to a person's behaviour (Stern, 1970). Maslow also studied human needs and became famous for his Hierarchy of Human Needs. He believed that the needs people experience are hierarchical, in which lower needs have to be met for an individual to experience higher needs (1943, 1970). In cognitive psychology, people are considered to be builders of theories: they erect structures of explanations, interpretations, and causal

relations in order to channel information flows advancing towards them (Linschoten, Leemeijer & Heuvel, 1988). Needs are predominantly considered in terms of the discrepancy between the perception of an ideal and the perception of actual reality. Yet another definition is from Freud, in which he states that a need is 'a conscious knowledge of a deficit' (Freud, 1940). From the perspective of psychology, in sum, a need is an individual's conscious perception of the state of discrepancy in which the individual finds himself.

In medical science examples of definitions of a need are given by Donabedian (1973) and Wilkin, Hallam & Doggett (1992). They state that the content of the concept is dependent on the perspective one reasons from. Donabedian (1973) emphasizes that, in health care, the term need should be reserved for describing a certain undesirable condition of an individual. He defines need as 'some disturbance in health and well-being'. In this definition, need exclusively relates to a disturbance, a disease, or a problem. The lack, shortage, or want refers to a health failing in an individual but not (yet) to the necessity of care. From this point of view, the undesirable condition may then be translated into a certain measure or kind of care. Need, therefore, is defined as a certain disturbance in the health and well being of an individual. In addition, Donabedian (1973) distinguishes two perspectives of the concept of need, viz., the clients' perspective and the professional perspective. From the clients' perspective, need is the clients' assessment of the conditions and situations in which they need care; from the professional perspective, it is the experts' assessment of the conditions and situations in which care is needed. Wilkin et al. (1992) state that needs assessment is dependent on the criteria that are used to gauge the need. This may be an ideal standard, a minimum level that should not be transgressed by any individual, or, thirdly, a level that is established by comparison with standards of other groups or individuals. A distinction similar to Donabedian's, which is often made to define the concept of need, is that between objective and subjective need. According to Moons et al. (1989), this distinction is also conditional upon the perspective one has in making the assessment, but in this case it involves a different set of terms: an objective need (need) is based on expert criteria, and a subjective need (want) is based on the perception of the person concerned. This is especially evident in Anglo-American literature, where the distinction between 'need' and 'want' is commonly made. Whenever the concept of need is discussed in literature, it is especially this distinction that gives rise to a lot of debate. 'Need' is often defined as the objective need and 'want' as the perceived, subjective need. Some object that, in principle, needs can only be seen as subjective preferences. 'To talk of objective need, defined by someone other than the individual himself, is to open the door to authoritarianism and infringements of individual liberty' (Percy-Smith, 1996). 'One must consider the individual patient as the only person who can balance dissatisfaction and satisfaction in assessing his 'quality of life' experiences (Haes & Knippenberg, 1985).

The various definitions of care needs can be subdivided in Bradshaw's 1977 classification, in which he distinguishes four types of needs definitions, viz., normative need, felt need, expressed need, and comparative need (these types are not mutually exclusive, but may overlap or even coincide) (Bradshaw, 1977). Normative need represents the need for care as assessed by the expert. Some desirable standard has been formulated, and if the actual standard of the individual is below this desirable standard, the individual has a need. The ideal standard and Wilkin's (1992) minimum level, as well as the definition used by Donabedian (1973) are also normative in this respect. Moreover, the distinction between objective versus subjective needs also fits into this classification: objective need equals normative need, and subjective need equals felt need.

In the second category of needs definitions, felt need equals want. In Bradshaw's (1977) view, this is the need for care services experienced by an individual when such a service is proposed or presented to him. Bradshaw's classification is cited by many authors in health care literature (Dijkstra, 2001, Goudriaan & Vaalburg, 1998). Remarkably, however, they define felt need as a subjective need, that is, the need as it is experienced by the person demanding care. What is being presumed here is that felt need is no more than the need that arises when a service from the actual range of services (supply-driven) is being proposed to a person. However, this does not cover everything a person experiences. For example, the need for improved vision would never arise before the invention of glasses or lenses. Felt need, therefore, can go beyond Bradshaw's definition. Felt needs are the totality of needs experienced by the individual, independent from the existing supply of services or anyone expressing an interest in this need. Phrased in this way, this definition also encompasses Murray's (1938) and Maslow's (1943 of 1970) definitions.

The third type distinguished by Bradshaw (1977) is the expressed need, or demand. This refers to that part of the felt need that has actually been translated into a demand for care. This transition process from need to demand is influenced by a variety of factors. The need for improved vision, for instance, may be translated into a demand for Braille or audio books. In many cases, the articulated need, therefore, will be a version of the original need that has been adapted to context factors. Several studies identify that care demands are only partially determined by care needs (Frederiks, 1990; Kempen, 1990; Wierik, 1991).

The comparative need, finally, which also encompasses Wilkin's (1992) third alternative, is the need for care derived from a comparison between those who are already receiving care and those with the same features who dot not receive care (Bradshaw, 1977).

In order to properly demarcate the conceptual framework for use in the demand-driven approach, a well-founded choice had to be made for which definition of need was going to be used. In this study 'quality of life' was taken as a key concept, since this is the goal of the demand-driven approach, though we were aware that social realities might possibly engender other feasible solutions.[2] Quality of life is defined in terms of a match between needs and the fulfilment of those needs. The felt quality of life, in other words, is determined by needs fulfilment in the fields of emotional well-being, interpersonal relationships and social bonds, material well-being, personal development, physical well-being, autonomy and self-determination, and spirituality (WHOQOL group, 1994). From the client's perspective, which is the central viewpoint in this study, this means that the individual's perception of quality of life is the key issue. If the perception of quality of life depends on the level of correspondence between this individual's needs and their fulfilment, we must base ourselves on the needs perception of the individual, or, in short, the felt need. In other words, if we look at demand-driven approaches in health care from the client's perspective, which pivots on the individual's perception of quality of life, the felt needs of those involved are the needs that ought to be fulfilled. According to Liss (1993) the term 'felt need' does not refer to feelings but to beliefs. A belief is not a need. Felt need for health care may therefore mean 'an opinion of the individual that there is a need for health care' (Liss, 1993). In sum, health care need is a flexible concept. 'Health' is the goal of health care need, but depending on the perspective there are different components in the concept of health. In his philosophical analysis of the concept of health care need Liss (1993) comes up with the definition 'P has a need for health care if, and only if, a) there is a difference between P's actual state and a goal, and b) health care is necessary in order to reach the goal'. In this study, since the client's perspective is the central viewpoint, the operational definition of health care needs could be as follows:

> *'A discrepancy in the individual's conscious perception between his actual and his desirable state of health and/or well-being, which is experienced by the individual as negative'.*

Subsequently, we need to gain an understanding of the gap between care needs on the one hand and care demands on the other. The process of translating care needs

2. This choice was made as, at present, the 'quality of life' concept is also considered to be a possible solution for scarcity issues. Some policymakers from both political and medical realms believe that this is the criterion that will allow selection issues, ensuing from scarcity, to be avoided or, at least, to be largely resolved satisfactorily. We should abandon our focus on sheer length of life or survival and, instead, resort to 'quality of life'. This would al least allow us to address issues of scarcity and selection in a socially acceptable way. The philosopher Achterhuis (1988) quite rightly raises the question here whether this concept will indeed offer a way out of the scarcity issue or whether it will just serve to reinforce its dominion.

into care demands, apparently, is susceptible to many factors. Bradshaw's taxonomy also makes clear that an articulated demand for care is only a part of a felt need. So the definition of the concept of demand could run as:

'That part of a felt need for health care that is actually translated into a demand for care'.

3.4 FACTORS INFLUENCING A CLIENT'S NEEDS

In order to be able to respond to clients' needs, it is essential, first of all, to establish how clients translate their felt needs into articulated demands. After all, this study investigates the extent to which organisations attune their supply to autonomous, individual clients and the extent to which this concerns their articulated demand or their individually felt need. It is essential, therefore, to have a clear grasp of both concepts and the factors responsible for these differences.

A care need consists of a multitude of aspects that must be articulated by the individual into a care demand. A concrete care demand of professional health care is preceded by a course of events that has eventually led to a care demand as it is currently being expressed in professional care. A health complaint or a health problem usually initiates this process, eventually ending in a care demand, with which an individual enters the field of health care. Ideally, care demands would not differ from care needs. Unfortunately, though, this is not the case in reality, in which clients' care needs are not always represented in the articulated care demand. Often, a person's circumstances are the deciding factors both in the formulation and content of the care demand, as well their view of where they should enter the existing field of all different health care services. The main factors involved here include the workload of those offering volunteer aid, housing conditions and the presence or absence of a spouse, the incidence of psychological or psycho-geriatric disorders, depression, and social isolation Bijsterveld, 2001; Boer, 1997; Penninx, 1996). Care needs have a multidimensional character, with the various dimensions impacting one another. The coherence between these dimensions is often highly complex (Andersen, 1995; Huysmans, 1990).

In his Socio-behavioural model, Andersen (1968, 1995) represents the various determinants that influence the use of health services by way of three interconnected categories, viz. predisposing or personal variables, which influence use inclination, enabling factors, which influence access to facilities, and need factors, which influence people's need to use health services. The widely used Socio-behavioural model (Meer, 1998; Goodwin & Andersen, 2002; Coughlin & Long, 2003) attempts to provide an explanation for the process that takes place and put it into a causal order (Andersen, 1995). According to this model, people's use of health care services, realized access (Coughlin & Long, 2003), is a function of factors predisposing them

to making use of health care services, factors facilitating their use of health care services, potential access (Coughlin & Long, 2003), and their perceived need of care. In contrast with Andersen's (1968, 1995) model, this study makes an additional distinction between care needs and care demands. Care demands are not explicitly included in the model, as it directly moves from care need to care consumption. However, in practice, the actual transition from care demand to care consumption can be ambiguous. If we assume that articulated demand is susceptible to people's perception of conditional factors, this may lead to discrepancies. Scarcity, for example, may lead to non-consumption of required care in health care practice. This additional step has been added to Andersen's (1968, 1995) model. The resulting model (Figure 3.1) can be used as a conceptual framework for further research.

3.5 CONCEPTUAL FRAMEWORK

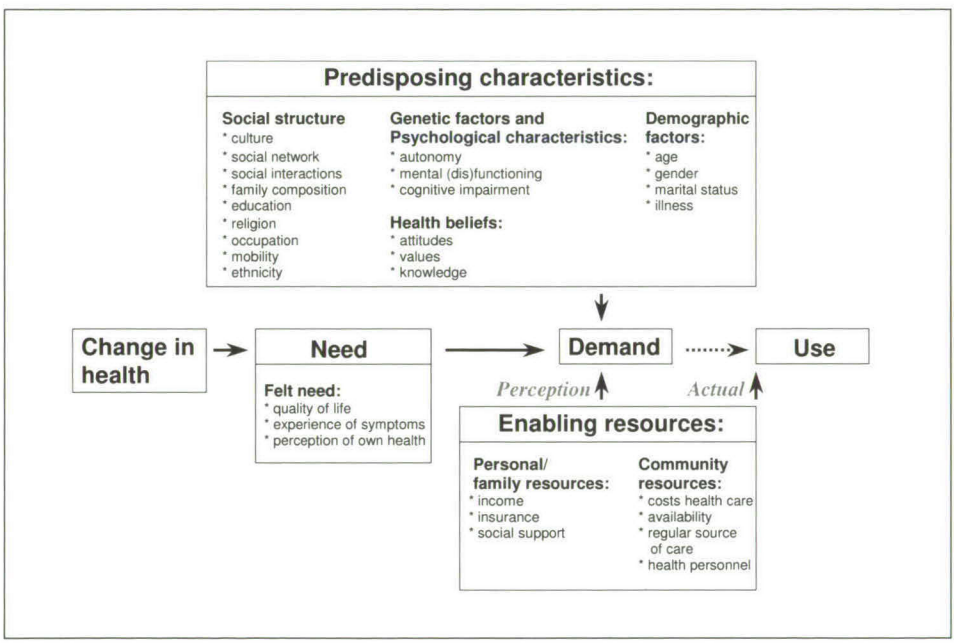

Figure 3.1 *Conceptual Framework*

In a certain state of quality of life, a health problem or complaint may occur. This infringement on the quality of life can be consciously experienced by the individual as a negative discrepancy between his actual and his desirable state of health and/or well-being. The level of this discrepancy can vary from high to low, which will have its influence on the subsequent process. Under the influence of predisposing characteristics and the perception of enabling resources, a felt need will either be blocked, or be transformed or articulated into a demand. Predisposing characteristics are fixed characteristics

of an individual, which have an influence especially on the perception of health and the level of satisfaction and quality of life. When for example an individual experiences a need for support because he has psychological complaints, predisposing characteristics like pride and/or shame can keep the individual from articulating a demand for psychological help. In this case, a demand could well be for helping out with daily activities. Enabling resources are the conditions that enable the individual to use health care services. These resources also have an effect on the actual articulation of a felt need for health care, but in this case not from a psychosocial perspective but from the perception of the possibilities the community offers. When we look at Coughlin and Long's (2003) described potential and realized access, there is a clear distinction. Especially with enabling resources it is important to distinguish between the actual accessibility of health care services (potential access) and the perception of those services. The actual use of health care (realized access) after all depends on the correctness of the perception and the actual existence of the resources. In other words, the perception of accessibility that generates the articulation of a felt need for health care, can be such, that there is a demand, but that there is no health care available.

3.6 CONCLUSION

The question asked at the beginning of this article can now theoretically be answered. As it is susceptible to various factors, an individual's demand cannot be equated with an individual's experienced need for health care. Articulated demand is certainly not always a sound foundation for health care supply aiming to fulfil those needs. The social structure, conceptions of health, psychological features, and genetic, demographic, personal, family, and community factors all affect felt need and may influence, inhibit, or largely alter its articulation. In order to contribute to the individual's quality of life, therefore, it is not sufficient to rely on demand only, as a demand for health care is itself often only a partial or modified version of an individual's felt need for health care. In other words, if the fulfilment of the individual's needs is the objective of the shift towards demand-driven care, in an ideal situation it seems that health care providers should take into account the influence of all these factors, and explore the underlying need, instead of listening to the articulated demand, while shaping, putting together and designing their services. This means among other things, that the given supply will probably not suffice to the individuals felt needs of every single individual. Individuals adjust their demands to the existing services. But the given supply may not be the best answer to their felt needs. It seems that somehow health care providers will have to come up with a way to disconnect the articulated demand from the existing supply and make way for new services to be developed, services that are better tuned to the wishes of the clients. In theory this is a necessary step in order to meet the goals set in a demand-driven approach. The first step however, should be to study the influence of these factors in practice.

Chapter 4

Demand-oriented and demand-driven health care: The development of a typology

In most European countries, there is an increasing demand for demand-oriented and demand-driven approaches in the development of health care policy and the organisation of health care services. Both approaches, in which the main focus is on 'the demand', are seen as counterparts of the supply-oriented approach, that has 'the supply' as point of departure. However, there is much confusion about the definition of the concepts. In order to identify the different views, and to examine to what extent there is consensus in the Netherlands about the concepts of demand-orientation and demand-driven care, a Delphi-study was done among 26 experts; scientists, health care insurance companies, health care suppliers, the government, independent advisory bodies, and client interest groups. The study resulted in a typology. The similarities and differences between the two concepts were demonstrated in five dimensions: responsibility, control, need-determination, way of imbedding of the view within the organisation and choice. Furthermore, the typology was used to identify existing types of services as being either demand-oriented or demand-driven services. The typology provides an understanding of the similarities and differences between the two concepts, and appears to be a useful tool in identifying services to the extent that they are demand-oriented or demand-driven.

4.1 INTRODUCTION

Societal developments and new insights are the cause of continuous changes in the field of health care and welfare. In the Netherlands, as in most European countries, there is an increasing demand for demand-oriented and demand-driven approaches

to the development of health care policy and the organisation of health care services. These new approaches are seen as counterparts of the strongly institutionalized, supply-oriented approach (Garretsen, 2001) in which the supply is point of departure. This search for a new role for patients reflects the current period of what may be called a 'paradigm flux', now affecting health service delivery in nearly every advanced industrialized country (Rosenthal, 1992; Saltman, 1994) and this shift manifests itself in many fields of our societal life (Roo, 1995).

Demand-orientation and demand-driven care are concepts used by many in the formulation of mission statements, policy goals, organisational visions, and advertisements. However, different actors define the two concepts that represent the new approaches in health care in different ways, and the definitions vary from 'taking the client into account', on the one hand to 'actual steering by the demand', on the other hand, with the client also having the means to do so (Rijckmans et al., 2002). Accordance about the meaning of both concepts is necessary from a scientific point of view, but also for a correct valuation of the implications for policy and practice. In a debate concerning whether or not a strongly institutionalized supply-oriented approach should be transformed into a more demand-oriented or demand-driven approach, it is essential that the different parties agree on the denotation of the concepts. A good communication is necessary. Especially the communication between different parties and the expectations that are raised, can lead to miscommunication through confusion of concepts.

The literature with regard to clarification of the content of the concepts is scarce. There does not seem to be enough insight into the content and the consequences of the concepts of demand-orientation and demand-driven care in the sector of health care and welfare. However, the concepts are used in practice on a large scale. The concepts originate from practice and concern various aspects of health care. Nevertheless, there is no general unambiguous conceptual framework. According to Rijckmans et al. (2002), there is a fundamental difference between the concepts. In the demand-oriented approach, the focus is on the extent to which those who provide services take the needs of individual patients into account. In this professional perspective, the health care provider is seen as the expert. Those supplying services guide demand. In the case of demand-driven care, the focus is on freedom of choice, with the individual patient having the final say on the type of care received. Demand-driven care is viewed from an administrative and financial perspective, in which hierarchical budget-driven approaches are replaced by more decentralised consumer-oriented perspectives. The emphasis is on the individual nature of demand. It is assumed that only individual patients have the experiential expertise necessary to make informed choices. In some instances, patient influence over demand can be extended even further, with individuals being given the financial resources necessary to ensure that desired services are provided. Supply can actually be influenced by demand

(Rijckmans et al., 2002). We wanted to investigate whether this difference could also be found in practice.

The objective of this study was to acquire insight into and provide an overview of the content of the concepts of demand-orientation and demand-driven care in practice, in the fields of rules and legislation, financing, and the execution and organisation of health care, in order to draw up a model that provides insight into the content of the concepts on an abstract level. Furthermore, since for each organisation the policy, the view on the position of the health care user, and the desired outcome of the provision of services can differ, we wanted to develop a model that could serve as a tool for policy and practice in the field of health care in order to help organisations decide how to provide their services. The model should serve as a means for the government and health care organisations to shape their view on the health care user and to acquire insight into the consequences of this for the organisation of their services.

To meet this objective, a typology (Luiten, 1987) was formulated. A typology identifies multiple ideal types. This research aims at the development of two ideal types with respect to health care: one type for the demand-oriented approach and one type for a demand-driven one. These ideal types are theoretical abstractions, and every type consists of a unique combination of elements (Doty & Glick, 1994). This typology of demand-oriented and demand-driven care consisted of elements acquired from practice in the field of health care.

In this study, the experts' views on the concepts of demand-orientation and demand-driven care in the fields of science, policy and health care practice, were investigated. To meet the objective, the following research questions were posed:

- Is there a difference between demand-orientation and demand-driven care in the opinions of experts in the field of health care?
- What elements are typical of the concepts of demand-orientated and demand-driven care?
- What dimensions are at the base of the difference between the concepts of demand-oriented and demand-driven care?
- How do demand-orientation and demand-driven care relate to each other in the given dimensions?
- Can the typology be used to identify types of services as either demand-oriented or demand-driven services?

4.2 METHODS AND MEASUREMENTS

4.2.1 Design

The aim of this research was to develop a current and unambiguous framework, a

theoretical exploration of concepts that originate from the health care practice. For this purpose, a method of theory development was required, in which the theory was founded in practice. The method used was the Grounded Theory (Glaser & Strauss, 1967). Since they originate form data, grounded theories offer insight, increase understanding, and offer a meaningful guideline for action (Strauss and Corbin, 1998). The main goal of this approach is the development of a systematic theory that matches the empirical field, and is based on personal experiences, existing theories, or derived from the ideas of others (Strauss and Corbin, 1998; Wester, 1995).

The Grounded Theory involves the systematic formulation of theory using data, which has been collected systematically. 'Grounded' should be interpreted as a search for analytical (appointed in concepts) justification of the phenomenon (Wester, 1995). In the process of theory development, four stages can be distinguished after the formulation of intuitive motives and perceptions: exploration (discovery of concepts), specification (development of concepts), reduction (determination of the core concepts), and integration (elaboration of the theory). Each stage has a goal that directs the research actions. The saturation of information with regard to that goal gives cause for the switch to the next stage (Wester, 1995).

Concepts which lead the research are called sensitizing concepts. They are the concepts with which the researcher approaches the field of interest. In our case, the sensitizing concepts were demand-orientation and demand-driven care. On the basis of the first data, other concepts are formulated. In the later research stages, when the theory has been developed, concepts are combined in more abstract concepts. A distinction arises between the central and the more peripheral concepts in the theory. Especially the main concepts have to be checked until their content is saturated (saturation). There is a difference between the researcher's concepts and concepts collected in the field. The latter are often more descriptive, while the first are often interpreted and explanatory and serve as a source for hypotheses and theory development (integration) (Wester, 1995).

4.2.2 Data collection and analyses

In view of the research objective the Delphi method of data collection was chosen. This method is particularly appropriate when the definition of the problem implies a certain 'uncertainty' (Ziglio, 1996). This uncertainty may consist in the lack of information about causes, and consequences or, as in this case more fundamentally, the absence of a conceptual framework. The Delphi method focuses on a certain type of knowledge: not so much empirically proven facts, but types of experience, insight, and 'informed judgment'. The Delphi method is based on a structured process to gather knowledge from a group of experts using questionnaires or discussion rounds. A controlled form of feedback occurs between the different rounds (Ziglio, 1996). The

goal is to come to one viewpoint for the entire group (Bastiaensen & Roebroeckx, 1994). The Delphi method provides an opportunity for experts to communicate their opinions and knowledge anonymously about a complex problem, to see how their evaluation of the issue aligns with others, and to change their opinions, if desired, after reconsideration of the findings of the group's work (Kennedy, 2004).

The Delphi method requires a 'select' expert group. In contrast to an experimental sample, the inclusion variable for this group is 'degree of expertise'. Participants were chosen who had specific knowledge of or experience with the research topic. The different perspectives that were found in the literature also had to be represented. A selection was made from experts originating from science/research, policy, and practice, who were expected to have a wide range of input with regard to the existing views. The study involved representatives from the Ministry of Public Health, Welfare and Sports, the county, legal, administrative, health economical, and health care professors, representatives form health care insurance companies, representatives from health care providers at the strategic as well as at the executive level, representatives from client organisations, and independent advisory bodies. Altogether, twenty-six experts were involved in the study (see Supplement 1). The researchers were of the opinion that, because of the large range of areas of expertise, the group of experts represented the existing views on demand-orientation and demand-driven health care.

The data were collected in two rounds. The goal of the first round was to gather as many typical elements for the concepts as possible. The first round consisted of a series of semi-structured expert interviews. The experts were informed in advance of the topics to be discussed so that they could prepare themselves for the interviews (Supplement 2). The goal of the second round was to have experts comment on the results of the first round, so as to test the researcher's insights expressed in the dimensions found, and the resulting conclusions concerning the meaning of the concepts of demand-orientation and demand-driven care. The data in round two were collected by written questionnaires. The report of the data analysis of the first round was sent to the experts who had participated in that round, as well as to a new group of experts. Questions were added to the report that had to be answered by all experts (Supplement 3).

The interviews were recorded using a memo recorder. The experts were asked whether they thought the concepts of demand-orientation and demand-driven care differed; what the differences and similarities between the concepts were; and what innovative projects/services they knew that were typical of either demand-orientation or demand-driven care. The emphasis was on gathering as many typical elements of the concepts as possible. The transcripts were analyzed using Kwalitan, a Dutch software program developed to provide assistance during qualitative analyses; it offers an efficient storage of data, and tools to analyze, encode, select and retrieve qualitative data (Peters, 2000).

For the second round, questions were added to the report of the results of the first round. The main goal of the second round was to see whether or not the majority of experts agreed with the experts' individual input collected in round one during the interviews. These questions mainly consisted of tables, which the experts had to fill in. The answers were processed and analyzed using the software program Excel. For question one, we asked the participants to indicate on a scale of 1 to 5 to what extent the different elements are demand-oriented or demand-driven or both (1 = absolutely not typical; 5 = very typical). When the majority of experts[3] gave an element a score of 4 or 5, the element was included in the final results. There was also an open-ended question (question 2). In this question, the experts were asked to comment on the dimensions that were formulated by the researcher following the analysis of round one. All the experts' remarks were listed, and in accordance with the number of remarks that the different experts made, alterations were made to the formulation of the dimension. The goal of question three was to have the experts place the various elements in the dimensions. After having read the descriptions of the dimensions, the experts were asked to place the elements in the dimensions using a scale from 1 through 5. On this scale, 1 represented the left side of the dimension and 5 represented the right side of the dimension. The scores given by all experts were averaged and in this way the elements were given their positions in the dimensions. By combining the results of questions one and three, an average was calculated for the concepts of demand-orientation and demand-driven care in each dimension: the sum was taken of the averages found in question one and was divided by the number of typical elements. For example, for dimension 1, the average of the elements 14 and 42 was calculated for demand-orientation (2,3 + 2,0 / 2 = 2,15) the average over the elements 12, 22 and 41 (3,8 + 3,5 + 3,9 / 3 = 3,73) for demand-driven care. In this manner the concepts could be placed on the dimensions.

4.3 RESULTS

4.3.1 Experts consider demand-orientation and demand-driven care as different

The results (Supplement 4) show that experts in the field regard the concepts of demand-orientation and demand-driven care as different. They named elements that were specific to one concept and not the other. They also named services that were either examples of demand-oriented or demand-driven care.

4.3.2 Typical elements of 'demand-orientation' or 'demand-driven care'

In the transcripts of the interviews of round one, 50 elements were found that were considered by at least one expert to be typical of one or both concepts. In round two,

3. Since there were no real differences between the opinions of experts in the different fields they represented, 'more than half of the number of experts' was considered as the majority.

the experts were asked to score the 50 elements gathered in round one, based on whether or not they were characteristic of demand-orientation or demand-driven care or both. The majority of experts in round two agreed upon 37 of the 50 elements that were gathered in round one (Table 4.1). The remaining 13 elements (shaded in the table) were not found to be typical of either demand-oriented or demand-driven care by the majority of the experts.

