Time for caring for the construction industry

a scenario-approach for determining the future contractor's position within the Dutch nursing and care sector

Tesselaar, G.W.M.

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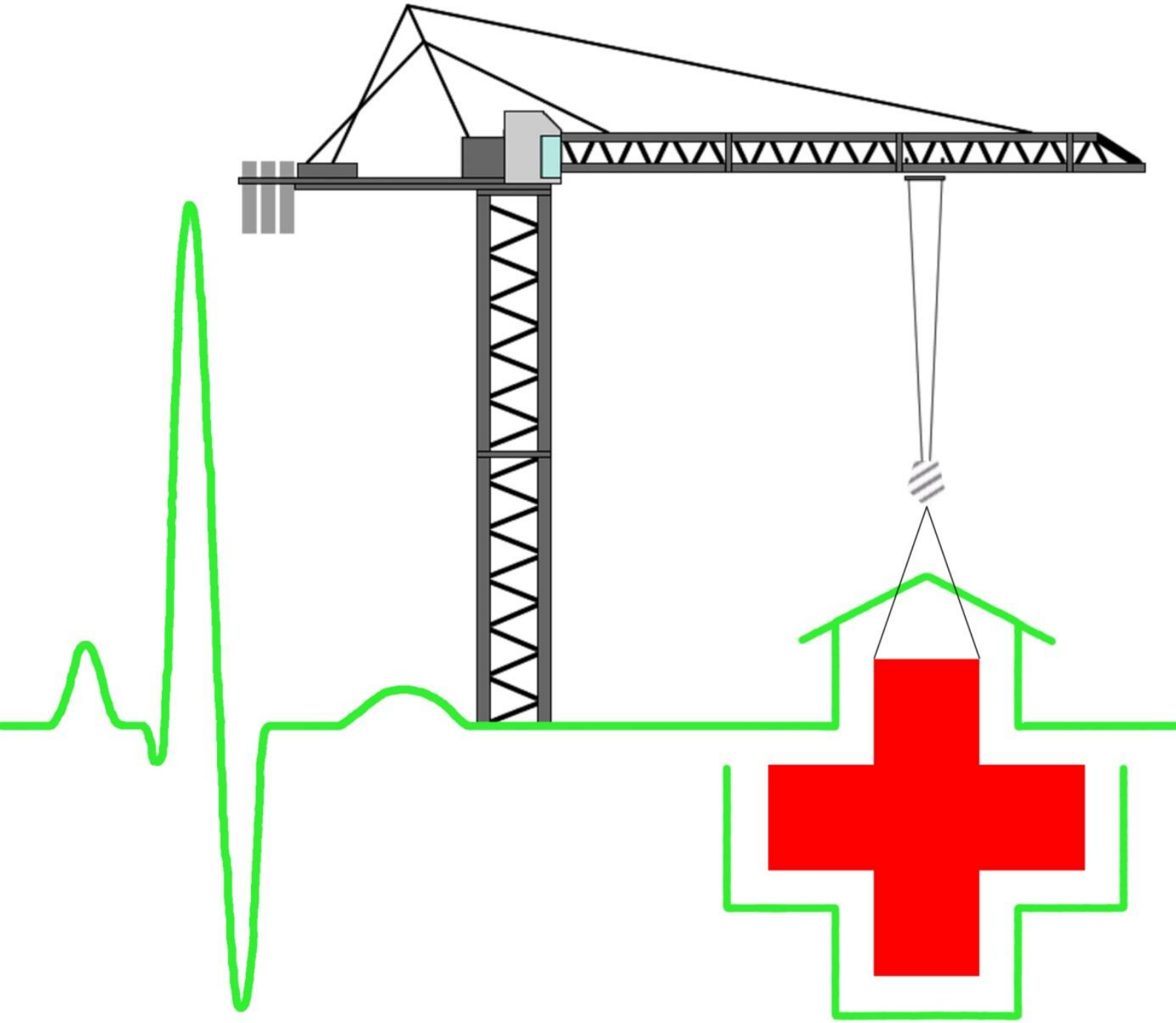

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ing. G.W.M. *(Gerard)* Tesselaar

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University

Technische Universiteit Eindhoven University of Technology
Where innovation starts

Eindhoven University of Technology
Department of Built Environment
Chair Construction Management and Urban Development
Den Dolech 2
Postbus 513
5600 MB Eindhoven
Phone: +31 (0)40 – 247 23 73

Company

VAN WIJNEN
Meer dan bouwen

Van Wijnen Noord B.V.
Projectontwikkeling
Badweg 42
Postbus 83
8400 AB Gorredijk
Phone: +31 (0)513 – 467 666

Author

ing. G.W.M. *(Gerard)* Tesselaar
Student number: 0726990
Phone: +31 (0)6 – 532 37 919
E-mail: gerard_tesselaar@hotmail.com

Graduation committee

prof. dr. ir. W.F. *(Wim)* Schaefer (TU/e)
dr. Q. *(Qi)* Han (TU/e)
ir. W.F. *(Erik)* Schot MRE (Van Wijnen)

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"Knowing what we know, and knowing what we do not know, that is what knowledge is."

Confucius, social philosopher of ancient China, 551 B.C – 479 B.C

Preface

With the completion of my master thesis, written for the master track Construction Management & Engineering (CME), I finished my study period at the Eindhoven University of Technology. A period in which I have developed myself personally as well as professionally. After receiving my bachelor's degree 'Bachelor of Built Environment' in Haarlem in 2009, I made the big step to study and live in Eindhoven, to get even more insight in the 'construction management' aspects in the built environment at the TU/e.

During the three years of study at the TU/e I have further developed my view on the built environment. With the 'luggage' collected during courses and projects, I started searching for a suitable graduation topic in November 2011. Soon I discovered the problems and challenges going on in the 'Dutch elderly care', the social relevance and large changes which are at its starting point drew my attention. With Van Wijnen as 'partner', recognizing the problems and relevance, brought me to their settlement in Gorredijk (Friesland region).

Although the process, called "graduating", did not go as 'smooth' as I hoped it would. I am satisfied with the results that I have achieved and very grateful for all guidance and support I received during my graduation but also during the period prior to the graduation.

That is why, right here, I do like to thank a few people.

Firstly my supervisors from the TU/e, Wim Schaefer and Qi Han, for their knowledge in our field of work and experience with applying research methods. And also of course the guidance of Van Wijnen, department project development in Gorredijk, especially my supervisor Erik Schot for his time and efforts.

I cannot forget my 'friends4life' of CME. Together, we have had an unforgettable study period in Eindhoven and we have been through a lot; both good and bad times. Thanks to you I was able to cope with the loss of our dear friend Jack, for which I am sincerely grateful! I will always remember our evenings (and nights) of; talking, dinners, going out and collaboration during projects, your support and of course Brazil.

I would also like to thank my girlfriend Daniëlle. Despite the large distance between the both of us, due to my graduation place in Gorredijk, she has always supported and motivated me doing my research. Something I have really appreciated!

Last but certainly not least, I would like to thank my parents. They offered me the opportunity to study and live in Eindhoven for three years. Without them, I would not have been able to build a good base for my future!

Hopefully you will enjoy reading my master thesis.

Gerard Tesselaar
Eindhoven, July 2012

Summary

Aging of the Dutch population will increase the pressure on the Dutch health care sector enormously. Especially the nursing and care sector will suffer from this, the growing demand for care spaces within this sector makes that a social as well as a financial pressure will occur. To prepare the nursing and care sector for this growth and control the spendings within this sector, the Dutch government started restructuring the regulation for the nursing and care sector. Amongst others the way regulation for the real estate of nursing and care institutions will change, hereby the strategic real estate management of a nursing and care institution will change. These changes will also influence the perspectives of a construction company which is active within this sector.

A deeper look at what the regulation change actually contents. A set of plausible scenarios about the possible future perspectives are designed. This research should provide an insight in the changing environment of the nursing and care sector for a construction company.

For analysing the possible future perspectives the scenario planning research methodology has been applied. To conduct the scenario planning research, an orientation on the research environment has been done, experts in the field of nursing and care are interviewed and the driving forces that influence the research environment are determined.

It can be concluded that there is a variety of driving forces that determine the research environment. The uncertainty that the government is causing at the moment is a large struggle point for nursing and care institutions for deciding their real estate strategy. Depending on the governments decision, the demand for the housing form can differ. Nursing and care institutions do need to makes choices between developing and manage in ownership or renting, larger scaled institutions will see opportunities to handle this in-house. Therefore private parties that could finance the real estate plans of nursing and care institutions are sought.

In the most probable future scenario the living will be separated from the care in the regulations. This means that care recipients become self-responsible for accommodate their housing, thereby the focus becomes more on practicing home care. Concerning the real estate; small units (life-proof housing) will be the future demand. Housing corporations will be involved by the institutions to develop and manage the real estate, the care will be the ‘additional service’ of a housing corporation. To get better insight the region specific demand of care recipients, nursing and care institutions will also focus more regionally; to become better informed in the specific needs and sooner see opportunities.

Table of contents

List of abbreviations

List of commonly used abbreviations.

A&O	Afbouw en Onderhoud	Finishing and maintenance
AWBZ	Algemene Wet Bijzondere Ziektekosten	Exceptional Medical Expenses Act
B&U	Burgerlijke en Utiliteitsbouw	Civil construction
BVO	Bruto Vloeroppervlak	Gross floor area
CBZ	College Bouw Zorginstelling	College care facility construction
CIZ	Centrum Indicatiestelling Zorg	Care Assessment Centre
GGZ	Geestelijke Gezondheidszorg	Mental Health care
GHZ	Gehandicaptenzorg	Health Care for disabled
GWW	Grond-, Weg en Waterbouw	Infrastructure & Civil engineering
NHC	Normatieve huisvestingscomponent	Normative housing component
NZa	Nederlandse Zorgautoriteit	Dutch Healthcare Authority
OGGz	Openbare Geestelijke Gezondheidszorg	Public mental health care
RIVM	Rijksinstituur voor Volksgezondheid en Millieu	National Institute for Health and Environment
V&V	Verpleging & Verzorging	Nursing and Care
VWS	Ministerie van Volksgezondheid, Welzijn en Sport	Ministry of Health, Welfare and Sport
Wmo	Wet Maatschappelijke Ondersteuning	Social Support Act
WTZi	Wet Toelating Zorginstellingen	Admission care law
Wvg	Wet voorzieningen gehandicapten	Law for the disabled
WZV	Wet Ziekenhuisvoorzieningen	Hospital Facilities Act
ZVW	Zorgverzekeringswet	Health insurance law
ZZP	ZorgZwaartePakket	Intensity of care package

1. Introduction

Since 2005 the Dutch government has been restructuring the health care sector. Besides this the pressure on the health care sector will increase enormously in the upcoming years due to demographic aging[1] of the Dutch population. Especially the nursing and care sector will be affected by this; the growing demand for 'elderly care' will force this sector to prepare to handling this increasing demand for care spaces and dealing with the new regulations.

> *"Wisdom does not automatically come with old age. Nothing does – except wrinkles. It is true, some wines improve with age. But only if the grapes were good in the first place."*
>
> **Abigail van Buren, American journalist, 1918**

In paragraph 1.1 the problem analysis is elaborated. In paragraph 1.2 the research model is displayed. The research objectives and limitations are given in paragraph 1.3. In paragraph 1.4 the relevance for both the Eindhoven University of Technology and Van Wijnen is given. In paragraph 1.5 the expected results are elaborated and in paragraph 1.6 a tassel for the reader is given.

1.1 Problem description

A part of the restructuring in the Dutch health care sector contains a regulation change within the V&V sector. This newly formed regulation causes that V&V institutions become self-responsible for all its real estate activities, both financing and management. Besides, the aging of the Dutch population (in 2020 almost 20% of the Dutch population will be 65 years or older, increasing to 25% in 2040 (CBS, 2012)) will impose an enormous social and financial pressure on the V&V sector; an increasing demand for care spaces will arise. All these changing forces in the V&V sector will also influence the perspectives of a construction company which is active in that sector. What are these future perspectives; which parties will be involved in construction processes, how will the construction process be organized, how will the real estate be financed and what will the future demand look like, are just a few questions that arises.

1.1.1 Problem definition

Exploring the future environment of a construction company active in the Dutch V&V sector, concerning; governmental regulation, housing, development organization and future demand perspectives.

[1] | Aging is the English designation for "Vergrijzing".

1.1.2 Research question

What are the future scenarios for a construction company active in the Dutch nursing and care sector?

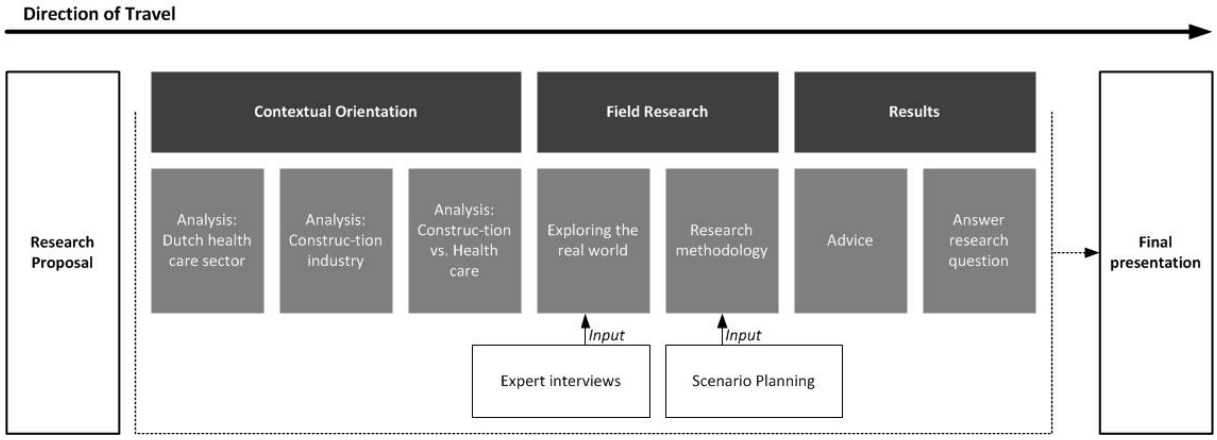
1.1.3 Sub-questions

- What are the characteristics of the Dutch health care sector?
- What are the characteristics of the Dutch construction industry?
- What is the content of the regulation change in the Dutch nursing and care sector?
- What is the real estate management strategy of nursing and care institutions?
- How should construction company Van Wijnen act for being able to keep in business in the Dutch nursing and care sector?

1.2 Research model

The research model as shown in figure 1; displays the steps that are undertaken during the process of the graduation research. The research model shows the cohesion within the research and the roadmap working towards the final results.

Figure 1 | Research model



1.3 Research objectives and limitations

The research will be defined and limited according three topics; viewpoint, field and focus. The viewpoint defines from which position the researcher is elaborating this graduation research. The field describes the subject area in which the researcher will perform its research. Within the focus it is defined in which particular part “sub-area” of the field is focussed on especially.

1.3.1 Viewpoint

The viewpoint of this graduation research is the contractor, specifically construction company van Wijnen, located in Gorredijk (The Netherlands).

1.3.2 Field

The field of this graduation research is the Dutch health care sector. To get a good insight in the possibilities for the construction industry in the Dutch health care sector, it is important to know what is currently going on in the Dutch health care sector.

1.3.3 Focus

The specific focus of this graduation research is on the V&V sector in the Netherlands. Only an analysis of the real estate activities will be within the contemplation of this research.

1.4 Research relevance

1.4.1 Relevance TU/e

This graduation research is elaborated for the master track CME. A master track that focuses on the urban environment on one hand and on the other hand combines entrepreneurship and industrial engineering aspects. For the elaboration of this graduation, research into the Dutch health care sector (the V&V sector more specifically) will be done. The changing governmental regulation and growth within this sector makes that the V&V sector will change the urban environment in the upcoming years. The strategic real estate management of V&V institutions is analysed. Besides, factors affecting the urban environment, like; aging and demographic change will be involved within this research.

1.4.2 Relevance Van Wijnen

Construction company Van Wijnen participates within the performance of this research. Van Wijnen is active in the V&V sector and is thereby subject to the governmental regulation change concerning the real estate. Working within a changing environment forces a company to orient on the new environment in which it is active. Within this research, the strategy of V&V institutions concerning their real estate management and how they look at their new environment will be analysed. Together with an orientation in the literature part, a set of four plausible scenarios about the possible future perspectives are elaborated. These scenarios will be a basis for the advice which will support Van Wijnen in creating a view on how their new business environment in the V&V sector could look like.

1.5 Expected results

As already stated in the title of this research, it is ‘time for caring for the construction industry’. Which of course is meant a bit cynical, but on the other hand it has a very serious meaning. The result of this research will provide an insight in the changing environment of the nursing and care sector; what are the trends and what does the regulation change exactly content, with a set of four scenarios the possible future perspectives are described. Besides that it will contain an advice to construction company Van Wijnen on how to deal with the future perspective. The goal of the advice is to help Van Wijnen in preparing for the future in the V&V sector.

1.6 Tassel

To be able to give a brief insight and some background information about the company that guided this research, the following chapter (see chapter 2), will provide some information about Van Wijnen. The substantive part of this research is divided in three parts. In part A (chapter 3 up to and including chapter 5) an orientation of the research environment (Dutch health care sector, construction industry and the correlation between both) is elaborated. Part B contains the field research, in chapter 6 the expert interviews are elaborated and in chapter 7 the scenario planning is extensively discussed. In part C the advice towards Van Wijnen is given (see chapter 8) and finally chapter 9 contains the conclusions of this research, discussion about the results as well as recommendations for further research. In part D the appendices for the complement of this report are included.