Table 4.1 *Elements in round 1*

Nr.	Element	Nr.	Element
1	Relevant for care	26	'Orientation towards the client'
2	Relevant for cure	27	'Client friendliness'
3	Supply is dependent on the health care user	28	Cost restriction
4	Other/new roles in health care	29	Quality of life
5	Satisfaction of health care user's needs	30	Aspects of quality
6	Way of treatment	31	Custom-made services
7	Importance of (being provided with) information	32	Health care user has final control
8	Importance of transparency of supply	33	Health care on a free-market basis
9	Better quality of health care	34	More coherence in the supply
10	Diversification of supply	35	Not paternalistic
11	Effective health care	36	Normalize
12	Emancipation of health care user	37	Attitude oriented towards the demand
13	Formal embedment of way of dealing with health care user's needs	38	Taking the health care user into account
14	Clamp down on demand	39	Give in to the demand
15	Greater variety in health care supply	40	Opposite of supply-driven
16	Steering of the demand by the supply	41	Health care user is responsible
17	Steering of the supply by the demand	42	Responsibility for health care
18	The system has to facilitate	43	Strengthen health care user's position
19	Bring help closer to the health care user	44	Takes place between health care user and health care provider
20	Health care provider determines the need	45	Health care user has final say
21	Need-determination in consultation with health care user	46	Health care user determines need
22	Individualization	47	Health care user has the means
23	Get insight into real demand	48	Health care user is dependent on the given supply
24	Choice	49	The health care user has to make much effort
25	Freedom of choice	50	Main focus is on the health care user

= There is consensus within a majority
= There is no consensus within a majority

4.3.3 Dimensions at the base of the difference between demand-oriented and demand-driven care

Using the data collected in round one, five dimensions were formulated: 1) responsibility, 2) control, 3) need-determination, 4) way of imbedding of the view within the organisation, and 5) choice. In Figure 4.1 the dimensions are shown. This figure shows what distinguishes the two concepts from each other. The digits above the dimension lines point to the place of the elements on the dimension involved, as indicated by the experts. The digits correspond with the numbers of the elements in Table 4.2. The concepts 'Demand-oriented' and 'Demand-driven' have been placed on the dimensions by means of the weighted sum of the concepts' typical elements. Three other independent researchers checked this arrangement. The experts in round two generally agreed upon the dimensions that were drawn up by the researcher. Some slight alterations were suggested, and these were made. Out of the 37 typical elements, 35 were categorized in the dimensions (Table 4.2). The element 'Counterpart of supply-driven care' was left out of the final model, as this was more an opposite than an element. The element 'Bringing help closer to the health care user' could not be categorized in a dimension and was described solely in the description of the typology.

At the base of the dimension 'Responsibility' is the degree of autonomy of the health care user: the extent to which the health care user is perceived as autonomous, an independent and equal individual who is capable of making his own decisions and taking responsibility for the consequences of those decisions, and the extent to which the health care user can watch over his rights and civic duties in relation to society. On the left side of the dimension, people other than the health care user are responsible for the decision-making and the consequences of this, a somewhat paternalistic view. On the right side of the dimension, the health care user is perceived as autonomous and thus responsible for the decision-making and its consequences.

The dimension 'Control' refers to the party which has final control over the decision about the type of health care provided, whether or not health care services are needed, and which health care provider is used. It refers to the right to make decisions concerning the use of health care services, and the direction of the process. On the left side of the dimension, a person other than the health care user (professional/expert) has final control; on the right side of the dimension, the health care user himself (client/client system) has final control. The dimension 'Need-determination' contains elements concerning who should determine 'needs'. On the left side of the dimension, a need is determined by the government/policy/health care providers. This is called an 'objective need', evaluated by a professional. On the right side of the dimension, the health care user determines the need. He is the one who experiences a need, a so-called 'felt need', and evaluates whether or not he requires some form of health care.

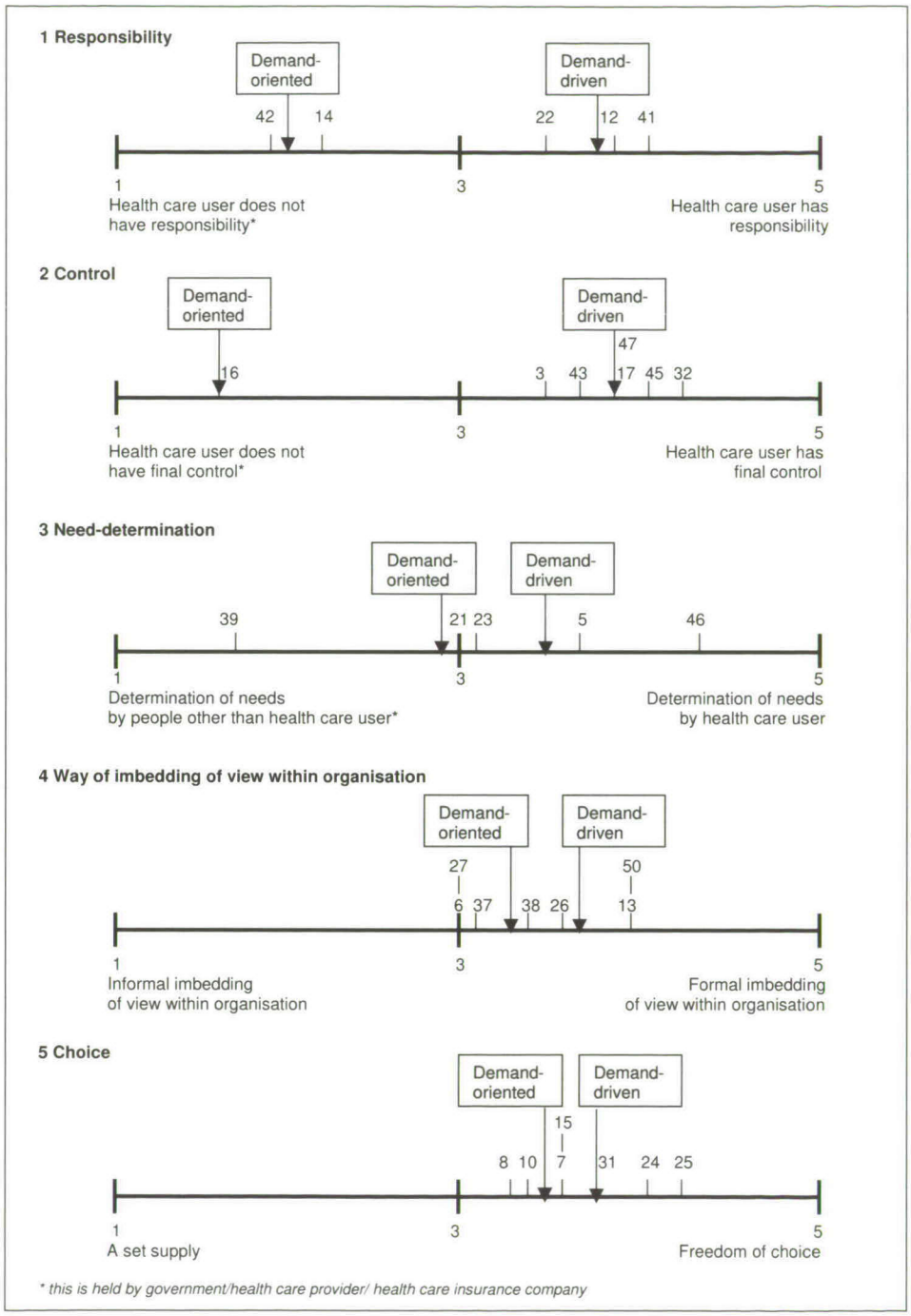

Figure 4.1 *Dimensions in the typology*

Table 4.2 *Elements within the dimensions*

Dimension	Nr.	Element	Demand-oriented	Demand-driven
Responsibility	12	Emancipation of health care user	-	X
	14	Clamp down on demand	X	-
	22	Individualization	-	X
	41	Health care user is responsible	-	X
	42	Responsibility for health care	X	-
Control	3	Supply is dependent on health care user	-	X
	16	Steering of the demand by the supply	X	-
	17	Steering of the supply by the demand	-	X
	32	Health care user has final control	-	X
	33	Health care on a free-market basis*	-	X
	43	Strengthen health care user's position	-	X
	45	Health care user has final say	-	X
	47	Health care user has the means	-	X
Need-determination	5	Satisfaction of health care user's needs	-	X
	21	Need-determination in consultation with health care user	X	X
	23	Get insight into real demand	-	X
	29	Quality of life*	-	X
	39	Give in to the demand	X	X
	46	Health care user determines need	-	X
Way of imbedding of view in organisation	6	Way of treatment	X	-
	9	Better quality of health care*	X	-
	13	Formal embedment of way of dealing with health care user's needs	X	X
	26	'Orientation towards the client'	X	X
	27	'Client friendliness'	X	-
	30	Aspects of quality*	X	-
	37	Attitude oriented towards the demand	X	X
	38	Taking the health care user into account	X	X
	50	Main focus is on the health care user	-	X
Choice	7	Importance of (being provided with) information	X	X
	8	Importance of transparency of supply	X	-
	10	Diversification of supply	X	X
	15	Greater variety in health care supply	X	X
	24	Choice	-	X
	25	Freedom of choice	-	X
	31	Custom-made services	-	X

* *added after round 2*

The fourth dimension, 'Way of imbedding of the view within the organisation', concerns the way the organisation's vision (demand-oriented or demand-driven) is embedded. Scores on the left side of the dimension indicate that there are no formal rules, but there is a certain attitude towards and recognition of the needs of the health care user. On the right side of the dimension, this vision is fully expressed in rules, protocols, and institutional characteristics, for example complaint regulations and formal client voice. The fifth dimension, 'Choice', refers to whether or not the health care user has the possibility of choosing from few or many alternatives. On left side of the dimension there is one standardized type of health care and no choice. On the right side, there is an unlimited variety of options, suited to every individual, and each individual is free to choose the services he wants.

4.3.4 The typology of demand-orientated and demand-driven care

Using the results obtained from research questions two (typical elements) and three (dimensions), the researchers formulated a typology showing the similarities and differences between the concepts (Figure 4.2). The five upper blocks stand for the five dimensions. The arrows point to the scores of the concepts on the dimensions. The blocks below the dimensions show the various elements of the dimensions. The elements printed in bold are typical of that type (demand-oriented or demand-driven) of care. The elements printed in italics belong to the dimension but are not typical of that type of care.

In the demand-oriented approach, people other than the health care user are responsible for making decisions and are responsible for the consequences of those decisions. From a professional perspective, boundaries are set on the health care user's demands. Furthermore, final control over the type of health care service provided, and when and where, is also in hands of people other than the health care user. The professional makes the final decision about whether or not health care services are brought in. The professional does, however, consult with the health care user about his felt needs and gives in to those needs as much as possible. The organisation's view of the health care user is formally embedded in its procedures. In this vision, the way of treating the health care user, the degree of 'client friendliness' and 'orientation towards the client' and the demand-oriented attitude are important. Finally, in this approach, importance is attached to informing the health care user, making the supply transparent, making sure there is variety in the supply and bringing help closer to the health care user.

Definition: Demand-oriented health care is care in which the responsibility for and final say in decision-making about health care services are in the hands of the professional. During this decision-making process, the professional takes the health care user and his wants and needs into account, treats the health care user in a pleasant manner, and informs him about the possibilities in his situation.

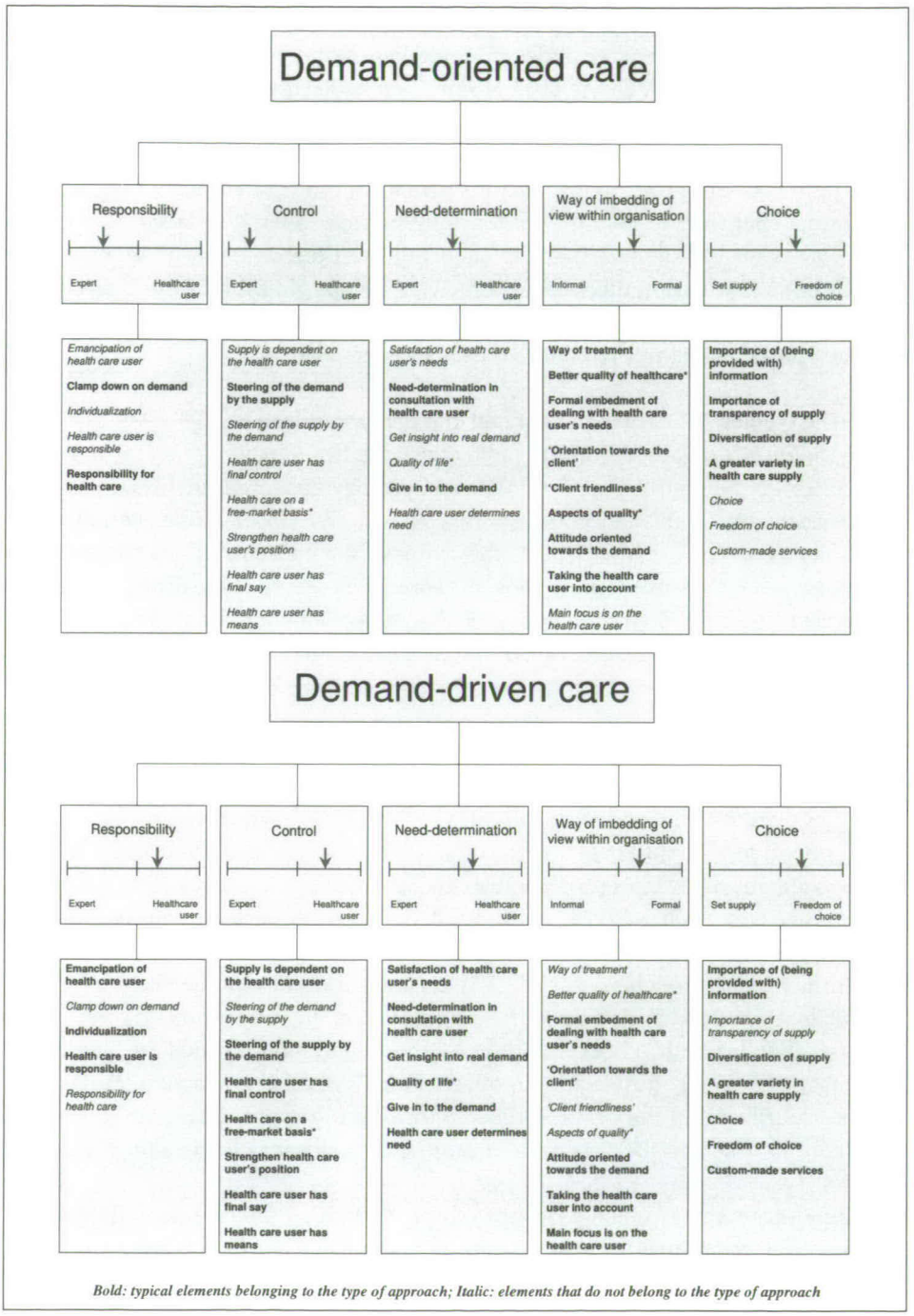

Figure 4.2 *Typology of demand-oriented and demand-driven health care*

In the demand-driven approach, the health care user is perceived as autonomous, an independent and equal individual who is capable of making his own decisions, and taking responsibility for the consequences of those decisions, and who can watch over his rights and civic duties in relation to society. The final control is in the hands of the health care user; he directs the complete process of deciding whether or not health care services are needed, and he has the (financial) means to do so. Supply gives in to the health care user's felt needs that arise from his perception of his quality of life. The professional consults with the health care user to gain insight into and to meet the real demand. In the demand-driven approach, the organisation's view of the health care user is formally embedded in its procedures. The organisation is oriented towards the client; the main focus is on the health care user and his demand. Finally, in this approach, importance is attached to informing the health care user, making sure there is variety in the supply, and giving the health care user freedom of choice.

Definition: Demand-driven health care is care in which the responsibility for and final say in decision-making about health care services are in the hands of the health care user. The health care user points out his wants and needs with regard to the type of health care services and, after being informed about the possibilities in his situation, has the freedom to choose what he wants.

4.3.5 Use of the typology in identifying health care services as being demand-oriented or demand-driven

In round one of the Delphi-study, 19 (types of) services or products were mentioned by one or more experts as being typical of either demand-orientation or demand-driven care. These services were scored by all experts in round two based on the 5 dimensions. Three of the services will be described below: 1) the Personal Budget (PGB (in Dutch); Figure 4.3 A): a budget a client gets and which he can spend on health care services. 2) Offering services in modules (Modularisering (in Dutch); Figure 4.3 B): in stead of offering a client one complete package, health care services are divided in specific parts and the client can chose which parts he wants. 3) The Diagnosis Treatment Combination (DBC (in Dutch); Figure 4.3 C): the financing of health care services is based on the combination of a diagnosis and the corresponding treatment method.

As we can see in figure 4.3(A), in using the Personal Budget, experts agree that health care users are the ones that have the responsibility and final control in the health care related decision-making. Furthermore, the health care user is also the one who determines what he needs. The vision on the health care user is to a certain extent formally embedded in the organisation and finally, the health care user has freedom of choice. Based on the typology, a Personal Budget can be classified as a typical demand-driven service.

Figure 4.3(B) is the model of offering services in modules. The experts in the study were of the opinion that people other than the health care user have responsibility and final control, that the professional and the health care user together determine the user's needs, that the organisational view of the health care user is to a certain extent formalised, and that there is variety in the supply. A comparison of the model of offering services in modules with the typology showed that this type of service was seen as typical of demand-oriented care.

In the Diagnosis Treatment combination, Figure 4.3(C), the experts were of the opinion that people other than the health care user have responsibility and final control, and that the professional and health care user together determine the user's needs. They found that the organisation's view of the health care user is to a certain extent formally embedded. They felt that in this type of service the health care user does not have much choice. Although a Diagnosis Treatment combination does have many elements similar to those of the demand-oriented approach, according to the typology, it is not a typical demand-oriented service because of the lack of choice.

4.4 CONCLUSIONS AND DISCUSSION

The main goal of this study was to gain insight into and provide an overview of the content of the concepts of demand-orientation and demand-driven care in practice, in the fields of rules and legislation, financing, and the execution and organisation of health care. Using the results of the Delphi study, it was possible to draw up such a model, consisting of elements acquired from policy and practice in the field of health care. Twenty-six representatives of all relevant fields in the health care sector gave their opinions on the content of the concepts of demand-orientation and demand-driven care. There seemed to be a certain degree of consensus within this expert group. The typology represents this consensus. The typology provides an understanding of the similarities and differences between the two concepts in the Netherlands, and can be used, for instance, by policymakers to provide clarity and transparency in their communication. The outlined accordance is of importance in order to assess the implications of the two new approaches for policy and practice. If, for instance, the government's policy aim were to make health care more demand-driven, this would imply according to the typology that the health care user should become responsible and get the final say. For part of the health care services, this may not be possible at this time (for example, because of scarcity), and for some part it may not be desirable (for ethical reasons). On the other hand, if the goal is rather to take the needs of the health care user into account, the term 'demand-orientation' should be used.

The applicability of the typology has been explored. Three examples of Dutch health care services were tested to determine the degree to which they were demand-oriented or demand-driven, through comparison with the typology. The model appeared to be

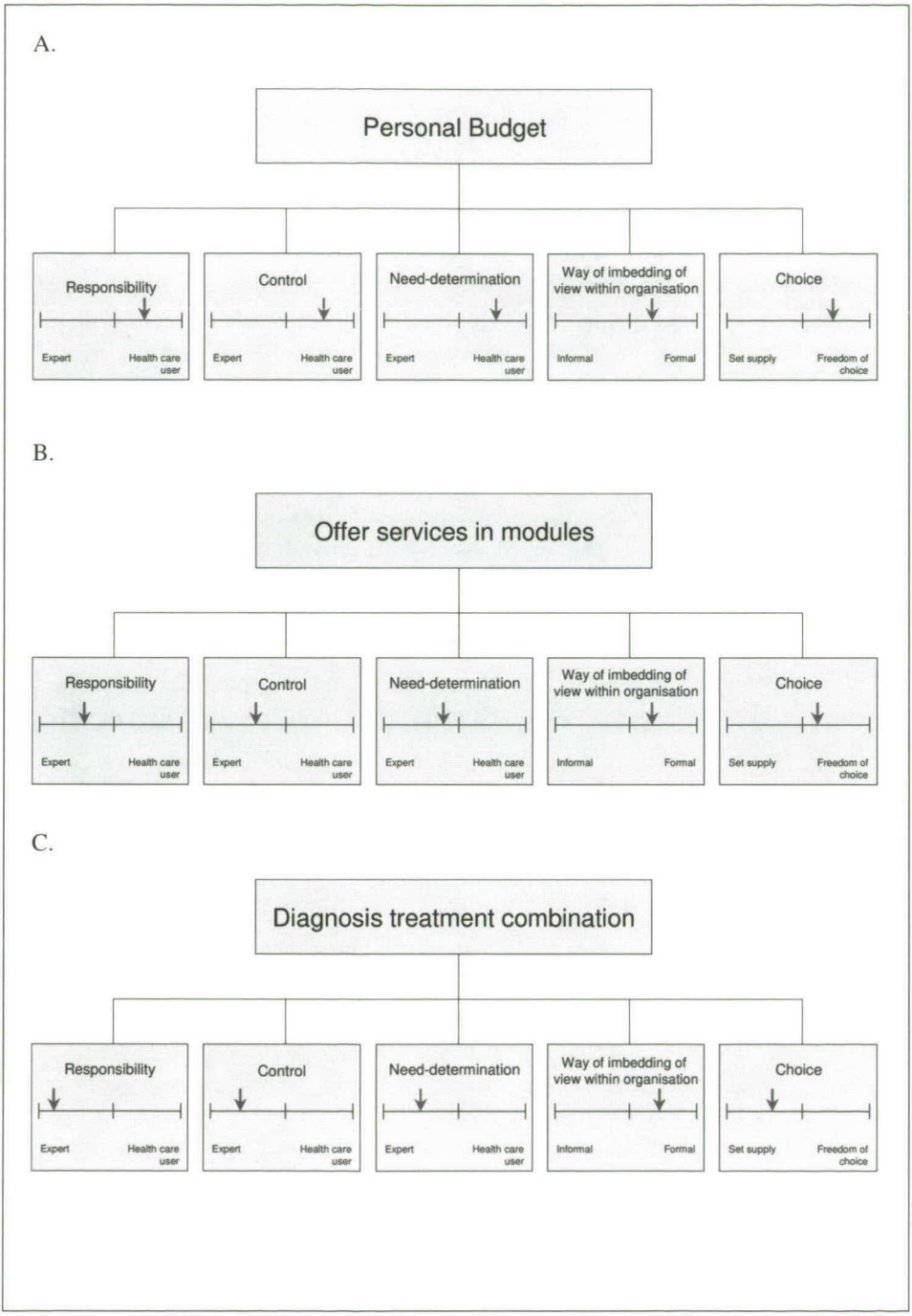

Figure 4.3 *Models of three existing services*

useful for this sort of classification of services. Furthermore, for services that are not typical of either demand-oriented or demand-driven approaches, like the Diagnosis Treatment combination, the model is useful in showing which aspects cause this. For example, if it is the goal of the introduction of a DBC to acquire more demand-orientation, more attention should be paid to creating choice options in the development of the DBC.

Whether this typology also represents the content of the concepts in other European countries remains to be seen. The typology was formulated based on the input of Dutch experts. It might be that experts in other countries would come up with other elements, and maybe even other dimensions. This could be influenced by, for instance, differences in the type of health care system. Further research is needed in order to make the typology represent the situation in other countries as well.

The distinction between the supply-oriented approach, on the one hand, and the demand-oriented and demand-driven approaches, on the other, is, as stated before, largely a matter of focus. The supply-oriented approach focuses on the existing supply; the demand-oriented and demand-driven approaches focus on the clients' perspective: 'what does the health care user need and want?' Further research, therefore, should be aimed at translating this typology into health care service practice, so that organisations can use it to study the needs, wants, and opinions of their specific target group and decide which approach meets the vision they wish to pursue.

Chapter 5

A client's perspective on demand-oriented and demand-driven health care

Background: In many West-European countries, there is an increasing request for demand-oriented and demand-driven approaches in health care. In these approaches, the emphasis is on the clients' perspective on health care policy and health care services. A study was conducted to gain insight into the clients' view on health care. Methods: In 2004 a survey was conducted within the Netherlands among 4,250 ambulatory mental health clients, by means of a postal questionnaire. To include clients with differential experiences with mental health care, the sample was stratified according to the length of the treatment history. Results: Elements that are found important by most clients are that the 'needs are determined in consultation with the client', that 'the client is treated in a pleasant manner', and that 'the professional informs the client about the possibilities in his situation'. Significant differences were found between groups with different background factors: income, education, age, sex, and treatment history all had significant correlations. Conclusion: Most clients in ambulatory mental health care appreciate the demand-oriented and demand-driven approaches. However, not all the elements are appreciated in the same manner. In general, clients do not seem to care much about who makes the decisions, but much more about the way the decision-making process is carried out. Clients especially value being heard and being involved in the process as a serious party.

5.1 INTRODUCTION

At this moment in time, health care in the Netherlands is undergoing a radical trans-

formation (Merks-van Brunschot, 2004). One of the big transformations in health care is the paradigm flux from a supply-driven to a more demand-oriented or demand-driven approach (Saltman, 1994). Both approaches are opposites of supply-driven health care (Garretsen, 2001). Because of this development, more and more attention is given to the extent to which clients are content about their treatment, to their specific needs and wants concerning their treatment (Veeninga, A.T. & Hafkenscheid, 2002) and to the client's goals (Anthony, W.A., Cohen, M., Farkas, M., Cohen & B.F., (2000). The demand-oriented and demand-driven health care approaches are believed to be key-concepts in this development (Van Diest, Van Wijngaarden, & Wijngaarden, 2002). It is claimed (Tranzo, 2001) that a demand-oriented or demand-driven approach puts more emphasis on the client's wants and needs and that, in this way, health care contributes to an enhancement in the client's experienced quality of life (Häyry, 1999).

In terms of content, the concepts of demand-oriented and demand-driven health care are not clearly distinct. Often the concepts are not defined at all (Rijckmans et al., 2002). In order to get some clarity, a typology of demand-oriented and demand-driven health care was developed, based on a Delphi-study among experts from science and practice (Rijckmans et al., 2004; 2005). Demand-orientation and demand-driven health care were defined as follows: 'Demand-oriented health care is health care in which experts have the responsibility and final say concerning the choice for the type of health care service'. In the decision-making, the expert takes the client's needs and wants into account, treats the client respectfully and informs him about the various possibilities. Demand-driven health care is health care in which the client has responsibility and final say concerning the choice for the type of health care service. The client determines what his needs are and, after experts have informed him about the various possibilities, has the freedom to make the decision him (Rijckmans et al., 2004; Rijckmans et al., 2005).

The typology consists of five dimensions: Responsibility (expert versus health care user) Control (idem), Need-determination (idem), Way of imbedding of the view within the organisation (informal versus formal), and Choice (set supply versus freedom of choice). These dimensions are constructed from elements that are typical of either demand-oriented or demand-driven health care or that are typical of both concepts.

Since, in the demand-oriented and demand-driven approaches, the emphasis is on the health care user's perspective, this study focussed on the question which elements health care users experience as important. Although the health care users opinion is crucial, their preferences have seldom been heard directly in this debate (Kremer & Gesten, 2003). For this purpose, a questionnaire was developed. The study was held among clients of one specific health care sector, ambulatory mental health care.

The central research question was: 'To what extent are the elements of demand-oriented and demand-driven care experienced as important by ambulatory mental health care clients?' Additional research questions were:

- Are there any differences between appreciation of elements between certain subgroups?
- Do ambulatory mental health care clients have a preference for demand-oriented or demand-driven elements?

5.2 METHODS AND MEASUREMENTS

5.2.1 Data collection

To answer the research questions, a survey was conducted in the southern part of the Netherlands in July 2004. For this survey, 4,250 ambulatory mental health clients aged 18 years and over were approached by postal questionnaires. Since the goal of the study was to come to a first exploration of the client's opinions about the elements in the typology of demand-oriented and demand-driven health care, the aim was to get the qualitative widest possible spread over subgroups, not to get a representative sample. To include clients with differential experiences in mental health care, the sample was stratified according to treatment history. The sample included 4,250 clients who attend ambulatory mental health care. The clients were divided into two strata: half of the clients had a treatment history of less than two years and half had a treatment history of more than two years, based on the registers of the mental health care institutions. The overall response rate was 20.4% (n=865) and was equally divided over the treatment history (< 2 years: 18% and >= 2 years: 21.2%).

5.2.2 Measurements

To measure the clients' views of the importance of the different aspects of 'demand-oriented' and 'demand-driven' health care, a questionnaire was developed (see supplement 5) based on the typology of 'demand-oriented' and 'demand-driven' health care (for the description of the typology, see Rijckmans et al., 2004; 2005). This questionnaire was checked by professionals of the three institutions as well as by some members of a client-council. They were asked to check the questionnaire on its comprehensibility and readability. Next, the questionnaire was pre-tested among ten persons in the general population.

The abstract elements of the five dimensions characterising 'demand-oriented' and 'demand-driven' health care were translated into 28 propositions, whose importance the respondents were asked to score. For example: one of the elements of the dimension 'Control' was 'Health care user has final control'. This element was translated into the proposition 'I find it important that I can determine which type of health care service I want to receive'. An element of the dimension 'Responsibility' was 'Set boundaries on the demand'. The translation of this element was 'I find it

important that a professional determines which demands are met and which are not' (complete questionnaire obtainable on request).

Besides scoring the importance of the 28 propositions, respondents were asked to score on a Likert-scale from 1 (absolutely not content) to 5 (very content) three questions concerning their subjective contentment with their general health, well-being and quality of life. Information on the following demographic variables was obtained: sex, age, education, daily activities, income, health insurance, number of people in household, city size, and religion. The length of the treatment history was checked by the question 'How long have you been in treatment at this institution?'

5.2.3 Analyses

Analyses were carried out using the program SPSS 12.0. The importance of the elements according to the respondents was scored by frequency tables. An element was categorised as important when two-third of the respondents scored the proposition belonging to the element as important. An element was categorised as not important when less than one-third of the respondents scored the proposition belonging to the element as important. The differences in importance with respect to treatment history, subjective general health, well-being, quality of life and background variables were bivariately analysed. Significance at the 5% level was tested by Chi-square statistic for dichotomous variables, by the Cramer's V statistic for nominal variables and by the Spearman Correlation coefficient for the ordinal variables.

5.3 RESULTS

5.3.1 Description of research sample

The sample's background variables are shown in Table 5.1. Two thirds of the total group consisted of women, three quarters were between 30 and 65, one third had a job, three fifth stayed at home sick or were incapacitated for work, and almost two thirds had a treatment history of two years and over.

5.3.2 ELEMENTS CONSIDERED AS IMPORTANT BY CLIENTS

In Table 5.2, the results are shown for the entire group of respondents concerning which elements are experienced as important and which are not. The dimensions 'Responsibility' and 'Control' generally do not seem to be very important in the eyes of the respondents. There are no elements of either dimension that are experienced as important by more than two thirds of the respondents. On the other hand, there are (numerous) elements in both these dimensions that are experienced as not important by more than two thirds of the respondents. Of the respondents, 75% do not find it important to have the (financial) means themselves, 72% do not find it important that the client should adjust his wishes to the existing supply, and 75% do

Table 5.1 *Description of research population*

		Total %
Sex	Female	67,9
	Male	32,1
Age	18 through 30	20,9
	30 through 45	36,2
	45 through 65	38,7
	≥ 65	4,2
Religion	No	24,1
	Christen	64,7
	Other	11,1
Position in household	Single	40,0
	Living together / Married	55,4
	Client in a home	4,7
Education	No education / primary education (A)	15,3
	Preliminary vocational education / Average general preliminary education (B)	22,9
	Average vocational education (C)	24,3
	Higher general preliminary education / preliminary scientific education (D)	12,6
	Higher vocational education / scientific education (E)	24,9
Position in relation to job market	Working (employed or shopkeeper)	31,0
	Job-seeker / unemployed	7,0
	Scholar / student	5,8
	Not employed / not job-seeking	13,9
	(Temporally) incapacitated for work	42,3
City size	0 through 10.000	14,9
	10.000 through 100.000	45,1
	≥ 100.000	40,1
Net monthly household income	< 1000 euro	31,8
	1000 through 1500 euro	23,3
	1500 through 2000 euro	18,5
	2000 through 3000 euro	18,5
	≥ 3000 euro	7,9
Insurance	National Health Service	13,8
	National Health service + supplementary insurance	69,3
	Private insurance	16,9
Treatment history	< 1/2 year	9,8
	1/2 through 1 year	11,6
	1 through 2 year	18,9
	≥ 2 year	59,7

n = 865

not find the element 'individualization' important. Most elements belonging to these dimensions, however, are experienced as important by one half of the respondents and as not important by the other half.

In the other three dimensions (Need-determination, Imbedding of vision within the organisation, and Choice) there is a total of eight elements that are experienced as important by more that two thirds of the respondents. The elements that were scored as important the most often were: 'to determine a client's needs in consultation with the health care user', 'The manner of treatment' and 'The importance of (being provided with) information'. The element 'Health care user determines the need' was experienced as not important by more than two thirds of the respondents.

Table 5.2 *Importance of elements in typology according to mental health care clients*

	% not important	% important
Dimension 1: Responsibility		
Emancipation of health care user	46.6	53.4
Individualization	74.4	25.6
Clamp down on demand	39.4	60.6
Health care user is responsible	48.5	51.5
Responsibility for health care	64.1	35.9
Dimension 2: Control		
Supply is dependent on the health care user	48.8	51.2
Steering of the demand by the supply	71.9	28.1
Health care user has final control/say	46.2	53.8
Strengthen health care user's position	61.2	38.8
Health care user has the means	74.9	25.1
Dimension 3: Need-determination		
Satisfaction of health care user's needs	23.5	76.5
Need-determination in consultation with health care user	14.5	85.5
Get insight into real demand	42.8	57.2
Give in to the demand	55.0	45.0
Health care user determines need	66.7	33.3
Dimension 4: Way of imbedding of the view within the organisation		
Way of treatment	19.2	80.8
Formal embedment of way of dealing with health care user's needs	63.9	36.1
'Orientation towards the client'	39.4	60.6
'Client friendliness'	24.9	75.1
Attitude oriented towards the demand	34.0	66.0
Taking the health care user into account	29.5	70.5
Main focus is on the health care user	30.7	69.3
Dimension 5: Choice		
Importance of (being provided with) information	20.1	79.9

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(table 5.2)	% not important	% important
Importance of transparency of supply	23.6	76.4
Possibility of choice	44.7	55.3
Freedom of choice concerning institution	42.5	57.5
Freedom of choice concerning type of health care	48.5	51.5
Custom-made services	49.5	50.5

n = 865

5.3.3 Differences in the appreciation of elements between subgroups

There are no large differences between the appreciation of elements between men and women. Men and women value the same elements. However, the results show that, for ten elements, significant differences were found between men and women (data not shown). In all cases, the percentage of women that find an element important is higher than the percentage of men. For example, 84% of women think the manner of treatment is important, versus 73% of the men. Especially the dimension Choice shows a consistent picture: women have a significantly higher percentage than men.

Table 5.3 *Differences in scores based on age*

	18/ 29	30/ 44	45/ 64	≥ 65	Spear-man Cor-relation	Sign.
Dimension 1: Responsibility						
Emancipation of health care user	43,4	48,5	61,7	73,5	0,165	0,000
Individualization	18,9	18,0	34,3	51,5	0,189	0,000
Clamp down on demand	63,4	55,6	62,7	70,6	0,026	0,454
Health care user is responsible	52,0	45,1	56,7	58,8	0,065	0,060
Responsibility for health care	29,9	32,9	39,6	64,7	0,123	0,000
Dimension 2: Control						
Supply is dependent on the health care user	56,9	44,3	55,2	47,1	0,005	0,879
Steering of the demand by the supply	22,9	21,6	32,9	58,8	0,138	0,000
Health care user has final control/say	51,1	48,9	58,6	64,7	0,078	0,024
Strengthen health care user's position	35,1	31,8	46,5	50,0	0,120	0,000
Health care user has the means	18,4	18,7	33,5	44,1	0,178	0,000
Dimension 3: Need-determination						
Satisfaction of health care user's needs	79,3	73,1	78,1	85,3	0,033	0,335
Need-determination in consultation with health care user	92,0	85,9	81,5	88,2	-0,086	0,013
Get insight into real demand	51,7	51,8	63,1	79,4	0,127	0,000
Give in to the demand	39,7	42,0	48,7	58,8	0,078	0,023
Health care user determines need	29,7	28,9	37,9	47,1	0,088	0,011

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(table 5.3)	18/ 29	30/ 44	45/ 64	≥ 65	Spearman Correlation	Sign.
Dimension 4: Way of imbedding of the view within the organisation						
Way of treatment	87,4	79,7	78,7	79,4	-0,064	0,063
Formal embedment of way of dealing with health care user's needs	28,7	29,6	43,1	64,7	0,162	0,000
'Orientation towards the client'	56,6	58,4	63,6	75,8	0,074	0,032
'Client friendliness'	76,4	72,1	75,9	79,4	0,007	0,850
Attitude oriented towards the demand	66,3	63,9	66,0	82,4	0,024	0,481
Taking the health care user into account	69,1	70,8	70,5	76,5	-,014	0,688
Main focus is on the health care user	69,7	64,9	71,2	88,2	0,046	0,181
Dimension 5: Choice						
Importance of (being provided with) information	82,3	78,0	79,0	91,2	-0,001	0,980
Importance of transparency of supply	80,0	76,4	75,2	76,5	-0,027	0,428
Possibility of choice	60,0	51,1	56,3	58,8	-0,012	0,737
Freedom of choice concerning institution	56,0	58,0	57,4	64,7	0,015	0,674
Freedom of choice concerning type of health care	49,7	49,2	53,3	60,6	0,039	0,256
Custom-made services	52,6	45,9	52,2	66,7	0,031	0,366

n = 838

As far as age is concerned (Table 5.3), for most elements of the three first-mentioned dimensions (Responsibility, Control, and Need-determination), there is a significant positive correlation: the older the respondents, the higher the percentage that scored these elements as important. This mainly goes for respondents of thirty years and over. One element has a significant negative correlation: the older the respondents, the lower the percentage of respondents that appreciate the element 'need-determination in consultation with the health care user'. The four socio-demographic variables, i.e., type of health care insurance, number of people in household, city size, and religion, hardly showed any significant differences (data not shown).

The length of the treatment history also leads to some significant differences (Table 5.4): the longer the treatment history, the higher the percentage of respondents that found certain elements important. For 9 of the 28 elements, there is a positive correlation between length of treatment history and height of percentage. For example: 56% of respondents that have a treatment history of two years and over valued the element 'emancipation of health care user', versus 44% of the respondents with a treatment history of less than half a year. The experienced health, well-being, and quality of life, hardly showed any significant differences (data not shown).

Table 5.4 *Differences in scores based on treatment history*

	< ½ year	½ < 1 year	1 < 2 year	≥ 2 year	Spear-man	Sign.
Dimension 1: Responsibility						
Emancipation of health care user	43,8	46,7	49,0	56,8	0,099	0,005
Individualization	31,3	17,2	20,3	26,9	0,039	0,273
Clamp down on demand	52,5	55,9	56,9	63,6	0,084	0,017
Health care user is responsible	47,5	47,8	47,1	52,9	0,051	0,145
Responsibility for health care	27,5	33,3	35,5	37,9	0,060	0,089
Dimension 2: Control						
Supply is dependent on the health care user	35,0	50,5	48,0	53,9	0,094	0,008
Steering of the demand by the supply	25,0	25,8	22,9	29,9	0,055	0,115
Health care user has final control/say	52,5	58,1	50,0	53,1	-0,004	0,900
Strengthen health care user's position	32,5	33,3	29,6	43,2	0,110	0,002
Health care user has the means	17,5	22,6	15,1	28,8	0,114	0,001
Dimension 3: Need-determination						
Satisfaction of health care user's needs	73,8	74,2	76,3	77,4	0,030	0,390
Need-determination in consultation with health care user	90,0	83,9	90,8	83,6	-0,062	0,078
Get insight into real demand	55,0	55,9	55,9	57,7	0,020	0,564
Give in to the demand	37,5	38,7	36,8	49,3	0,110	0,002
Health care user determines need	27,8	37,6	24,8	33,8	0,036	0,304
Dimension 4: Way of imbedding of the view within the organisation						
Way of treatment	85,0	79,6	80,4	80,7	-0,014	0,701
Formal embedment of way of dealing with health care user's needs	38,8	34,4	25,7	38,8	0,053	0,135
'Orientation towards the client'	57,5	50,5	55,6	65,1	0,101	0,004
'Client friendliness'	83,8	71,0	74,5	73,8	-0.032	0,361
Attitude oriented towards the demand	60,0	58,1	67,3	68,4	0,068	0,053
Taking the health care user into account	65,0	63,4	65,4	73,7	0,093	0,008
Main focus is on the health care user	72,5	69,9	71,9	67,6	-0,039	0,266
Dimension 5: Choice						
Importance of (being provided with) information	81,3	79,6	83,0	78,2	-0,035	0,316
Importance of transparency of supply	78,8	73,1	79,1	75,7	-0,014	0,687
Possibility of choice	55,0	53,8	48,4	57,6	0,047	0,179
Freedom of choice concerning institution	60,0	61,3	52,3	57,7	-0,004	0,908
Freedom of choice concerning type of health care	55,0	53,8	43,1	53,0	0,019	0,594
Custom-made services	42,5	46,2	43,8	53,8	0,091	0,010

n = 806

Table 5.5 *Differences in scores based on education*

	A	B	C	D	E	Spear-man	Sign.
Dimension 1: Responsibility							
Emancipation of health care user	66,4	53,9	55,1	46,7	47,1	-0,113	0,001
Individualization	45,5	29,7	25,6	14,0	15,8	-0,217	0,000
Clamp down on demand	67,7	62,2	61,7	57,9	56,0	-0,075	0,030
Health care user is responsible	62,1	52,3	51,5	43,9	48,3	-0,085	0,014
Responsibility for health care	60,2	40,4	36,4	21,7	23,9	-0,239	0,000
Dimension 2: Control							
Supply is dependent on the health care user	62,1	48,2	51,0	49,5	48,3	-0,059	0,088
Steering of the demand by the supply	43,5	38,9	27,1	20,6	12,9	-0,250	0,000
Health care user has final control/say	60,5	52,3	56,8	51,4	49,8	-0,055	0,110
Strengthen health care user's position	52,0	43,5	40,8	29,9	28,2	-0,167	0,000
Health care user has the means	38,7	31,6	20,9	21,5	16,7	-0,170	0,000
Dimension 3: Need-determination							
Satisfaction of health care user's needs	74,2	74,6	78,6	77,6	76,1	0,020	0,571
Need-determination in consultation with health care user	79,8	82,4	88,8	91,6	84,2	0,055	0,110
Get insight into real demand	66,7	62,0	56,8	46,7	52,6	-0,110	0,001
Give in to the demand	51,6	48,2	43,4	38,3	43,1	0,066	0,054
Health care user determines need	49,6	34,2	30,6	23,4	30,6	-0,117	0,001
Dimension 4: Way of imbedding of the view within the organisation							
Way of treatment	78,2	78,8	82,6	84,1	81,3	0,036	0,291
Formal embedment of way of dealing with health care user's needs	52,8	37,3	27,3	33,6	34,0	-0,102	0,003
'Orientation towards the client'	72,6	60,9	57,5	59,8	56,0	-0,089	0,010
'Client friendliness'	77,4	71,5	76,2	74,8	75,1	0,004	0,917
Attitude oriented towards the demand	69,9	66,3	67,1	62,6	63,2	-0,046	0,187
Taking the health care user into account	75,0	71,5	71,0	72,9	65,6	-0,058	0,094
Main focus is on the health care user	75,0	74,6	73,9	61,7	60,3	-0,129	0,000
Dimension 5: Choice							
Importance of (being provided with) information	79,8	78,2	78,3	81,3	81,8	0,027	0,432
Importance of transparency of supply	75,8	74,6	75,8	76,6	78,5	0,028	0,420
Possibility of choice	62,6	53,9	53,6	57,9	52,6	-0,040	0,243
Freedom of choice concerning institution	64,5	57,0	54,6	55,1	57,4	-0,034	0,320
Freedom of choice concerning type of health care	60,5	51,6	48,8	47,7	50,2	-0,055	0,109
Custom-made services	62,6	56,8	42,5	50,5	44,5	-0,118	0,001

n = 839

As far as education is concerned (Table 5.5), there is a significant negative correlation for half of the elements. The higher the education, the lower the percentage of respondents that indicate the elements as important. This is especially the case for the elements belonging to the first two dimensions (Responsibility and Control). There is a significant difference on all elements of the dimension Responsibility: 60% of the respondents with at the most primary education is of the opinion that an expert should have the responsibility for health care versus 24% of the respondents with minimally higher vocational education. In the comparison on the basis of the position in relation to the job market, there was a significant difference for 11 elements, mainly on the dimensions Responsibility and Control (data not shown). The difference can be found between respondents that work and respondents that do not work or are incapacitated for work. Within this second group, there is a larger number of respondents that value an element than in the first group. Also the net income leads to 11 significant differences between the groups (data not shown). These differences can be found especially in the dimensions Responsibility, Control, and Need-determination: the higher the income, the smaller the percentage of respondents that experience the elements of these dimensions as important.

5.4 CONCLUSION AND DISCUSSION

In 2003/2004, Rijckmans et al. formulated a typology of the concepts of demand-oriented and demand-driven health care, based on the results of a Delphi-study among experts (Rijckmans et al., 2005). The aim of the present study was to see which elements of the typology clients experienced as important. The (first) sector that was chosen to investigate this question was ambulatory mental health care.

The results show that many clients value (elements of) the demand-oriented and demand-driven approaches in health care. However, not all elements and all dimensions were valued in the same manner. This differs for each dimension. For example, 85% of all clients find it important that they are consulted in the determination of their health care needs, and that this happens together with the professional. Besides, 80% think it is important that they are informed about the possibilities for health care in their situation and also want this done in a pleasant manner. The elements that are found important mainly belong to the dimensions Need-determination, Imbedding of the vision within the organisation, and Choice.

According to the typology mentioned, the difference between the demand-oriented and demand-driven approaches is especially visible on the dimensions Responsibility and Control. In the case of demand-oriented health care, the professional has the responsibility and control; in the case of demand-driven health care, responsibility and control are in the hands of the client. None of the elements belonging to the dimensions Responsibility and Control are experienced as important by more than

two thirds of the clients. Furthermore, three out of the four elements that are experienced as not important by more than two thirds belong to these two dimensions. Specific elements for demand-driven health care, such as 'Health care user is responsible' and 'Health care user has final say' are experienced as important by half of the clients, whereas the other half does not value them. Three quarters of the client group experience the element 'Health care user has the (financial) means' (an element on which a Personal Budget is based), as not important. Despite the overall opinion about the elements of both dimensions, there is a slight preference visible in a certain group of clients: looking at the significant differences in treatment history, there is a preference for the demand-driven elements in clients with a treatment history of two years and over. The percentage of clients that value the demand-driven elements is higher than the percentage for clients with a treatment history of less than two years.

In general, clients in ambulatory mental health care do not seem to care much about who makes the decisions in the process, but much more about the way the decision-making process is carried out. Clients especially value being heard and being involved in the process as a serious party. This could imply that the mental health care institution's policy should emphasize such aspects as the manner of treatment, information provision, and involving the client in the decision-making process, and that there might be less attention for aspects like shifting responsibility and control (and financial means) towards their clients. In order to give more general guidelines for government policy directed towards the complete field of health care, more research is needed on the appreciation of demand-oriented and demand-driven elements among clients in other health care sectors.

Some results concerning the dimensions Responsibility and Control might be explained through the composition of the research population: ambulatory mental health care clients. A Personal Budget, for instance, may not have a lot of additional value. Clients in this sector may not be able to do much with such a budget. It may even be an extra burden. In other sectors, especially chronic health care, such as the care for the mentally handicapped and the elderly, this element might well be found important more often. The results of this study show that the percentage of clients with more chronic problems (clients with a treatment history of two years and over) that experience this element as important is higher than clients with a treatment history of less than two years (29% versus 20%). It seems that, within this client group, some dimensions are valued more than others. Furthermore, there are differences between certain subgroups. In general, the same elements are appreciated by all subgroups. However, certain subgroups (men, younger clients, and highly educated people) find fewer elements important than other subgroups. An explanation for the significant correlations for age, education, and income could be that older and poorly educated

people find themselves in relatively more 'vulnerable' positions (low Socio- Economic Status) and therefore feel more powerless and insecure in their relations with professionals. They might prefer to gain more control, certainty in this situation. People with a high SES may feel less of a need for extra control. This group is more articulate and, besides, they also have more means themselves (financial, access to information, etc.) to fulfil their needs and wants.

This study was exploratory. The main goal was an exploration of the clients' view with regard to the importance of the elements derived for the typology of demand-oriented and demand-driven health care. Methodologically, the aim in this study was not to get a representative sample, but to get a sufficient representation of respondents within the subgroups about which statements had to be made. The research population was ambulatory mental health care, with a focus on the length of the treatment history. It is not clear whether or not the non-response was selective. It is thinkable that people who did participate find it more important to express their opinion about demand-oriented and demand-driven health care and that they also would prefer a more demand-oriented or demand-driven approach in health care. In order to examine whether patients and clients in other health care sectors appreciate other elements and dimensions of the concepts of demand-oriented and demand-driven health care, it is recommended to do similar research among, for example, people with a mental of physical handicap, the elderly, and the chronically ill. If one does research for which the main goal would be to get a representative picture of clients in a certain sector, one will have to keep in mind such issues as the dispersion of respondents over the different types of institutions in the Netherlands, the dispersion over the different types of health care services, and the possible selectivity of non-response.

Chapter 6

Clients' experiences with ambulatory mental health care

Objective: In the Netherlands, as in many other Western European countries, there is an increasing attention for demand-oriented and demand-driven approaches in health care. In these approaches, the emphasis is on the client's perspective in health care policy and health care services. The current study was conducted to gain insight into the clients' view concerning the presence of these approaches in the health care they received. Method: A survey was conducted in July 2004 within the southern part of the Netherlands among 4,250 clients, aged 18 and over, of ambulatory mental health care. The survey was conducted by means of a postal questionnaire. To include clients with divergent experiences of mental health care, the sample was stratified according to treatment history. Results: Clients mainly seem to recognise aspects concerning the way their needs are determined and the way they are treated by the institution. They recognise that their needs are determined in consultation with the health care provider. They also recognise that they are treated in a pleasant manner and that the institution is client-friendly. Furthermore, aspects concerning who is responsible, who has control over the decision-making process, and the number of options as regards the type of treatment or the institution are not recognised as being present in the ambulatory mental health care provided. Conclusions: The results of this study suggest that only some of the elements that are typical of either demand-oriented or demand-driven care are recognised by clients in the mental health care provided. On the other hand, a substantial number of the aspects that were experienced as important by most clients were recognised.

6.1 INTRODUCTION

At this moment in time, health care in the Netherlands is undergoing a radical transformation (Merks-van Brunschot, 2004). One of the big transformations in health care is the paradigm flux from a supply-driven to a more demand-oriented or demand-driven approach (Saltman, 1994). Both approaches are opposites of supply-driven health care (Garretsen, 2001). In the supply-driven approach, the existing supply is the point of departure, while in the demand-oriented and demand-driven approaches the clients and their needs and wants are the starting-point. In mental health care, this shift is also taking place (Kragten, 1998). Because of this development, there is more and more attention for the clients' satisfaction, for the clients' specific wants and needs concerning the treatment (Kremer & Gesten, 2003; Veeninga & Hafkenscheid, 2002) and for the clients' personal goals (Anthony et al., 2000). Demand-orientation and demand-driven care are key-concepts in this development (Van Diest et al., 2002; Kragten, 1998). It is claimed (Tranzo, 2001) that a demand-oriented or demand-driven approach puts more emphasis on the client's wants and needs and that health care thus contributes to an increase in the client's experienced quality of life (Häyry, 1999).

The concepts of demand-oriented and demand-driven health care are not clearly distinguished. Often the concepts are not defined at all (Rijckmans et al, 2003). In order to get some clarity, a typology of demand-oriented and demand-driven health care was developed, based on a Delphi-study among experts from science and practice (Rijckmans et al, 2005). Demand-oriented health care and demand-driven health care were defined as follows: 'Demand-oriented health care is health care in which experts have the responsibility and final say concerning the choice of the type of health care service. In the decision-making, the expert takes the client's needs and wants into account, treats the client respectfully and informs him about the various possibilities. Demand-driven health care is health care in which the client has responsibility and final say concerning the choice of the type of health care service. The client determines what his needs are and, after he is informed by experts about the various possibilities, has the freedom to make the decision him' (Rijckmans et al, 2005). The typology consists of five dimensions: Responsibility (expert versus health care user) Control (idem), Need-determination (idem), Way of imbedding of the view within the organisation (informal versus formal) and Choice (set supply versus freedom of choice). These dimensions are constructed of elements that are typical of either demand-oriented or demand-driven health care or, for some elements, of both concepts.

In view of the demand-oriented and demand-driven approach, the focus is on the clients' perspective, the individual client's wants and needs, and his perceived quality of life. This is why a follow-up study was done in order to find out which elements of the typology mentioned were experienced as important by clients in ambulatory mental health care (Rijckmans et al., 2005). The results of this study showed that the elements

'way of treatment', 'need determined in consultation with health care user' and 'the importance of (being provided with) information' were scored as important most frequently by clients in ambulatory mental health care. Besides these elements, the elements 'client-friendliness', 'taking the health-care user into account', 'satisfaction of health care user's needs', 'the main focus on the health care user' and 'importance of transparency of supply' were also experienced as important by a majority of the respondents (Rijckmans et al, 2005). These aspects resemble some of Farkas, Anthony and Cohen's (1989) Key Rehabilitation Values. They resemble values aimed at person orientation (treating the person as a whole), involvement (including individuals as full partners in all aspects of the rehabilitation), choice (a focus on the person's preferences throughout the process) and outcome orientation and growth potential (focus on the client outcomes and on improvement in a person's success and personal satisfaction) (Farkas, Anthony and Cohen, 2002).

Following the above-mentioned research, this study's goal is to explore whether the demand-oriented and demand-driven elements, which were experienced as important by clients were also recognised in the health care they had received.

The research questions in this study were:

- Which of the elements typical of demand-oriented and/or demand-driven health care that were experienced as important by clients are recognised in the health care they received?
- Does the length of the treatment history and type of institution (state versus private) have any influence on the extent to which the provided health care is experienced as being demand-oriented or demand-driven?

6.2 METHODS AND MEASUREMENTS

6.2.1 Data collection

In order to answer the research questions, a written questionnaire was sent to 4,250 ambulatory mental health care clients of 18 years and over. The study was done in the southern part of the Netherlands.

To include clients with divergent experiences of mental health care, the sample was drawn within two different mental health care settings and stratified according to treatment history. In the Netherlands, clients have the choice to use the services of either the regular/state mental health care institutions or of private psychologist practices. The services of state institutions are fully reimbursed after referral by, for example, the general practitioner. The services of private practices in most cases have to be partly or fully paid by the clients themselves depending on the insurance they have. The sample included 4,000 clients of state mental health care (2,000 clients of

institution A and 2,000 clients of institution B) and 250 clients of private mental health care. The sample of state mental health care clients was divided into two strata: the clients' treatment history was either less than two years (2,000 clients) or more than two years (2,000 clients) based on the registers of the mental health care institutions. The overall response rate was 20.4% (N=865) and was equally divided over state versus private mental health care (19.6% versus 20.8%) and treatment history (<= 2 years: 18% and >= 2 years: 21.2%).

6.2.2 Measurements

To measure the clients' views of the importance of the various aspects of 'demand-oriented' and 'demand-driven' health care, a questionnaire was developed (see Supplement 5) based on the typology of 'demand-oriented' and 'demand-driven' health care (for the description of the typology, see Rijckmans et al., 2005).

This questionnaire was checked by professionals of the three institutions as well as by some members of a client-council. They were asked to check the questionnaire on its comprehensibility and readability. Next, the questionnaire was pre-tested among ten persons in the general population.