2. Company: Van Wijnen

This graduation research has been elaborated in cooperation with construction company Van Wijnen. In paragraph 2.1 the organization of Van Wijnen is explained in more detail. In paragraph 2.2 the national coverage of Van Wijnen is elaborated including a geographical map. See paragraph 2.3 for the different market sectors and activities of the company Van Wijnen. This chapter should provide a brief insight and some background information about the company that guided this research.

2.1 Organization

The Van Wijnen company employs builders and developers, all focussed on achieving realisation. That is what made Van Wijnen one of the largest construction and property development companies in the Netherlands. Van Wijnen realises homes, schools, health care institutions, offices, shopping malls and sport & leisure accommodations. In some of the projects Van Wijnen is only assigned to construct, more often Van Wijnen is already involved in the initiative phase or even takes the initiative.

In 2011 the Van Wijnen company had about 1,500 employees and achieved a turnover of more than €635 million.

For over a century Van Wijnen has been working on a variety of innovative and sustainable projects and is also active in the fields of development, construction, maintenance and management.

2.2 National coverage

Figure 2 | Van Wijnen settlements[2]

Source: (Van Wijnen Corporate, 2012)

The Van Wijnen Holding N.V. is a national construction and property development company divided over five regions in which all activities are housed. These five regions are the pillars of the Van Wijnen company. The decentralized organizational structure with 22 settlements spread across the country (see figure 2), makes it possible to operate as close as possible to the client and the market. Each of the 25 settlements operates with its own identity, knowing its environment and following the local and regional developments closely. They simply 'speak the language' of the region.

[2] | Each dot is presenting a Van Wijnen settlement. The flag points out the settlement Gorredijk, from where this graduation research has been elaborated.

The regional settlements are supported from the headquarter in Baarn. Van Wijnen wants to be close to the market in which it operates, and be accessible to its clients.

2.3 Market sectors and activities

Because Van Wijnen is active in a wide variety of work, the daily variety of projects in progress are very diverse. To be able to handle such a variety of projects in progress, Van Wijnen has several market sectors on which will be focussed and gain knowledge in that specific market. The following market sectors are designated; housing, offices, restructuring, shopping, public buildings, health care, education, sports and culture, leisure, parking, maintenance and renovation. In appendix I background information of all market sectors are summarized, in the following paragraph only 'health care' is elaborated because that is the topic on which this graduation is focussed.

2.3.1 Health care

One of the main market sectors for Van Wijnen is the Dutch health care sector, Van Wijnen recognizes the increasing demand within this sector. Due to changes in the financing structure for care institutions, you will find sufficient information about that in the rest of this report, the needs of those care institutions is changing. The changed financing structure even increases the high demand on quality and durability of its housing in the health care. Through years of experience and contributing to many projects (see table 1); Van Wijnen has gathered a lot of specific knowledge about the Dutch health care sector which has led to insight in the needs of health care institutions. Van Wijnen is one of the first contractors with experience in building in the health care budget. Assurance of quality is provided through clear agreements on the quality and budget in which the project must be realized.

In table 1, it is possible to see the annual amount of projects within the Dutch health care sector in which Van Wijnen has participated for the last decade. The table is divided into projects executed by the Van Wijnen Holding N.V. and projects executed by the Van Wijnen North region, from where this graduation research has been elaborated. Only projects that were newly developed are shown.

Table 1 | Projects executed within Dutch health care sector

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Van Wijnen Holding N.V.	6	4	13	12	9	8	10	7	12	9
Van Wijnen North	5	4	7	4	6	2	5	2	6	4

Part A

Contextual Orientation

3. A closer look: the Dutch health care sector

In this chapter a closer look at the health care sector in The Netherlands is taken. This is done by an explanation of what the Dutch health care sector actually contains (see paragraph 3.1). After forming a better view of the Dutch health care sector, elderly care is focused on, which is the focus of this graduation research (see paragraph 3.2). At the end of this chapter a trend analysis is made. It gives definition of the changes in the elderly care over the last few years and some expectations for the future (see paragraph 3.3). This chapter is finishes with conclusions (see paragraph 3.4), it should be clear on which specific type of care the focus will be for the elaboration of this graduation research and its content.

3.1 Introduction; the Dutch health care sector

The total supply of care, the Dutch health care sector, are all institutions that provide medical care for care recipients (Dols, 2011). A distinction is made between two specific types of medical care, namely 'cure' and 'care'. Cure and care seem to be clear topics, but looking at it more closely, it does not seem to be that simple. Therefore, some attention to those definitions needs to be given.

For ages the idea was that the public health only had to be focused on the traditional pharmaceutical sector, or treatment 'cure' of diseases. There were no thoughts about the total aspect of what public health actually was needed for; welfare of humans, or 'care' (RVZ, 2001).

3.1.1 Cure

The specific focus of the cure sector is on the healing and/or recovery of care recipients. Institutions active in the cure sector are for example hospitals, dentists and general practitioners.

Table 2 | Cure sector

	Cure
Goals c.q. functions	▪ Healing ▪ Recovery
Activities	▪ Medical care ▪ Rehabilitation ▪ Short-term care
Professions	▪ Medics ▪ Paramedics
Period	▪ Temporary ▪ Short-term
Location	▪ Hospitals ▪ Dentists ▪ Physiotherapists
Insurance	▪ Health insurance

Source: (RVZ, 2001)

3.1.2 Care

The increasing amount of chronically ill humans highlighted the need for a new type of care, a type of care that does not focus on the treatment of diseases but focuses on the support and medical interventions of care recipients. Institutions in the care sector, such as care and nursing homes, relieve the symptoms, prevent complications and attend care recipients (RVZ, 2001). Important is that these institutions do not influence the treatment of any disease, but treatments are necessary for the care recipient's wellbeing (van Hilten, Kleima, Langenberg, & Warns, 2005).

Table 3 | Care sector

Care	
Goals c.q. functions	▪ Limiting disorders and diseases
Activities	▪ Nurse ▪ Care ▪ Attend ▪ Support
Professions	▪ Nurses ▪ Carers ▪ Activities attendants
Period	▪ Chronically ▪ Long-term
Location	▪ Care homes ▪ Nursing homes ▪ Home care
Insurance	▪ AWBZ

Source: (RVZ, 2001)

3.1.3 Financing health care

In table 4 the total money involved in the Dutch health care sector can be seen. The Dutch government finances 83% of the total costs within the health care sector. The rest is financed by the users of care, amongst others through the health care insurance, companies and foreign sources. The V&V sector consumes almost 20% of the total costs for the Dutch health care sector.

Table 4 | Health care costs [year 2010]

	Amount (x mln euro)	% of total	Per capita (euro)	% GDP[3]
Hospital	22,400	25.7	1,347	3.8
V&V	16,000	18.4	965	2.7
GHZ	7,900	9.1	477	1.4
General practitioners	7,000	8.0	419	1.2
GGZ	5,400	6.2	325	0.9
Others	28,400	32.6	1,709	4.8
Total Dutch health care	**87,100**	**100**	**5,242**	**14.8**

Source: (CBS, 2011)

[3] | GDP (Gross Domestic Product) is the English designation for "BBP (Bruto Binnenlands Product)".

3.1.4 Remaining

Although the previous two paragraphs implicate that there is a clear line of demarcation between 'cure' and 'care', there are some exceptions. Institutions providing mental health care belong to both sectors, because they may execute both cure and care. Furthermore, in the Dutch health care sector there is some overlap for some institutions. For example care and nursing homes mostly provide more than just 'loving care' to care recipients, in most situations those institutions also have a minor treatment orientation.

In figure 3 the distinction between the two terms 'cure' and 'care' are overviewed, beside the figure a size comparison is made. This is done to provide a better view of the distinction between those two terms.

Figure 3 | Cure versus Care [year 2010]

Source: (Steegh, 2011)

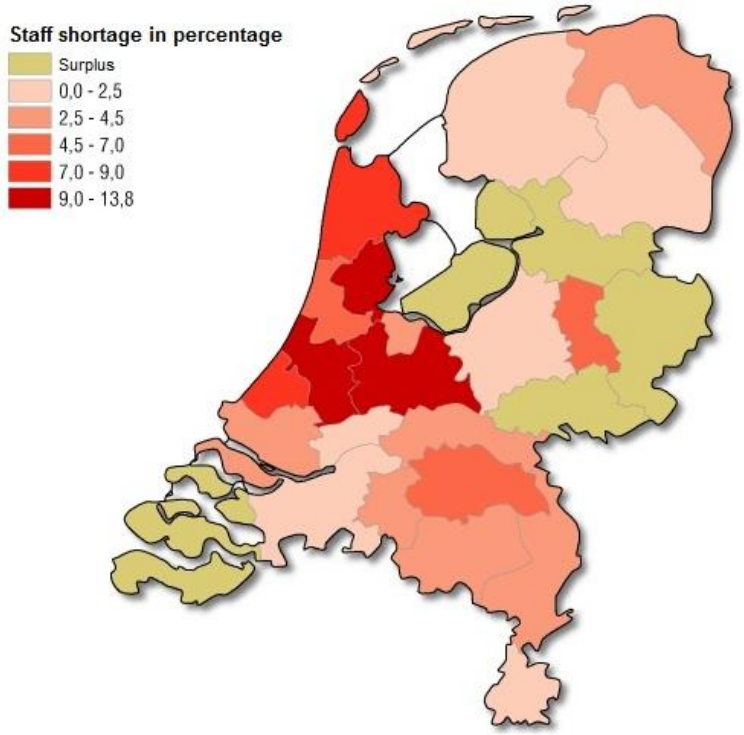
Because somehow everybody is involved with health care, the Dutch health care sector occupies an important position. To get a sense of what the care industry consists of, table 5 represents the total size, distribution and amount of employees for the Dutch health care sector.

Table 5 | Size of the Dutch health care sector [year 2010]

	Total	Academic hospitals	Common hospitals	Specialized hospitals	GGZ	GHZ	V&V
Companies	833	8	76	23	98	139	489
Employees	920,380	70,790	190,640	16,840	83,690	158,700	399,720
Total FTE	571,100	54,920	129,790	11,550	63,440	98,870	212,530

Source: (CBS, 2011)

Figure 4 | Shortage of staff [year 2012]



Source: (Nationale Atlas Volksgezondheid, 2012)

Within the entire Dutch health care sector, over 900,000 people are employed. With a total labour force[4] of about 7.8 million, it can be concluded that almost 12% of the Dutch labour force works in the health care sector. This shows that the Dutch health care sector is an important employer. Although so many people already work in the Dutch health care, there is still a shortage of staff (see figure 4). With the prospect of aging (see paragraph 3.3.1), and the associated expectation of increasing demand for care, it is expected that this shortage will only increase in the future.

3.2 Nursing and Care (V&V)

Because the focus of this graduation research is on the V&V sector, and this sector is the most important and largest sector within the AWBZ, it is of added value to know more about this specific sector. Institutions within the V&V sector are care and nursing homes as well as home care. Sometimes the V&V sector is also characterized as VVT sector, where the 'T' stands for home care[5]. Within the V&V sector nursing, care, guidance and support will be provided to care recipients, with the goal to limit the disadvantages of diseases, disorders and constraints. In the following paragraphs (3.2.1 to 3.2.4) some V&V sector specific definitions are elaborated.

3.2.1 Care recipients

The main group of 'potential customers' for the V&V sector are elderly people, although there is no minimum age for people receiving care in the V&V sector. People needing care will be tested by the CIZ, an institution that will provide an indication and permission for specific care that can be given to the care recipient. From the total group of people receiving care from the AWBZ, 72% makes use of home care, 18% of a care home and 10% of a nursing home. Due to aging (see paragraph 3.3.1) the amount users of AWBZ care will annually grow with 1.2% till 2030. Within the V&V sector this growth will even be 1.4% annually (CPB, 2012).

[4] | Labour force is the English designation for "Beroepsbevolking".
[5] | Home care is the English designation for "Thuiszorg".

3.2.2 Staff

In 2010, 399,720 people were working within the V&V sector, which is about 5.1% of the total Dutch labour force. These group of employees delivered care for about 212,530 full time equivalent (FTE). Just like for the total Dutch health care (see figure 4), it is expected for the V&V sector that for the future an increasing shortage of staff will occur. Expected is that the demand for staff will annually grow with 1.7% for care and nursing institutions (CPB, 2012).

3.2.3 Care and nursing homes

Within the Dutch 'care' sector, care and nursing are always typified as V&V sector. Interesting to know is what the difference between those two actually are. According to the Dutch governmental website about health care (kiesBeter.nl, 2012), there is a small similarity between care and nursing homes. Which makes it even more interesting to know what the differences are.

> *"Both nursing homes and care homes provide care in a sheltered or protected environment, this means that people living in a housing of the institution, here does the similarity ends."*
>
> **(kiesBeter.nl, 2012)**

Care homes

Care homes[6] offer care to care recipients that cannot take care of themselves anymore. For these people it is not possible to stay at home alone anymore. Care recipients will be helped with washing, dressing and eating. In care homes the focus is not on the medical 'cure' side of care, but on the 'care' side of care; enabling care recipients in their everyday life (Rijksoverheid, 2012).

Nursing homes

Nursing homes[7] on the other hand provide a more specialized and intensive type of care. Within nursing homes care recipients are treated with major medical treatments and in a very intensive way. The more a care recipient is limited, the higher the need for nursing. Nurses working in nursing homes are in need of special education for the ability of working in such a nursing home (Rijksoverheid, 2012).

3.2.4 Intramural, semi mural and extramural

Within the V&V sector there are three types of care which can be provided; intramural, semi-mural and extramural, each of these three types bring along a specific type of real estate. In table 6 the differences are shown.

[6] | Care home is the English designation for "Verzorgingshuis".
[7] | Nursing home is the English designation for "Verpleeghuis".

Intramural

Care recipients in the need of intramural care are actually live in the institution and have 24/7 access to care. An intramural institution is a place where; living, care, supervision, services and nursing is provided in one place. Usually, this is the type of care most people think of when talking about care and nursing. For this type of care the actual delivered care and the housing are financed and regulated within the AWBZ (see paragraph 5.3.1).

Semi-mural

As the name probably already declares, semi-mural is the type of care that is positioned between intramural and extramural. Care recipients that cannot take care of themselves anymore but are not that limited that they need fully intramural care, are provided with semi-mural care. The largest difference with intramural is that the care recipients will not stay overnight in the institution where they receive care during the day.

Extramural

For the extramural delivered care, care recipients will stay at their own home and care will be delivered as 'home care'. For this type of care, only the actual delivered care is financed and regulated within the AWBZ (see paragraph 5.3.1).

Table 6 | Intramural, semi-mural and extramural

	Intramural	Semi-mural	Extramural
Care	Care home	Small-scale housing	Home care
Nursing	Nursing home	Small-scale housing	Home care

For this graduation research the focus is on the intramural and semi mural health care. The reason for that is that it is better to view the extramural type of care as a 'normal residential real estate' (see paragraph 5.1). Concerning the objective of this research, this type is not relevant.

3.3 Trends

In recent years it was possible to notice several trends in the care industry. These trends occurred under social circumstances, changing legislation and (technological) innovation. In this paragraph some of these trends are discussed.

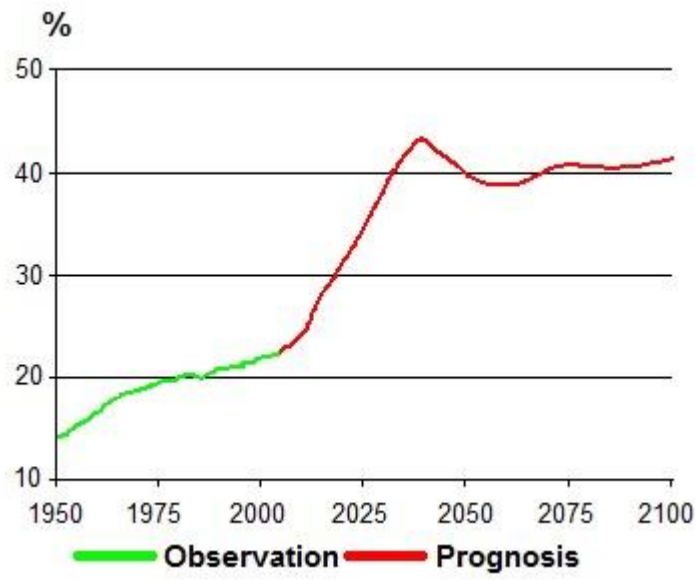
3.3.1 Aging of the Dutch population

After the Second World War until the early 1970s The Netherlands had a higher birth rate compared to the period after. Due to this trend, the Dutch population contains a large group of 39-63 year olds; this trend is called aging. Since 2011, part of the population is 65 years and older. Besides that people get older due to better medical health care. People aged 65 in 2025 have a 70% chance of reaching the age of 80 years old, while in 1990 this chance was only 60% (de Jong & van Duin, 2010).

"Aging is the result of an increased life expectancy and a declining birth rate."

(Stichting Habion, 2007)

Figure 5 | Grey pressure prognosis



Source: (CBS, 2012)

The above described fact results in the growth of the number of elderly people. The grey pressure[8] at the moment is 26% (CBS, 2012). This means that of every 100 people in labour force, 26 persons are 65 years or older. Expected is that from now on, this grey pressure will only increase as can be seen in figure 5, with a top in 2040.

The total amount of 65 year olds in the Netherlands will increase from 2.6 million now to 4.6 million in 2040. For a more detailed view of the effect of aging in The Netherlands, a Dutch population forecast is shown in table 7.

Table 7 | Dutch population forecast

%	2011	2015	2020	2025	2030	2035	2040	2045	2050
Age 0 – 20 years	23.5	22.7	22.0	21.3	21.3	21.4	21.5	21.4	21.2
Age 20 – 65 years	60.9	59.6	58.3	57.0	55.0	53.3	52.6	53.1	53.7
Age 65+ years	15.6	17.7	19.7	21.7	23.7	25.3	25.9	25.5	25.1
Total	100	100	100	100	100	100	100	100	100

Source: (CBS, 2012)

In table 7 the forecast for the Dutch population can be seen. Therefore the population is divided over three age categories, 0-20 years, 20-65 years and 65 years and older. This is done because the second category is the labour force which should finance the other two

[8] | Grey pressure is the English designation for "Grijze druk".

categories. For this research we consider everyone older than 65 years as ‘elderly’ and as a potential care recipient for the V&V sector, this group is the third category.

Figure 6 | Dutch population structure 1950, 2000, 2012 and 2040

Source: (CBS, 2012)

As can be seen in figure 6 the Dutch population structure is subject to large changes. In the 1950s a large group of young people formed the wide basis of the pyramid and a small group of elderly people formed the tight top. In the current situation the top is getting wider and the basis is becoming smaller, this effect will continue in the future. Besides, this effect will strengthen the aging because humans get older.

"In the next few decades, aging will cause an increasing demand for long term care. Therefore, the pressure on both the social and financial aspect of the long term care system will grow."

(Eggink, Oudijk, & Sadiraj, 2012)

The effect of aging will cause a growing pressure on the long-term care system, as can be deduced from the quote above (Eggink, Oudijk, & Sadiraj, 2012). Aging will cause a growing demand for health care in the coming decades. This higher demand will influence the financial pressure on the expenditures on care, more elderly people need to be cared for while there are less people to provide care and finance. Besides, the higher demand for health care will influence the demand for space where health care can be practiced, extra places or an expansion of existing places will be needed to fulfil the new demand. Due to the aging there is a chance that the supply of labour will not be sufficient for the future (see figure 4) (Antonissen, 2007).

3.3.2 Growing stock of homes for the elderly

Results of a research done by the RIVM (van den Berg Jeths, Timmermans, Hoeymans, & Woittiez, 2004) show that the total stock of homes for elderly people, apartments in care homes and nursing homes, has grown during the last years. Since the late 1990s the total stock of homes for elderly people has grown significantly. Due to new developments since 1990, 100,000 elderly homes have been added.

Of course the growth of this stock has a reason, for the last decades a growth of demand of elderly homes is visible. In table 8 this growth can be seen, disappointing is that this research stopped in 1998, after that, no data is available.

Table 8 | Elderly homes

	1981	1985	1990	1994	1998
Percentage 65+ living in elderly homes	9	11	12	15	25

Source: (van den Berg Jeths, Timmermans, Hoeymans, & Woittiez, 2004)

Location change

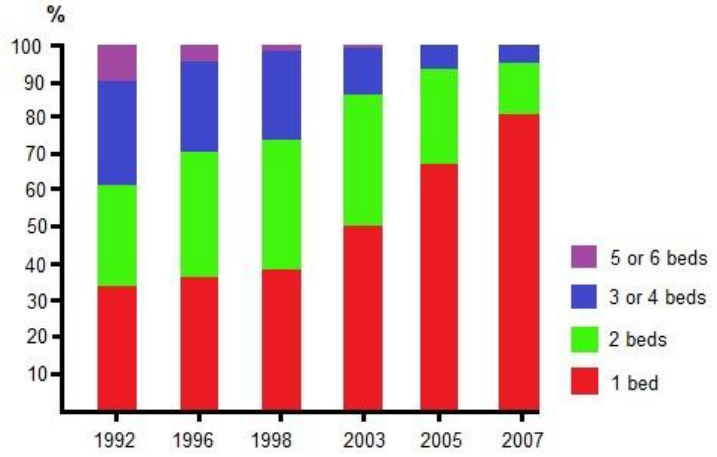
Besides the growth of this stock, the preferred location of a home for elderly people is specific. Because the mobility of elderly people will decrease due to their age, homes for elderly have to meet those elderly discomforts. These elderly homes are more and more situated close to stores and public transport facilities. This type of elderly homes is called life-proof housing[9].

[9] | Life-proof housing is the English designation for "Levensloopbestendige woning".

3.3.3 Quality improvement

Another trend in the care industry is the improvement of the quality. Attempted is to increase the total amount of single rooms. This way care recipients have more privacy; this will influence the feeling of quality. Over the last 20 years the growth of the number of single rooms can be seen (see figure 7). Through the improvement of quality and privacy, placing own furniture and receiving visitors in their own room, care recipients will feel better (Plexus & BKB, 2010).

Figure 7 | Number of beds per room in nursing homes



Source: (Dols, 2011)

3.3.4 Extramuralisation

One of the trends in the Dutch elderly care is the extramuralisation, which means that elderly people are more and more receiving care at home. The Dutch government is committing to separate living and care, goal is to achieve a limitation in the intramural health care budget. The extramural health care is cheaper compared to the intramural, this because institutions do not have to possess real estate property. The last years the extramural health care has grown faster compared to the intramural health care, despite efforts of the Dutch government. The cause is that the extramural health care is not yet replacing the intramural health care to a sufficient amount (Plexus & BKB, 2010) and the period of people living at home receiving home care is extended. At older ages and with more complications these people will receive intramural care. Relatively less elderly people are using intramural health care, but the total amount of elderly people is growing and therefore the total demand for care.

Another side effect for the fact that extramural health care is not yet able to replace intramural health care is that it is not yet possible to provide extramural health care in all the existing housing. Institutions respond to this by, whether or not with the help of housing corporations, developing life-proof housing. The life-proof housing is situated in the direct environment of care and nursing homes, so that care recipients can receive total extramural health care.

3.4 Conclusions

The Dutch health care sector can be seen as an important sector in The Netherlands, not only because it cures and cares for the people, but also because of its large influence. Besides, 12% of the total labour force in The Netherlands works in the health care sector.

The following trends can be defined;

- Aging of the Dutch population;
- Growing stock of homes for the elderly;
- Location change;
- Quality improvements;
- Extramuralisation.

These trends are in some way influencing the demands concerning the real estate for care and nursing homes. Due to the aging it can be concluded that there will be a higher demand for spaces in care and nursing homes; new capacity will be needed. On the other hand we see that elderly are more and more willing to stay at home, extramuralisation is the result of this. But due to the aging, we do not see a stagnation of the intramural health care. Besides the needs are changing, elderly prefer to have their own place; improvement of the quality by reducing the beds per room.

4. A closer look: the construction industry

In this chapter the Dutch construction industry is defined and elaborated. This is done by a description of the size of and involved industries within the Dutch construction industry (see paragraph 4.1). Afterwards a brief elaboration of what a contractor is (see paragraph 4.2). This chapter is ends with a conclusion (see paragraph 4.3), at the end of this chapter it should be clear what is meant with the construction industry.

4.1 Introduction; the Dutch construction industry

In the ancient world construction relied on the environmental resources to create shelters for communities. The first shelters and settlements were constructed from stone, mud and materials collected in the forests. These shelters provided protection against cold, wind, rain etc.. In the ancient world, construction was an activity for all members of the community (Ngowi, Pienaar, Talukhaba, & Mbachu, 2005). Since then, the construction industry has professionalized more and more, with the industrial revolution in the 18th century as tipping point.

Since the 18th century the construction industry has professionalized and developed itself towards the unique construction industry as we know it at present day. Since the professionalization , the construction industry has a long tradition of fragmentation. The current construction process is separated in initiation, design and construction, many different parties are involved and they all contribute to the constructed object (Moons, 2010). A commonly used definition to explain 'construction' is (according to the housing law[10]):

> *"Placing, in whole or in parts, renew or change the enlargement of a building, as well as wholly or partly up, renew or change and increasing a pitch."*
>
> **Quote from the Dutch housing law**

A building is any kind of building structure of any size. This does not always have to be a building (office, housing, hospital, factory, etc.) but can also be a road or a bridge. Thereby the construction industry is divided over three sectors (Onos, Meijer, Leenders, & Elders, 2008):

- Civil construction (B&U);
- Infrastructure & Civil engineering (GWW);
- Finishing and maintenance (A&O).

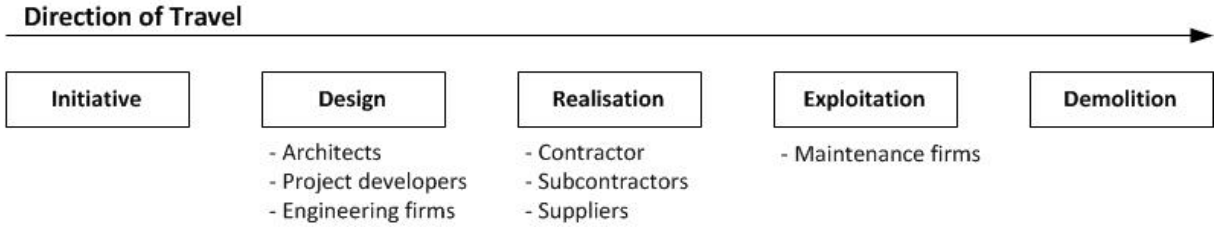
[10] | Housing law is the English designation for "Woningwet".

Due to the characteristics and diversity of activities which characterize the construction industry, it is possible to say that the construction industry is far from being a single activity. Large-scale construction projects are the result of human multitasking and extensive collaboration between many stakeholders. With the growing complexity of the project the need for better collaboration increases. The following five characteristics are specific for the construction industry (Myers, 2008);

- Each project is regarded as a unique one of a kind product;
- The construction industry is dominated by a large number of relatively small firms;
- The general state of the economy influences the demand;
- Prices are determined by tendering;
- Projects are characterized by their 'lumpiness' in terms of their scale and expense.

In figure 8 the theoretical linkage of the sectors involved in the construction chain is schematically shown for new developments. The figure shows the linkage of the sectors for a new development involving a traditional organization. Note that in practice the organization, of the listed sectors, is much more complex most of the time, or is even more extensive with more and other stakeholders (Holtackers & Grootenboer, 2011).

Figure 8 | Schematic representation of the construction chain



Source: (Holtackers & Grootenboer, 2011)

As already mentioned, traditionally there are many parties involved in a construction project. In table 9 these parties are summed. For each of the parties a brief description about their contribution to a construction project is given.

Table 9 | Parties traditionally supplying a construction project

Parties involved in supply	Responsibilities
Architects	▪ Provide program of requirements ▪ Provide design ▪ Requests building permit
Project developers	▪ Develop construction plans ▪ Acquire location ▪ Financing
Engineering firms	▪ Elaborate the engineering of the building
Main contractor	▪ Manages work on site ▪ Contracts subcontractors
Subcontractors	▪ Supply specialist skills
Suppliers	▪ Provide building materials and related components

The amount of companies active in the Dutch construction industry almost hits the number of 115,000. Specific for the construction industry is the large proportion of the so-called self-employed[11] and companies with only a single person employed. On average 70% of the companies are such 'small' companies. In table 10 the amount of companies divided over involved industries are shown.

Table 10 | Size of the Dutch construction industry

	Companies	Small companies[12]	Other companies
Total	114,460	80,305	34,155
Project development	2,815	1,565	1,250
General contractors	39,775	30,125	9,650
Infrastructure & Civil engineering	4,665	2,710	1,955
Installation & Finishing	50,610	34,755	15,855
Demolition / Earthworks	4,435	2,795	1,640
Specialized construction	12,160	8,355	3,805

Source: (Bouwend Nederland, 2012)

[11] | Self-employed is the English designation for "ZZP'er". Do not confuse "ZZP'er" with the ZZP (Intensity of care package) as described in chapter 5.
[12] | With small companies is meant; companies with a single person employed and ZZP.

Table 11 | Operating results 2010 Dutch construction industry

	Net turnover (x mln euro)
Project development	5,647
General contractors	32,824
Infrastructure & Civil engineering	13,155
Installation & Finishing	27,723
Demolition / Earthworks	2,398
Specialized construction	5,951
Total	87,698

Source: (CBS, 2012)

In table 11 the net turnover of the Dutch construction industry can be seen. The net turnover is divided over the involved industries. As can be seen that the general contractors are responsible for a large share, about 37%, of the total net turnover in the Dutch construction industry.

4.2 The contractor

The viewpoint from which this graduation research is elaborated is the 'main contractor', also called 'prime contractor' and 'general contractor'; in this report simply called contractor. In this paragraph, the term contractor is shortly discussed and how its working environment looks like.

4.2.1 Contractor

As already can be concluded from paragraph 4.1, the contractor is the firm that is in primary contract with the owner or client for the construction of a project. This contract is either the entire project or for some designated portion thereof, and in that way responsible for the construction and management on the actual construction site.

If the owner or client has chosen to award the construction of the entire project to a single contractor, the contractor brings together all the diverse elements and inputs of the construction process to achieve the goal. To achieve this, most contractors contract sub-contractors to construct the project. But, the contractor will stay responsible to coordinate the total construction process and for the delivery of the finished job, which has to be constructed in accordance to the contract documents, deliver the finished job on schedule and within the agreed budget to the owner or client (Clough, Sears, & Sears, 2008).

The other option, when the owner or client has chosen to award separate contracts, the project will not be constructed under supervision and responsibility of one single contractor. Rather, on the construction site several independent contractors will work on the project simultaneously. Each of the contractors will be responsible for a designated portion of the constructed project. In this way, each of the contractors is in contract with the owner or client and functions independently of the other contractors. The responsibility for the coordination of the construction process may be undertaken by the owner or client, or to another assigned firm (Clough, Sears, & Sears, 2008).

Clients of contractors can be various parties, from private persons, to governmental organizations, companies, project developers and investment companies.

4.2.2 Developing contractor

More and more contractors start to provide more facilities belonging to the construction chain. An example of this is the developing contractor, a contractor also fulfilling the role of a property developer. Mostly these activities are placed within a subsidiary, operating with the same name as the contractor.

4.3 Conclusions

In general the construction industry can be seen as a complicated and specialized industry. Because construction projects are becoming increasingly complex, the importance of good collaboration between all involved parties in the construction phase is necessary for a good result of the project. The Dutch construction industry consists of a large part, about 70%, of self-employed and single person employed companies. The total Dutch construction industry has a net turnover of about €87.7 billion. Concerning contractors, they more and more start to offer extra services, like property development and architecture. This way they are able to offer a total solution, turn-key, to the clients.

5. Construction vs. health care

The goal of this chapter is to elaborate the link between the construction industry and the health care sector. In paragraph 5.1, the existing stock of what nursing and care homes look likes in The Netherlands are elaborated. In paragraph 5.2 the changing regulation concerning financing real estate in the Dutch health care sector, from the former situation, up to 2006, towards the cause and need of the change and a brief insight towards the new (current) situation is described. To make it possible to change towards the current regulation, the legislation has undergone substantial changes, this is elaborated in paragraph 5.3. In paragraph 5.4 some specific policies for the Dutch health care sector concerning the real estate is further discussed. In paragraph 5.5 the consequences for institutions resulting from the changing policy are summarised. And in the last paragraph, paragraph 5.6, conclusions are given.

5.1 Care and nursing real estate

The total Dutch health care sector has an estimated 23.4 million square meters of BVO[13] of floor space. The V&V sector is the largest user of these square meters, with 13.8 million of square meters BVO (almost 60%). Just like the three different types of care that can be delivered (intramural, semi mural and extra mural, see paragraph 3.2.4), the real estate in the V&V sector can be classified in the same categories.

Intramural

Institutions providing intramural care mostly occupy large complexes in which the living, care, supervision, additional services and care & nursing can be delivered. In most cases each care recipient has its own living room, but can also use the common areas.

Semi-mural

A good example of a semi-mural real estate object is the assisted living[14]. A (smaller) independent living space in the close neighbourhood of a care support center. Note: this care support center can for example be an intramural institution.

Extramural

For extramural, no specific type of real estate can be designated because the care recipient will remain to live at its own house.

5.1.1 Obsolescence care and nursing real estate

Not only the Dutch population is subject to aging (see paragraph 3.3.1), also real estate properties in the V&V sector heavily olden. Research of the CBZ has shown that almost two-

[13] | BVO is the surface area of a room or a group of rooms, measured at floor level and along the outer periphery of the ascending separation elements, which separates the respective space or group of rooms from each other's (BRIS, 2007).

[14] | Assisted living is the English designation for "Aanleunwoning".

third of people living in care homes and half of the people living in nursing homes, live in housing that does not meet the basic quality standards. The main cause of this is the aging of the real estate itself. In the course of the years, the function of care and nursing homes has changed, together with this change the design requirements have also changed (CBZ, 2006).