The abstract elements of the five dimensions characterising 'demand-oriented' and 'demand-driven' health care were translated into 28 propositions, whose importance the respondents were asked to score. For example: one of the elements of the dimension 'Control' was 'Health care user has final say'. This element was translated into the proposition 'I find it important that I can determine which type of health care service I want to receive'. An element of the dimension 'Responsibility' was 'Set boundaries on the demand'. The translation of this element was 'I find it important that a professional determines which demands are met and which are not' (see Figure 6.1 for two examples).

Besides scoring the importance of the 28 propositions, information on the following socio-demographic variables was obtained: sex, age, education, daily activities, income, health insurance, number of people in household, city size, and religion. The length of the treatment history was checked by the question 'How long have you been in treatment at this institution?'. Based on the answer to this question concerning length of treatment history, the analyses were made. If the length of the treatment history according to the respondents differed from the length according to the institution's registration, the former length was taken.

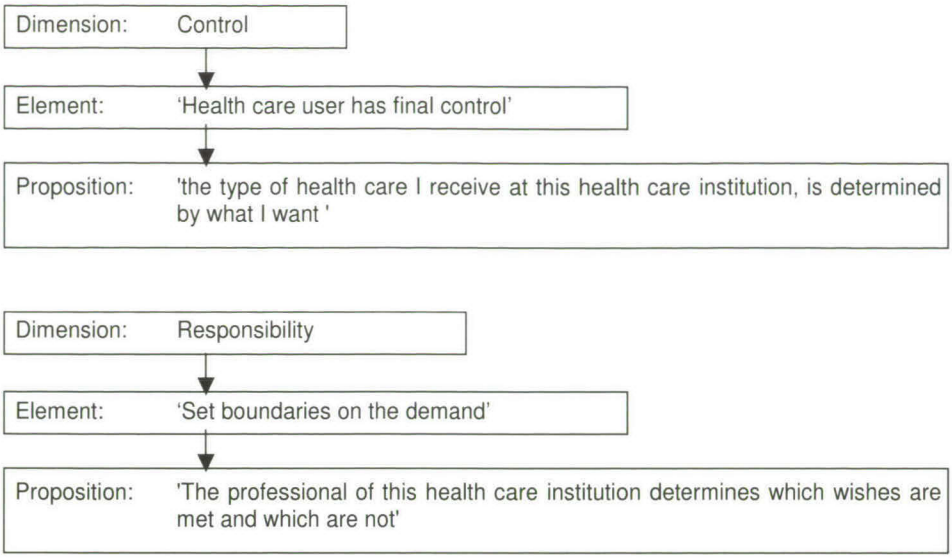

Figure 6.1 *Examples of propositions*

6.2.3 Analyses

Analyses were carried out using the program SPSS 12.0. Whether respondents recognised the elements in the received health care was scored through frequency tables. An element was categorised as 'recognised' when a majority (> 50%) of the respondents scored the proposition belonging to the element as such. An element was categorised as 'not recognised' when a majority did not recognise the proposition.

The differences in recognition of the element with respect to type of institution (state versus private), treatment history and the background variables were bivariately analysed. Significance at the 5% level was tested by Chi-square statistic for dichotomous variables, by the Cramer's V statistic for nominal variables and by the Spearman Correlation coefficient for the ordinal variables.

6.3 RESULTS

6.3.1 Description of research sample

The sample's background variables are shown in Table 6.1. Two thirds of the total group consisted of women, three quarters were between 30 and 65, one third had a job, three fifth stayed at home sick or were incapacitated for work, and almost two thirds had a treatment history of two years and over, 51% of the respondents received mental health care services at state institution A, 43% received services at state institution B, and 6% received services at a private institution for mental health care.

Table 6.1 *Description of the research population*

		Total %	Institution A %	Institution B %	Private practice %
Sex	Female	32,1	32,9	32,4	23,5
	Male	67,9	67,1	67,6	76,5
Age	18 through 30	20,7	16,9	22,6	33,3
	30 through 45	36,0	33,7	40,8	31,4
	45 through 65	38,5	39,9	36,3	35,3
	≥ 65	4,0	7,9	0,3	0,0
Religion	No	24,1	21,4	26,6	26,9
	Christen	64,7	67,0	62,5	61,5
	Other	11,1	11,7	11,0	11,5
Position in household	Single	40,0	39,7	40,8	39,2
	Living together / Married	55,4	51,6	58,6	60,8
	Client in a home	4,7	8,6	0,6	0,0
Education	No education / primary education (A)	15,3	20,6	10,5	5,7
	Preliminary vocational education / Average general preliminary education (B)	22,9	22,3	26,4	7,7
	Average vocational education (C)	24,3	23,3	25,0	23,1
	Higher general preliminary education / preliminary scientific education (D)	12,6	11,3	13,1	17,3
	Higher vocational education / scientific education (E)	24,9	22,6	25,0	46,1
Position in relation to job market	Working (employed or shopkeeper)	31,0	23,1	35,6	65,4
	Job-seeker / unemployed	7,0	5,3	8,6	3,8
	Scholar / student	5,8	6,0	4,3	11,5
	Not employed / not job-seeking	13,9	16,6	10,3	13,5
	(Temporally) incapacitated for work	42,3	48,9	41,3	5,8
City size	0 through 10.000	14,9	15,8	14,4	10,6
	10.000 through 100.000	45,1	43,1	47,3	42,6
	≥ 100.000	40,1	41,1	38,3	46,8
Net monthly household income	< 1000 euro	31,8	35,8	31,6	6,1
	1000 through 1500 euro	23,3	24,6	22,1	22,4
	1500 through 2000 euro	18,5	18,1	18,4	20,4
	2000 through 3000 euro	18,5	15,5	19,5	26,5
	≥ 3000 euro	7,9	6,0	8,3	24,5
Insurance	National Health Service	13,8	13,0	16,1	3,9
	National Health service + supplementary insurance	69,3	70,2	69,8	56,9
	Private insurance	16,9	16,8	14,1	39,2
Treatment history	< 1/2 year	9,8	2,3	14,5	40,0
	1/2 through 1 year	11,6	3,8	16,5	38,0
	1 through 2 year	18,9	17,4	22,0	10,0
	≥ 2 year	59,7	76,6	47,0	12,0

n = 865

6.3.2 Elements recognised in the provided mental health care

The results of the clients' experiences with the elements from the typology are shown in Table 6.2. Out of the 28 elements, 7 are recognised by a majority (> 50%) of clients in the health care received. Of the total group of respondents, 71% are of the opinion that they are treated in a pleasant manner, 65% think the institution is client-friendly, and 58% of the respondents are of the opinion that the health care need is determined in consultation with the professional and the health care user. The elements recognised by a majority all belong to the dimensions 'Need-determination' and 'Way of imbedding of the view within the organisation'. There are no elements of the dimensions 'Responsibility', 'Control' and 'Choice' on which a majority of respondents agree as regards their recognition in the mental health care received.

Table 6.2 *Degree of recognition of elements from the typology*

	% I do not agree	% I partly agree	% I agree
Dimension 1: Responsibility			
Emancipation of health care user	16,2	44,7	39,1
Individualization	22,9	47,9	29,3
Clamp down on demand	33,9	44,2	21,9
Health care user is responsible	26,2	47,4	26,4
Responsibility for health care	16,6	48,5	35,0
Dimension 2: Control			
Supply is dependent on the health care user	21,3	49,2	29,5
Steering of the demand by the supply	27,1	38,2	34,7
Health care user has final control/say	34,4	45,3	20,2
Strengthen health care user's position	31,2	48,1	20,7
Health care user has the means	72,5	15,0	12,6
Dimension 3: Need-determination			
Satisfaction of health care user's needs	14,7	37,5	47,9
Need-determination in consultation with health care user	12,4	29,2	58,3
Get insight into real demand	17,1	27,5	55,4
Give in to the demand	13,7	38,2	48,1
Health care user determines need	16,4	46,1	37,5
Dimension 4: Way of imbedding of the view within the organisation			
Way of treatment	5,2	23,7	71,1
Formal embedment of way of dealing with health care user's needs	17,1	46,1	36,8
'Orientation towards the client'	5,1	28,3	66,7
'Client friendliness'	7,4	27,1	65,4
Attitude oriented towards the demand	8,6	40,8	50,6
Taking the health care user into account	8,6	35,0	56,4
Main focus is on the health care user	15,8	43,5	40,6

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(table 6.2)	% I do not agree	% I partly agree	% I agree
Dimension 5: Choice			
Importance of (being provided with) information	24,2	33,3	42,5
Importance of transparency of supply	26,8	37,7	35,5
Possibility of choice	39,9	33,2	26,9
Freedom of choice concerning institution	52,1	21,4	26,5
Freedom of choice concerning type of health care	37,8	35,9	26,2
Custom-made services	26,6	40,7	32,7

n = 865

Only two out of the 28 elements were scored as 'not recognised' by a majority. A majority of respondents (73%) did not recognise the proposition 'I myself have the financial means at hand to buy my own health care'. This high percentage can be explained by the fact that only 6% of the respondents actually used a Personal Budget. Besides, 52% did not recognise the proposition 'I was free to choose which mental health care institution I wanted to go to'.

In earlier research (Rijckmans et al., 2005), it was shown that the elements 'way of treatment', 'need-determination in consultation with health care provider' and 'the importance of (being provided with) information' were labelled as important most frequently by clients in ambulatory mental health care. Besides these three elements, 'client friendliness', 'take health care user into account', 'satisfaction of health care user's needs', 'main focus on the health care user', and 'importance of transparency of supply' were experienced as important by a majority of more than two thirds. It was examined whether these elements were recognised in the health care services received. Four out of the eight elements were actually recognised: 'way of treatment', 'need-determination in consultation with health care provider', 'client friendliness', and 'take health care user into account'. The others were not recognised by a majority. These were, however, recognised at least partly by approximately 75% of the clients.

6.3.3 Differences between state and private institutions

As regards the extent of recognition of the elements for the various institutions, it seems that it differs significantly for almost all of the elements (Table 6.3). Most differences can be found between the state-institutions on the one hand and the private institution on the other.

The percentage of clients from the private institution that recognise two elements that are typical of demand-driven health care, namely 'emancipation of health care user' and 'supply is dependent of the health care user', is higher than that of the clients from the state-institutions. For the state mental institutions, the percentage of clients

that recognise the elements typical of demand-oriented care, 'professional is responsible' and 'a professional determines which needs will be met', is higher. There is, however, one exception, namely the typical demand-driven element 'health care user has the financial means'. In the private institution, only 4% of the clients recognise this element; in the state mental institutions, the percentages were 17% (institution A) en 9% (institution B) respectively. For the remaining elements for which significant differences were found, there was a difference of approximately 10% to 20% between the state mental institutions on the one hand and the private mental health care institution on the other (see Table 6.3). The percentage of clients of the private institution who recognise the element in the health care received is higher that the percentage in the state institutions.

Table 6.3 *Differences in scores (% who agrees with proposition) between institutions*

	Institution A	Institution B	Private practice	Cramer's V	Sign.
Dimension 1: Responsibility					
Emancipation of health care user	38,6	35,2	65,4	0,108	0,001
Individualization	30,5	30,5	13,5	0,090	0,012
Clamp down on demand	23,9	19,9	19,6	0,065	0,151
Health care user is responsible	27,9	24,5	25,0	0,049	0,418
Responsibility for health care	37,7	34,2	17,6	0,074	0,070
Dimension 2: Control					
Supply is dependent on the health care user	29,7	25,9	49,0	0,110	0,001
Steering of the demand by the supply	38,0	34,9	13,5	0,137	0,000
Health care user has final control/say	22,6	14,2	28,8	0,117	0,000
Strengthen health care user's position	22,8	17,5	20,0	0,046	0,540
Health care user has the means	16,9	8,5	4,0	0,101	0,004
Dimension 3: Need-determination					
Satisfaction of health care user's needs	49,4	42,4	67,3	0,106	0,001
Need-determination in consultation with health care user	58,2	55,3	70,6	0,077	0,050
Get insight into real demand	55,4	51,4	73,1	0,098	0,004
Give in to the demand	49,4	43,1	63,5	0,101	0,003
Health care user determines need	41,3	33,0	29,4	0,088	0,016
Dimension 4: Way of imbedding of the view within the organisation					
Way of treatment	70,1	68,7	86,3	0,067	0,122
Formal embedment of way of dealing with health care user's needs	40,9	29,4	48,1	0,094	0,011
'Orientation towards the client'	64,4	63,5	90,4	0,098	0,004
'Client friendliness'	64,9	61,6	84,6	0,093	0,008
Attitude oriented towards the demand	48,8	47,4	75,0	0,099	0,003
Taking the health care user into account	56,6	51,0	84,6	0,118	0,000
Main focus is on the health care user	40,2	36,0	67,3	0,110	0,001

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(table 6.3)	Institution A	Institution B	Private practice	Cramer's V	Sign.
Dimension 5: Choice					
Importance of (being provided with) information	43,8	37,5	57,7	0,081	0,030
Importance of transparency of supply	37,5	31,1	40,4	0,075	0,062
Possibility of choice	27,4	23,5	34,6	0,057	0,274
Freedom of choice concerning institution	24,6	21,4	74,5	0,210	0,000
Freedom of choice concerning type of health care	24,6	23,1	59,6	0,146	0,000
Custom-made services	32,3	28,9	50,0	0,095	0,006

n = state institution A = 404 / state institution B = 347 / private practice = 52

To see whether the differences found could be attributed to differences between the institutions or to differences between characteristics of certain groups, the results of the entire research population were examined on some of the socio-demographic variables. Neither age nor sex or income and education led to a substantial number of significant differences. This was also the case for the length of the treatment history (data not shown). Clients with a treatment history of two years and over did not recognise less or more elements than clients with a treatment history of, for example, less than half a year. Therefore, it seems that the differences can be largely attributed to the differences between the nature and execution of the institutions' services.

As stated earlier, the elements 'way of treatment', 'need-determination in consultation with health care user' and 'the importance of (being provided with) information' were most often marked as important (Rijckmans et al., 2005). It was examined whether or not there were differences in the recognition of these elements between the various institutions. For each institution, a majority of the respondents recognise that they are treated in a pleasant manner. Also a majority recognises that, in the health care services provided, the health care user's needs are determined in consultation with health care professional and health care user. Being properly provided with information about the health care possibilities in the client's specific situation is not recognised everywhere. Only a majority (58%) of clients form the private institution recognise this. For the two state mental institutions, this was a minority, viz. 44% and 38% respectively.

6.4 CONCLUSIONS AND DISCUSSION

In 2003/2004, Rijckmans et al. formulated a typology of the concepts of demand-oriented and demand-driven health care, based on the results of a Delphi-study among experts (Rijckmans et al., 2005). The aim of the present study was to see which elements of the typology were recognised by clients in the health care services

they received. The (first) sector that was chosen to investigate this question was ambulatory mental health care.

The results show that clients recognise only a limited number of elements from the typology in the mental health care serviced they received. These are elements from the dimensions 'need-determination' and 'way of imbedding of the view within the organisation'. A majority of the clients agree that their needs are determined in consultation with the professional and the client, that the professional makes a great effort to gain insight into the real demand, that they are treated in a pleasant manner, that the institution is client friendly and oriented towards the clients, that the personnel's attitude is oriented towards the demand, and that the clients' needs and wishes are taken into account.

The results also show that there is a significant difference between the clients' experiences concerning the recognition of either typical demand-oriented or demand-driven elements in the private practice on the one hand, and at the state mental health care institutions on the other. In general, there are more clients from the private mental health care institution who recognise elements typical of demand-driven health care in the services provided than from the state mental health care institutions. In the state mental health care institutions' services, there are more clients who recognise elements typical of demand-oriented health care. In spite of these differences, the most typical and distinctive elements are hardly recognised at all. In other words, the majority of clients do not have a clear view of either the position of the professional or the health care user in the decision-making process. In this process, they do not see where the responsibility lies and who has the final say. There is one exception: a majority of clients from the private practice recognise the proposition that the client's opinion carries as much weight as the professional's.

The dimensions 'Need-determination', 'Way of imbedding of the view within the organisation' and 'Choice' are less distinctive between the two approaches than the two prior ones. For the dimension 'Need-determination', it seems that a majority of clients recognise that the needs are determined in consultation with the professional and the health care user, and that the professional makes a great effort to gain insight into the client's real demand. At the level of the institutions, there is a majority of clients who, besides the just-mentioned elements, also recognise that the health care services provided meet the clients' needs and that the institution meets their demands.

Most of the elements belonging to the dimension 'Way of imbedding of the view within the organisation' are recognised by a majority of clients for all institutions. This dimension therefore seems to be strongly represented in health care practice: clients are of the opinion that the institutions' visions are oriented towards the client,

clients find the institutions client-friendly, clients are treated in a pleasant manner, and their needs and wishes are taken into account.

The results of the total research population show that, in contrast to the last-mentioned dimension, the dimension 'Choice' is not represented at all in the services provided. In general, clients have a feeling that they do not have enough options of choice, that they are not sufficiently informed in order to be able to choose, that the supply of services is not transparent, that there is no freedom of choice, and that there is an insufficient number of custom-made services. When the institutions are examined separately, it appears that clients from the private mental health care institution do recognise some of the elements typical of demand-driven care (diversification of supply, options of choice, freedom of choice, and custom-made services). For the two state mental health care institutions, not one element from this dimension was recognised.

Taking the typology of demand-oriented and demand-driven care formulated by Rijckmans et al. (2005) as a starting-point, not one of the three institutions for ambulatory mental health care can be labelled as typical demand-oriented or demand-driven, particularly because of the absence of elements from the dimensions 'Responsibility', 'Control' and 'Choice'. The institution that leans towards the demand-driven approach the most is the private institution, while the two state institutions lean more towards the demand-oriented approach. However, as established in earlier research (Rijckmans et al., 2005), clients in ambulatory mental health care do not value the dimensions 'Responsibility' and 'Control' so much, but attach much more importance to the way the decision-making process in their situation is carried out (elements from the other three dimensions). Clients especially value being heard and being involved in the process as a serious party. The main elements according to clients were the way of treatment, involving the client in the decision-making process, and the importance of provision of information (Rijckmans et al., 2005). The first two elements were recognised in the health care services received by a majority of all the clients in the study. Many elements from the dimensions 'Need-determination' and 'Way of imbedding of the view within the organisation' were recognised. Although both dimensions do not discriminate between the two approaches, they are constructed of elements that are typical of both approaches, namely as counterparts of the supply-oriented approach. Through these dimensions, the health care user is given a more central role in health care.

The element 'I am being informed sufficiently about the health care possibilities in my situation' was only recognised by a majority of clients from the private institution. This could be a recommendation for the state mental health care institutions. A majority of clients are of the opinion, apparently, that they are being informed in-

sufficiently about the health care service possibilities in their situation. Besides, the other five elements that were experienced as important by clients are worth taking a closer look at. There is no majority of clients for any of the institutions that recognise transparency in the supply. The provision of more clarity about the various possibilities and services could therefore be a point of attention for all institutions involved in this study. A majority of clients for each institution did recognise that the institution's health care services were client-friendly and that the clients' wishes were taken into account. The elements 'satisfaction of health care user's needs' and 'main focus on the health care user' were only recognised by a majority of the private institution's clients. Clients form the state mental health care institutions are apparently of the opinion that the focus is on other things rather than on the clients (with their needs and wishes).

Returning to Rijckmans' typology (2005), the following can be concluded: the results in this study show that clients recognise only some of the elements typical of either demand-oriented or demand-driven care in the health care services provided. An explanation could be that both approaches are fairly new and still in the making. It can require quite some time before these new procedures are implemented in the activities of the shop floor and have reached the actual clients' experiences. Which approach will be given preference from the clients' perspective, the demand-oriented or demand-driven approach, and which approach the institutions that participated in this study aim at, is hard to say at this point in time.

This study was exploratory. The main goal was an exploration of the clients' experiences with regard to the recognition of the elements derived for the typology of demand-oriented and demand-driven health care. The research population was ambulatory mental health care in the southern part of the Netherlands, with a focus on the type of health care institution (state versus private). In this first exploration, the researchers strived for a sufficient representation of respondents within the subgroups about which statements had to be made. It is not clear whether or not the non-response was selective. It is conceivable that the people who did participate find it more important to express their opinion about demand-oriented and demand-driven health care and that they would also prefer a more demand-oriented or demand-driven approach in health care.

In this study, there was a focus on the length of the treatment history. It is interesting to see that this point of attention does not result in significant differences in the recognition of elements in the health care services provided. There was also a focus on the type of institution. It was shown that there was a difference between the two types in the study. However, in order to make a definitive statement about this, a multi-variate analysis should be made on the data (for both length of treatment

history and institution). Because of the small sample of respondents from the private institution, it was not possible in this case to make such a statement.

The results in this article give a first impression of the utility of the formulated typology of demand-oriented and demand-driven health care. They sketch the extent to which the institutions' health care services are experienced as demand-oriented or demand-driven. In order to substantiate these results, more research needs to be done. Each health care institution has its services organized in its own fashion. Pronouncements about a certain sector are therefore hard to make; it rather comes down to pronouncements about an institution. If further research is done, which aims at getting a representative picture of the clients' experiences with a certain institution, one will have to keep in mind such issues as a sufficient response, the dispersion of respondents over the different types of services within the institution, and the possible selectivity of response and non-response.

Chapter 7

Reflections on demand-oriented and demand-driven care within the current health care system

7.1 INTRODUCTION

Health care is an almost constant topic of public debate in the Netherlands. Many points of view are offered and many problems identified. An important point is the discrepancy between demand and supply. Factors contributing to a growth in the demand for health care are increased individualism, greater independence, and increasing affluence (Garretsen, 2001). Additionally, medical-technical developments provide new treatment options leading not only to greater costs but also to longer lives which feeds the demand for more care. Health care expenses are high and increasing. There are currently a great number of discussions taking place now regarding the introduction of more market forces into the health care market (Garretsen, 2001). Health appears to be increasingly seen as an economic commodity in which assessment of services used takes place within a market economy (Janssen, 1997). Nijhuis (2001) speaks of an economic priority and states that the provision of health care services is increasingly removed from people's everyday lives. The fact is that demand and supply do not match up.

Government policy over recent years has aimed to give a more important place to the preferences and requirements of those who use the health care system (Janssen, 2003). The terms demand-oriented and demand-driven are key words in new thinking about health care, welfare, and living and are seen by many as the answer to those problems confronting us today. What is meant by demand-oriented and demand-driven care? In a study of the meaning of demand-oriented and demand-driven health care Rijckmans et al. (2005) developed a typology, which described the similarities and differences of these two approaches to health care. Both approaches were developed as reactions to a more supply-oriented approach and attempted to give the individual seeking health care a more central role. The typology consists of two ideal types constructed from five dimensions: 1) Responsibility, 2) Control, 3) Need-determination, 4) Way of imbedding of the view within the organisation, and 5)

Choice. These dimensions stem from a clustering of various elements (Rijckmans et al., 2005). In this typology demand-oriented care means care in which responsibility for and final say over the provision of services lies with experts. The expert takes the needs and wishes of the health care user into account, treats him or her pleasantly and informs him or her of relevant options. In contrast, demand-driven care is care in which responsibility for and final say over the provision of services lies with the health care user. The health care user indicates his or her needs and wishes and, after being informed by an expert of the possible courses of action, has the freedom to choose his or her treatment (Rijckmans et al., 2005).

Although Rijckmans' typology (2005) takes into account that the other three dimensions also contain a few distinguishing elements, the principle differentiation between the approaches lies in the first two dimensions, to wit, Responsibility and Control. Demand-oriented care places responsibility and control in the hands of experts, while demand-driven care leaves these with the health care user. The question, however, is the degree to which these ideal types are limited by current administrative and financing practices. As an ultimate form they may be utopian. Demand-driven care matches the neoclassical interpretation of the consumer in a completely free market: he is autonomous, informed, there are substitutes, he chooses independently and pays for it himself (Janssen, 2003). These characteristics, in fact, also point out the limitations of this ideal type. After all, many a time in health care these conditions will not be met.

To begin, it is assumed that an important goal of demand-oriented and demand-driven approaches is to contribute to the maintenance and expansion of individual quality of life (Tranzo, 2001). However, contributing to the quality of life is limited not only by technical (im)possibilities, but also largely by other, financial concerns. Social reality demands that the typology be seen within the general framework of existing health care financing and its limitations. Furthermore, the government has been active in establishing laws to protect those who seek care from the knowledge and power wielded by the medical profession, such as the Professions in Individual Health Care Law (which covers who is qualified to practice medicine; in Dutch 'Wet BIG') and the Medical Practice Agreement Law (which regulates patients' general rights; in Dutch 'WGBO').

In order to make the typology practicable, to get it to make operational judgments, and permit it to be a practical instrument for policy and practice, it must be viewed in light of the current organisation of the health care system. In the health care system, parties around the individual, such as the government and health care insurers, have a major influence on health care supply, allocation and expenditures. 'The health care system defines authority, responsibilities and autonomy of the health care

parties and formulates rules for their mutual relationships' (Polder & Jochemsen, 2000). Furthermore, governmental policy and social-cultural trends influence change processes within health care which must be taken into account in the development, implementation and evaluation of new forms of (demand-oriented) aid and service provision (Schols, 2004). This article attempts a classification of health care services based on the possibilities and limitations of the law and financing of the health care system in which those parts of the system which have to do with demand-oriented and demand-driven care are identified. The central question of this article is: given the current legal and financial situation, what are the possibilities and limitations for the demand-oriented and demand-driven approaches within the Dutch health care system? The typology will be viewed based on the extant legal and financing situation of the health care system. The basic philosophy and shape of the system will be closely examined from this perspective.

Before addressing the current legal status and financing of the present system, a few generalities relating to the demarcation of the article must first be described. These include the level both approaches employ (micro, meso, macro) and various visions of health care. Subsequently, the most distinguishing dimensions of the typology, Responsibility and Control, will be assessed for their relation to the law. This will take place by means of current visions of people (are they autonomous entities which are in any way prepared to take on the responsibility for their actions?), extant legal system (how are responsibilities divided legally), and a division of care services based on these responsibilities. Next, the question of authority over which care will be provided and the means by which this takes place, will be addressed. In this respect the article addresses the right of self determination as well as the ability of the government to place limits upon that right. Finally, from an economic perspective the terms 'market' and 'free market system', the Dutch finance system, and the micro-level limitations within the health care economy will be addressed. The article ends with some general conclusions regarding the possibilities of the demand-oriented and demand-driven approaches within the current system.

7.2 DEMARCATION

When dealing with demand-driven health care three levels can be differentiated, to wit, the micro-level (individual between provider or insurer and health care user), the meso-level (collective, between insurers and providers) and the supervisory level, the macro-level (see Figure 7.1).

It is important to indicate which levels of this relational system will be discussed. Since the typology was developed for demand-orientation and demand-driven care at the individual level, relations relevant to the individual will be addressed. At the meso-level (collective) steering by the demand takes place from insurers to providers.