The CBZ performed research within the existing stock of care and nursing homes and labelled the properties of each type (for both nursing and care). Label red indicated that the property does not meet the minimum requirements anymore. Label orange means that it is better compared to the red label, but is not sufficient yet. Properties receiving the green label meet the minimum requirements for housing. The aspects the CBZ used in their research were: apartment, sanitary, accessibility and common area.

> *"You cannot stop aging, but you can stop renewal."*
>
> **Hans van Mierlo, Dutch politician – cofounder D66, 1931**

Quality care homes

Sixty-three percent of the elderly people living in care homes lives in a property that received the red or orange label. The only point of concern, also causing the relative bad label of the common care homes, is that in most cases the sanitary facilities in care homes are too small. Besides still 25% of the apartments in care homes is still smaller than 24 square meters, a minimum that was regular in earlier years. Only 10% meets the new requirements for size of 45 square meters.

Quality nursing homes

Nursing homes scored a little better compared to the care homes. Fifty-three percent of the elderly people living in nursing homes live in a property that received the red or orange label. Again, the sanitary facilities are a problem. These are too small and not wheelchair friendly, something that is essential for this sector.

5.2 Changing regulation

In this paragraph the regulation change within the Dutch health care sector is shortly discussed. From the former situation, up to 2006, to the cause of these regulation changes and finally the current situation are briefly elaborated.

5.2.1 Former situation

Up to the year 2006 institutions in the Dutch health care sector, like hospitals, establishments and V&V institutions, did not have any risk on their real estate policy. The WZV[15] regulated the so called construction regime[16] in the Dutch health care sector.

[15] | Although the name of the WVZ (Hospital Facilities Act) seems to indicate that it only refers to hospitals, the WVZ was there for the common Dutch health care sector.

[16] | Construction regime is the English designation for "Bouwregime".

Institutions submitted property development plans to the CBZ, where the plans were assessed with a set of frameworks. If the CBZ gave a permit for the development plans, and the construction budget fitted in the budget of the VWS, the institution could start with the construction phase. Eventually, the NZa financed the new property development (Dols, 2011).

So far, institutions faced no risks at all. After the property was yielded to the institution, again there were not any worries for the institutions. The capital costs of the new property were fully reimbursed through calculation. The calculation was based on standards for building area, the fee was not taking into account the occupancy, delivered services, inefficient use of space or the need for care that was delivered. The calculation meant that, if the property was realized within the budget, the annual interests and write-off in the real estate were fully reimbursed. With this, hospitals, establishments and V&V institutions not faced risk of any kind and were not motivated to be creative concerning housing policy. If the CBZ gave a permit for the development plans, the exploitation was financially covered. To make it even better for institutions, if they were able to (financially) perform better than was regulated in the standards, institutions were able to make a profit (Plexus & BKB, 2010).

5.2.2 Cause of regulation change

As already shortly mentioned, Dutch health care institutions were not fully motivated to be creative in their housing policy, and why should they? The policy was not conductive to an entrepreneurial management of the health care institutions.

> *"The capacity of intramural care in The Netherlands is the result of private initiative and not by the government planned and executed construction program. However, the government determines the rate at which particular initiatives may be realized. This is done for a controlled increase in the cost as possible. A disadvantage of the current system is bureaucratic regulations. Also leads the budget certainty of institutions to livelihoods, making them less cost effective and efficient action. This potential productivity improvements are not realized."*
>
> **Quote from the letter capital costs in 2005 of the Dutch government (Plexus & BKB, 2010)**

As can be deduced from the quote above, the policy was no longer desired by the Dutch ministry. The former Minister of Health, Welfare and Sports (VWS), Hans Hoogervorst (2003-2007) published a plan to change the policy in 2005. This new policy changed the financing of staff and real estate for Dutch health care institutions. The calculation standards will adapt to the amount of 'clients', less care recipients will result in less financing for both staff and real estate, this is further elaborated and discussed in paragraph 5.4. Dutch health care institutions are forced to carry out policies as entrepreneurs.

In the former situation it was an executing institution that was guaranteed of its income, now it is the entrepreneurial institution that will compete with other institutions to increase the utilization of its capacity. The result will be a more customer-oriented, more efficient operations and innovative real estate management in the Dutch health care institutions (Antonissen, 2007).

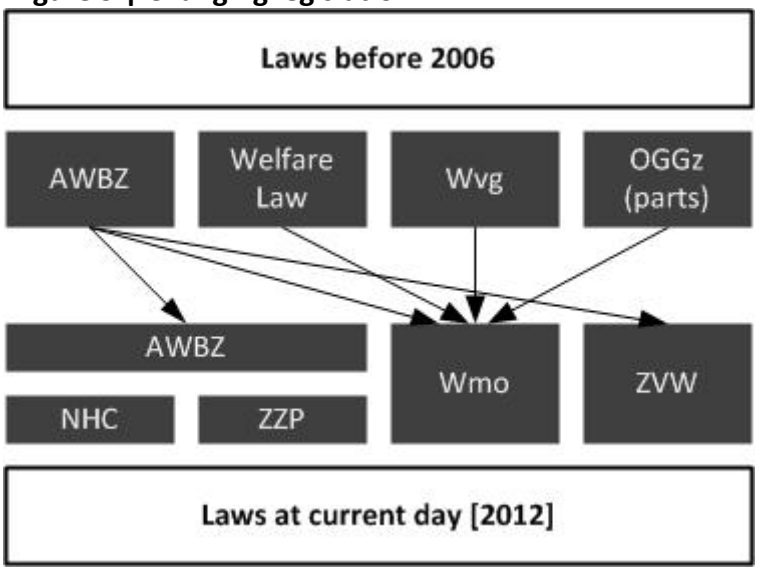
5.2.3 Current situation

In the transition period, the new regulation situation was slowly taken into use. This started with the abolition of the construction regime. The permits system, approval by the CBZ for property development plans, as described in paragraph 5.2.1, disappeared. On January 1st 2008 for the hospital sector and a year later for the rest of the Dutch health care sector. Health care institutions are now self-responsible for their property and property development plans (Plexus & BKB, 2010).

5.3 Changing legislation

To be able to implement the changing regulation as described in paragraph 5.2, different laws had to be adjusted and new laws were introduced. The most important ones for the care and nursing institutions are explained. All changes as defined in paragraphs 5.3.1 to 5.3.3 are summarized in figure 9.

Figure 9 | Changing legislation



5.3.1 AWBZ

Since the transition started, the AWBZ has altered the most. So is the part of the AWBZ that regulated the home care, together with the welfare law, Wvg and parts of the OGGz transformed in a new law, the Wmo. Another change is the advent of the ZVW, which is discussed in the following paragraph (paragraph 5.3.2).

The last substantial change within the AWBZ is the change to 'intensity of care funding'. Institutions will be financed in relation to the delivered care to care recipients. These new compensations are introduced in the way of ZZP and NHC. Which is widely elaborated in paragraph 5.4. It is hard to say what the exact start date of the new AWBZ is due to still slightly changing content of the law.

5.3.2 ZVW

The ZVW is a new law since January 1st, 2006 and replaces the old health insurance system. In the old system people who earned less than €33,000,-- annually, were obliged to be insured by the public health insurance for a relatively low premium. Everybody who did earn more than €33,000,-- annually was not obliged to be insured but had the possibility to take an insurance by private insurance companies.

In the new system, since January 1st, 2006, everybody is obliged to have a basic-health-insurance with the same content for everyone. People with a low income will be compensated with a health care benefit[17]. The obliged basic-health-insurance can be expanded with extra packages at the insurance company, which will logically result in a higher premium.

5.3.3 WTZi

The WTZi was introduced on January 1st, 2006. This law regulates the admission of institutions that want to provide health care that is financed by the AWBZ or regular ZVW. The WTZi provides regulations for institutions and granted permits for institutions; without these permits, institutions are not eligible for financing by the AWBZ or ZVW. Construction plans of institutions will be tested by a construction college on the basis of performance requirements in relation to: location, flexibility, accessibility, experience, residency and construction costs.

5.4 Care policy

The goal of implementing such changes in the regulation and legislation as described in paragraphs 5.2 and 5.3 is to increase the market forces in the Dutch health care sector. As already can be seen in paragraph 5.3, the largest change was the introduction of the intensity for care funding. This funding coincides with the ZZP and NHC which is further elaborated in paragraphs 5.4.1 and 5.4.2. Besides the result of the changes, working towards self-conscious health care institutions, is discussed in paragraph 5.4.3.

5.4.1 ZorgZwaartePakket (ZZP)

To increase the market forces in the Dutch health care sector the new way of financing the health care is regulated in a care compensation regulation. Institutions receive compensation for the delivered care, classified according to the intensity needs of the care recipient “performance funding”. For the cure sector the compensation regulation is defined in the Diagnostic Treatment Combinations (DBC[18]), for the care sector these regulations are defined in the ZZP (Plexus & BKB, 2010). Because this research is focussed on care and nursing, the DBC will not be further discussed or explained in this report.

ZZP can be seen as a ‘menu’ for the Dutch care and nursing, for each package (the menu) has been determined what specific care (the dish) will be delivered. The NZa has developed and

[17] | Health care benefit is the English designation for “Zorgtoeslag”.
[18] | DBC is “Diagnose Behandel Combinaties”.

composed the ZZP's. For the care sector the NZa had prepared a total of 52 ZZP's, each year the NZa will determine the compensation coupled to each ZZP (NZa, 2010). For the V&V sector the following ZZP's (CVZ, 2011) are composed (see appendix II for the content of each ZZP);

- ZZP 1 VV | Sheltered housing with some guidance;
- ZZP 2 VV | Sheltered housing with support and care;
- ZZP 3 VV | Sheltered housing with counselling and intensive care;
- ZZP 4 VV | Sheltered housing with intensive support and extended care;
- ZZP 5 VV | Sheltered housing with intensive dementia care;
- ZZP 6 VV | Sheltered housing with intensive care and nursing;
- ZZP 7 VV | Sheltered housing with intensive care, due to specific diseases, with emphasis on counselling;
- ZZP 8 VV | Sheltered housing with intensive care, due to specific disease, with emphasis on care / nursing;
- ZZP 9 VV | Protected stay with restorative nursing and care;
- ZZP 10 VV | Protected stay with intensive palliative-terminal care.

5.4.2 Normatieve huisvestingscomponent (NHC)

Besides the 'performance funding' like the ZZP the funding of the real estate for the Dutch health care has changed. Just like in the ZZP system, the funding for real estate is regulated in comparison of the present ZZP care spaces. The legislation enrolled for this is called the NHC, and is coupled to the ZZP packages. In the future the NHC could be integrated in the ZZP, one total compensation for the delivered care and the real estate (Dols, 2011).

Table 12 | Transition period NHC

Year	Budget NHC	Costing
2011	0%	100%
2012	10%	90%
2013	20%	80%
2014	30%	70%
2015	50%	50%
2016	70%	30%
2017	85%	15%
2018	100%	0%

Source: (NZa, 2011)

To make it more bearable for institutions to adjust to the new legislation concerning their financing of the real estate, the Dutch government introduced a transition period of six years (from 2012 to 2018), within this period the financing of the real estate will be phased; from 100% costing in 2011 to 0% in 2018 (see table 12). Afterwards institutions become self-responsible for the financing of their real estate. Within the transition there are still some decisions to be made, at the moment there are still points of concern concerning the regional differences in cost of land (for example the land cost in Amsterdam will be significant higher compared to the land cost in for example Friesland and Limburg). Besides, the new NHC has to deal with existing housing and new developments (NZa, 2010).

During the composition of the NHC, the NZa worked with two scenarios to determine the feasibility of the compensation. In these two scenarios new developments and renovation were the two main determining factors (NZa, 2010);

- Scenario one: 20 years after realization of the property the building will be thoroughly renovated, 20 years after that (with a life span of 40 years) the property will be replaced.
- Scenario two: no renovation will be conducted. After a period of 30 years the property will be replaced[19].

Table 13 | Compensation of NHC per ZZP

ZZP	Compensation[21]
1 VV	€ 22,83
2 VV	€ 23,97
3 VV	€ 26,56
4 VV	€ 26,93
5 VV	€ 26,93
6 VV	€ 27,52
7 VV	€ 28,37
8 VV	€ 29,19
9 VV	€ 34,50
10 VV	€ 29,19

Source: (NZa, 2011)

The construction of the compensation is like this: the construction level of 2008 is the basis of the calculation for the NHC funding, annual institutions will receive 0.8% of the resale value with an annual interest of 5.2% for the conservation maintenance[20], a construction period of 18 months and an occupancy rate of 97% (NZa, 2010). In table 13 the financial compensation for each ZZP package is displayed

Other discussions which are still on-going: the idea is to abolish the compensation for housing (NHC) in the future. Care recipients are responsible for renting the housing, whether or not by the health care institution, which is a saving item on health care by the Dutch government. All these uncertainties about the compensation for housing form a risk for institutions. The uncertainties make investors hesitant to invest money in Dutch health care real estate.

5.4.3 Self-conscious health care institutions

The goal of the transition, as described in this paragraph (paragraph 5.2), is to create self-conscious health care institutions with an entrepreneurial attitude. Institutions should become self-responsible for their risks by investing in real estate and making decisions in their housing policy. The result of implementing strategic real estate management within

[19] | The NZa still has to investigate or the 30 years period of usage without any renovation is feasible for the installations in a health care property.
[20] | Conservation maintenance is the English designation for “Instandhoudingsonderhoud”.
[21] | The compensation is per care recipient per day.

institutions has two sides: the benefits (usage, return on investment and freedom etc.) as well as the charges (vacancy, maintenance and financing etc.) are for health care institutions own account. Strategic real estate management should contribute to a higher productivity, reduction of costs and might give institutions the possibility to achieve return on investment. Another goal of the pursuit to implement strategic real estate management is to force institutions to think about the total life-cycle of their housing. This way it will become possible for institutions to enlarge investments in their new developments, which can result in lower exploitation costs. This way higher investments can be recovered and should stimulate the market forces[22] amongst institutions.

In table 14 the changes that the transition should bring about within institutions are shown. In the left column points from the former situation, as described in paragraph 5.2.1, are shown. In the right column points from the current situation, as described in paragraph 5.3, are shown.

Table 14 | Transition towards strategic property management

From a traditional housing management	Towards a strategic property management
Maximizing space and investment costs	Fewer but better quality square meters
Hardly cost awareness among end users	Tax costs to end users
Plans based on norms and standards	Investment decisions based on prudential considerations
Assets fixed in Real estate	Real estate decision based on value for the primary process
Naturally owner of Real estate	Deliberate decisions to rent/sale/lease
Depreciation oriented thinking	Aware of performance and value
Integrated owner and user role	Separation of owner and user role
Execute everything in-house	Sourcing strategy for property based on value for the primary process

Source: (Hoepel, Visser, & de Vries, 2009)

5.5 Consequences for the V&V sector

It is not hard to imagine that the transition from years of riskless developing of health care real estate towards strategic real estate management for institutions will be hard. The internal processes of institutions are mostly tailored on a riskless environment with calculation, though; real estate is indispensable for the primary process of institutions (delivering care to care recipients). The internal financing of the housing causes institutions to become aware of their risks, risk management and a more professionalized organization

[22] | Market forces is the English designation for “Marktwerking”.

(concerning their housing) will be a result. Within the legislation, institutions should make choices between ownership or rent of their real estate (Steegh, 2011).

5.5.1 Ownership

The choice to have ownership of the real estate does have advantages and disadvantages for institutions. The largest con for institutions is that a large part of their equity needs to be invested in the real estate, together with mistakes this will influence the 'core business' of institutions: caring. The most important advantages and disadvantages of ownership are shown in table 15.

Table 15 | Advantages and disadvantages of ownership

Advantages	Disadvantages
Value increase	High capital expenditure in the first years
Decision-making powers	Obtain financing
	Own functional / staff structure needed for management
	Less capital available for core business

Source: (Steegh, 2011)

5.5.2 Rent

Where ownership in the former situation was preferred, more and more institutions are starting to rent the real estate. It is mostly housing corporations that rent real estate. Advantage is that the annual costs for housing are fixed, there are no risks for institutions. Besides, in this situation institutions are able to stay focussed on their core business. The most important advantages and disadvantages are shown in table 16.

Table 16 | Advantages and disadvantages of rent

Advantages	Disadvantages
No risks on the real estate	Limited decision-making powers
Responsibility for maintenance by third parties	No benefits of performance on real estate
Less staff needed for real estate management	Reduction of knowledge concerning real estate
	Annual rental adjustment

Source: (Steegh, 2011)

5.6 Conclusions

The Dutch government wants the health care sector to act more targeted, innovative, customer-focused and efficient. Since the start of this year (January 1, 2012), the transition to achieve these goals has made its appearance. In this transition period there will be worked towards market forces by performance funding for institutions. With the modernised AWBZ and the new WTZi, institutions should receive more freedom and own responsibilities due to decreasing government interference. Because of the market forces in the Dutch health care sector, the specific needs of care recipients will become more important, care recipients can now increasingly be approached as customers. Part of the competition amongst institutions will be the real estate, with their housing, institutions have the ability to respond to future demands. The current (limited) offer of health care real estate does not match the diversity of wishes of the dependent groups.

The modernised AWBZ will bring risks for institutions on the real estate aspect. Because investments in real estate are one of the largest for institutions, in the current situation these investments will be better considered and be done more efficiency-driven. For institutions it will be important to only do investments in real estate which can be earned back with the compensation of the NHC, therefore institutions should consider their strategic real estate management, risk management, funding possibilities and long-term plans. Therefore some specific real estate knowledge is needed, if this knowledge is not available within institutions, they will be forced to turn to specialized companies. With the pressure of increasing competition amongst institutions, a good strategic real estate management can make the difference between a successful and less successful institution.