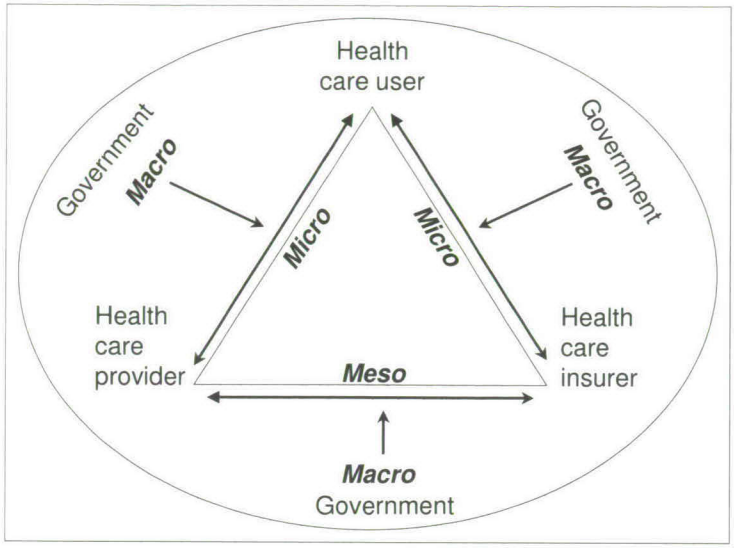

Figure 7.1 *Levels of demand-driven care*

This is steering by the demand on an 'aggregated' level. Insurers take on the role of translators of the collective demand of society on providers (some insurers were originally cooperative, not-for-profit associations) in order to provide an as good and effective as possible set of services (including managed care, Jochemsen, 1997). An expert working for health care insurers act as an agent: towards the health care providers he acts in the name of the insured. Yet he also acts for the insurance company. That is to say, in fact he 'wears two hats simultaneously'. Although this form of steering by the demand can be found elsewhere nowadays (think of the conflict between general practitioners and the Minister over the modified role of insurers (Ministry of Public Health, Welfare and Sport, 2005)) and is increasingly being implemented (for example by means of the Diagnosis Treatment Combinations), it falls beyond the scope of this research and will not be pursued further. Society and its norms and values can be viewed as demand at the macro-level. These norms and values are monitored by the government and converted into law. The government sets minimum requirements for the purpose of a qualitative acceptable provision of care and supervises compliance. Vis-à-vis the market, the government's role can be described as corrective (Boot & Knapen, 2001). Similar rules exist as well for the two micro-level relations and those at the meso-level. These rules determine, among other things, what costs society is prepared to bear as well as which standards will be set regarding accessibility to and quality of care. Relevant here are those rules governing relations between health care user and care provider as well as those between health care user and health care insurer. This level of analysis will be discussed with the aid of Dunning's (1991) typology of three different views to health care.

The Dunning report (1991) describes three views to health and health care and their respective consequences for the organisation of care: individual, medical-professional and community-oriented. It is important to gain insight into which of those visions fits the current view on health care best. These visions of health and health care are of great consequence for making choices and, should one be chosen, each view then mandates new choices. In the individual view 'health' and 'need' depend on what an individual is able and wants to do, which varies per person. This approach makes no choices between necessary and unnecessary services as all personal preferences are considered valid as long as the means are available (i.e., 'experienced needs', Rijckmans et al., 2005). Demand-driven care as described in this typology fits well with this individual-based view. The medical-professional approach views health as limited to 'normal' biological and medical functioning. Choice of diagnostic and approach is made by the provider within the doctor-patient relationship. Necessary care is thus essentially specified by professionals (i.e., 'evaluated need', Rijckmans et al., 2005) by virtue of results and health benefit. The community-oriented approach does not place individual preferences and needs or professional standards foremost, but the core question is rather what care should be provided based on the needs of society. Social values and norms determine the social good. In the Dutch democratic and social constitutional state, the most important values and norms are explicated in international treaties and the Constitution, in unwritten, general principles of law, and in laws which govern the design and functioning of the Dutch health care system (Dunning, 1991). Every society uses these means to provide a normative framework within which social need is defined. The Scientific Council for Governing Policy (WRR, 2003) report specifies current principle values and norms. It is important to recognise which view best fits the Dutch situation and design of the health care system and the consequences of this regarding choices and possibilities for demand-orientation as well as demand-driven care. Dunning (1991) argues that the social approach describes this best.

7.3 THE LEGAL ASPECTS OF HEALTH CARE

As indicated earlier (Rijckmans et al., 2005), the dimensions Responsibility and Control appear to best differentiate the demand-oriented and demand-driven approaches. Current law specifies multiple aspects of responsibility and final say for health care users as well as experts. These shall be considered successively.

The dictionary definition of responsibility is: 'the obligation to ensure that everything functions well, works, and is justified (= explanation and defence of practices, actions and motives)' (Van Dale, 2002). A health care user should be able to explain and defend his or her practices, actions and motives. The question is whether a health care user can be bothered to do this with all aspects of health care. There are various forms of responsibility and various people held responsible: the health care

user is responsible for his or her lifestyle, the care provider for optimal information flow and quality of service, the government for the availability of health care and the protection of autonomy, and the health insurer among other things for suitable financing. The responsibility dimension of this typology does not, however, cover all aspects of health care responsibility. In the typology of demand-oriented and demand-driven care, the responsibility dimension, as formulated in the expert Delphi-study, includes elements which bear on the degree of health care user's autonomy. The issue here is to what extent the health care user is seen as an autonomous entity, an independent and equal individual prepared to make choices and take responsibility for the consequences of those choices and to what extent the health care user is able to guard his rights and assume his duties vis-à-vis society at large (Rijckmans et al., 2005). It is specifically concerned with who has (and who does not have) responsibility for obtaining health care. Thus the question is not: is the provider or the health care user responsible. This dimension is concerned with the question as to who is responsible for the decision as to whether care will be provided. Is the expert's advice supportive or decisive.

In order to ascertain how responsibility is distributed among the various parties at this point, we should first take a look at their visions of 'person'. This vision plays an important role in norms regarding rights to and legal specification of health care. It varies by culture, society and belief. There is no global view of what constitutes a person. There is, however, agreement on certain general beliefs (Leenen, 2000). Global declarations, such as the Universal Declaration of the Rights of Man (Ministerie van Buitenlandse Zaken, 1949) and the International Covenant on Civil and Political Rights (Office of the Higher Commissioner for Human Rights (1976), establish a general vision of man: he is an autonomous person whose self-determination and physical and mental integrity must be protected against infringement; he must also be permitted access to all social services in order to foster his development. The legal vision of a person proceeds from values and norms based on humanity and judgments of rights and justice such as these have been developed in society (Leenen, 2000).

In order to protect the health care user and his self-determination the government passes laws. The Medical Practice Agreement Law (in Dutch WGBO) is designed to define patient general rights. This law, however, makes it impossible for the health care user to bear responsibility for the care they ask for: the treating practitioners expertise cannot be excluded. The care provider has the right to refuse to deal with unreasonable health care user's requests. The care provider makes decisions based on his expertise and may refuse a health care user's requests. Most health care users do not have the necessary medical knowledge to make health care decisions and there is consequently an information asymmetry. This knowledge and skill is regulated by law whereby the government determines that not everyone is permitted to dis-

pense medical advice. The Professions in Individual Health Care Law states simply that, 'a number of treatments are reserved for qualified professionals'. This does not prevent good advice and once a decision is made on a firm basis in consultation with the care provider, the care provider is then ultimately responsible for the decision. This is true for all health care which falls under the Professions in Individual Health care Law. Ultimate legal responsibility for treatment, medication, remedies by (para-) medical personnel for cure and care lies with the medical expert. A demand-driven approach to this part of health care is thus more or less out of the question and this means that for this part only the demand-oriented approach is feasible. Note that a health care user must himself agree to a treatment and may also refuse it. In this regard the health care user is indeed autonomous. This can perhaps be viewed as a 'negative form of steering by the demand'. There are, however, other forms of health care which stand outside of this law. As concerns non-medical care, legal responsibility for cure and care can rest with the health care user. For these categories both a demand-oriented and a demand-driven approach are possible.

Responsibility cannot be seen as separate from control and final say. After all, without any control an individual cannot be held responsible. The typology dimension Control is concerned with which party ultimately has the final say and the means over which care is provided when and by whom. In other words, who has the right to make final decisions and who has the (financial) means to get treatment. Legally speaking, control is translated and laid down in light of the right of self-determination. In the Declaration on the Promotion of Patient's Rights in Europe (WHO, 1994) the right to self-determination is expressly mentioned in article 1.2: 'Everyone has the right to self-determination'. A person's right to self-determination over his own life is a legal maxim. The principle right to self-determination provides a normative framework for the testing of (legal) positions in health care and with respect to medical treatment outside of the health care system (Leenen, 2000). This is of particular importance because the option to act in accordance with one's own judgment is currently under pressure in these sectors. The causes of this are the dependence of the health care user on the provider and the health care system, the drastic character of medical care which can touch a person profoundly, and the control that social institutions and sometimes the government have over individuals. The right to self-determination is well established. Yet the state can impose limitations on this right, such as with psychiatric patients, for example. Even in those cases, however, this right must be respected and everything must be done to permit every health care user to exercise it to the best of his abilities. This is the basis of the law governing admission to psychiatric hospitals (in Dutch BOPZ) and with regard to the legal representation and unnamed substitutions in the WGBO, this ensures that these are obliged to include the health care user as much as is possible while carrying out their task (Leenen, 2000).

The role of the government is to protect the citizen's right to self-determination. This is accomplished by protecting basic individual rights, of which the right to self-determination is fundamental. The government, however, can also place limits on individual rights and thereby on this right as well. Very convincing reasons are needed to justify such limits (Leenen, 2000):

- One basis for such limitations is others' right to self-determination. Individual space is limited by the rights of others.
- A second basis for such limitations is that the exercise of these rights does not hurt others. This can refer to damage to another person, but also to the collective good ('Do not unto others what you do not want done to yourself' (The Scientific Council for Public Policy (WRR), 2004).
- A third basis for limiting the right to self-determination can also result from a desire to regulate unjust inequality or power relations.

That the government can impose such limits is in keeping with the community-oriented view to health care in which the community, not the individual, is central. Responsibility and authority are in fact here given over to the community as represented by the government. The goal of health care law is to protect the rights of individuals and to create a balanced relationship in health care (Leenen, 2000). This vision is also prominent in the new legislation for the new care system: the objectives of a single basic insurance plan are: 1) to protect its citizens from their own injudicious decisions as well as those of others (paternalistically protecting the individual from himself and others) and 2) to offer a solid health insurance package accessible by all (the burden of the sick vs. cost effectiveness) (Knottnerus, 2003). In short, because the Dutch health care system most closely matches the community-oriented approach, which limits the responsibility and freedom of citizens, in this respect a demand-driven approach is not entirely feasible.

7.4 HEALTH CARE FINANCE

In addition to the legal aspect of control, there is also control based on the disposition of (financial) resources. The free market is an instrument and was taken as a guiding principle in (the policy of) structuring and financing health care in 1988 (Boot & Knapen, 2001). There are all kinds of factors that can determine the extent to which one can speak of market or market-like conditions for individual products or services (Lapré, et al., 2001). The so-called 'care market' has certain imperfections when compared to an ideal market. As stated earlier, these imperfections directly limit a demand-driven (neoclassical) approach. The health care market differs from the ideal market by virtue of its uncertainty, amongst other reasons (Janssen, 2003). Demand for care is determined by the health of an individual (in addition to other factors such as education, income, distance, etc.). Given that an individual request for care in many cases does not depend on the desire for care, but is a consequence of the somewhat

stochastic probability distribution of the need for care, in many cases we cannot speak of free choice. In these cases one of the basic conditions for a market, an autonomous choice, is not satisfied, and therefore a wide class of commodities is non-marketable (Arrow, 1963). Someone who asks for health care, is asking for information at that moment (to reduce uncertainty) or is suffering in a way that a cure or care in some form should be given. The designation 'consumer' for those seeking health care is expressly avoided. The compulsory character of a request for care undermines the argument for rational choice; after all, anyone seeking health care is not a consumer who can choose whether or not to purchase care, but a person in a (potentially emergency) situation in which care is very much needed or even essential.

In addition to this uncertainty, the market for health care is also characterised by limited competition. The government has set regulations in all kinds of ways. At the level of the relationship between health care user and care provider, in the new health care system, the government abolished the commitment for insurers to offer contracts to all providers with the intent to offer more choice for health care users. This way, insurers are able to provide for more differentiation in the supply. Providers are then confronted with market processes (competition) as if they were all entrepreneurs in a market reacting to demand and supply. This is not a true market, however, because on one side tight governmental legislation limits competition (Janssen, 2003) and on the other because of the 'insurance principle' a basic condition for a free market in the economic sense is (partially) eliminated. There is no discussion of a price mechanism between the health care user and care provider for a great deal of care provided. The control to dispense money to purchase care is considerably restricted because of the 'insurance principal', and lies with the so-called 'third party', the health care insurer (principle agent relation). The roles of a consumer as decision makers, payers and users in the health care market are largely spread across diverse actors (Janssen, 2003). All of this demonstrates that the market for health care is far from perfect (Janssen, 2003). What is possible, however, are 'market-like mechanisms' through which care providers attempt to link up with health care users (and insurers) by other than financial means such as quality of service, short waiting lists, and a professional reputation. Care providers can 'price themselves out of the market' with unacceptably long waiting lists, for example. The way in which care is currently organised is, in fact, a recognition that for a wide assortment of care services there is no discussion of a 'real market': were control equally distributed between health care users and providers, then we could speak of a market. As things now stand, however, this 'market' is organised in a indirect manner through insurers, and thus on an aggregated (meso) level.

Steering by the demand is also possible in the relationship between the health care user and health care insurer. Financial accessibility to care, that is, the availability of

indispensable care to the ill, is a foregone conclusion (Boot & Knapen, 2001). Under the current system, insurers offer various supplementary packages beside the sick-benefit fund (for which the content is set by law). Close examination reveals that the packages vary only slightly. Treatment is in principle the same everywhere and this is known as 'formal medicine'. After 2006 the provision of services which are part of the new basic package will be the same regardless of insurer as the package will be determined by law. As regards this part of health care, steering by the demand is limited to the possibility of buying supplementary packages. Beside this, there can be some form of market forces on the nominal premium charges. What remains for insurers is competition for quality: a demand-driven aspect here might be, for example, to permit a choice of providers. In this way a health care user who learns that he must wait two months for a scan at his local hospital may go to another hospital in order to get his need fulfilled more quickly. In this case there is no possibility of the primary hospital making a claim, but rather the so-called exit-option which in many cases is covered by insurers.

As described above, both relations at the micro-level are limited in various ways by the state (the macro-level). These limitations, based on social norms and values, are regulated by the government. One of these values is solidarity which is described as a willingness to bear the consequences of one's fellowship with others. Within the Dutch health care system the principle of solidarity means that citizens are aware that their compatriots can get sick and need care for which they cannot pay. For this reason citizens are legally bound to carry health insurance. What is and is not supported by solidarity (i.e., is or is not covered by the basic package), is determined by predetermined criteria. A basic insurance package of this kind (the same coverage for everyone) is principally based on the socially-oriented approach. According to Dunning, it is obvious that an individual approach to health and health care in which personal preferences are central cannot be achieved during a period of permanent economic scarcity. The commission Dunning proceeds from the assumption that the sum of all individual claims is greater than society wants to pay. This is all the more so when other services ñ education, housing, the environment ñ deserve to be considered as components of individual health care. At any given moment society is not prepared to make available unlimited funds for public health. In this connection Post (2003) asserts that demand-driven care originates when times are good and there are no shortages and, because demand is endless, control is always an issue. Thus, there is no right to unlimited health care. It is rather dependent upon current financial possibilities (Dunning, 1991). Where the individual approach has freedom of choice and in principle everyone's needs are met, costs create inequality in accessibility to care and it does not determine which care is more or less needed. The community-oriented view curtails individual freedom of choice. This approach also limits the professional autonomy of professionals (Dunning, 1991). The new Health

Care Law uses social, not individual, norms to determine the contents of the basic health insurance package. If society agrees that the social system is responsible for a certain portion of health care, then it is included in the basic package. That which is not so covered must be financed with supplementary insurance or paid for out of pocket.

Which health care services are put in the basic package is determined by its necessity, efficacy, expediency and whether they could be paid and accounted for by the health care user himself (see Figure 7.2). Only care which falls under the community-oriented criteria as necessary, efficacious, and expedient will be covered (Dunning, 1991). Medical services are professionally indexed and socially regulated. Providers' responsibility is thereby circumscribed and inescapable. It is presumed that those costs not covered by the basic package will be borne by the individual.

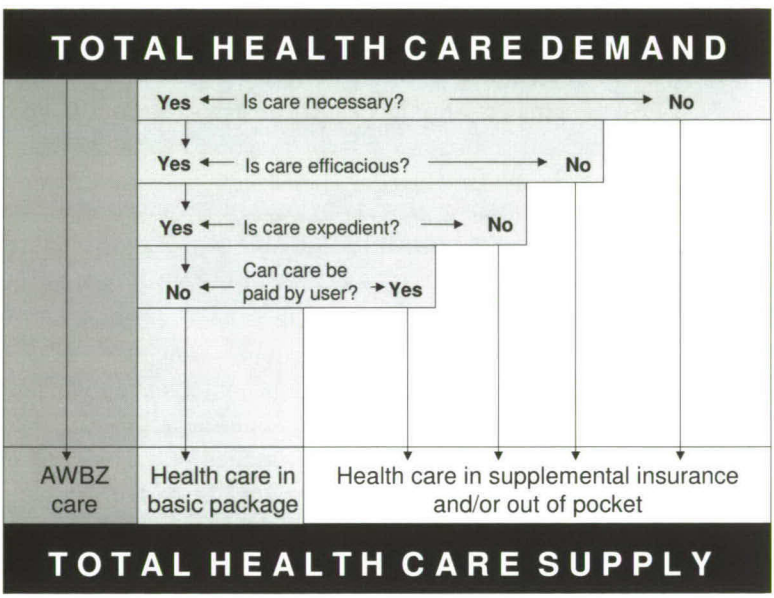

Figure 7.2 *Division of care based on Dunning's (1991) criteria*

There are different kinds of necessity to be distinguished based on the community-oriented view. Necessary care must then not only be specified, but also requires a ranking in order to be able to determine more and less needed care (and consequently which services will be covered by the basic package). The basic package consists of acute medical treatment in all cases where today we speak of a risk with regard to illness or accident. This portion of health care will be financed via insurance: based on the principle of solidarity and the coverage of risk, the total of premiums collected will be divided between health providers by politicians. Basic

package care, considered medically necessary and for which expert practitioners are responsible, will have no price mechanism in health care user-provider relations (excepting the meso-level, the so-called Diagnosis Treatment Combinations (DBC's)). Describing the basic package fills in part of the total continuum of health services. That which remains after the basic package is decided upon, is nonetheless still important for the quality of life. This care can be bifurcated into AWBZ care, such as home care for chronic illnesses, and care which can be financed from supplemental insurance and out of pocket (such as dental care, but also special procedures such as laser eye surgery or face lifts). This care can give rise to diversity and in this regard one can speak to some degree of 'choices' and thus a market-like situation. The health care user can develop more direct influence on the treatments offered. The Personal Budget (PGB), as alternative for care paid in kind, may be seen as an ultimate form of demand-driven care in which the budget is made available to the health care user who purchases care himself.

7.5 CONCLUSIONS AND DISCUSSION

As mentioned above, Rijckmans' (2005) typology consists of two ideal types. Of the two ideal types, this article demonstrates that for much of health care the demand-driven variant appears to be a utopian reflection of reality. The ultimate version of demand-driven care would consist of the health care user entering 'the market' with a sack of money and buying those services he thought he needed. Responsibility for the prudent use of this money would likewise lie with the health care user. This approach to health care covered by the basic package could be achieved only with difficulty in the Netherlands today. An extreme situation would then arise in which the health care user's money would run out while he still needed care and because he would not be able to count on a safety net, he would be left to his fate. When it comes to essential care, this would not be acceptable in the Netherlands. Yet unbridled acceptance of a health care user's needs also does not fit into the current vision of health care, which share the most common ground with the community-oriented view. Although a similar care system might be acceptable in other nations or other periods, this approach is limited in the Netherlands by the current system of norms and values, represented in current legal and financial options.

Given the options and limits of the legal and financial regulation of health care, an attempt was made to differentiate care services which qualify for demand-oriented as well as those for demand-driven care. It goes without saying that these divisions are hardly distinct and can vary considerably per individual. When dealing with demand for care, there is a continuum from medically essential, immediate care (e.g., heart attack) at one end and optional treatments (e.g., face lifts) at the other. Somewhere in between these two extremes is a point of social consensus defining the border between essential and non-essential care. Thus for example, eyelid surgery could well

be classified as necessary health care from a psychosocial point of view, and on the other side, it could also be considered a luxury item. Plasters are part of care, but their low cost means that they will be classified as normal household attributes. In case of serious injury however, they are covered by insurance. The conclusion to be drawn here is that no firm border can be drawn, but that judiciousness leads to workable solutions.

When the current legal situation is examined vis-à-vis responsibility and control, it appears that as regards (para)medical care ultimate responsibility for treatment, prescriptions, remedies, and care lies with the expert practitioner. A fully demand-driven approach to this part of health care is thus more or less out of the question. Outside of the law, however, there are other forms of health care. For non-medical care the health care user can be held legally responsible. These forms of care are amenable to both demand-oriented and demand-driven approaches. As regards the right to decide, it appears that the government is permitted to limit citizens' choice. Because Dutch health care comes closest to matching the community-oriented approach which limits citizens' responsibility and freedom, in this respect a demand-driven approach is not fully possible.

When we finally examine control on the basis of (financial) means, the earlier differentiation between unliberalised and liberalised care partly coincides with that covered by the current basic package (and from 2006 the new Health Insurance Law) on one hand and with the option for either supplemental insurance or self-financing on the other. In the second case the need for care can fall under market forces up to a certain level. Those needs which are not covered by the basic package offer the greatest chance for a practical, demand-driven approach. Remaining services are more easily handled by a demand-oriented approach.

In light of the current health care system and associated legislation and financing of health care in the Netherlands, it is clear that it is community-oriented and the planned care system for demand-oriented care will offer scores of options and that this approach fits well with the extant vision of health care. Conversely, the individual demand-driven care offers limited options. Socially accepted norms and values with regard to expertise and control over the provision of health services limit individual freedom of choice for certain treatments and services. Based on solidarity, this system ñ whose limits are determined by national authorities including who may dispense health care services ñ limits individual access to care. Despite the existence of market-like mechanisms, which can contribute to improvements in quality and patient service, ultimately demand-driven care is largely out of the question. A health care user's desires will be limited by law in a number of ways: indexing by experts, an absence of financial means, etcetera. That part of care, which is not based on (para-)

medical knowledge and for which the health care user can pay (a Personal Budget, but also private financing), the demand-driven approach is possible. Within the current legal and financial system, the vast majority of care qualifies best for a demand-oriented approach. In order to make demand-driven care possible, a change not only in care offered, but much more in the general view of health care and current norms and values would have to take place. Should the individual approach, which matches the demand-driven variant nicely, receive more support and the health care system take more into account than social concerns alone, a more demand-driven approach would be possible. This would bring with it a great number of legal and financial implications, however. In short, although a demand-driven approach to health care would certainly contribute to a more central role for the health care user on various fronts, for the overwhelming bulk of care within the current, community-oriented view a demand-oriented approach fits better.

Chapter 8

General conclusions and discussion

8.1 INTRODUCTION

Demand-orientation and demand-driven care are seen by many as the key concepts in innovative thinking about health care, welfare, and living (Van Diest, Van Wijngaarden & Wijngaarden, 2002). The two concepts are seen as the answer to many of the problems currently confronting our health care system. However, different actors define the two concepts in different ways. There is little literature that attempts to define these concepts. Furthermore, there does not seem to be enough insight into the content and the consequences of the concepts of demand-orientation and demand-driven care in the health care and welfare sectors. Because of the lack of scientific knowledge about the meaning of the concepts, the topicality of the subject, and the great interest from the field, a PhD study was initiated in May 2001. This study's aim was to gain insight into the concepts of demand-oriented and demand-driven health care, and fill them in. The main goal was the development of a model for scientific use that could also serve as a tool for policy and practice in the field. It should serve as a means for the government and health care organisations to shape their vision with respect to the health care user and acquire insight into the consequences of different ways of organizing their services. In this study, the following questions were addressed:

- What is meant by the concepts demand-orientation and demand-driven care?
- To what extent are the abstract dimensions present in the current supply?
- How do health care users value the concepts?
- How do the approaches match with current societal rules and legislation and ways of financing of the health care system?

8.2 THE MEANING OF THE CONCEPTS DEMAND-ORIENTED AND DEMAND-DRIVEN HEALTH CARE

First, a literature study was conducted to determine the existing definitions of the concepts demand-oriented and demand-driven health care. Although there was confusion among the different parties, a few common themes could be identified. It was con-

cluded that there seems to be a fundamental difference between the two concepts. Demand-orientation focuses on the extent to which those who provide services take the needs of individual patients into account. This is largely a matter of a professional perspective, with those supplying services still guiding demand. In the case of demand-driven care, the focus is on freedom of choice, with the individual patient having the final say on the type of care received. Demand-driven care is seen from a more administrative perspective, with hierarchical budget-driven approaches being replaced by more decentralised consumer-oriented perspectives. The emphasis is on the individual nature of demand. Demand-driven care assumes that only individual patients have the necessary experiential expertise to make informed choices. In some instances, patient influence can be extended even further, giving individuals the necessary financial resources to ensure that desired services are provided. Demand-driven care can thus be viewed from an economic perspective, where supply is actually influenced by demand. In the case of demand-orientation, supply guides demand, while in the case of demand-driven care, demand guides supply.

An important goal of the two new approaches is that health care should contribute to the fulfilment of the individuals' health-care-related needs and, therefore, to their perceived quality of life. Before conducting fieldwork on the meaning of demand-oriented and demand-driven health care, another literature study was performed on the key-concepts 'quality of life', need, want, and demand. The study provided an initial understanding of these fundamental concepts that are at the heart of the demand-oriented and demand-driven approaches. The study showed that, in order to contribute to an individual's quality of life, it is not sufficient to rely on the articulated demand, as a demand for health care is in itself often only a partial or modified version of an individual's felt need for health care. In other words, if fulfilling the individual's needs is the objective of the shift towards demand-driven care, health care providers should ideally take into account all the factors that influence the articulation of a demand, and explore the underlying need, instead of only listening to the articulated demand while shaping, putting together, and designing their services. This means, among other things, that the given supply will probably not address the needs of every single individual. Individuals adjust their demands to the existing services, but the given supply may not be the best answer to their felt needs. It seems a necessary step for health care providers to disconnect the articulated demand from the existing supply and make way for new services to be developed, to meet the goals set in a demand-driven approach.

After the underlying key-concepts 'need', 'demand' and 'quality of life' had been clarified, a Delphi study investigated whether the definitions of 'demand-orientation' and 'demand-driven care' found in the literature, agreed with the meaning of the concepts given to them by the different parties in practice. Twenty-six representatives

of all relevant fields in the health care sector gave their opinions on the content of the concepts of demand-orientation and demand-driven care, resulting in the formulation of a typology. There was a certain consensus within this expert group, and the typology represents this consensus, providing insight into the similarities and differences of the two concepts, based on five dimensions[3]: Responsibility, Control, Need-determination, Way of imbedding of the view within the organisation, and Choice. Based on the typology, demand-oriented health care was defined as care in which the responsibility for and final say in decision-making about health care services are in the hands of the professional. During this decision-making process, the professional takes the health care user and his wants and needs into account, treats the health care user in a pleasant manner, and informs him about the possibilities in his situation. Demand-driven health care was defined as care in which the responsibility for and final say in decision-making about health care services are in the hands of the health care user. The health care user points out his wants and needs with regard to the type of health care services and, after being informed about the possibilities in his situation, has the freedom to choose what he wants.

The typology provides an understanding of the concepts as they are applied in the Netherlands, and can be used, for instance, by policymakers to provide clarity and transparency in their communication. The outlined typology is important for assessing the implications of the two new approaches for policy and practice.

The applicability of the typology was explored by investigating whether the dimensions also appear in practice. Three examples of Dutch health care services were compared with the typology in order to determine the degree to which they are demand-oriented or demand-driven. The model appeared useful for this sort of classification of services. Furthermore, the model seems useful in explaining why services are not typical of either the demand-oriented or demand-driven approach.