The financial situation of each institution will be the guide for making decisions for its real estate management. Institutions will be considered to take informed decisions for deciding to take ownership or to rent the property. Successful institutions will distinguish themselves with an optimal mix of housing and nursing. This can only be achieved if there is enough, and specialized, knowledge present of both facets.

Part B

Field Research

6. Expert interviews

This chapter is about the performed interviews. In paragraph 6.1 the goal of the interview is given. The purpose of the interviews and which information was sought after, is explained in this paragraph. After that, information about the interviewees is given, which is elaborated in paragraph 6.2. In paragraph 6.3 the report of all interviews are given. The conclusions that can be made following the performed interviews are given in paragraph 6.4.

6.1 Goal of interview

> *"Doing business without a vision is like winking at a girl in the dark."*
>
> **Author unknown**

By performing interviews among different health care institutions, focussed on care and nursing institutions, an attempt was made to compare the contextual orientation as elaborated in chapters 3 till 5 with the practical relevance. Besides that, during each interview the current trends and problems in the health care sector regarding the strategic real estate management were analysed. During each interview the goal was finding a strategy for the real estate management of each institution. The key question is; do institutions have any strategy to deal with the changing environment or not? And if so; what does the strategy looks like?

The data from the interviews has been processed into a 'report' (see paragraph 6.3), the data gained from the interviews will be used for designing scenarios (for more precise information see chapter 7).

6.1.1 The interview

Prior to the interview, a set of questions about the research topic were set up. The set of questions should lead towards information about; the institution where the interviewee is working, the interviewee, current trends that the institutions are dealing with and the strategy used for the ability to deal with these changes. The interview was so-called semi-structured, there was a set of questions available. But during each individual interview it was possible to change order, to refine wording and to anticipate by adding new questions. Because each of the interviewed parties do have more or less the same activities and are active in the same field, the V&V sector, by asking the same questions during each interview, it was possible to compare views within the V&V sector. Hereby, similarities, differences and misconceptions can be recognized. The formulated set of questions, the questionnaire, can be seen in appendix III.

6.1.2 Responsibility questionnaire

In this paragraph, the goal of each question is explained. A collection of asked sub-questions is given, ones that are not in the questionnaire but are a addition for the research.

1. Can you introduce yourself?

- Do you have a 'care management' background?

These questions are included to get a better view of the interviewee. In some of the interviews, more information about the interviewee's background is asked; but also if the interviewee has experience within the health care sector or if they have only recently been working within this sector.

2. Job definition.

The purpose of this question is to get more insight in the structure of the organisation where the interviewee is employed; what are the daily proceedings and responsibilities of the interviewee.

- Only responsible for the real estate management or also in the area of care?

This question is asked in some of the interviews to be able to form a more complete view of the job definition. The activities concerning the real estate, are they positioned by a 'specialized' employee, or is it just something a manager of director doing besides his activities.

Since 2006 the Dutch government has been working on redesigning the financing related to the health care sector. The introduction of the ZVW, changing the AWBZ, funding through ZZP are just a few of the changes. By introducing these changes, the Dutch government wanted to create a more cost-conscious, competitive health care sector which is more efficient. The result is the ability to reduce the money spent on care.

3. Where these changes needed to achieve the goals of the government in your opinion?

This question is asked to find out if the changing regulation was really necessary (as purposed by the government). Do the measures meet their goal or not? Following questions about alternatives how these changes could have been designed are asked in some of the performed interviews.

4. What is your opinion about these changes?

This question is asked to find out what the main opinion about the governmental changes is, from the health care institutions point of view.

Concerning everything I have studied so far, I believe that care institutions should keep a closer eye on trends and the needs of care recipients. This way, they will be able to compete with other institutions in a better way. Trends such as small scale living, can be seen and more extramural care will be delivered in the future.

5. Are there any other trends in the V&V sector?

This question is asked to find out if the recognized trends as described in paragraph 3.3 are correct. The trends as described by the interviewees can add valuable information for the designed scenarios.

- Are these trends set in motion by the government, or do they have other reasoning?

This question is asked in two of the interviews and is asked to find out which impulse sets the described trends in motion. Why are these trends happening?

Part of these changes are also served at the financing of real estate in the health care sector, the introduction of the NHC is an example of that. This will force institutions to start a renewed strategic real estate management plan.

6. Does …*(name institution)*… have a real estate management strategy to be able to adapt to these changes?

This question is included to analyse whether Dutch health care institutions in the V&V sector, have determined a strategy for the ability to adapt to the changing regulations of the government.

7. What is the particular strategy that …*(name institution)*… has regarding its real estate management?

This question should provide information in which way the V&V institution deals with the changes. Within the strategy regarding its real estate management should be recorded how to deal with it; what are the particular choices that are made in the strategic real estate management?

- Which risks will be for the institution's own account, and which will be outsourced by other parties?

This question is asked to determine to which level institutions are willing to take risks by themselves; which ones for their own account and which ones not.

- Which activities in the real estate management will be outsourced to other parties?

To be able to create a view of the process and which parties will be involved within the process, it is asked which activities will be outsourced to other parties.

8. Do you expect more private parties to get involved in the Dutch health care sector? And if so; which role will they fulfil?

Fact is that the market for the V&V sector will grow in the future, other parties might see opportunities for themselves if they start acting in the V&V sector. What specific parties will enter the V&V sector and in which way will they contribute? Or is the role of parties acting in the V&V sector changing because they see extra benefits by delivering extra service.

- Do you only see them as financer; or is it possible that they will fulfil a other role?

Most interviewees came with private parties entering the V&V sector to finance real estate developments. By asking this question, the possible opportunity of another role is checked.

9. What can external parties, in your opinion, do better?

This question should determine what other parties can do to contribute to a more fluent working development and management process.

6.1.3 Information processing interview

Each interview is recorded, so it is possible to retrieve what is exactly said during the interviews. Besides each interview is elaborated, these elaborations can be seen in appendix V. In paragraph 6.3 a report of all the interviews combined is elaborated and in paragraph 6.4 some particular conclusions that can be drawn from the interviews are summarized.

6.2 List of interviewees

To be able to create a broader image of what the problems in the V&V sector are and to distinguish different types of strategies, four institutions active in the V&V sector are interviewed. Three of them are institutions that provide care, amongst others within the V&V sector, one (Habion) is a housing corporation that develops and manages real estate for care and nursing institutions. In this paragraph additional information about the core activities of those institutions and the interviewees are given. In appendix IV, more extensive information of each interviewed institution is given in Dutch.

6.2.1 Stichting Habion

- Interviewee: drs. R. *(René)* Lolkema
- Function: Development Manager

Habion is a housing corporation that focusses on the housing within the V&V sector. Thereby, Habion develops and manages the housing for institutions. Clients for Habion are health care institutions. Habion rents care and nursing homes, sheltered housing, life-proof housing and medical practices.

Habion has a national coverage in The Netherlands and rents 9,754 units.

6.2.2 Stichting Palet

- Interviewee: M. *(Machiel)* Talsma MBA
- Function: Project Director Housing and Services

Palet is an institution that is active in all three categories within the V&V sector; intramural, semi-mural and extramural. Besides, Palet also delivers care to deaf, demented and rehabilitative care recipients as well as domestic help.

Palet is active in the northwest of the Friesland region and has six care homes, one nursing home and five locations where semi-mural care is provided.

6.2.3 Stichting De Stouwe

- Interviewee: drs. P.G. *(Peter)* Visch
- Function: Director

De Stouwe is an institution providing care and nursing within the intramural and extramural categories. Besides, De Stouwe has a nursing home for demented care recipients.

De Stouwe is active in the near surroundings of Meppel and has six care/nursing homes (excluded is the nursing home for demented care recipients).

6.2.4 Stichting Zorggroep Tellens

- Interviewee: A. *(Arend)* Schenkel
- Function: Chairman of the Board of directors

Tellens is an institution that offers several services within the elderly care. Tellens also offers homecare and small-scaled intramural care and nursing.

Tellens is active in the southwest of the Friesland region and has 24 care/nursing homes.

6.3 Report interviews

In this paragraph a report 'overview' of all the performed interviews is given. The data from the interviews is classified according to the questions from the questionnaire (see appendix III). For each question the general view of the interviewees is given, the broad sense of the answer is looked at because everyone has a different formulation that covers the same meaning. The elaboration of each separate interview can be seen in appendix V.

1. Can you introduce yourself?

- Do you have a 'care management' background?

By the introduction of the interviewees it was possible to see that each of the interviewees had a total different background, namely; nurse, economist and public officer[23]. Just one of the interviewees had a 'care management' background. The fact that each of them is currently involved with, amongst others, real estate management makes this interesting.

2. Job definition.

All the interviewees are involved in real estate management, but all hold a different position within the institution.

- Only responsible for the real estate management or also in the area of care?

Two of the interviewees were general directors, from both the 'care' activities and the real estate management. The other two were focused on the real estate management.

Since 2006 the Dutch government has been working on redesigning the financing related to the health care sector. The introduction of the ZVW, changing the AWBZ, funding through

[23] | Public officer is the English designation for "ambtenaar".

ZZP are just a few of the changes. By introducing these changes, the Dutch government wanted to create a more cost-conscious, competitive health care sector which is more efficient. The result is the ability to reduce the money spent on care.

3. Where these changes needed to achieve the goals of the government in your opinion?

All four interviewees agreed that the way of financing within the Dutch health care sector needed a change. In the former situation it was too easy for care institutions to practice care. The new regulation already is a slight progress, but all of the interviewees share the opinion that the goals of the government could have been achieved in a different way and are in need of a little more attention.

4. What is your opinion about these changes?

All the interviewees are positive about the idea and goal of the regulation change. The old regulation was simply even worse; care institutions were not forced to work cost-efficient. Especially the ZZP is criticised; two of them believe that this way the costs will only increase in the future. The interviewees are satisfied with the NHC; this makes that institutions are better developing towards the needs and only what is needed, in terms of space and type of building.

Concerning everything I have studied so far, I believe that care institutions should keep a closer eye on trends and the needs of care recipients. This way, they will be able to compete with other institutions in a better way. Trends such as small scale living, can be seen and more extramural care will be delivered in the future.

5. Are there any other trends in the V&V sector?

The ideas about this are quite diverse. Two of the interviewees think that in the future the battle for V&V institutions will not be to attract the care recipient, but to attract staff. Aging will increase the demand for care, so that is not the problem; the problem will be the smaller group in the labour force (see paragraph 3.1.4). Two others think that V&V institutions will receive a much broader social role on district level. The traditional V&V institution will disappear, whole communities will be involved in delivering care, and private parties will add facilities within the new V&V institution. One interviewee thinks that there will be a scale-enlargement while one interviewee thinks that there will be smaller scaled. Flexibility is another recognized trend by three of the interviewees; logically V&V real estate will be subject to vacancy after the summit of aging in 2040. Therefore more flexible real estate will be developed so that the property can also be used for other functions after that period.

- Are these trends set in motion by the government, or do they have other reasoning?

The development of more flexible real estate is a result of the action by the government. Because V&V institutions become self-responsible for their real estate; flexibility has become a more important item. So that the property is multifunctional.

Part of these changes are also served at the financing of real estate in the health care sector, the introduction of the NHC is an example for that. This will force institutions to start a renewed strategic real estate plan.

6. **Does …*(name institution)*… have a real estate management strategy for being able to adapt on these changes?**

All interviewees explain that their institution does have a strategy concerning the real estate. One interviewee says that the strategic real estate plan has just finished. In the former situation they 'globally' had an idea how to deal with their real estate. But due to the introduction of the NHC they decided to make a more intensive strategic real estate plan.

7. **What is the particular strategy that …*(name institution)*… has regarding its real estate management?**

   - Which risks will be for the institution's own account, and which will be outsourced by other parties?
   - Which activities in the real estate management will be outsourced to other parties?

Concerning the strategy for real estate a diversity of answers were given. There is a dichotomy concerning the size of the care institution. Small-scaled institutions are mostly outsourcing the real estate activities to for example housing corporations. Long-term rent agreements, up to a period of 20 years, are made with housing corporations. These small-scaled institutions are not willing to take risks, vacancy, concerning their real estate because they do not have the expertise within the institution nor the ability to acquire staff with real estate expertise. Besides, most of these institutions are not wealthy enough to develop and manage in-house. While the larger-scaled institutions mostly develop and manage in-house for the intramural type of care. All other forms are also outsourced by for example housing housing corporations. Most of the larger-scaled institutions do have a 'real estate department'. Interesting to see is that two of the interviewees pointed out that their focus concerning real estate will be on major maintenance or renewal of their property stock. This is a result of the uncertainty caused by the government, as long as there will be no clarity; institutions are not willing to make any decisions and keep focussing on their existing property stock. All the interviewees who state that their institution will keep on developing and managing their real estate in-house, indicate that flexibility is an important issue. So that they are less sensitive for vacancy. One of the interviewees states that it does not matter whether an institution has a rent contract or a mortgage lending, both are a long-term burdening on the finances of an institution. Either ownership or rent means an investment decision for a period of 20 years. The only advantage of having the property in-house is the benefit of possible value increase, but looking at the current market, these value increases are nil. This interviewee also states that some of his 'colleague institutions' think that if real estate activities are outsourced, the institution is not in the need of any expertise concerning real estate. But this expertise is in some way needed to judge whether the current strategy of the institution is still the right one, which is a point of attention for most institutions.

Here, it is also possible to see a dichotomy between smaller scaled V&V institutions and larger scaled V&V institutions. The smaller scaled institutions are not very willing to take any risk at all, while the larger scaled institutions see opportunities in taking risks. For example vacancy risks or maintenance risks.

8. Do you expect more private parties to get involved in the Dutch health care sector? And if so; which role will they fulfil?

All interviewees say that private parties will be involved in the Dutch health care sector. Each of the interviewees indicates that the involvement of private parties is in another stage. They see that private parties also recognize the growing market of the health care; private parties are willing to profit from that growing market. During the interviews investors, pension funds, health insurers and project developers are designated as parties which will enter, or are entering, the Dutch health care sector.

- Do you only see them as financer; or is it possible that they will fulfil a other role?

The role of these private parties will be as financer, the interviewees do not expect that private parties will assume a different role. One of the interviewees stated that research of the Rabobank made clear that the banking sector in the future can no longer cope with the financing needs of the Dutch health care sector. So other parties, such as private parties, are needed to fulfil these financing needs.

9. What can external parties, in your opinion, do better?

Each of the interviewees has a different point of view on this question. One interviewee states that V&V institutions are struggling too much with the new legislation, a decision has to be made for being able to let this market succeed. Another interviewee says that between V&V institutions and the construction industry a better understanding of one another should be present. One interviewee states that it is time to better construct demand-oriented in the V&V sector. The last interviewee states that the government should make a clear regulation for the upcoming 20 years, so that it will be bearable for V&V institutions to make decisions and act on it. In his opinion it might be a solution that the government designates areas of concern to V&V institutions in which they can practice their activities. While the V&V sector should better inform the population about their activities and how they work.

6.4 Conclusions

The interviews gave a good insight in the problems that V&V institutions have concerning their real estate, a diversity of struggle points became clear. The interviews are held with different 'types' (size, activities, etc.) of institutions; two smaller-scaled institutions, one large-scaled institution and a housing corporation focusing on the V&V sector. This variety of institutions gave insight in the diversity of problems within each different type of institution. Below the most important and striking points gained through the interviews are listed;

- All interviewees agreed that the regulation in the Dutch health care sector had to be changed (old situation), current regulation is just a slight progress but still needs to be fine-tuned to be able to succeed;
- The future battle of V&V institutions will not be to 'attract' care recipients, due to aging there will be plenty of 'potential customers', but to maintain a sufficient amount of staff to practice their activities, which could become a main issue in the Dutch health care sector;
- All interviewees state that there is a strategic real estate management plan within their organization;
- The larger-scaled institutions will remain to develop and manage their real estate in-house, while the smaller-scaled institutions will outsource this activities to a project developer or housing corporation;
- The governmental uncertainty causes institutions to not be willing to make decisions concerning their real estate;
- Private parties are carefully explorering the opportunities within the V&V sector. Most institutions see these private parties; investors, pension funds, health insurers and project developers, just as financer and not playing any other role in the V&V sector.

7. Research methodology

In this chapter the research methodology, scenario planning, is applied. To be able to get an idea of how the research methodology is working, in paragraph 7.1 a brief introduction of scenario planning is given. It is also explained how scenario planning is applied within this research. In paragraph 7.2 and paragraph 7.3 the actual scenarios are designed and elaborated. This chapter ends with conclusions, see paragraph 7.4, that can be made following the designed scenarios.

7.1 Introduction to scenario planning

This paragraph starts with a brief introduction to scenario planning. In appendix VI additional information about scenario planning is given.

7.1.1 The art of the long view

Scenario planning is a tool developed and used by organizations to create and analyse different 'stories' about future perspectives. Each 'story' is based on research and driving forces that determine the research environment and are designed to express surprising and unexpected future environments.