8.3 THE HEALTH CARE USER'S VIEW ON DEMAND-ORIENTED AND DEMAND-DRIVEN HEALTH CARE

As stated before, the distinction between the supply-oriented approach, on the one hand, and the demand-oriented and demand-driven approaches, on the other, is largely a matter of focus. The supply-oriented approach focuses on the existing supply; the demand-oriented and demand-driven approaches focus on the clients' perspective: 'what does the health care user need and want?' Therefore, the next step in

3. These dimensions are not independent, but instead, together they form aspects of the complex reality. In constructing the dimensions, elements were clustered. It is also important to notice that there are interdependencies among these elements.

the study was to find out how health care users view the concepts and which elements of the typology clients experience as important. The population that was chosen to investigate this, was clients of the ambulatory mental health care. The results showed that many clients value (elements of) the demand-oriented and demand-driven approaches in health care. However, not all elements and all dimensions were valued in the same manner, with results differing for each dimension. The elements that were found important mainly belonged to the dimensions Need-determination, Imbedding of the vision within the organisation, and Choice.

However, according to the typology, the difference between the demand-oriented and demand-driven approaches is especially noticeable in the dimensions Responsibility and Control. Yet none of the elements belonging to the dimensions Responsibility and Control were experienced as important by more than two thirds of the clients, and three out of the four elements that were experienced as not important by more than two thirds belong to these two dimensions. Despite a general consensus about the dimensions, a slight preference is visible when differences in treatment history are considered: clients with a treatment history of two years and over valued the demand-driven elements more than clients with a treatment history of less than two years.

In general, clients in ambulatory mental health care do not seem to be very concerned about who makes the decisions in the process, but much more about the way the decision-making process is carried out. Clients especially value being heard and being involved in the process as serious parties. This could imply that the mental health care institution's policy should emphasize such aspects as the manner of treatment, information provision, and involving the client in the decision-making process, while placing less emphasis on aspects like shifting responsibility and control (and financial means) towards their clients.

After studying the importance of the elements in the two approaches, their presence in current health care services was studied. Clients recognised only a limited number of elements from the typology in the mental health care serviced they received, namely those from the dimensions 'Need-determination' and 'Way of imbedding of the view within the organisation'. A majority of the clients agreed that their needs were determined in consultation with the professional, that the professional made a great effort to gain insight into the real demand, that they were treated in a pleasant manner, that the institution was client friendly and oriented towards the clients, that the personnel's attitude was oriented towards the demand, and that the clients' needs and wishes were taken into account. The results also showed that there was a significant difference between clients' experiences of either typical demand-oriented or demand-driven elements in the private practice on the one hand, and at the state mental health care institutions on the other. In general more clients of private mental health

care institution recognised elements typical of demand-driven health care in the services provided them than clients of state mental health care institutions. In the state mental health care institutions, more clients recognised elements typical of demand-oriented health care. In spite of these differences, the most typical and distinctive elements were hardly recognised at all. In other words, the majority of clients did not have a clear view of the position of either the professional or the health care user in the decision-making process; they did not have a clear notion of where the responsibility lies and who has the final say.

Taking the typology of demand-oriented and demand-driven care as a starting-point, none of the three institutions for ambulatory mental health care can be labelled as typical demand-oriented or demand-driven, particularly because of the absence of elements from the dimensions 'Responsibility', 'Control', and 'Choice'. The private institution leaned a bit more towards the demand-driven approach the most, while the two state institutions leaned a little bit more towards the demand-oriented approach. However, an earlier phase of the study established that clients in ambulatory mental health care do not value the dimensions 'Responsibility' and 'Control' so much, attaching much more importance to the way the decision-making process in their situation is carried out (elements from the other three dimensions). Clients especially value being heard and being involved in the process as serious parties. According to clients, the most important factors were the way of treatment, involvement in the decision-making process, and the provision of information. A majority of all the clients in the study recognised the first two elements in the health care services they received. Many elements from the dimensions 'Need-determination' and 'Way of imbedding of the view within the organisation' were recognised. These dimensions do not discriminate much between the two approaches, but they are constructed of elements that are typical of both, namely as counterparts of the supply-oriented approach. Through these dimensions, the health care user is given a more central role in health care. In sum, the results of this part of the study showed that clients only recognised some of the elements typical of either demand-oriented or demand-driven care in the health care services provided. Since both approaches are fairly new and still very much in development, it may require some time before these new procedures are implemented in the activities of daily practice and affect the actual clients' experiences. At present it is hard to say whether clients would prefer the demand-oriented or demand-driven approach, and difficult to say which approach, according to the experiences of their clients, the institutions that participated in this study are aiming at.

8.4 THE DEMAND-ORIENTED AND DEMAND-DRIVEN APPROACHES WITHIN THE CURRENT SOCIAL RULES, LEGISLATION AND WAYS OF FINANCING OF THE HEALTH CARE SYSTEM

The final part of the study considered the possibilities for both approaches in the current health care system, based on the current legal and financial situation. The different

types of services were arranged, and an attempt was made to indicate which part of the services would be eligible for either the demand-oriented or demand-driven approach. In light of the current rules, legislation, and financing of health care in the Netherlands, it is clear that the existing community-oriented view on health care offers limited possibilities for demand-driven health care. Socially accepted standards and values concerning the provider's professionalism and the control over who provides services, restrict the individual in his freedom to choose health care services. The current system, based on solidarity, whose boundaries are guarded by professionals, restricts the individual in his free access to health care. Despite the existence of 'market-like mechanisms', which can contribute to an improvement of quality and make the service more 'client-oriented', total demand-driven care is more or less out of the question for a large part of health care. The health care user's wants and needs are restricted in multiple ways: professional referral, the absence of financial means, etc. Health care which is not based on (para)medical knowledge and for which the user has the financial means (whether a personal budget or private financing) is most suitable for a demand-driven approach. This means, within the current system of legal and financial regulations, a large part of health care, is only eligible for the demand-oriented approach. A shift will have to take place in order to make demand-driven health care possible, not only in the supply, but especially in the existing view on health care, and existing values and standards. If the individual approach, in which demand-driven care fits nicely, gained more support, and health care focused more on individual wishes instead of on the standards set by the society, a demand-driven approach would become possible for a much larger part of health care. However, this would impose huge legal and economic implications for the current health care system. In sum, although a demand-driven approach can certainly place the health care user in a more central position, at present, given the existing community-oriented view, the main part of health care is mainly eligible for the demand-oriented approach.

8.5 LIMITATIONS

The formulated typology provides an understanding of the two concepts in the Netherlands. The question is whether or not the typology can be used in a broader context. It remains to be seen whether it also represents the content of the concepts in other European countries. The typology was formulated based on the input of Dutch experts. It is possible that experts in other countries would come up with other elements, and maybe even resulting in other dimensions. This could be influenced, for instance, by differences in the type of health care system. Further research is needed to develop a typology that represents the situation in other countries as well.

This quantitative study among clients was exploratory. The main goal was to determine the clients' views of the importance of the elements derived from the typology of demand-oriented and demand-driven health care, as well as to categorize the

clients' experiences with regard to the recognition of the elements. Methodologically, this study did not aim to get a representative sample, but to get a sufficient representation of respondents within the different subgroups about which statements had to be made. It is not clear whether or not the non-response was selective with regard to the dependent variables. It is conceivable that the people who did participate find it more important to express their opinion about demand-oriented and demand-driven health care and that, therefore, they would also prefer a more demand-oriented or demand-driven approach.

The results suggest the utility of the formulated typology of demand-oriented and demand-driven health care. They sketch the extent to which the institutions' health care services are currently experienced as demand-oriented or demand-driven. In order to substantiate these results, more research needs to be done. As each health care institution organizes its services in its own fashion, pronouncements about a certain sector are hard to make. At present little more can be done than making statements about a given institution. If further research is done, aiming at a representative picture of the clients' experiences with a certain institution, one will have to keep in mind such issues as a sufficient response, the dispersion of respondents over the different types of services within the institution, and the possible selectivity of response and non-response.

8.6 CONCLUSIONS

In brief, the results of the complete study provide a scientifically grounded insight into the meaning and consequences of the concepts demand-oriented and demand-driven health care. The study also provides an initial investigation of health care users' views of the concepts. The health care users involved in this research valued elements of both approaches, especially elements of the dimensions Need-determination, Way of imbedding of the view within the organisation and Choice. Furthermore, the results suggest the utility of the formulated typology of demand-oriented and demand-driven health care in examining health care users' needs, wants, and experiences concerning health care institutions' services. As seen, clients of ambulatory mental health care did not have a specific preference for having the responsibility and final control associated with the demand-driven approach. In general, it seems that clients in this sector don't care as much who makes the decisions in the process and who has the final say, as about the way these decisions are made. For this sector, a demand-oriented approach may suffice to contribute to the quality of life. In other sectors, other needs may be prevalent. In the case of chronic care for the physically handicapped, health care users may well have the need to exert influence on the decision which type of health care services to choose and at which organisation, given the financial resources to do so. In ambulatory mental health care, there is a slight preference among clients with more chronic problems (those who have received care

for more than two years) for the element 'having the (financial) means', in comparison to clients with a treatment history of less than two years. On the other hand, it is also possible that in the cure sector, this need is not felt as strongly. In order to choose for either the demand-oriented or demand-driven approach, further research within different sectors is desirable. And finally, the study finishes off with some implications for policy and practice concerning the possibilities of the two approaches in the existing health care system: it is concluded that, although a demand-driven approach to health care would certainly contribute to a more central role for the health care user on various fronts, for the overwhelming bulk of care within the current, community-oriented view a demand-oriented approach fits better.

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Summary

Societal developments and new insights are causing continuous changes in the health care and welfare sector. In the Netherlands, as in most European countries, there is an increasing tendency toward demand-oriented and demand-driven approaches in the development of health care policy and the organisation of health care services. The concepts demand-orientation and demand-driven care are seen by many as the key words in innovative thinking about health care and welfare, and thus as the answer to the problems confronting these sectors today. Both approaches, in which the main focus is on 'the demand', are seen as counterparts of the supply-oriented approach, which has 'the supply' as point of departure. However, there is confusion about the meaning of the concepts, literature clarifying the concepts is scarce, and, in practice, the concepts of demand-orientation and demand-driven health care are defined in various manners. Therefore a study was designed and carried out to develop a typology of the concepts of demand-oriented and demand-driven health care. The main goal was the development of a model for scientific use that could also serve as a tool for policy and practice in the field. The study consists of three phases. First, two literature studies were done concerning the exisiting definitions of the demand-oriented and demand-driven approaches in the professional and scientific literature and the key words underlying these approaches. Next a Delphi-study was carried out among experts to find specific elements characteristic for both concepts. The third phase focused on the health care users' views and consisted of a questionnaire study among clients in the ambulatory mental health care.

The study starts by examining the different definitions in the scientific and professional literature, comparing them on the basis of common and distinctive elements. The results of that comparison show that there seems to be a fundamental difference between the concept of demand-orientation on the one hand and that of demand-driven care on the other. In the case of demand-orientation, supply steers the demand, though the demand is considered when putting together and shaping the supply. In

the case of demand-driven care, supply is steered by the demand, and freedom of choice for the user is central. Additionally, in the case of demand-driven care, the user even has the (financial) means to instrument this freedom.

The swing from supply-oriented care to demand-oriented and demand-driven care is fuelled by the current trend to put the individual in the foreground, considering the individual's quality of life, needs and wants. Therefore, a second literature study was done in order to get insight into the key concepts, 'need', 'demand' and 'quality of life', which are at the heart of these approaches. According to the WHO's widely used definition, 'quality of life' is determined by needs fulfilment in the fields of emotional well-being, interpersonal relationships and social bonds, material well-being, personal development, physical well-being, autonomy and self-determination, and spirituality (WHO, 1994). Applying Bradshaw's model of need (Bradshaw, 1977), health care 'need' was defined as 'a discrepancy in the individual's conscious perception between his actual and his desired state of health and/or well-being, which is experienced by the individual as negative' and 'demand' was defined as 'that part of a felt need for health care that is actually translated into a demand for care'. This allows a framework for research for this new view in health care, which describes the process from experiencing a need to finally articulating a demand. The model is based on Andersen's widely used Behavioural Model (Andersen, 1968; 1995). According to this model, the articulation of a felt need can be influenced by predisposing characteristics and the perception of enabling resources, and be blocked, or transformed into an altered articulated demand. In order to contribute to the individual's quality of life, therefore, it is not sufficient to rely exclusively on demand, as a demand for health care is itself often only a partial or modified version of an individual's felt need for health care. The study concludes by stating that if the shift towards demand-driven care aims at fulfilling the individual's needs, in an ideal situation health care providers should take into account the influence of all these factors and explore the underlying need, instead of just listening to the articulated demand, while shaping, putting together, and designing their services.

Next, in order to identify the different views that the various relevant parties hold, and to examine the degree of consensus in the Netherlands about the concepts of demand-orientation and demand-driven care, a Delphi-study was conducted, based on the Grounded Theory (Glaser & Strauss, 1967). The twenty-six experts that participated in the study, were representatives of the relevant actors in the field: scientists, health care insurance companies, health care suppliers, the government, independent advisory bodies, and client interest groups. The experts were asked whether or not they considered the two concepts as different, and if so, to point out specific elements that, in their opinion, were characteristic of either demand-oriented or demand-driven care. The study resulted in a typology of the two concepts, demonstrating the simila-

rities and differences between the concepts in five dimensions: 1) Responsibility, 2) Control, 3) Need-determination, 4) Way of imbedding of the view within the organisation, and 5) Choice. According to the typology, in demand-oriented health care the responsibility for and final say in decision making about health care services are in the hands of the professional. During this decision-making process, the professional takes the health care user's wants and needs into account, treats the health care user in a pleasant manner, and informs him or her about the possibilities in his situation. In demand-driven health care, conversely, the responsibility for and final say in decision making about health care services are in the hands of the health care user. The health care user identifies his or her wants and needs with regard to the type of health care services and, after being informed about the possibilities, has the freedom to choose what he or she wants. The typology seemed to provide an understanding of the similarities and differences between the two concepts. After the two concepts had been defined, the typology was used to identify three examples of existing types of services as either demand-oriented or demand-driven and appeared to be a useful instrument.

Then, since the demand-oriented and demand-driven approaches emphasize the health care user's perspective, the views that health care users have of the importance of the elements in the typology were explored. A survey was conducted among 4,250 ambulatory mental health care clients in the Netherlands, by means of a postal questionnaire. To include clients with different experiences with mental health care, the sample was stratified according to the length of treatment history. The results showed that most clients found it important that the 'needs are determined in consultation with the client', that 'the client is treated in a pleasant manner', and that 'the professional informs the client about the possibilities in his situation'. Significant differences were found between groups with different background-factors: income, education, age, sex, and treatment history all had significant correlations. It was concluded that most clients in ambulatory mental health care appreciate the demand-oriented and demand-driven approaches, although not all elements were appreciated to the same extent. In general, clients seemed to care less about who makes the decisions, and more about the way the decision-making process is carried out. Clients especially valued being heard and being involved in the process as serious parties.

Next, the clients' opinions were explored concerning the presence of the elements in the health care they received. The first research question was 'Which of the aspects of demand-oriented or demand-driven care that clients experience as important do clients recognise in the health care they receive?' The second research question was 'Are there any differences between the opinions of clients in state and private institutions and those of clients with different treatment histories?' Clients mainly seemed to recognise aspects concerning the way their needs were determined and

the way they were treated by the institution. They recognised that their needs were determined in consultation with the health care provider, that they were treated in a pleasant manner, and that the institution was client-friendly. On the other hand, clients did not recognise certain aspects of demand-oriented and demand-driven care in the ambulatory health care they received. These aspects included who is responsible, who has control over the decision-making process, and the number of options regarding the type of treatment or institution. Only some of the elements that are typical of either demand-oriented or demand-driven care were recognised by clients in the mental health care they received. On the other hand, a substantial number of the aspects that most clients considered important were recognised.

Finally, the possibilities of the new approaches and the developed typology were considered given the current legal and financial situation. The main question addressed was given the current legal and financial situation, what are the possibilities and limitations for the demand-oriented and demand-driven approaches within the Dutch health care system? In light of the current health care system and associated legislation and financing of health care in the Netherlands, it is clear that it is community-oriented and the planned care system for demand-oriented care will offer scores of options and that this approach fits well with the extant vision of health care. Conversely, the individual demand-driven care offers limited options. Socially accepted norms and values with regard to expertise and control over the provision of health services limit individual freedom of choice for certain treatments and services. Based on solidarity, this system ñ whose limits are determined by national authorities including who may dispense health care services ñ limits individual access to care. Despite the existence of market-like mechanisms, which can contribute to improvements in quality and patient service, ultimately demand-driven care is largely out of the question. A health care user's desires will be limited by law in a number of ways: indexing by experts, an absence of financial means, etcetera. That part of care, which is not based on (para)medical knowledge and for which the health care user can pay (a Personal Budget, but also private financing), the demand-driven approach is possible. In short, although a demand-driven approach to health care would certainly contribute to a more central role for the health care user on various fronts, for the overwhelming bulk of care within the current, community-oriented view a demand-oriented approach fits better.

In brief, the complete study provides a scientifically grounded insight into the meaning and consequences of the concepts demand-oriented and demand-driven health care. The study also provides an initial investigation of health care users' views of the concepts. The health care users involved in this research valued elements of both approaches, especially elements of the dimensions Need-determination, Way of imbedding of view within the organisation, and Choice. The results

suggest the utility of the formulated typology of demand-oriented and demand-driven health care in examining health care users' needs, wants, and experiences with health care institutions. Clients of ambulatory mental health care did not have a specific preference for the responsibility and final control associated with the demand-driven approach. In general, it seems that clients in this sector do not care as much about who makes the decisions in the process and who has the final say, as they do about the way these decisions are made. For this sector, a demand-oriented approach may suffice to contribute to the quality of life. In other sectors, other needs may be prevalent. In the case of chronic care for the physically handicapped, health care users may well want to influence the choice of health care services and provider, given the financial resources to do so. In ambulatory mental health care, there is a slight preference among clients with more chronic problems (those who have received care for more than two years) for the element 'having the (financial) means', compared to clients with a treatment history of less than two years. On the other hand, it is possible that in the cure sector, this need is not felt as strongly. In order to choose either the demand-oriented or demand-driven approach, further research within different sectors is desirable. Finally, the study concludes with some implications for policy and practice concerning the possibilities of the two approaches in the existing health care system: it is concluded that, although a demand-driven approach can certainly place the health care user in a more central position, at present, given the existing socially-oriented view (Dunning. 1991), the majority of health care is notably eligible for the demand-oriented approach.

Samenvatting

Maatschappelijke ontwikkelingen en nieuwe inzichten zorgen ervoor dat de gezondheidszorg en welzijnssector continu veranderen. In Nederlands, alsook in de meeste Europese landen, is er een toenemende behoefte aan vraaggerichte en vraaggestuurde benaderingen in de ontwikkeling van gezondheidszorgbeleid en de organisatie van de zorg. De concepten vraaggerichtheid en vraagsturing worden gezien als sleutelbegrippen in het innovatieve denken over (gezondheids-)zorg, welzijn en wonen. Deze concepten worden door velen gezien als het antwoord op de problemen die ons vandaag de dag confronteren. Beide benaderingen, waarin 'de vraag' central wordt gesteld, worden gezien als tegenhangers van de aanbodgerichte benadering waarin het aanbod als uitgangspunt genomen wordt. Echter, er is veel verwarring over de betekenis van de concepten. De literatuur met betrekking tot verheldering van de begrippen is schaars en bovendien worden deze begrippen door de diverse partijen op uiteenlopende wijzen gedefinieerd. Vandaar dat er een onderzoek werd ontworpen en uitgevoerd met als centrale doelstelling de ontwikkeling van een typologie van vraaggerichte en vraaggestuurde zorg. Deze typologie moest kunnen dienen als wetenschappelijk instrument voor beleid en praktijk. Het onderzoek bestond uit drie fasen. Als eerste werden twee literatuuronderzoeken uitgevoerd naar respectievelijk de bestaande definities van de begrippen in de professionele en wetenschappelijke literatuur, alsook naar de kernbegrippen welke ten grondslag liggen aan beide benaderingen. Vervolgens werd een Delphi-onderzoek uitgevoerd onder deskundigen om daarmee specifieke elementen te vinden die karakteristiek waren voor vraaggerichte of vraaggestuurde zorg. Tijdens de derde fase richtte de aandacht zich op de mening van zorgvragers ten opzichte van de beide benaderingen door middel van een kwalitatief onderzoek onder cliënten van de ambulante geestelijke gezondheidszorg.

Het onderzoek start met een vergelijking van de verschillende soorten definities uit de wetenschappelijke en professionele literatuur, waarin is gezocht naar gemeenschappelijke en onderscheidende elementen. Uitgaande van de huidige literatuur lijkt

er een fundamenteel verschil te bestaan tussen de wijze waarop het concept vraaggerichtheid wordt ingevuld en de invulling van het concept vraagsturing. In het geval van vraaggerichtheid stuurt het aanbod de vraag, waarbij in het samenstellen van het aanbod de vraag wel wordt meegenomen. In het geval van vraagsturing wordt het aanbod gestuurd door de vraag, waarbij keuzevrijheid voor de zorgvrager als centraal element wordt gesteld en de klant zelfs de middelen in handen heeft om dit te bewerkstelligen.

Een belangrijke reden voor de omslag van aanbodgericht naar vraaggericht is de trend om het individu en diens behoeften en kwaliteit van leven meer central te stellen. Vanuit deze invalshoek is een tweede literatuurstudie is uitgevoerd naar de betekenis van de kernbegrippen 'behoefte', 'vraag' en 'kwaliteit van leven', die aan de basis liggen van de nieuwe benadering van de gezondheidszorg. Volgens de WHO wordt voor de conceptualisering van kwaliteit van leven uitgegaan van een benadering in termen van een match tussen behoeften en realisatie van behoeften. Centraal staat de gedachte dat behoeften en behoefterealisatie op het vlak van emotioneel welbevinden, interpersoonlijke relaties en sociale binding, materieel welzijn, persoonlijke ontwikkeling, lichamelijk welzijn, autonomie en zelfbepaling alsmede spiritualiteit maatgevend zijn voor de waargenomen kwaliteit van het bestaan (WHO, 1994). Middels een bestudering van Bradshaw's behoeftemodel (Bradshaw, 1977), werd 'zorgbehoefte' gedefinieerd als 'een door het individu negatief ervaren discrepantie tussen zijn feitelijke en gewenste staat van gezondheid en/of welzijn', en 'zorgvraag' als 'het deel van de ervaren zorgbehoefte dat daadwerkelijk is omgezet in een vraag naar zorg'. Vervolgens werd in dit onderzoek een onderzoeksraamwerk ontwikkeld voor deze nieuwe benadering van de gezondheidszorg, dat het proces beschrijft van het ervaren van een behoefte tot aan het uitspreken van een zorgvraag. Dit model is gebaseerd op het veel gebruikte Socio-Behavioral Model van Andersen (Andersen, 1968; 1995). Volgens het raamwerk kan het uitspreken van een ervaren behoefte onder invloed van predisponerende karakteristieken en de perceptie van voorwaardelijke factoren, worden geblokkeerd, ofwel kan de ervaren behoefte worden bijgestuurd tot een aangepaste uitgesproken vraag. Om een bijdrage te leveren aan de kwaliteit van leven, is enkel uitgaan van de vraag onvoldoende, daar de vraag slechts een deel of zelfs een gewijzigde versie is van de ervaren behoefte van een individu. Geconcludeerd wordt dat wanneer de realisatie van de behoeften van een individu het doel is van de omslag naar een vraaggestuurde zorg, in een ideale situatie zorgaanbieders met de invloed van al deze factoren rekening zouden moeten houden en de onderliggende behoefte zouden moeten exploreren tijdens het samenstellen en ontwerpen van hun zorgaanbod.

Om de verschillende visies vanuit de betrokken maatschappelijke velden helder te krijgen en na te gaan of er onderling consensus bestaat over de inhoudelijke betekenis van de begrippen vraaggerichte en vraaggestuurde zorg, werd vervolgens een

Delphi-onderzoek uitgevoerd, op basis van de Gefundeerde Theorie (Glaser & Strauss, 1967). De zesentwintig deelnemende deskundigen waren vertegenwoordigers van de in de literatuur aangetroffen relevante velden, te weten: wetenschappers, verzekeraars, zorgaanbieders, de overheid, onafhankelijke adviesorganen en cliëntenorganisaties. Hen werd onder andere gevraagd om specifieke elementen te benoemen voor zowel vraaggerichte als vraaggestuurde zorg. Het onderzoek resulteerde in een typologie van de begrippen vraaggerichtheid en vraagsturing, waarin de verschillen en overeenkomsten tussen de benaderingen inzichtelijk werden gemaakt op basis van een vijftal dimensies, te weten: 1) Verantwoordelijkheid, 2) Macht, 3) Behoeftebepaling, 4) Formele inbedding van visie in organisatie en 5) Keuzemogelijkheid. Volgens de typologie is vraaggerichte zorg, zorg waarbij de verantwoordelijkheid voor en zeggenschap over de in te zetten hulp- en dienstverlening bij deskundigen liggen. De deskundige houdt in deze beslissing rekening met de behoeften en wensen van de cliënt, bejegent deze op aangename wijze en informeert hem/haar over de diverse mogelijkheden. Vraaggestuurde zorg, daarentegen, is zorg waarbij de verantwoordelijkheid voor en zeggenschap over de in te zetten hulp- en dienstverlening bij de cliënt liggen. De cliënt geeft aan wat zijn/haar behoeften en wensen voor zorg zijn en krijgt, na door de deskundige geïnformeerd te zijn over de diverse mogelijkheden, de vrijheid om zelf de keuze te maken. De typologie gaf inzicht in de overeenkomsten en verschillen tussen de twee concepten. Nadat de beide begrippen in de typologie gedefinieerd waren, werd de typologie gebruikt om enkele voorbeelden van bestaande vormen van zorgaanbod te benoemen als vraaggericht of vraaggestuurd. De typologie bleek hiervoor een bruikbaar instrument te zijn.

Daar in beide benaderingen de nadruk ligt op het cliëntenperspectief, werd vervolgens een inventarisatie gedaan naar de mening van zorgvragers met betrekking tot het belang dat zorgvragers hechtten aan de elementen in de typologie. Er werd een onderzoek gehouden onder 4.250 cliënten van de ambulante geestelijke gezondheidszorg in het zuiden van Nederland, middels een schriftelijke vragenlijst. De steekproef werd gestratificeerd naar de lengte van behandelduur om op die manier cliënten met verschillende ervaringen met geestelijke gezondheidszorg te betrekken. De resultaten lieten zien welke elementen door de meeste cliënten als belangrijk werden ervaren: 'de behoefte wordt bepaald in overleg met de zorgvrager', 'de zorgvrager wordt op een aangename wijze bejegend' en 'de hulpverlener informeert de zorgvrager over de verschillende mogelijkheden in zijn/haar situatie'. Er werden significante verschillen gevonden tussen de subgroepen op basis van de socio-demografische variabelen: inkomen, opleiding, leeftijd, geslacht en lengte van behandelduur. Er werd geconcludeerd dat een groot deel van de cliënten in de ambulante geestelijke gezondheidszorg (elementen van) een vraaggerichte en/of vraaggestuurde benadering waardeert, maar dat niet alle elementen evenveel gewaardeerd werden. In het algemeen leek het erop dat cliënten niet zozeer belang hechten aan wie de

beslissingen neemt in het proces, maar meer aan de wijze waarop dat gebeurt. Cliënten hechtten met name belang aan het als een serieuze partij gehoord en betrokken worden in het totale proces.