> *"He who predicts the future lies even if he tells the truth."*
>
> **Old Arab proverb**

Scenario planning is a tool for organizations to determine their (long-term) strategic plans and how to act in their 'new' environment for the (near) future. It is in no way a tool to pick a preferred future perspective or prediction of the future. Scenario planning can be a helpful tool to create a context in which it is possible to discuss and think about all the driving forces that are creating your environment. Within this context it is possible to consider the several future opportunities that might occur, and consider how your organization should (re)act on it (Schwartz, 1996).

For companies scenario planning can contribute to;

- Stimulating through and communication within companies;
- Improving internal flexibility of response to environmental uncertainty and providing better preparation for possible system breakdowns;
- Reorienting policy options according to the future context on which their consequences would impinge.

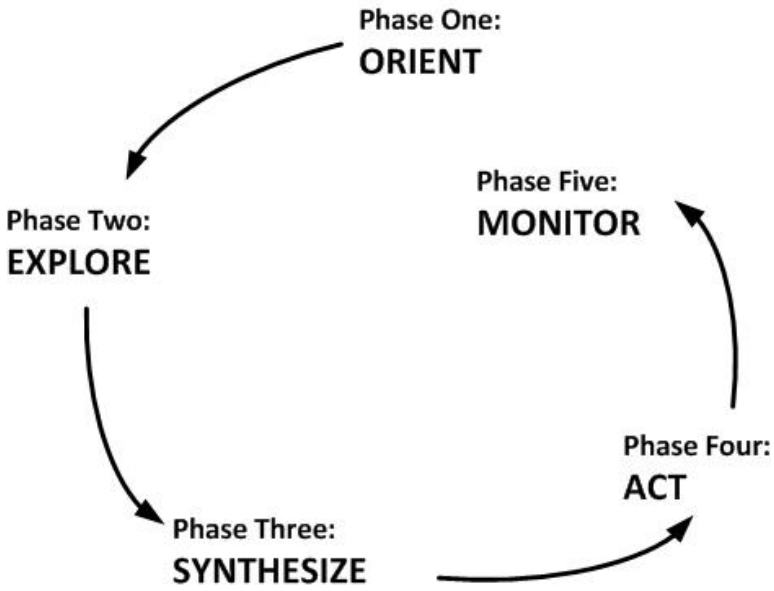
7.1.2 Developing scenarios

(Scearce & Fulton, 2004) Describing the process of scenario planning, they assume that the process of developing scenarios must be divided into five different phases. According to these phases scenario planning will be applied within this research, the five phases are (also see figure 10);

- Phase one: Orient;
- Phase two: Explore;
- Phase three: Synthesize;
- Phase four: Act;
- Phase five: Monitor.

For more insight into and an explanation of each phase, see appendix VI.

Figure 10 | The basic five-phase scenario thinking process



Source: (Scearce & Fulton, 2004)

7.1.3 Scenario planning approach within this research

The scenario planning phases as described by (Scearce & Fulton, 2004) will, as already mentioned, be used as guidance for the elaboration of scenario planning within this research.

Phase one: Orient

The orientation phase is elaborated in; Part A | Contextual Orientation. The Dutch health care sector, construction industry and the overlap area involving both sectors are oriented in this part.

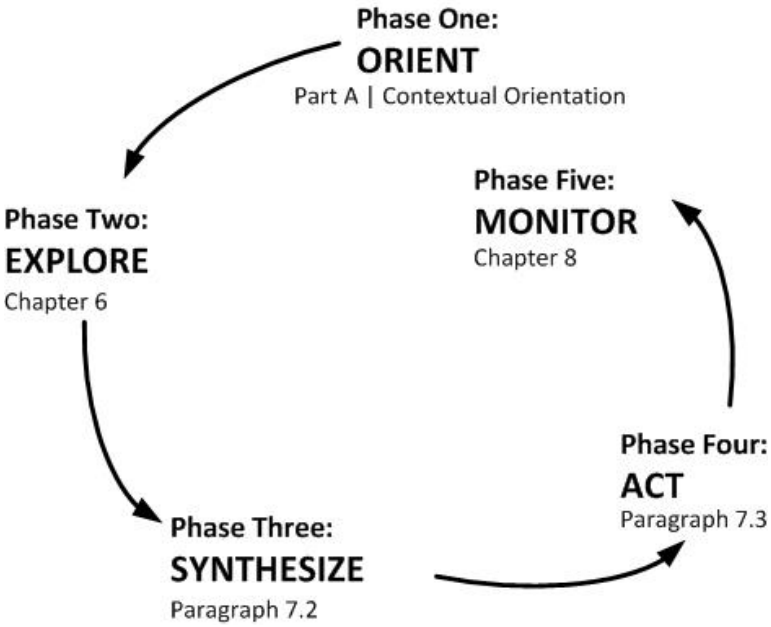
Phase two: Explore

For exploration of the research environment, interviews are held with experts within the field of health care, specifically the V&V sector. The elaboration of this can be found in chapter 6.

Phase three: Synthesize

The results of the performed interviews will be classified and overviewed in a model. All driving forces that can be determined from phase two are discussed. The elaboration of this is done in paragraph 7.2.

Figure 11 | The basic five-phase scenario thinking process within this research



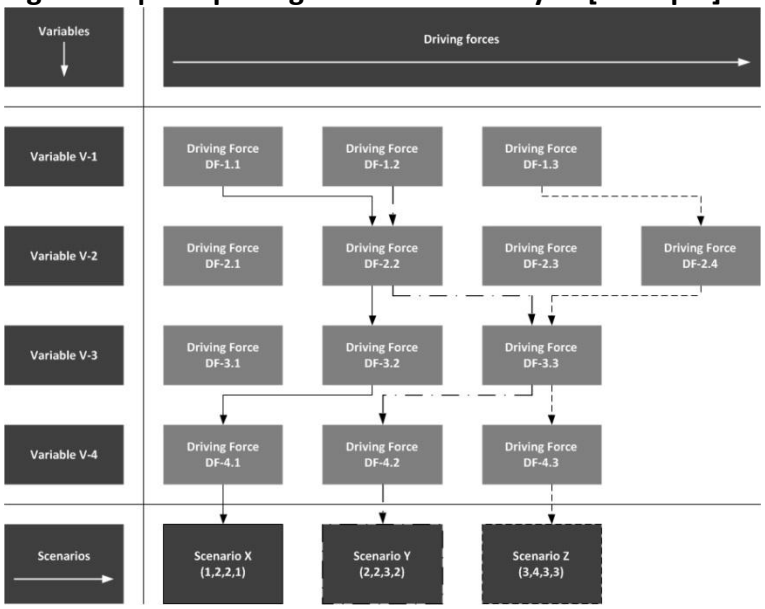
Phase four: Act

According to the determined driving forces in phase three, there will be designed scenarios. Elaboration of each scenario can be found in paragraph 7.3.

Phase five: Monitor

Results from the designed scenarios will lead towards an advice for Van Wijnen, how to deal with the V&V sector. This advice report is elaborated in chapter 8.

Figure 12 | Morphological scenario analysis [example]



Source: (Godet, 2000)

Remaining

Due to the high number of determining driving forces that influence the research environment (the V&V sector) it has been decided to apply a 'morphological analysis' as described by (Godet, 2000) in phase three and four. Morphological analysis makes it possible to process a high number of driving forces in a clear way. As a result, various combinations between the driving forces can be made and this enables the researcher to select the most probable scenarios. Figure 12 shows how the tool works well, more extensive information and explanation can be found in appendix VI.

7.2 Synthesize

In this paragraph, the actual 'scenario design' is started with. The scenario design is performed according to the method described in paragraph 7.1. This will be done by determining all driving forces that can be concluded from the interviews. This will be done according to 'variables', variables describe a certain area within the research environment. For this research a variable can be compared with a 'key-question' which is related to a question, or a set of questions, from the performed interviews. Then, for each variable the driving forces will be determined. For this research a driving force can be compared with an answer, or a set of answers, given by the interviewees during the performed interviews. The results can be seen in figure 13.

7.2.1 Variable V-1: Government

One of the main issues that became clear during the interviews was that the uncertainty of the government is causing V&V institutions to not be willing to make decisions concerning their real estate. The interviewees indicate that the government is a partner that cannot be trusted. On one hand they want to promote market forces in the health care sector, but on the other hand; the government still interferes with almost everything. While the new form of regulation is already a slight progress, the rate of success is still limited.

Driving force DF-1.1: Separate living and care

As a saving item on the health care sector, the Dutch government doubts to separate living and care. This means that care recipients become self-responsible for their housing and V&V institutions will only be responsible for the care they practice. This means that V&V institutions will not be compensated for living, in other words; the NHC will be abolished. This means that care recipients will influence the way V&V housing looks like in the future and the care that is provided can be seen as an 'additional service'.

Driving force DF-1.2: Partially separate living and care

Partially separating living and care means that the NHC for the two most 'light' forms of care in the ZZP (ZZP 1 VV and ZZP 2 VV), will be abolished. In the opinion of the government, those care recipients are able to live at home and receive home care; this way they will be encouraged to remain at home. This will cause that for care recipients in the real need of care, space within the V&V institution will be maintained. For the ZZP 1 VV and ZZP 2 VV, living and care will be separated from 2014. At the moment discussion is going on to abolish the NHC for ZZP 3 VV and ZZP 4 VV, at present day it is not clear whether and from when this measure should address.

Driving force DF-1.3: Maintain living and care

Another option to consider is that the structure of living and care within V&V institutions will be maintained. Because the regulation of NHC is newly introduced, it is imaginable that the government will maintain its original regulation.

7.2.2 Variable V-2: Forms of housing

During the interviews, several perspectives of how the future forms of housing might look like within the V&V sector were given by the interviewees. The kind of housing form that is most probable in the future depends on several aspects. Again, the government is one of the determining factors, besides that staff is also important. Due to aging the demand for health care will increase, while there are less people to practice care (see also paragraph 3.1.4). When a shortage of staff will occur, it is imaginable that some forms of health care will disappear.

Driving force DF-2.1: Intramural

Due to the growing demand for care in the V&V sector in combination with the shortage of staff, V&V institutions are focusing more on intramural complexes. This way, the staff can be used more efficiently so that V&V institutions can provide care for a larger amount of care recipients. The inefficiency of home care causes the disappearance of this type of care, V&V institutions are already struggling to handle the large amount of care recipients, they can afford to focus just on intramural care.

Driving force DF-2.2: Independent on care site

Another way of unfolding the future form of housing is that on a certain area (the site) several housing will be developed for care recipients. From a central location on the site a V&V institution will provide the care. This way it is possible for care recipients to still live independently, but within the near reach of care.

Driving force: DF-2.3: Wellness

Due to the welfare in the last decades, the current generation of elderly people expects higher quality housing. The current generation has a total different opinion on the role of health care in their last phase of life. They do not accept the ‘patient concept’ that is currently common in the V&V sector, they would prefer it more as a ‘wellness concept’. Remain to live as long as possible, as good as possible, remain to form a part of society and receive support for those things they cannot do by themselves anymore.

Driving force: DF-2.4: Home care

Due to the separation of living and care, the focus of health care within the V&V sector will be more on practicing home care. Besides, elderly people are willing to stay on their own as long as possible. This will result in V&V institutions not in the need of intramural institutions anymore; their focus will be specific on care.

7.2.3 Variable V-3: Organisation V&V institutions real estate management

One of the main objectives of performing interviews was to analyse how V&V institutions are organizing their real estate management. What does their strategic real estate management look like? Are they developing in-house, or are they outsourcing these activities?

Driving force DF-3.1: Ownership
The final clarity of the government causes V&V institutions to be willing to take risks and develop and manage their real estate in-house as an owner. To be able to take risk, institutions are also in the need of knowledge in real estate.

Driving force DF-3.2: Rent
The unclarity of the government concerning the regulation and the constant interference of the government causes V&V institutions to outsource all real estate activities. This means that institutions are going to rent.

7.2.4 Variable V-4: Private parties entering the Dutch health care sector
As in most situations private parties are searching for business opportunities to make money. Because the V&V sector is a growing market it is imaginable that private parties are willing to enter the V&V sector. The interviewees expect that a variety of private parties will enter the V&V sector to invest money. Which kind of private party will enter, depends on the type of V&V institution and organisation concerning the real estate management.

Driving force DF-4.1: Housing corporation
Due to the aging of the Dutch population, a higher demand for the V&V sector will occur, this will result in an increasing need for space where care can be practiced. Housing corporations see opportunities for developing V&V real estate. Besides with the expertise and knowledge of housing corporations concerning real estate management, housing corporations are able to take over the real estate activities of institutions, so they can focus on their core business; practicing care.

Driving force DF-4.2: Investor
Investors see that the market for V&V care is growing and will grow in the following years; therefore investors are willing to invest within the V&V sector. Real estate needs to be financed, and probably, this type of housing will be free of vacancy due to aging. Therefore this will be an interesting market for investors to invest in.

Driving force DF-4.3: Project developer
The growing demand for new or renovated space for V&V care will cause project developers to offer their knowledge to institutions. Thereby project developers will be involved in the V&V sector.

7.2.5 Variable V-5: Future role V&V institution
With the growing demand for V&V care, due to aging, the change in the regulation by the government will result in an increasing pressure on both the social and financial aspects. All this together will change the role a V&V institution is occupying, therefore the interviewees all gave their perspectives on that.

Driving force DF-5.1: Regional

Because for V&V institutions it is much more important to compete with other institutions, due to the increasing market forces, created by the government. V&V institutions focuses more on acting regional. By focussing on a smaller service area it becomes much easier to adapt on the needs of the care recipients. Institutions will become better informed and are better enabled to bind with the regional society.

Driving force DF-5.2: Care oriented

Due to the increasing demand for health care and the shortage of staff, institutions will start to focus on their 'core-business'; practicing care. All other facilities that we know nowadays, delivered in V&V institutions will decrease or be practiced by other parties.

Driving force: DF-5.3: Social involvement

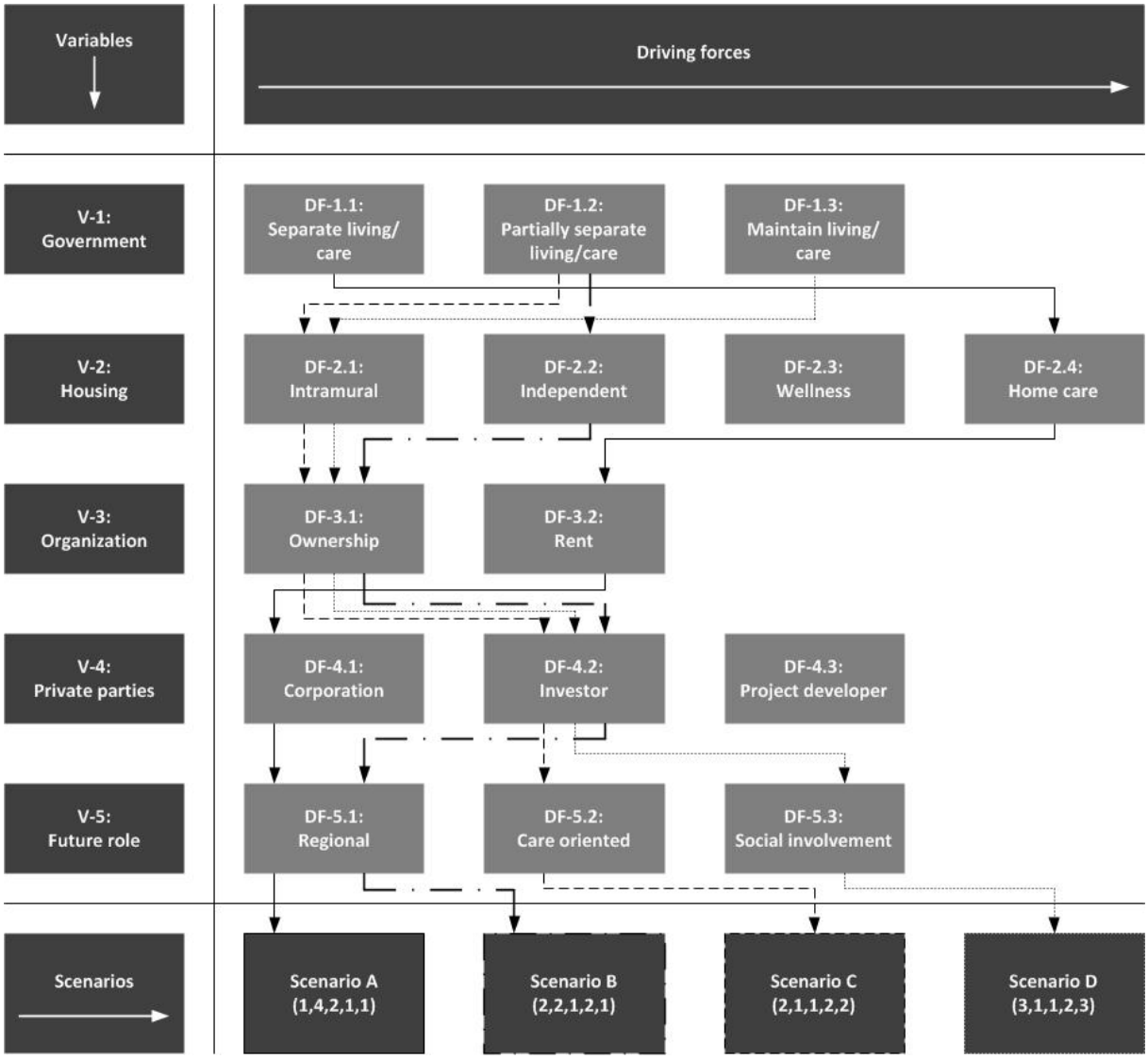
The traditional V&V institution as we know it nowadays will disappear. The social environment will be more involved with taking care in the V&V sector. This means that commercial parties will assume tasks.

Figure 13 | Morphological scenario analysis [variables and driving forces]

7.3 Act

Results from paragraph 7.2, make it possible to elaborate the actual scenario design, in this paragraph all the scenarios are elaborated. The combination of a set of driving forces for each scenario are determined by logically analysing the interaction amongst variables in the V&V environment. The combination of a set of driving forces for each scenario can be seen in figure 14.

Figure 14 | Morphological scenario analysis [scenarios]



7.3.1 Scenario A

- V-1 Government: Separate living and care (DF-1.1)
- V-2 Forms of housing: Home care (DF-2.4)
- V-3 Organization V&V institutions real estate management: Rent (DF-3.2)
- V-4 Private parties entering the Dutch health care sector: Housing corporation (DF-4.1)
- V-5 Future role V&V institution: Regional (DF-5.1)

Due to the economic crisis of the last years, anno 2014 the Dutch government has to achieve great cutbacks in the budget. With the prospective of aging and associated growth of need for health care, also financial pressure, the health care will also have to be economized. For care recipients within the V&V sector this means that they will be encouraged to remain to live at home, which will save spending's of the government. The government decides to separate living and care for the V&V sector, result; the NHC will disappear. Institutions will only receive fund for the delivered care, by the ZZP.

This means that care recipients become self-responsible to accommodate their housing. For intramural institutions, rent will be paid in order to live in an intramural V&V institution. This financial impulse in the new regulation will force care recipients will much better consider whether to remain live at their own house or within an institution. Much more care recipients will decide to remain live at their own house as long as possible, they feel much more comfortable and prefer their 'own and trusted' environment above a new one in an institution.

The focus of V&V institutions will be more on home care; therefore institutions are not willing to take any risks (e.g. vacancy) with their property for intramural care. Renting the property will be the new trend anno 2014. With the outsourcing of most of the real estate activities, institutions can fully focus on their 'core business'; practicing care.

The combination of outsourcing all real estate activities of institutions, together with the trend of renting in the V&V sector. Housing corporations see opportunities for doing business within the growing market of the V&V sector. The knowledge and experience of housing corporations with real estate make them the ideal partner for V&V institutions to develop and manage their property. The focus of institutions to their core business makes that housing corporations will rent directly to the care recipients; housing corporations are willing to take the risk concerning vacancy and maintenance.

Because V&V institutions are more and more forced to compete with others, and the focus will be shifted to delivering more home care; the orientation of institutions will be more regional. This way institutions will become better informed with the specific regional needs and will sooner see opportunities, which will make it easier to do business. Besides the regional orientation has benefit in the flow from care recipients receiving home care towards the intramural care, this will become smoother and more structured.

7.3.2 Scenario B

- V-1 Government: Partially separate living and care (DF-1.2)
- V-2 Forms of housing: Independent on care site (DF-2.2)
- V-3 Organization V&V institutions real estate management: Ownership (DF-3.1)
- V-4 Private parties entering the Dutch health care sector: Investor (DF-4.2)
- V-5 Future role V&V institution: Regional (DF-5.1)

The prospective of aging and the thereby associated growth of need for health care will result in a shortage of care spaces. The Dutch government wants to encourage care recipients to remain to live at home as long as possible; thereby the pressure on the existing care spaces will be illuminated. An extra benefit is that it will also save spending's of the government because; only a part of the V&V sector will remain to receive the NHC. From 2014 on, the NHC will be abolished for the two lightest forms of V&V care (ZZP 1 VV and ZZP 2 VV). From 2016 on, the NHC will be abolished for the following two ZZP's (ZZP 3 VV and ZZP 4 VV).

For care recipients this means that the changed regulations by the government, care recipients will become self-responsible to accommodate their housing for the four lightest forms of ZZP care from 2016 on. Elderly people will consider which form of housing they will choose for their last phase of life. A sheltered environment within the near reach of care will have the most preference. This way care recipients will remain to live independently, but within the near reach of care. This way the specific need of care (ZZP level) can change, but the housing will stay the same and trusted for the care recipient. This form of housing makes it much more flexible for institutions.

Because the housing is important for determining the quality of the institution, this will influence the choice of the care recipient. Institutions will develop and manage their property in-house. In the first stages elderly people can rent the housing, later on if the need for care has grown the NHC compensation for the institution will do.

Because the development of the housing will be done in-house. Together with the fact that with the development of such a 'landscape' of housing will need a lot of capital, investors will be searched by institutions to realise their plans. Because the V&V sector will be a growing market up till 2040, investors see opportunities to make money.

Because V&V institutions are more and more forced to compete with others, and therefore have to be familiar with the specific needs in each region. The orientation of institutions will be more focussed on regional activities. This way institutions will become better informed with the specific regional needs and will sooner see opportunities, which will make it easier to do business. This will help to determine the size of the institution and quality standards needed within the specific region.

7.3.3 Scenario C

- V-1 Government: Partially separate living and care (DF-1.2)
- V-2 Forms of housing: Intramural (DF-2.1)
- V-3 Organization V&V institutions real estate management: Ownership (DF-3.1)
- V-4 Private parties entering the Dutch health care sector: Investor (DF-4.2)
- V-5 Future role V&V institution: Care oriented (DF-5.2)

The prospective of aging and the thereby associated growth of need for health care will result in a shortage of care spaces. The Dutch government wants to encourage care recipients to remain to live at home as long as possible; thereby the pressure on the existing care spaces will be illuminated. An extra benefit is that it will also save spending's of the government because; only a part of the V&V sector will remain to receive the NHC. From 2014 on, the NHC will be abolished for the two lightest forms of V&V care (ZZP 1 VV and ZZP 2 VV). From 2016 on, the NHC will be abolished for the following two ZZP's (ZZP 3 VV and ZZP 4 VV).

In this situation the care recipient will partially become self-responsible for accommodating its housing. Because of the shortage of staff, there are just very few institutions that still provide home care; due to the inefficient use of staff. Because of the need for care, care recipients are willing to have intramural care within institutions. Because this is one of the few methods in which V&V care can be provided to care recipients. This way the specific need of care (ZZP level) can change, but the housing will stay the same and trusted for the care recipient. Which will ensure for institutions that they will keep 'customers' within their institution.

Due to the growth of stock of elderly people, there will be an increase of demand for V&V care space. The expected shortage of V&V care spaces will result in the fact that institutions are willing to take risks concerning their real estate management; the strategy will change to ownership. The development and management of property will be done in-house. Care recipients will rent their housing from the institution, and for the more intense care recipients (upward of ZZP 5 VV), the NHC compensation will be received.

Because the development of the housing will be done in-house, and most V&V institutions are not wealthy, institutions will look for investors who will help them finance their real estate plans. Because the V&V sector will be a growing market up till 2040, investors see opportunities to make money within this sector.

Aging will be of great pressure on the total V&V sector, activities outside of its 'core business' will no longer be taken. The focus of V&V institutions will become more care oriented. Additional services provided as we know it from present day, will be outsourced to commercial parties.

7.3.4 Scenario D

- V-1 Government: Maintain living and care (DF-1.3)
- V-2 Forms of housing: Intramural (DF-2.1)
- V-3 Organization V&V institutions real estate management: Ownership (DF-3.1)
- V-4 Private parties entering the Dutch health care sector: Investor (DF-4.2)
- V-5 Future role V&V institution: Social involvement (DF-5.3)

Because of the aging and the thereby associated increase of demand for V&V care spaces, the government oversees an upcoming of problematic situation. Therefore the government wants to maintain its control within the V&V sector; living and care will not be separated. This way the development for new and extra V&V care spaces must be encouraged, this should counter the arise of a shortage of V&V care places.

With the continuity of the current regulation in the V&V sector, care recipients are not encouraged to remain to live at home anymore. The growing pressure on the V&V sector is resulting in a shortage of staff, there are just very few institutions that still provide home care; due to the inefficient use of staff. Therefore the choice of care recipients will mainly focus on the intramural care form. Besides, intramural care is the most efficient type of V&V care which can be practiced.

The growth of the stock of elderly people will result in an increase of the demand for V&V care spaces. Because the summit of this growth will be in 2040 and the expected shortage of V&V care spaces will result in that institutions are willing to take risks concerning their real estate management. Developments and management of property in the V&V sector will be done in-house by institutions themselves; ownership over the property.

Because the development of the housing will be done in-house, and most V&V institutions are not wealthy, institutions will look for investors who will help them finance their real estate plans. Because the V&V sector will be a growing market up till 2040, investors see opportunities to make money within this sector.

The pressure on the V&V sector, due to aging; is forcing that staff will be used more efficient. Therefore, nursing tasks will be more focussed on the ‘core business’, delivering care. ‘Additional services’ as it can be named, will be assumed by commercial parties. The new V&V institution will be in the middle of the social environment; educational training for care will be positioned within the institutions, students will live, work and learn in an institution. Day activities will be outsourced to commercial parties; elderly working out in the gym, neighbourhood supermarket for the care recipients and the residents from the neighbour more volunteering.

7.4 Conclusions

With the background from the previous chapters, the scenario design is made in this chapter. The determination of all variables and following all driving forces (synthesize) gave a good insight in the wide variety of actors which are involved in the V&V sector. While making the scenarios it is remarkable to see the importance and influence of the Dutch government. Therefore variable 'V-1: Government' is chosen as starting point for designing each of the scenarios. While reading the 'story' of each interview, it is possible to see that even in next steps (variables), the influence of the government can be noticed. Although each scenario describes a certain plausible future perspective for the Dutch V&V sector (structure of cause and effect); it is logical that not each scenario is equally likely. For the designing of the scenarios in this research, the 'stock of elderly people' is generalized to a one of a kind. But of course there will be small differences or nuances between elderly people; one person is not like the other. For each scenario a brief advice is elaborated in paragraph 8.3, so that if one scenario will act, a basis advice how to act can be found within this report. The general advice, see paragraph 8.4, is based on the most probable scenario.

With the information gained during the elaboration of this research, together with the viewpoints of the interviewees, the author has made an argued choice of which scenario is the most likely to act. Based on the growing pressure (both social and financial) on the V&V sector forces it to change. The Dutch governments has to achieve 'savings' on the health care budget, with the same budget a larger group of people needs to be helped. By making the care recipients become self-responsible for accommodate their housing, an attempt is made to lower the pressure on the V&V institutions; care recipients will longer remain to live at home. At present day the first steps of the government towards a total separation of living and care have already been made (by separating living and care for the first two ZZP's, and probably the following two ZZP's will follow). Therefore the argued most probable scenario that is likely to happen is scenario A. An advice regarding this scenario is described in paragraph 8.4.

Part C

Results

8. Advice

Conclusions that are made in the previous chapters, together with the scenario planning leads towards an advice for Van Wijnen. In this chapter the advice towards Van Wijnen is elaborated. Paragraph 8.1 describes more precisely who the advice is actually aimed at. The fundament on which the advice is based on is described in paragraph 8.2. For each of the designed scenarios, see paragraph 7.3, there is a brief advice, this is elaborated in paragraph 8.3. The general advice towards Van Wijnen is elaborated in paragraph 8.4.

8.1 Advice recipient

> *"Wise men do not need advice, fools do not want."*
>
> **Benjamin Franklin, American politician, scientist and statesman, 1706 - 1790**

This graduation research is elaborated under the supervision of construction company Van Wijnen. The final result of this research is the general advice, as elaborated in paragraph 8.3. The advice is specifically written for the supervisory company; Van Wijnen, especially the project development department. The advice can be used as appliance for determining the future activities of Van Wijnen in the V&V sector in the Dutch health care.

8.2 Fundament for advice

As already mentioned; the advice towards Van Wijnen will be based on the designed scenarios as elaborated in paragraph 7.3. Within each scenario it is described what the environment for each of the determining variables might look-like in the future. The advice is based on the coherence of the variables and the probability of acting of the scenario.

8.3 Advice for each scenario

Each of the designed scenarios, see paragraph 7.3, has a probability of happening. Therefore a brief advice for Van Wijnen is written for each of the designed scenarios.

8.3.1 Advice for scenario A

In this scenario the focus of V&V institutions will mainly be on practicing home care. For the construction industry this will mean that the demand from the elderly people will be mainly small units; life-proof housing. Besides, adjustments to the existing housing stock have to be made, in order for the care recipient to remain living at home. The focus of institutions will more and more be on renting, housing corporations are the parties that will be involved in the future. If Van Wijnen wants to do business in the V&V sector, partners in housing corporations have to be found. These are the parties that in the future will invite tenders for developing V&V property. Together with a housing corporation it might be possible to

develop a ‘standard’ or general design, which is cost efficient (in development and management), flexible in use for the housing corporation. Van Wijnen has the possibility to build the ‘standard’ design several times; overhead costs can be spread out over several projects and experience will be gained.

8.3.2 Advice for scenario B

The future perspective described in this scenario makes it hard for the construction industry to be in business in the V&V sector. Care recipients will partly remain to live at home, for the remaining care recipients large scaled construction projects are needed to develop. Institutions move towards ownership of the property, this means that there will be another client for each new project. This will ask lots of energy from Van Wijnen to arise a market share within this sector. Being active on regional level will help to gain projects, whilst the focus of institutions will also become at a more regional level. In this case it is important for Van Wijnen to remember that institutions do not have enough knowledge or experience with real estate, provide good guidance and point out the decisions that have to be made by institutions; this all for a fluent project.

8.3.3 Advice for scenario C

The future environment in this scenario has lots of similarities with scenario B. The position of institutions to develop their real estate plans in-house and with ownership; will make it hard for Van Wijnen to do business in the V&V sector. Because the focus will be on the intramural housing form, the property stock will not differ much from the current situation. The regional orientation of the institutions will make that the size of the institution will differ per region; depending on the service area of the institution. Being active on regional level for Van Wijnen will be important to gain projects. Also for this situation it is important for Van Wijnen to provide good guidance for institutions, because these do not have the experience and knowledge that is needed to create a fluent real estate development process.

8.3.4 Advice for scenario D

This scenario has lots of similarities of the current situation within the V&V sector. Also in this situation it will be hard for Van Wijnen to do business within the V&V sector. The in-house development and management of real estate and ownership of the institutions themselves, will force Van Wijnen to create a large network amongst V&V institutions. The social involvement within the role of V&V institutions makes the real estate property very complex; an involvement of different stakeholders can be a result. The building process becomes more complex, Van Wijnen has to be a kind of mediator between the involved stakeholders. Within this situation it will be important for Van Wijnen to provide good guidance for the V&V institutions, because these do not have the experience and knowledge that is needed to create a fluent real estate development process.

8.4 General advice

The environment as described in scenario A contains a variety of construction activities. While at first glance it might seem that for Van Wijnen there are no opportunities at all in the V&V sector, it becomes clear that; this is only apparent. The shifted focus in the V&V sector towards delivering home care does not mean that there will be no construction demands.

Where in this scenario the care recipient becomes self-responsible for accommodating their own housing, in the first place the care recipients will try to remain to live at home as long as possible; in their own and trusted environment. The start of the elderly process starts with the pensioners, this group of 'new elderly' will prefer to live in a life-proof house, which is future proof for them. The growing demand for this type of housing makes that new developments within this sector needs to be constructed.

The focus of V&V institutions is shifted more and more to delivering home care; which does not mean that the intramural care will disappear. Only in first instance, when elderly people become care recipients of the first need of care those will remain to live at their own homes. In this early stage of being care recipient it is possible to remain to live at home. In a later stage, when the care recipient becomes in the need of more intense care, the care recipient will transfer to live in an intramural V&V care place.

A V&V institution will orient more and more on renting their real estate. Because there will come more transition of care recipients from their home towards the intramural V&V institution. Those institutions will focus on practicing care and do not engage with the housing of their care recipients as well as the real estate management. Together with a housing corporation the real estate of a V&V institution will be developed. The separation of living and care makes that the care recipient will rent an intramural apartment in the institution from the housing corporation. Since the housing corporation will become the 'organiser' in the real estate activities, these are the parties that in the future will assign projects to construction companies such as Van Wijnen. Together with the more regional active oriented V&V institution makes that these three parties (the V&V institution, housing corporation and Van Wijnen) will analyse the specific needs and market opportunities within the specific region. Therefore Van Wijnen will seek for opportunities to collaborate with a housing corporation. Together with the housing corporation it might be possible to develop a 'standard' or general design which can be used on several locations, this 'standard' will be designed for more effectiveness on several aspects (development, management and ease of use). By doing so Van Wijnen can gain expertise with developing V&V real estate that is adjusted for more efficiency for the V&V institution.

9. Conclusions and Recommendations

In this chapter the answers on the research questions are given. In paragraph 9.1 the general conclusion is given and the research question as well as the sub-questions are answered. In paragraph 9.2 the research results are discussed, within this paragraph The feedback from Van Wijnen is also processed. The recommendations for further research are presented in paragraph 9.3.

9.1 Conclusion

The conclusions that can be drawn from the elaboration of this research are given in this paragraph. The conclusion will be given by answering the research question (as formulated and described in paragraph 1.1.2) in paragraph 9.1.1. The answer of the research question will be underpinned by the answering of the sub-questions (as formulated and described in paragraph 1.1.3) in paragraph 9.1.2.