Vervolgens werd de mening van cliënten verkend met betrekking tot hun ervaringen met de aanwezigheid van de verschillende elementen uit de typologie in de ontvangen hulp- en dienstverlening. Gezocht werd naar welke van de door hen als belangrijk aangemerkte elementen van vraaggerichte of vraaggestuurde zorg zij herkenden in de door hen ontvangen hulp- en dienstverlening. Resultaten van de tweede centrale onderzoeksvraag toonden aan dat cliënten voornamelijk aspecten herkennen die betrekking hebben op de wijze waarop hun behoeften worden bepaald en op de wijze waarop zij door de instelling benaderd worden. Ze herkennen dat hun behoeften worden bepaald in overleg tussen de zorgvrager en de hulpverlener. Daarnaast herkennen ze dat ze op een aangename wijze bejegend worden en dat de instelling klantvriendelijk is. Aspecten als wie verantwoordelijk is, wie de zeggenschap heeft in het proces en of de cliënt keuzemogelijkheden heft met betrekking tot het type behandeling of het type zorgaanbieder, werden niet herkend als aanwezig in de ontvangen hulp- en dienstverlening. De resultaten suggereerden dat slechts bepaalde elementen die typerend zijn voor vraaggerichte of vraaggestuurde zorg door cliënten herkend werden in de door hen ontvangen geestelijke gezondheidszorg. Aan de andere kant, een substantieel deel van de elementen die als belangrijk waren beoordeeld, werden wel herkend.

Om het onderzoek af te sluiten werd als laatste gereflecteerd op de mogelijkheden van de vraaggerichte en vraaggestuurde benaderingen in het licht van de huidige maatschappij. De centrale vraag was hoe de benaderingen passen binnen de bestaande wet- en regelgeving en wijze van financiering van het gezondheidszorgsysteem. In het licht van de huidige gezondheidszorg systeem en de bijbehorende wet- en regelgeving en financiering van de zorg in Nederland wordt duidelijk dat het gemeenschapsgerichte bestaande én het toekomstige zorgstelsel voor vraaggerichte zorg tal van mogelijkheden biedt en deze benadering sluit dan ook goed aan bij de bestaande visie op gezondheidszorg. Voor de individuele vraaggestuurde zorg daarentegen, biedt het stelsel beperkte mogelijkheden. Maatschappelijk geaccepteerde normen en waarden met betrekking tot het vakmanschap en de controle over de uitvoering van zorgdiensten, beperken het individu in zijn/haar keuzevrijheid voor het al dan niet ondergaan van bepaalde behandelingen en inzetten van hulp- en dienstverlening. Het op solidariteit gebaseerde stelsel, waarvan de grenzen door de nationale overheid worden bepaald en waarvan de toelating door professionals wordt bewaakt, beperkt het individu in zijn/haar vrije toegang tot de zorg. Ondanks het bestaan van marktachtige mechanismen, die een bijdrage kunnen leveren aan kwaliteitsverbetering en klantgerichtheid, is ultieme vraagsturing voor een groot deel van de zorg niet aan de orde. De wensen van de zorgvrager worden in meerdere opzichten wettelijk beperkt:

indicering door de deskundige, afwezigheid van financiële middelen, etcetera. Voor zorg welke niet op (para)medische kennis is gebaseerd én waarvoor de zorgvrager zelf de financiële middelen in handen heeft (PGB, maar ook private financiering) kan sprake zijn van vraagsturing. Kortom, hoewel een vraaggestuurde benadering van de gezondheidszorg zeker op verschillende fronten een bijdrage kan leveren aan het meer centraal stellen van de zorgvrager, komt het overgrote deel van de zorg binnen de huidige bestaande gemeenschapsgerichte visie met name in aanmerking voor een vraaggerichte benadering.

Concluderend, de resultaten van het complete onderzoek verschaffen een wetenschappelijk gefundeerd inzicht in de betekenis en bijbehorende consequenties van een vraaggerichte en vraaggestuurde bendering van de gezondheidszorg. Daarnaast biedt het onderzoek tevens inzicht in de bruikbaarheid van de ontwikkelde typologie van vraaggerichte en vraaggestuurde zorg in het inventariseren van de behoeften, wensen en ervaringen van zorgvragers ten opzichte van het zorgaanbod. De zorgvragers welke in dit onderzoek betrokken waren, waardeerden elementen van beide benaderingen, met name elementen behorende bij de dimensies 'Behoeftebepaling', 'Formele inbedding van de visie in de organisatie' en 'Keuzemogelijkheid'. Het lijkt erop dat cliënten van de ambulante geestelijke gezondheidszorg geen uitgesproken voorkeur hebben voor de meer vraaggestuurde elementen als het hebben van de verantwoordelijkheid en zeggenschap binnen het zorgverleningproces. Voor deze sector zou het kunnen zijn dat een vraaggerichte benadering voldoet om een bijdrage te kunnen leveren aan de ervaren kwaliteit van leven. In andere sectoren zouden andere voorkeuren kunnen prevaleren. In het geval van de meer chronische problematiek, zoals bijvoorbeeld de zorg voor lichamelijk gehandicapten, zou het kunnen zijn dat zorgvragers meer de behoefte ervaren om, bijvoorbeeld door het zelf in handen hebben van de financiële middelen, invloed te kunnen uitoefenen op de beslissing welke zorg wordt ingezet en door wie. Zo blijkt er in de ambulante geestelijke gezondheidszorg een kleine voorkeur te zijn onder cliënten met een langere behandelduur (meer dan twee jaar) voor het zelf in handen hebben van de financiële middelen in vergelijking tot cliënten met een behandelduur van minder dan twee jaar. Daarentegen is het evenwel mogelijk dat bijvoorbeeld in de cure-sector deze behoefte veel minder leeft. Om tussen beide benaderingen te kunnen kiezen is het dan ook wenselijk om verder onderzoek uit te voeren binnen de verschillende sectoren. Het onderzoek eindigt met enkele implicaties voor beleid en praktijk met betrekking tot de mogelijkheden van de benaderingen in het bestaande gezondheidszorgsysteem: er wordt geconcludeerd dat, hoewel een vraaggestuurde benadering zeker een bijdrage levert aan het meer centraal stellen van de zorgvrager, op dit moment, gegeven de bestaande gemeenschapsgerichte houding ten opzichte van de gezondheidszorg (Dunning, 1991) en de huidige wet- en regelgeving, het overgrote deel van de zorg met name in aanmerking komt voor een vraaggerichte benadering.

Appendix

Supplement 1	Experts in Delphi-study
Supplement 2	Questions round 1 Delphi-study
Supplement 3	Questions in report round 2 Delphi-study
Supplement 4	Results of round 2 Delphi-study
Supplement 5	Questionnaire for ambulatory mental health care

SUPPLEMENT 1: EXPERTS IN DELPHI-STUDY

Organisation	Profession	Round
College van Zorgverzekeringen	Beleidsmedewerker Stafunit Beleidsanalyse; Projectleider Zorgvernieuwing	1 & 2
CZ Actief in gezondheid	Directeur Zorg	2
GGD Rotterdam e.o.	Hoofd afdeling interventies	1 & 2
GGZ Midden Brabant	Sociaal psychiatrisch verpleegkundige	2
GGZ Midden Brabant	Senior Psycholoog	2
GGZ Midden Brabant	Manager Zorggroep Volwassenen	2
K2 Kenniscentrum Jeugd	Wetenschappelijk medewerker	2
Kruiswerk Mark en Maas	Manager verpleging en verzorging	2
Kruiswerk Mark en Maas	Wijkverpleegkundige	2
Landelijke Organisatie Cliëntenraden	Algemeen directeur	2
Ministerie van VWS	Volksgezondheid: Directeur Innovatie, beroepen en ethiek	1 & 2
Nationale Patiënten/Consumenten Federatie	Programmacoördinator Zorginnovatie en Kwaliteit	1 & 2
Provincie Noord-Brabant	Beleidsmedewerker	2
PRVMZ Noord-Brabant	Directeur	1
Regionaal Patiënten/Consumenten Platform	Directeur	2
Rijks Universiteit Groningen	Hoogleraar Orthopedagogiek	1 & 2
Sociaal Cultureel Planbureau	Wetenschappelijk medewerker	1 & 2
Stichting De Riethorst	Hoofd Zorggroep Verpleeghuis	2
Stichting De Riethorst	Hoofd zorggroep	2
Stichting De Riethorst	Directeur Zorg; Hoogleraar Chronische zorg	2
Stichting Pameijer Keerkring	Bestuurder	2
Thebe Holding BV	Lid Raad van Bestuur	2
Universiteit van Maastricht	Universitair docent	2
Universiteit van Tilburg	Hoogleraar Economie van de gezondheidszorg; Bestuurder	1 & 2
Universiteit van Tilburg	Hoogleraar Sociaal recht en Sociale politiek	1 & 2
Universiteit van Tilburg	Hoogleraar Strategie en management van organisaties in de gezondheidszorg	1 & 2
Zorgverzekeraars Nederland	Afdeling Zorg	1
Zorgverzekeraars Nederland	Manager Zorg; Coördinator Modernisering AWBZ	1 & 2

SUPPLEMENT 2: QUESTIONS ROUND 1 DELPHI-STUDY

Delphi-onderzoek vraaggerichtheid en vraagsturing

1a. Wat zijn volgens u de belangrijkste ontwikkelingen in visies in het zorgbeleid?
1b. Hoe ziet u dat terug in wet- en regelgeving?
1c. Hoe ziet u dat terug in de financiering?
1d. Hoe ziet u dat terug in de zorgpraktijk?

Graag wil ik het met u hebben over de begrippen vraaggerichtheid en vraagsturing en of u van mening bent dat er een verschil bestaat tussen beide begrippen.

2. Wat verstaat u onder vraaggerichtheid?
2b. Wat zijn volgens u de centrale elementen van het concept vraaggerichtheid?

3. Wat verstaat u onder vraagsturing?
3b. Wat zijn volgens u de centrale elementen van het concept vraagsturing?

4. Wat zijn volgens u de verschillen tussen de twee concepten?

5. Wat zijn volgens u de overeenkomsten tussen de twee concepten?

U heeft in het begin van het gesprek aangegeven welke ontwikkelingen op dit moment volgens u het belangrijkste zijn in het zorgbeleid.

6. Welke van de ontwikkelingen die u heeft genoemd zijn uitingen van vraaggerichtheid?
6b. Kunt u dit toelichten?

7. Wat zijn volgens u op dit moment de meest innoverende projecten op het gebied van zorg, welzijn en wonen m.b.t. vraaggerichtheid?

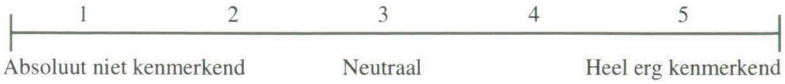
8. Welke van de ontwikkelingen die u heeft genoemd zijn uitingen van vraagsturing?
8b. Kunt u dit toelichten?

9. Wat zijn volgens u op dit moment de meest innoverende projecten op het gebied van zorg, welzijn en wonen m.b.t. vraagsturing?

SUPPLEMENT 3: QUESTIONS IN REPORT ROUND 2 DELPHI-STUDY

VRAAG 1 (behorend bij paragraaf 6.2)

Hieronder de totale lijst met elementen die genoemd is door de deskundigen uit de eerste ronde van het Delphi-onderzoek. Kunt u deze elementen elk een score geven (van 1 tot 5) met betrekking tot de mate waarin het element kenmerkend is voor vraaggerichtheid en een score met betrekking tot de mate waarin het element kenmerkend is voor vraagsturing? *A.u.b. alle elementen van 2 scores voorzien.*



Hier volgt een voorbeeld waarin het element 'Macht bij de zorgvrager' als absoluut niet kenmerkend gezien wordt voor vraaggerichtheid en heel erg kenmerkend voor vraagsturing:

Nr.	Element	Mate van vraaggerichtheid	Mate van vraagsturing
32	**Macht bij de zorgvrager**	**1**	**5**

V1.1

Tabel 3: Scores van elementen op mate van vraaggerichtheid en vraagsturing

Nr.	Element	Mate van vraaggerichtheid	Mate van Vraagsturing
1	Aan de care kant		
2	Aan de cure kant		
3	Aanbod is afhankelijk van de zorgvrager		
4	Andere/nieuwe rollen in de zorg		
5	Behoeftebevrediging zorgvrager		
6	Bejegening		
7	Belang van informatie en voorlichting		
8	Belang van transparantie aanbod		

vervolg tabel 3

Nr.	Element	Mate van vraaggerichtheid	Mate van vraagsturing
9	Betere kwaliteit zorg		
10	Diversificatie aanbod		
11	Effectiviteit zorg		
12	Emancipatie zorgvrager		
13	Formele verankering van omgaan met behoeften van zorgvrager		
14	Grenzen aan vraag stellen		
15	Grotere variëteit zorgaanbod		
16	Het sturen van de vraag door het aanbod		
17	Het sturen van het aanbod door de vraag		
18	Het systeem moet faciliteren		
19	Hulp dichter bij de zorgvrager brengen		
20	Hulpverlener bepaalt behoefte		
21	In overleg met zorgvrager behoefte bepalen		
22	Individualisering		
23	Inzicht krijgen in werkelijke vraag		
24	Keuzemogelijkheden		
25	Keuzevrijheid		
26	'Klantgerichtheid'		
27	'Klantvriendelijkheid'		
28	Kostenbeperking		
29	Kwaliteit van leven		
30	Kwaliteitsaspecten		
31	Maatwerk		
32	Macht bij de zorgvrager		

vervolg tabel 3

Nr.	Element	Mate van vraaggerichtheid	Mate van vraagsturing
33	Marktwerking		
34	Meer samenhang in aanbod		
35	Niet paternalistisch		
36	Normaliseren		
37	Op vraag georiënteerde attitude		
38	Rekening houden met zorgvrager		
39	Tegemoetkomen aan de vraag		
40	Tegenhanger van aanbodsturing		
41	Verantwoordelijkheid bij zorgvrager		
42	Verantwoordelijkheid voor de zorg		
43	Versterking klantpositie		
44	Vindt plaats tussen zorgvrager en zorgverlener		
45	Zeggenschap bij de zorgvrager		
46	Zorgvrager bepaalt behoefte		
47	Zorgvrager heeft de middelen		
48	Zorgvrager is afhankelijk van het aanbod		
49	Zorgvrager moet veel doen		
50	Zorgvrager staat centraal		

VRAAG 2 (behorend bij paragraaf 6.3)

Op- of aanmerkingen over de dimensies:

V2.1 Bent u het eens met de indeling van de vijf beschreven dimensies?

V2.2 Bent u het eens met de elementen die binnen de dimensie zijn geplaatst?

V2.3 Zijn er elementen die niet in de dimensie thuis horen? Als dat zo is, waar moet het element dan geplaatst worden?

V2.4 Ontbreken er elementen bij de dimensies?

V2.5 Indien u bij V2.4 nieuwe elementen heeft genoemd, kunt u deze dan scoren op de mate van vraaggerichtheid en vraagsturing zoals bij vraag V1.1? *(Mocht u onvoldoende ruimte hebben, dan kunt u op de achterzijde verder schrijven)*

V2.1

Dimensie 1:

Dimensie 2:

Dimensie 3:

Dimensie 4:

Dimensie 5:

V2.2

Dimensie 1:

Dimensie 2:

Dimensie 3:

Dimensie 4:

Dimensie 5:

V2.3

Dimensie 1:

Dimensie 2:

Dimensie 3:

Dimensie 4:

Dimensie 5:

V2.4

Dimensie 1:

Dimensie 2:

Dimensie 3:

Dimensie 4:

Dimensie 5:

V2.5

Tabel 9: Scores van nieuwe elementen op mate van vraaggerichtheid en vraagsturing

Nr.	Element	Mate van vraaggerichtheid	Mate van Vraagsturing

VRAAG 3 (behorend bij paragraaf 6.3)

Kunt u bij elke van de hierna genoemde dimensies aangeven waar u de afzonderlijke elementen behorende bij die dimensie zou plaatsen door middel van een score 1 tot en met 5? Hier volgt een voorbeeld waarin op de dimensie VERANTWOORDELIJKHEID het element 'emancipatie zorgvrager' gescoord wordt. Vindt u dit element op de dimensie passen aan de kant van 'verantwoordelijkheid enigszins bij de burger', dan zet u een kruisje in kolom 4.

Dimensie 1: Verantwoordelijkheid

Nr.	Element	1	2	3	4	5
12	Emancipatie zorgvrager				X	

V3.1

Dimensie 1: Verantwoordelijkheid

Score 1= Verantwoordelijkheid ***helemaal*** bij overheid/zorgverlener
Score 2= Verantwoordelijkheid ***enigszins*** bij overheid/zorgverlener
Score 3= ***Neutraal***
Score 4= Verantwoordelijkheid ***enigszins*** bij burger/zorgvrager
Score 5= Verantwoordelijkheid ***helemaal*** bij burger/zorgvrager

Tabel 10: Plaats van de elementen op dimensie 1

Nr.	Element	1	2	3	4	5
4	Andere/nieuwe rollen in de zorg					
12	Emancipatie zorgvrager					
14	Grenzen aan vraag stellen					
22	Individualisering					
35	Niet paternalistisch					
41	Verantwoordelijkheid bij zorgvrager					
42	Verantwoordelijkheid voor de zorg					
49	Zorgvrager moet veel doen					

V3.2

Dimensie 2: Macht

Score 1= Zeggenschap ***helemaal*** bij overheid/zorgverlener/verzekeraar
Score 2= Zeggenschap ***enigszins*** bij overheid/zorgverlener
Score 3= ***Neutraal***
Score 4= Zeggenschap ***enigszins*** bij burger/zorgvrager
Score 5= Zeggenschap ***helemaal*** bij burger/zorgvrager

Tabel 11: Plaats van de elementen op dimensie 2

Nr.	Element	1	2	3	4	5
3	Aanbod is afhankelijk van de zorgvrager					
16	Het sturen van de vraag door het aanbod					
17	Het sturen van het aanbod door de vraag					
32	Macht bij de zorgvrager					
43	Versterking klantpositie					
45	Zeggenschap bij de zorgvrager					
47	Zorgvrager heeft de middelen					
48	Zorgvrager is afhankelijk van het aanbod					

V3.3

Dimensie 3: Behoeftebepaling

Score 1= Behoeftebepaling ***helemaal*** door overheid/zorgverlener/zorgverzekeraar
Score 2= Behoeftebepaling ***enigszins*** door overheid/zorgverlener/zorgverzekeraar
Score 3= ***Neutraal***
Score 4= Behoeftebepaling ***enigszins*** door burger/zorgvrager
Score 5= Behoeftebepaling ***helemaal*** door burger/zorgvrager

Tabel 12: Plaats van de elementen op dimensie 3

Nr.	Element	1	2	3	4	5
5	Behoeftebevrediging zorgvrager					
20	Hulpverlener bepaalt behoefte					
21	In overleg met zorgvrager behoefte bepalen					
23	Inzicht krijgen in werkelijke vraag					
39	Tegemoetkomen aan de vraag					
46	Zorgvrager bepaalt behoefte					

V3.4

Dimensie 4: Inbedding in organisatie

Score 1= Inbedding in organisatie ***helemaal*** informeel
Score 2= Inbedding in organisatie ***enigszins*** informeel
Score 3= ***Neutraal***
Score 4= Inbedding in organisatie ***enigszins*** formeel
Score 5= Inbedding in organisatie ***helemaal*** formeel

Tabel 13: Plaats van de elementen op dimensie 4

Nr.	Element	1	2	3	4	5
6	Bejegening					
13	Formele verankering van omgaan met behoeften van zorgvrager					
18	Het systeem moet faciliteren					
26	'Klantgerichtheid'					
27	'Klantvriendelijkheid'					
37	Op vraag georiënteerde attitude					
38	Rekening houden met zorgvrager					
44	Vindt plaats tussen zorgvrager en zorgverlener					
50	Zorgvrager staat centraal					

V3.5

Dimensie 5: keuzemogelijkheid

Score 1= Aanbod ***helemaal*** vast
Score 2= Aanbod ***enigszins*** vast
Score 3= ***Neutraal***
Score 4= ***Enigszins*** keuzevrijheid
Score 5= ***Helemaal*** keuzevrijheid

Tabel 14: Plaats van de elementen op dimensie 5

Nr.	Element	1	2	3	4	5
7	Belang van informatie en voorlichting					
8	Belang van transparantie aanbod					
10	Diversificatie aanbod					
15	Grotere variëteit zorgaanbod					
24	Keuzemogelijkheden					
25	Keuzevrijheid					
31	Maatwerk					
34	Meer samenhang in aanbod					

VRAAG 4 (behorend bij paragraaf 6.4)

Hieronder volgt per dimensie een tabel. Kunt u bij elke van de hierna genoemde uitingen aangeven hoe u vindt dat deze scoort op elk van de vijf genoemde dimensies?

Wilt u de uitingen scoren door middel van het plaatsen van een kruisje in de bijbehorende tabel. Als u vindt dat door casemanagement de verantwoordelijkheid voor de zorg bij de burger ligt, dan scoort u dit als 5 (zet een kruisje in kolom 5), als u vindt dat door casemanagement de verantwoordelijkheid bij overheid/zorgverleners ligt, dan kiest u 1 (zet een kruisje in kolom 1). Als u de dimensie neutraal of niet van toepassing vindt, scoort u dit als 3). In onderstaand voorbeeld wordt op de dimensie VERANTWOORDELIJKHEID aan casemanagement de score 5 gegeven.

Dimensie 1: Verantwoordelijkheid

1 2 3 4 5

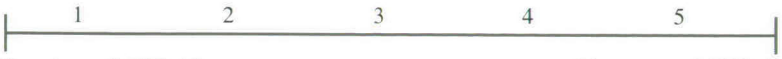
Verantwoordelijkheid niet bij burger/zorgvrager (overheid/zorgverlener)

Verantwoordelijkheid bij burger/zorgvrager

Nr.	Uiting	1	2	3	4	5
1	Casemanagement					X

V4.1

Dimensie 1: Verantwoordelijkheid



Verantwoordelijkheid niet bij burger/zorgvrager (overheid/zorgverlener)

Verantwoordelijkheid bij burger/zorgvrager

Tabel 16: Scores van uitingen op dimensie 1

Nr.	Uiting	1	2	3	4	5
1	Casemanagement					
2	Diagnose behandelcombinaties					
3	Differentiatie indicatiestelling					
4	Extramuralisering					
5	Functionele aanspraak					
6	Functionele bekostiging					
7	Functionele indicatiestelling					
8	Levensloopbestendig wonen					
9	Modernisering AWBZ					
10	Modularisering					
11	Onafhankelijke indicatiestelling					
12	Ontstaan van cliëntenorganisaties					
13	Patiëntenwetgeving					
14	Persoonsgebonden Budget					
15	Rugzakje					
16	Tevredenheid zorgvrager meten					
17	Wachtlijstaanpak					
18	Zorg op maat					
19	Zorgplicht					

V4.2

Dimensie 2: Macht

Zeggenschap niet bij burger/zorgvrager (zorgverlener/verzekeraar)

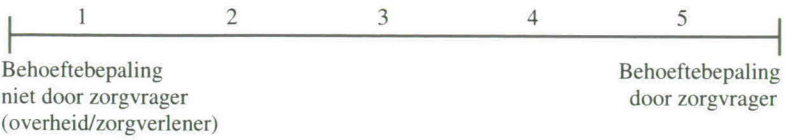
Zeggenschap bij burger/zorgvrager

Tabel 17: Scores van uitingen op dimensie 2

Nr.	Uiting	1	2	3	4	5
1	Casemanagement					
2	Diagnose behandelcombinaties					
3	Differentiatie indicatiestelling					
4	Extramuralisering					
5	Functionele aanspraak					
6	Functionele bekostiging					
7	Functionele indicatiestelling					
8	Levensloopbestendig wonen					
9	Modernisering AWBZ					
10	Modularisering					
11	Onafhankelijke indicatiestelling					
12	Ontstaan van cliëntenorganisaties					
13	Patiëntenwetgeving					
14	Persoonsgebonden Budget					
15	Rugzakje					
16	Tevredenheid zorgvrager meten					
17	Wachtlijstaanpak					
18	Zorg op maat					
19	Zorgplicht					

V4.3

Dimensie 3: Behoeftebepaling

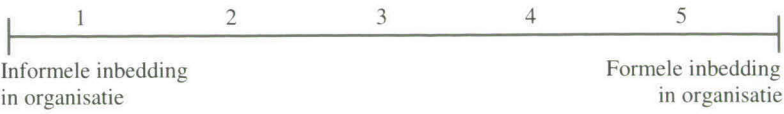


Tabel 18: Scores van uitingen op dimensie 3

Nr.	Uiting	1	2	3	4	5
1	Casemanagement					
2	Diagnose behandelcombinaties					
3	Differentiatie indicatiestelling					
4	Extramuralisering					
5	Functionele aanspraak					
6	Functionele bekostiging					
7	Functionele indicatiestelling					
8	Levensloopbestendig wonen					
9	Modernisering AWBZ					
10	Modularisering					
11	Onafhankelijke indicatiestelling					
12	Ontstaan van cliëntenorganisaties					
13	Patiëntenwetgeving					
14	Persoonsgebonden Budget					
15	Rugzakje					
16	Tevredenheid zorgvrager meten					
17	Wachtlijstaanpak					
18	Zorg op maat					
19	Zorgplicht					

V4.4

Dimensie 4: Inbedding in organisatie

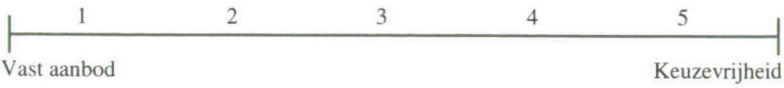


Tabel 19: Scores van uitingen op dimensie 4

Nr.	Uiting	1	2	3	4	5
1	Casemanagement					
2	Diagnose behandelcombinaties					
3	Differentiatie indicatiestelling					
4	Extramuralisering					
5	Functionele aanspraak					
6	Functionele bekostiging					
7	Functionele indicatiestelling					
8	Levensloopbestendig wonen					
9	Modernisering AWBZ					
10	Modularisering					
11	Onafhankelijke indicatiestelling					
12	Ontstaan van cliëntenorganisaties					
13	Patiëntenwetgeving					
14	Persoonsgebonden Budget					
15	Rugzakje					
16	Tevredenheid zorgvrager meten					
17	Wachtlijstaanpak					
18	Zorg op maat					
19	Zorgplicht					

V4.5

Dimensie 5: keuzemogelijkheid



Tabel 20: Scores van uitingen op dimensie 5

Nr.	Uiting	1	2	3	4	5
1	Casemanagement					
2	Diagnose behandelcombinaties					
3	Differentiatie indicatiestelling					
4	Extramuralisering					
5	Functionele aanspraak					
6	Functionele bekostiging					
7	Functionele indicatiestelling					
8	Levensloopbestendig wonen					
9	Modernisering AWBZ					
10	Modularisering					
11	Onafhankelijke indicatiestelling					
12	Ontstaan van cliëntenorganisaties					
13	Patiëntenwetgeving					
14	Persoonsgebonden Budget					
15	Rugzakje					
16	Tevredenheid zorgvrager meten					
17	Wachtlijstaanpak					
18	Zorg op maat					
19	Zorgplicht					

SUPPLEMENT 4: RESULTS OF ROUND 2 DELPHI-STUDY

Answers to question 1

V1	Element	Demand-oriented						Demand-driven					
	Scale	1	2	3	4	5	?	1	2	3	4	5	?
1	Relevant for care	4	4	11	3	2	1	5	1	8	7	3	1
2	Relevant for cure	4	5	5	8	2	1	5	8	8	2	1	1
3	Supply is dependent on the health care user	4	4	5	8	2	2	1	3	1	4	14	2
4	Other/new roles in health care	3	4	7	6	4	1	6	2	6	4	6	1
5	Satisfaction of health care user's needs	3	6	8	6	1	1	0	3	5	8	9	0
6	Way of treatment	1	1	6	10	7	0	4	2	9	5	5	0
7	Importance of (being provided with) information	2	2	5	10	5	1	2	2	4	7	10	0
8	Importance of transparency of supply	1	2	3	12	7	0	4	3	6	4	8	0
9	Better quality of health care	1	1	10	5	8	0	4	2	10	8	1	0
10	Diversification of supply	3	1	8	9	4	0	2	2	8	4	9	0
11	Effective health care	3	5	7	6	3	1	3	3	9	7	3	0
12	Emancipation of health care user	6	6	4	6	2	1	1	2	1	6	15	0
13	Formal embedment of way of dealing with health care user's needs	1	1	8	7	7	1	3	2	6	8	6	0
14	Clamp down on demand	4	4	4	4	8	1	10	4	5	2	2	2
15	Greater variety in health care supply	3	1	8	6	7	0	4	2	5	5	9	0
16	Steering of the demand by the supply	5	4	3	4	9	0	16	2	2	3	2	0
17	Steering of the supply by the demand	8	4	5	5	3	0	2	1	0	4	18	0
18	The system has to facilitate	3	2	10	4	6	0	4	4	7	2	8	0
19	Bring help closer to the health care user	1	3	8	9	4	0	2	3	8	7	5	0
20	Health care provider determines the need	8	2	4	3	8	0	17	3	2	0	3	0
21	Need-determination in consultation with health care user	1	2	8	9	5	0	2	2	5	8	8	0
22	Individualization	7	3	6	5	4	0	0	3	4	5	13	0
23	Get insight into real demand	5	4	5	8	2	1	2	0	4	8	11	0
24	Choice	5	3	5	8	4	0	0	1	4	7	13	0
25	Freedom of choice	7	8	4	4	2	0	1	1	2	7	14	0
26	'Orientation towards the client'	0	2	6	8	9	0	4	1	7	7	6	0
27	'Client friendliness'	1	2	5	13	4	0	2	1	11	7	3	1
28	Cost restriction	6	4	7	3	5	0	9	6	6	0	3	1
29	Quality of life	4	2	10	4	5	0	1	2	6	5	11	0
30	Aspects of quality	1	3	8	5	8	0	1	4	8	7	5	0
31	Custom-made services	2	3	11	4	5	0	2	1	5	4	12	1
32	Health care user has final control	8	6	7	2	2	0	2	2	2	1	18	0
33	Health care on a free-market basis	3	3	13	4	2	0	1	3	6	8	6	1
34	More coherence in the supply	2	3	10	7	3	0	4	5	8	4	2	2
35	Not paternalistic	3	5	9	5	3	0	3	5	6	3	8	0
36	Normalize	2	3	12	6	0	2	3	6	11	3	1	1
37	Attitude oriented towards the demand	1	4	5	9	6	0	2	1	5	8	9	0
38	Taking the health care user into account	2	2	6	10	5	0	1	1	5	8	10	0
39	Give in to the demand	2	3	5	11	4	0	2	0	5	5	12	1
40	Opposite of supply-driven	6	5	6	5	2	1	0	0	2	7	14	2
41	Health care user is responsible	10	5	7	3	0	0	0	2	3	6	14	0
42	Responsibility for health care	2	3	3	4	12	1	4	5	7	4	4	1
43	Strengthen health care user's position	3	4	8	8	2	0	1	0	4	9	11	0
44	Takes place between health care user and expert	1	2	9	5	6	2	2	1	8	7	5	2
45	Health care user has final say	8	4	8	2	2	1	2	1	1	5	16	0
46	Health care user determines need	7	5	7	5	1	0	1	1	1	10	12	0
47	Health care user has the means	11	5	6	1	2	0	1	2	3	4	15	0
48	Health care user is dependent on the given supply	4	5	4	6	6	0	12	2	5	3	3	0
49	The health care user has to make much effort	4	6	10	2	1	2	1	5	7	6	5	1
50	Main focus is on the health care user	3	4	5	7	5	1	2	1	2	3	17	0

Answers to question 3

V3.1	Dimension 1	Score 1	Score 2	Score 3	Score 4	Score 5	Average
4	Other/new roles in health care	5	4	10	3	2	2,70
12	Emancipation of health care user	0	3	4	12	5	3,80
14	Clamp down on demand	6	10	5	2	1	2,25
22	Individualization	2	2	6	11	3	3,46
35	Not paternalistic	5	6	5	7	1	2,71
41	Health care user is responsible	1	2	3	10	8	3,92
42	Responsibility for health care	8	11	2	1	1	1,96
49	Health care user has to make much effort	0	2	5	12	5	3,83

V3.2	Dimension 2	Score 1	Score 2	Score 3	Score 4	Score 5	Average
3	Supply is dependent on the health care user	2	5	3	10	4	3,38
16	Steering of the demand by the supply	12	8	3	1	0	1,71
17	Steering of the supply by the demand	1	3	2	11	7	3,83
32	Health care user has final control	0	2	2	8	12	4,25
43	Strengthen health care user's position	1	3	4	13	3	3,58
45	Health care user has final say	0	2	2	13	7	4,04
47	Health care user has the means	2	4	3	3	12	3,79
48	Health care user is dependent on the given supply	9	8	4	3	0	2,04

V3.3	Dimension 3	Score 1	Score 2	Score 3	Score 4	Score 5	Average
5	Satisfaction of health care user's needs	1	2	6	9	6	3,71
20	Expert determines need	12	5	3	3	1	2,00
21	Need-determination in consultation with health care user	2	5	8	8	1	3,04
23	Get insight into real demand	4	3	8	6	4	3,12
39	Give in to the demand	4	7	3	8	1	2,78
46	Health care user determines need	0	0	1	13	10	4,38

V3.4	Dimension 4	Score 1	Score 2	Score 3	Score 4	Score 5	Average
6	Way of treatment	2	6	7	6	2	3,00
13	Formal embedment of way of dealing with health care user's needs	3	0	1	7	11	4,06
18	The system has to facilitate	3	5	5	2	7	3,23
26	'Orientation towards the client'	1	5	4	6	7	3,57
27	'Client friendliness'	2	8	3	7	3	3,04
37	Attitude oriented towards the client	2	5	5	8	3	3,22
38	Taking the health care user into account	0	6	4	8	5	3,52
44	Takes place between health care user and expert	1	4	9	7	1	3,14
50	Main focus is on the health care user	1	0	6	6	10	4,04

V3.5	Dimension 5	Score 1	Score 2	Score 3	Score 4	Score 5	Average
7	Importance of information	2	3	6	8	5	3,46
8	Importance of transparency of supply	3	4	5	7	5	3,29
10	Diversification of supply	0	7	4	10	3	3,38
15	Greater variety in health care supply	1	4	4	13	2	3,46
24	Choice	0	1	2	11	9	4,22
25	Freedom of choice	0	1	4	4	15	4,38
31	Custom-made services	1	2	5	10	6	3,75
34	More coherence in the supply	1	2	13	8	0	3,17

Answers to question 4

V4.1	Dimension 1	Score 1	Score 2	Score 3	Score 4	Score 5	?	Average
2	Diagnosis Treatment Combination (DBC)	13	9	2	0	0	0	1,54
10	Offering services in modules (Modularisering)	5	7	7	1	0	4	2,20
14	Personal Budget (PGB)	2	1	2	8	11	0	4,04

V4.2	Dimension 2	Score 1	Score 2	Score 3	Score 4	Score 5	?	Average
2	Diagnosis Treatment Combination (DBC)	9	11	2	2	0	0	1,88
10	Offering services in modules (Modularisering)	6	8	6	2	0	2	2,18
14	Personal Budget (PGB)	1	1	1	6	14	1	4,35

V4.3	Dimension 3	Score 1	Score 2	Score 3	Score 4	Score 5	?	Average
2	Diagnosis Treatment Combination (DBC)	8	11	3	2	0	0	1,96
10	Offering services in modules (Modularisering)	1	8	8	3	1	3	2,76
14	Personal Budget (PGB)	0	1	1	12	10	0	4,29

V4.4	Dimension 4	Score 1	Score 2	Score 3	Score 4	Score 5	?	Average
2	Diagnosis Treatment Combination (DBC)	2	0	4	8	10	1	4,00
10	Offering services in modules (Modularisering)	1	2	6	7	5	4	3,62
14	Personal Budget (PGB)	3	2	6	6	7	1	3,50

V4.5	Dimension 5	Score 1	Score 2	Score 3	Score 4	Score 5	?	Average
2	Diagnosis Treatment Combination (DBC)	8	6	6	4	1	0	2,36
10	Offering services in modules (Modularisering)	3	1	6	11	2	2	3,35
14	Personal Budget (PGB)	0	1	1	7	15	0	4,50

SUPPLEMENT 5: QUESTIONNAIRE FOR AMBULATORY MENTAL HEALTH CARE

UNIVERSITEIT VAN TILBURG

VRAGENLIJST OVER DE WENSEN EN ERVARINGEN VAN CLIENTEN IN DE GEESTELIJKE GEZONDHEIDSZORG

Universiteit van Tilburg
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tranzo

Deelname aan dit onderzoek is vertrouwelijk en anoniem. Individuele gegevens worden aan niemand meegedeeld.

Geachte mevrouw, meneer,

We willen u vragen deze vragenlijst in te vullen. De vragen hebben betrekking op uw ideeën en ervaringen over de geestelijke gezondheidszorg. Wij zijn geïnteresseerd in uw beleving en door uw bijdrage zorgt u ervoor dat de mening van cliënten in de geestelijke gezondheidszorg wordt meegenomen.

Er zijn geen 'goede' of 'foute' antwoorden: het is uw mening die telt.

Het beantwoorden van de vragen neemt ongeveer een kwartier in beslag. Let op: de vragenlijst is zowel aan de voorzijde als aan de achterzijde bedrukt!

U geeft uw antwoord aan op volgende wijze:

Voorbeelden:

Bent u een man of vrouw?

☒ vrouw

☐ Man

	In welke mate bent u het eens met de onderstaande uitspraken?	Niet mee eens	Deels eens, deels oneens	Mee eens
A	Ik vind dat de hulpverlening moet worden bepaald door mijn wensen	1	(2)	3

Indien u vragen of opmerkingen heeft over deze vragenlijst of indien u meer informatie wenst over dit onderzoek, aarzel niet om contact op te nemen met:

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Mocht u geïnteresseerd zijn in de resultaten van dit onderzoek, dan kunt u los van de vragenlijst een briefje sturen aan bovenstaand adres. Wij sturen u dan een samenvatting van het onderzoek.

Alvast bedankt voor uw medewerking!

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I. Achtergrondinformatie

1. Wat is uw leeftijd? _____ jaar

2. Bent u man of vrouw?

- ❑ vrouw
- ❑ man

3. Waar zijn uw ouders geboren?

Vader	**Moeder**
❑ Nederland	❑ Nederland
❑ Ander land binnen Europa	❑ Ander land binnen Europa
❑ Buiten Europa	❑ Buiten Europa

4. Tot welke godsdienst behoort u?

- ❑ Geen
- ❑ Boeddhisme
- ❑ Christendom
- ❑ Hindoeïsme
- ❑ Islam
- ❑ Jodendom
- ❑ Anders

5. Wat is uw positie in het huis?

- ❑ Thuiswonend kind
- ❑ Alleenstaand
- ❑ Samenwonend met partner of gehuwd
- ❑ Cliënt in een tehuis (bv. bejaardenhuis, verzorgingstehuis, opvang)

6. Uit hoeveel personen bestaat uw huishouden? _____ personen

7. Wat is uw hoogst afgeronde opleiding (of opleiding van vergelijkbaar niveau)**?**

- ❑ Geen
- ❑ Lager onderwijs
- ❑ VBO / MAVO
- ❑ MBO
- ❑ HAVO / VWO
- ❑ HBO
- ❑ WO

8. Wat is uw positie ten opzichte van de arbeidsmarkt?

- ❑ Werkend (in loondienst)
- ❑ Zelfstandige
- ❑ Werkzoekend
- ❑ Scholier / student
- ❑ Niet werkend / niet zelfstandig / niet werkzoekend (bv. gepensioneerd, huisvrouw/huisman)
- ❑ Arbeidsongeschikt / tijdelijk in ziektewet

9. Hoe groot is ongeveer de gemeente waar u woont?

- ❑ tot 5000 inwoners
- ❑ 5000 tot 10.000 inwoners
- ❑ 10.000 tot 50.000 inwoners
- ❑ 50.000 tot 100.000 inwoners
- ❑ 100.000 of meer inwoners

10. Kunt u ongeveer aangeven hoe hoog het netto maandinkomen is van het huishouden waartoe u behoort?

- ❑ netto minder dan 1000 euro per maand
- ❑ netto 1000 tot 1500 euro per maand
- ❑ netto 1500 tot 2000 euro per maand
- ❑ netto 2000 tot 3000 euro per maand
- ❑ netto 3000 euro of meer per maand

II. Algemene vragen geestelijke gezondheidszorg

De vragen 11 tot en met 15 gaan over de geestelijke gezondheidszorg in het algemeen. Graag zouden wij willen weten hoe volgens u de geestelijke gezondheidszorg geregeld zou moeten zijn.

De eerste 3 blokken (vraag 11 t/m 13) hebben betrekking op waar u vindt dat de verantwoordelijkheid en zeggenschap over beslissingen in verband met de in te zetten hulpverlening zou moeten liggen en wie zou moeten bepalen welke hulp nodig is. Dat kan enerzijds bij u zijn, of anderzijds een deskundige zoals een hulpverlener, de overheid of een zorgverzekeraar.

De laatste 2 blokken (vraag 14 en 15) hebben te maken met hoe volgens u de hulp- en dienstverlening door de instelling geregeld zou moeten zijn.

Hieronder volgt een aantal uitspraken. Kunt u (door een antwoord te omcirkelen) aangeven in hoeverre u het met de stelling eens bent.

11	**In welke mate bent u het eens met de onderstaande uitspraken?**	Niet mee eens	Deels eens, deels oneens	Mee eens
A	Ik vind dat ik in de beslissing over het soort hulp- en dienstverlening dezelfde rechten moet hebben als de hulpverlener	1	2	3
B	Een deskundige* moet bepalen aan welke vragen wel en niet tegemoet gekomen moet worden	1	2	3
C	De vraag van een individu is belangrijker dan de collectieve vraag vanuit de samenleving	1	2	3
D	Ik vind dat het mijn verantwoordelijkheid is om te beslissen over het soort hulp dat ik krijg	1	2	3
E	Ik vind dat deskundigen* verantwoordelijk zijn voor mijn zorg	1	2	3

** = hulpverlener, overheid, zorgverzekeraar*

12	**In welke mate bent u het eens met de onderstaande uitspraken?**	Niet mee eens	Deels eens, deels oneens	Mee eens
A	De hulpverlening moet worden bepaald door mijn wensen en zorgbehoeften	1	2	3
B	Ik vind dat ik mijn wensen moet afstemmen op de aangeboden hulpverlening	1	2	3
C	Ik moet kunnen bepalen welke soort hulp- of dienstverlening ik krijg	1	2	3
D	Ik vind dat in de wetgeving moet worden vastgelegd dat ik mag beslissen over welke zorg ik wil krijgen	1	2	3
E	Ik moet zelf het geld in beheer krijgen om mijn zorg in te kunnen kopen	1	2	3

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13	In welke mate bent u het eens met de onderstaande uitspraken?	Niet mee eens	Deels eens, deels oneens	Mee eens
A	Ik vind dat de geboden hulpverlening aan mijn behoeften moet voldoen	1	2	3
B	Dat wat ik nodig heb, moet worden bepaald door mijzelf en de hulpverlener samen	1	2	3
C	Ik vind dat de hulpverlener er alles aan moet doen om er achter te komen wat ik wil	1	2	3
D	Ik vind dat aan mijn wensen en ideeën voor hulp- en dienstverlening tegemoetgekomen moet worden	1	2	3
E	Ik kan het beste bepalen wat mijn behoeften en wensen voor zorg zijn	1	2	3

14	In welke mate bent u het eens met de onderstaande uitspraken?	Niet mee eens	Deels eens, deels oneens	Mee eens
A	Ik vind dat er op een aangename manier met mij omgegaan moet worden	1	2	3
B	De manier waarop hulpverleners moeten omgaan met mijn wensen, moet officieel zijn vastgelegd door de instelling	1	2	3
C	Een instelling moet hulp- en dienstverlening bieden waarvan zij verwacht dat deze tegemoet komt aan de behoeften en wensen van de cliënten	1	2	3
D	Ik vind dat de hulp- en dienstverlening van een instelling klantvriendelijk moet zijn	1	2	3
E	Een instelling moet zich zo opstellen dat ze gericht is op de behoeften en wensen van de cliënten	1	2	3
F	Ik vind dat in de geestelijke gezondheidszorg rekening gehouden moet worden met de wensen van de cliënten	1	2	3
G	Ik vind dat bij alles wat een instelling doet, de belangen van de cliënten centraal moeten staan	1	2	3

15	In welke mate bent u het eens met de onderstaande uitspraken?	Niet mee eens	Deels eens, deels oneens	Mee eens
A	Ik vind dat ik goed geïnformeerd moet worden over wat in mijn situatie de mogelijkheden voor hulp- en dienstverlening zijn	1	2	3
B	Ik vind dat het voor mij helder moet zijn wat in mijn situatie de mogelijkheden voor behandeling zijn	1	2	3
C	Ik vind dat ik moet kunnen kiezen uit verschillende soorten hulp	1	2	3
D	Ik vind dat ik vrij moet zijn in de keuze naar welke instelling voor geestelijke gezondheidszorg ik ga	1	2	3
E	Ik vind dat ik vrij moet zijn in de keuze voor het soort hulp- en dienstverlening	1	2	3
F	Ik vind dat de hulpverlening op maat gemaakt moet worden voor iedereen afzonderlijk	1	2	3

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III. Belang

Kunt u in de volgende vraag in de eerste kolom door middel van een kruisje aangeven welke van de stellingen u allemaal belangrijk vindt (u kunt meerdere stellingen aankruisen).

Kunt u in de 2e kolom aankruisen welke **3 stellingen** u de allerbelangrijkste vindt?

16	Ik vind het belangrijk dat.....	Belangrijk	Top 3
1	...ik in de beslissing over het soort hulp- en dienstverlening dezelfde rechten heb als de hulpverlener	❑	❑
2	...een deskundige* bepaalt aan welke vragen wel en niet tegemoet gekomen wordt	❑	❑
3	...er meer nadruk ligt op de vraag van het individu dan op de collectieve vraag van de samenleving	❑	❑
4	...ik verantwoordelijk ben om te beslissen over het soort hulp dat ik krijg	❑	❑
5	...deskundigen* verantwoordelijk zijn voor mijn zorg	❑	❑
6	...de hulpverlening wordt bepaald door mijn wensen	❑	❑
7	...ik mijn wensen afstem op de aangeboden hulpverlening	❑	❑
8	...ik zelf kan bepalen welke soort hulp- of dienstverlening ik krijg	❑	❑
9	....in de wetgeving vastligt dat ik mag beslissen over welke zorg ik krijg	❑	❑
10	...ik zelf het geld in beheer krijg om daarmee mijn zorg in te kunnen kopen	❑	❑
11	...de geboden zorg aan mijn behoeften voldoet	❑	❑
12	....ik sámen met mijn hulpverlener bepaal wat ik nodig heb	❑	❑
13	...de hulpverlener er alles aan doet om er achter te komen wat ik wil	❑	❑
14	...aan mijn wensen en ideeën voor hulp- en dienstverlening tegemoetgekomen wordt	❑	❑
15	...ik degene ben die bepaal, wat mijn behoeften en wensen voor zorg zijn	❑	❑
16	...er op een aangename manier met mij wordt omgegaan	❑	❑
17	...de manier waarop hulpverleners om moeten gaan met mijn wensen, officieel is vastgelegd door de instelling	❑	❑
18	...een instelling hulp- en dienstverlening biedt waarvan zij verwacht dat deze tegemoet komt aan de behoeften en wensen van de cliënten	❑	❑
19	...de hulp- en dienstverlening van een instelling klantvriendelijk is	❑	❑
20	...een instelling zich zo opstelt dat ze gericht is op de behoeften en wensen van de cliënten	❑	❑
21	...in de geestelijke gezondheidszorg rekening gehouden wordt met de wensen van de cliënten	❑	❑
22	...bij alles wat een instelling doet, de belangen van de cliënt centraal staan	❑	❑
23	...ik goed geïnformeerd word over wat in mijn situatie de mogelijkheden voor hulp- en dienstverlening zijn	❑	❑
24	...het voor mij helder is wat in mijn situatie de mogelijkheden voor behandeling zijn	❑	❑
25	...ik kan kiezen uit verschillende soorten hulp- en dienstverlening	❑	❑
26	...ik vrij ben om te kiezen naar welke instelling ik ga	❑	❑
27	...ik vrij ben in mijn keuze voor het soort hulp- of dienstverlening	❑	❑
28	...de hulpverlening precies op maat gemaakt wordt voor ieder afzonderlijk	❑	❑

** = hulpverlener, overheid, zorgverzekeraar*

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IV. Uw huidige hulpverlening in de geestelijke gezondheidszorg

De vragen 17 tot en met 22 hebben betrekking op **uw situatie** en de hulp- en dienstverlening die u op dit moment ontvangt bij **de instelling voor geestelijke gezondheidszorg die u deze vragenlijst heeft toegestuurd.**

17. Hoe bent u verzekerd?

- ❑ Ziekenfonds (basis)
- ❑ Ziekenfonds + aanvullende verzekering
- ❑ Particulier (basis)
- ❑ Particulier + aanvullende verzekering

18. Hoe lang bent u bij deze ggz-instelling in behandeling (geweest)?

- ❑ minder dan een ½ jaar
- ❑ tussen ½ en 1 jaar
- ❑ tussen 1 en 2 jaar
- ❑ meer dan 2 jaar

19 Hoe tevreden bent u op dit moment met:

		 zeer ontevreden		Neutraal		zeer tevreden
1	uw kwaliteit van leven?	1	2	3	4	5
2	uw gezondheid?	1	2	3	4	5
3	uw welzijn?	1	2	3	4	5
4	de hulp- en dienstverlening die u bij deze ggz-instelling ontvangt?	1	2	3	4	5
5	de mate van verantwoordelijkheid die u heeft in de keuze voor de hulpverlening die u bij deze ggz-instelling krijgt?	1	2	3	4	5
6	de mate waarin u bij deze ggz-instelling kunt beslissen welke hulp- en dienstverlening u ontvangt?	1	2	3	4	5
7	de manier waarop bij deze ggz-instelling uw behoefte aan hulp bepaald is?	1	2	3	4	5
8	de wijze waarop de instelling geregeld heeft hoe er met cliënten omgegaan moet worden?	1	2	3	4	5
9	de keuzemogelijkheden die u in de geestelijke gezondheidszorg heeft?	1	2	3	4	5

20. Bent u bekend met de volgende vormen van hulpverlening en/of wet- en regelgeving?
(meerdere antwoorden zijn mogelijk)

A. Ik ben bekend met:

- ❑ Een Persoonsgebonden Budget (PGB)
- ❑ Een casemanager
- ❑ Een Cliëntenraad
- ❑ Wetgeving rondom patiëntenrechten

B. Ik maak gebruik van:

- ❑ Een Persoonsgebonden Budget (PGB)
- ❑ Een casemanager

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21	In hoeverre bent u het eens met de volgende punten?	Niet mee eens	Deels eens, deels oneens	Mee eens
1	Bij deze ggz-instelling telt mijn mening even zwaar als de mening van de hulpverlener	1	2	3
2	De hulpverlener van deze ggz-instelling bepaalt aan welke vragen wel en niet tegemoet gekomen wordt	1	2	3
3	In de huidige maatschappij wordt de vraag van een individu als belangrijker gezien dan de collectieve vraag van de samenleving	1	2	3
4	Het wordt als mijn verantwoordelijkheid gezien om te beslissen over het soort zorg dat ik krijg	1	2	3
5	Deskundigen* worden verantwoordelijk gehouden voor de zorg	1	2	3
6	De hulpverlening die ik krijg bij deze ggz-instelling, wordt bepaald door datgene wat ik wil	1	2	3
7	Ik moet mijn wensen afstemmen op de door deze ggz-instelling aangeboden hulpverlening	1	2	3
8	Ik kan bij deze ggz-instelling zelf bepalen welke soort zorg ik krijg	1	2	3
9	In de wetgeving is vastgelegd dat ik mag beslissen over welke zorg ik krijg	1	2	3
10	Ik heb zelf het geld in beheer gekregen om daarmee mijn zorg in te kunnen kopen	1	2	3
11	De geboden hulpverlening van deze instelling voldoet aan mijn behoefte	1	2	3
12	Mijn hulpverlener en ik hebben samen bepaald wat ik nodig heb	1	2	3
13	Voor mijn gevoel heeft mijn hulpverlener er alles aan gedaan om er achter te komen wat ik wilde	1	2	3
14	Aan mijn behoeften wordt door deze ggz-instelling tegemoet gekomen	1	2	3
15	Mijn hulpverlener vindt dat ik het beste kan bepalen wat mijn behoeften en wensen zijn	1	2	3
16	Er wordt in deze instelling op een prettige manier met mij omgegaan	1	2	3
17	De manier waarop hulpverleners bij deze ggz-instelling moeten omgaan met mijn behoeften, is volgens mij door de instelling officieel vastgelegd	1	2	3
18	Ik denk dat deze ggz-instelling zorg biedt waarvan zij denken dat deze tegemoet komt aan de behoeften van de cliënten	1	2	3
19	Ik vind de diensten van deze ggz-instelling klantvriendelijk	1	2	3
20	Het personeel van deze ggz-instelling stelt zich zo op dat het gericht is op de behoeften en wensen van de cliënten	1	2	3
21	Bij deze ggz-instelling wordt rekening gehouden met mijn wensen	1	2	3
22	Bij alles wat deze instelling doet, stelt ze mijn belangen centraal	1	2	3
23	Ik word goed geïnformeerd over wat in mijn situatie de mogelijkheden voor hulp- en dienstverlening zijn	1	2	3
24	Het is voor mij helder wat mijn mogelijkheden voor zorg zijn	1	2	3
25	Ik heb kunnen kiezen uit verschillende soorten hulp- en dienstverlening	1	2	3
26	Ik was vrij om te kiezen naar welke ggz-instelling ik wilde	1	2	3
27	Ik was vrij om te kiezen wat voor soort hulp- en dienstverlening ik wilde	1	2	3
28	De hulpverlening die ik bij deze ggz-instelling ontvang, is voor mij op maat gemaakt	1	2	3

** = hulpverlener, overheid, zorgverzekeraar*

Madeleine Jeanne Noëlle Rijckmans *was born in Goirle on the 27th of December 1973. After attending Gymnasium ß from 1986 to 1992, she studied psychology at Tilburg University. In 2001 she started her PhD research within the Tranzo research programme. Besides her work at the university she also works as a psychologist in a private mental health care practice.*

Societal developments and new insights are causing continuous changes in the health care and welfare sector. In the Netherlands, as in most European countries, there is an increasing tendency toward demand-oriented and demand-driven approaches in the development of health care policy and the organisation of health care services. The concepts demand-orientation and demand-driven care are seen by many as the key words in innovative thinking about health care and welfare, and thus as the answer to the problems confronting these sectors today. However, there is confusion about the meaning of the concepts, literature clarifying the concepts is scarce, and, in practice, the concepts of demand-orientation and demand-driven health care are defined in various manners. Therefore a study was designed and carried out to develop a typology of the concepts of demand-oriented and demand-driven health care. The complete study provides a scientifically grounded insight into the meaning and consequences of the concepts demand-oriented and demand-driven health care and also provides an initial investigation of health care users' views of the concepts within the field of ambulatory mental health care.

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