9.1.1 Answer research question

"What are the future scenarios for a construction company, active in the Dutch nursing and care sector?"

The research that has been elaborated in this report focusses on the aspects that influence the real estate affairs in the V&V sector. The research revealed that the future perspectives for the construction activities in the V&V sector can be determined by a group of variables; government, forms of housing, organisation V&V institution's real estate management, private parties entering the Dutch health care sector and the future role of a V&V institution. The combination between the possibilities of each variable (driving forces) make a future perspective of the environment. With the design of four possible scenarios (see chapter 7), four possible future perspectives for a construction company active in the Dutch V&V sector are elaborated.

9.1.2 Answers sub-questions

What are the characteristics of the Dutch health care sector?
This sub-question is answered in the contextual orientation, see chapter 3.

The Dutch health care sector occupies an important position in several ways. First of all because it practices medical care for the Dutch population and on the other hand it offers employment to 12% of the Dutch labour force. The Dutch health care sector is divided over several 'specialities' (e.g. GGZ, V&V and hospital care) all of them specialized in specific treaties of several types of medical care. Inter alia due to the labour-intensive nature of this sector, the medical expenses in the Netherlands almost reach 15% of the GDP (which equates to around €1,700 per capita). The Dutch health care sector is divided over in types

of medical care, namely ‘cure’ and ‘care’. The ‘cure’ type is for the treatment of diseases, where the ‘care’ type is for the welfare of humans.

What are the characteristics of the Dutch construction industry?
This sub-question is answered in the contextual orientation, see chapter 4.

In the construction industry a distinction can be made between three different sectors (B&U, GWW and A&O). The construction industry is characterized by the diversity of; activities, complexity and extensive collaboration between many stakeholders; that is why each project can be seen as a unique one of a kind product. Almost 115,000 companies are active in the Dutch construction industry, who on average 70% are ‘small’ companies (self-employed and companies with only a single person employed). The annual turnover of the Dutch construction industry is about €87.7 billion.

What is the content of the regulation change in the Dutch nursing and care sector?
This sub-question is answered in the contextual orientation, see chapter 5.

Up to 2006 nursing and care institutions did not have any risks concerning their real estate management, the capital costs of their property were fully reimbursed through calculation; this policy was not conductive to an entrepreneurial management of V&V institutions. This policy was no longer desired by the government; V&V institutions should be ‘rewarded’ for their delivered care. To achieve these goals, the government changed the AWBZ regulation. The modernised AWBZ makes the V&V institutions become self-responsible for their real estate management. Within the modernised AWBZ, the ZZP and NHC are introduced. The ZZP regulates the financing of the delivered care, classified according to the intensity needs of the care recipient. The NHC regulates the compensation of the real estate for nursing and care institutions. This will cause that that nursing and care institutions will consider their investments in real estate much better and will be done more efficiency-driven.

What is the real estate management strategy of nursing and care institutions?
This sub-question is answered in the field research, see chapter 6.

The V&V institutions with whom an interview is performed do all have a real estate management strategy. Due to the introduction of the NHC, the real estate management strategy became more intensive and detailed. A dichotomy concerning the size of the V&V institution for the adapted strategy can be deduced. Because the NHC makes that V&V institutions become self-responsible for their real estate activities, more intense knowledge of real estate is needed in order to make good decisions. The small-scaled V&V institutions do not want to take risks and see they do not have enough expertise within the field of real estate. Due to the small-scale of their institution, there is a lack in the ability to acquire staff with real estate expertise. Therefore they outsource all their real estate activities to for example housing corporations. For the intramural type of care, the larger-scaled V&V institutions mostly develop and manage their real estate in-house, all other forms of housing (assisted living and semi-mural) are outsourced to for example housing corporations. The

current uncertainty of the Dutch government makes that V&V institutions are not willing to make any decisions and keep focussing on their existing property. The change in the content of the regulation makes that all institutions see that the quality of their real estate can be a competition tool to compete with other V&V institutions; real estate will become a tool for attracting care recipients (who in the modernised regulation can better be typified as 'customer').

How should construction company Van Wijnen act for being able to keep in business in the Dutch nursing and care sector?

This sub-question is answered in the results, see chapter 8.

In the chosen argued scenario which describes the future 'goings' in the V&V sector, can be deduced that care recipients become self-responsible for their housing. V&V institutions will seek for housing corporations to develop and manage their real estate activities. Besides the V&V institutions become more regionally active to be able to adapt on their changing environment. To be able to keep in business in the V&V sector; collaboration with housing corporations should be pursued. With the regional orientation of both the V&V institution and housing corporation; Van Wijnen should take advantage of their decentralized structure across the country. Nationwide a 'standard' design or elements for a V&V institution can be developed. This basis should help all involved parties; for Van Wijnen to optimize the engineering due to gained knowledge and spread out the made costs, for the housing corporation a flexible and maintenance property can be developed and for the V&V institution a property that can contribute to the efficiency of the care activities. Specialisation will make Van Wijnen an attractive partner with a functional concept.

9.2 Discussion

> *"Knowledge remains until the political decision to intervene arises, then all the knowledge you gained becomes useless."*
>
> **Erik Schot, Lelystad - March 27, 2012**

9.2.1 Author's discussion

The elaboration of this research has been spread out over a period of six months. Already within this period some of the influencing actors were changed, before the elaboration of this research could be completed. In some cases assumptions for the course of this research were already made, while afterwards these actors changed.

- First of the dismission of the Dutch government. With new elections in the near future, discussions about the political course are 'hot news'. Within this discussion also the course of the ZZP, NHC and Dutch health care system. Although it is not imaginable that the course will change '180 degrees', in some points the new political conceptions can be in conflict with the described procedures in this research.

- Very recently it has been possible to point out the 'housing corporation scandal' in The Netherlands as a very interesting one, which could influence the field of this research. Assumed in this research is the involvement of housing corporations in the development process of real estate for V&V institutions (see paragraph 6.3, chapter 7 and chapter 8). These recent developments in the housing corporation sector making the future of this sector uncertain. This will also influence whether the housing corporation sector can continue to fulfil their current role or expand the role as described within this research.

9.2.2 Company's discussion

For determining the plausibility of the scenarios that are designed in chapter 7, the outcomes of the scenarios are discussed with the supervisory company (Van Wijnen). The variables and driving forces, as well as the coherence between variables is discussed.

The first point of attention is that within this research, for the designing of the scenarios, the 'stock of elderly people' is generalized to a one of a kind; as one group. In the real world this will not be the case as one person differs with any other arbitrarily person. Therefore the situations as described within the scenarios describe the 'general trend' in the V&V sector. This means that it reflects the largest part of the Dutch population the group with social incomes[24] towards the average incomes[25]. This means that if one scenario occurs there will be slight differences between groups of elderly people, but the largest group will fit within the environment as described in the scenarios.

The dichotomy in variable 'V-3: Organization' between ownership (DF-3.1) and rent (DF-3.2) is not as strictly separated as is occurred. It will be a more economic driven decision making choices to have ownership or renting. In the future housing will be a competition tool for V&V institutions, if rent is chosen, the competition advantage can disappear. Housing will be a tool to meet the quality demands of the care recipients and design a property that supports the efficiency for carrying out the (care) work. The economic advantage and possibilities will probably be determined by the size of the V&V institutions. Larger scaled V&V institutions sooner have economic possibilities to develop and manage their real estate in-house compared to the smaller scaled V&V institutions.

Argued is that with the independent housing on the care site early pensioners do have the possibility to make their first step towards their age. In the first period they only live on the care site, in a later stage this housing form should also provide the possibility to receive care. In the opinion of Van Wijnen this will not work, the presence of the care institution will scare the early pensioners, the institution press an impression on their housing which is not intended. For early pensioners there will be a difference in the presence and the ability of care in the housing form. Therefore a larger part of this group will receive home care in their early stage as care recipient.

[24] | Social incomes is the English designation for "Sociale inkomens".
[25] | Average incomes is the English designation for "Modale inkomens".

As already discussed in the author's discussion (see paragraph 9.2.1), the current situation in the 'housing corporation world' in The Netherlands already influences the V&V sector. More and more housing corporations do not see opportunities for them in the V&V sector anymore and therefore are (currently) not active in the V&V sector. Exception on this is a slight group of housing corporation specialized in the health care sector.

9.3 Recommendations for further research

The Dutch V&V sector is subject to large changes in the upcoming years. The elaboration of this research gave insight in a large part of the changes that are upcoming, with the answering of the research question and sub-questions just gave insight in a part of the interesting field of the V&V sector. Besides answers, during the elaboration of this research also new questions that are worth to be investigated raised. Some recommendations that are interesting for further research to me are;

- Applying the Quality Function Deployment (QFD) research method for the V&V sector. QFD is a method to translate customer preferences and market demands into design demands. With this method it is possible to analyse what the precise demand of the care recipients within the V&V sector actually is. Knowing more precisely what the actual preferences of the (future) care recipient will be makes it easier to determine what type of real estate property for the V&V sector is needed to be developed.
- To be able to better determine the precise building production for a construction company such as Van Wijnen it is interesting to know what the possible construction size will be. Analyse region specific what the future demand per year will be for V&V care (demographic change) and what the current capacity of the V&V sector is in that specific region. The gap between both should reflect whether or not there will be an opportunity for construction in the future.

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Part D

Appendices

Appendix I | Van Wijnen

Source: (Van Wijnen Corporate, 2012)

In this appendix some additional information about the market sectors in which Van Wijnen is active is elaborated.

Housing
Van Wijnen establishes homes. From small projects to the more luxury villas and complete residential housing areas. For example in commission of a housing corporation. Also renovation, maintenance and management of homes are examples of the core businesses.

Offices
Van Wijnen has extensive experience in the construction and redevelopment of office buildings. Van Wijnen achieves to do this quickly and effectively, with an optimum price/product ratio and a high degree of flexibility and often based on a set of requirements that the client has made. If desired, an associated maintenance plan will already be made during the development and preparation phase. This gives the customer the possibility of making agreements on systematic maintenance programs in an early stage of the process.

Restructuring
Van Wijnen has a rich experience in (district) restructuring projects. This is not limited to performing (large) maintenance, but the environment will also receive a 'remake'. This includes the demolition of dwellings, like the rebuilding, renovation, restoration and new estate.

Restructuring means, and most importantly, communication with residents. Van Wijnen experienced that good communication is crucial for the successful completion of a project in a residential area.

Shopping
When it comes to shopping, Van Wijnen is not only active in the expansive residential boulevards, but also in the heart of many villages and cities. This means that Van Wijnen is closely involved in the development of various plans within city centers. Van Wijnen acts as a constructor and initiator to transform shopping centres into vibrant shopping areas with a combination of residential, business and leisure functions.

Public buildings
Over the years Van Wijnen has constructed, designed and renovated many buildings for municipalities, provincial and national government. The knowledge and experience in the field of public-private partnership (PPS) is often used. The creative and sustainable solutions for the design, development and construction and maintenance of a (semi)governmental building are not only minded, but also the financing and operating part.

Education
Everywhere in the Netherlands schools and educational complexes are built, expanded, adapted to new requirements or renovated by Van Wijnen. Often it is the dynamic that underlies the Dutch educational system, with all its mergers and relocations. In such cases Van Wijnen presents itself as a developer: Van Wijnen provides advanced certainty about the development potential of the released education locations.

Sports and Culture
From football stadiums to municipal swimming pools, cinema to theatre, Van Wijnen has realized many centers for sports and culture. There is an increasingly tendency to the clustering of building features to increase the synergy. Clustering not only enhances the feasibility of individual projects, it also makes the development and exploitation opportunities more promising.

Leisure
'Van Wijnen Recreatiebouw B.V.' within Van Wijnen is the specialist in the development of leisure projects. In the Netherlands (but also abroad) designed, constructed or renovated recreational accommodations by Van Wijnen can be found.

Parking
Plenty and good parking facilities are an absolute necessity for the successful operation of urban and shopping centres. When it comes to the development, realization and operation of parking facilities Van Wijnen works, where appropriate, in close cooperation with specialized partners.

Maintenance
From all Van Wijnen offices in the country, specialized professionals are deployed for small renovations, repairs and emergency repairs. Clients can also contact Van Wijnen for long-term maintenance, even for projects not realized by Van Wijnen.

For immediate injuries that must be resolved quickly, clients can rely on the 24-hour service from Van Wijnen.

Renovation
Renovation work is a true craft that requires knowledge of specific techniques, modern and classic. For this speciality Van Wijnen has hired professionals who can perform renovations in any style and enhance in detail. There may also be securities offered in terms of cost, schedule and desired quality.

Appendix II | Description ZZP for care and nursing

Source: (Overheid.nl, 2012)

In this appendix the description of each ZZP (ZZP 1 VV – ZZP 10 VV) is given for care and nursing. For each ZZP can be seen what the specific client profile is, the score of limitations, psychiatric and counselling for the care recipient and the residence features.

This appendix is in Dutch.

ZZP 1 VV	Beschut wonen met enige begeleiding

Cliëntprofiel

Deze cliëntgroep heeft enige begeleiding nodig, in een beschutte woonomgeving, omdat ze niet meer helemaal zelfstandig kan wonen.

De cliënten hebben ten aanzien van hun *sociale redzaamheid* vooral behoefte aan enige begeleiding op het gebied van het nemen van besluiten, het komen tot oplossingen, deelname aan het maatschappelijk leven, het uitvoeren van complexere taken en het huishoudelijk leven. De begeleiding bestaat uit toezicht of stimulatie. Betreffende het uitvoeren van complexere taken kan ook overname van zorg nodig zijn.

De cliënten hebben in het algemeen weinig ondersteuning nodig ten aanzien van de *psychosociale/cognitieve functies.* Vanwege bijvoorbeeld eenzaamheid of lusteloosheid kan bij deze cliënten af en toe behoefte bestaan aan hulp, toezicht of sturing ten aanzien van motivatie, geheugen en denken en het psychosociaal welbevinden.

Ten aanzien van *ADL* zijn de cliënten meestal zelfstandig. Zij kunnen wel behoefte hebben aan toezicht en stimulatie betreffende kleine verzorgingstaken en wassen en kleden, zodat de cliënt zich goed blijft verzorgen.

Ten aanzien van *mobiliteit* zijn de cliënten in het algemeen redelijk zelfstandig. Betreffende het verplaatsen buitenshuis, het lopen van korte afstanden, kunnen cliënten wel behoefte hebben aan toezicht en stimulatie (bijvoorbeeld door aan te geven hoe ergens te komen).

Bij deze cliënten is geen sprake van *verpleging*.

Bij deze cliënten is meestal geen sprake van *gedragsproblematiek*.

Bij deze cliënten is meestal geen sprake van *psychiatrische problematiek*.

De *aard van het begeleidingsdoel* is bij de cliënten vaak stabilisatie.

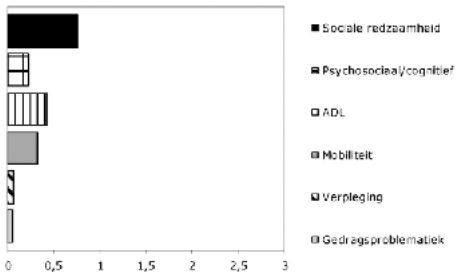
Het *beperkingenbeeld* van deze cliënten verandert meestal langzaam.

De *zorgverlening* is volgens afspraak en direct oproepbaar (bijvoorbeeld 24 uur per dag via een alarmeringssysteem) of voortdurend in de nabijheid te leveren.

De *dominante grondslag* voor dit cliëntprofiel is meestal een somatische ziekte/aandoening of een (beginnende) psychogeriatrische ziekte/aandoening.

Voorbeelden van cliëntgroepen zijn:
De 'lichte' bewoner in het verzorgingshuis.

Gemiddelde scores beperkingen



Aard van de psychiatrische problematiek

Aard van het begeleidingsdoel

Functies en tijd per cliënt per week

Woonzorg				Dagbesteding	Behandelaars (BH)	Totaaltijd
Functie	BG	PV	VP	Is integraal onderdeel van het ZZP.	Bij de zorgverlening zijn geen behandelaars betrokken.	Inclusief dagbesteding: 3,0 tot 5,0 uur
	ja	ja	nee			

Verblijfskenmerken

Setting: beschut wonen.
Nachtdienst: oproepbare wacht.
Leveringsvoorwaarde: volgens afspraak en direct oproepbaar, of voortdurend in de nabijheid.

ZZP 2 VV	Beschut wonen met begeleiding en verzorging

Cliëntprofiel

Deze cliëntgroep kan niet meer zelfstandig wonen en heeft vanwege vooral somatische problematiek dagelijks behoefte aan begeleiding en verzorging in een beschutte woonomgeving.

De cliënten hebben ten aanzien van hun *sociale redzaamheid* in het algemeen weinig ondersteuning nodig. Met name kan behoefte bestaan aan toezicht of stimulatie betreffende deelname aan het maatschappelijk leven en besluitnemings- en oplossingsvaardigheden. Bij het uitvoeren van complexere taken en het huishoudelijk leven kan ook behoefte bestaan aan het overnemen van zorg. Er kan sprake zijn van een beginnend verlies van regie over het dagelijks leven.

De cliënten kunnen ten aanzien van alle *psychosociale/cognitieve functies* af en toe behoefte hebben aan hulp, toezicht en sturing, met name vanwege beperkingen met betrekking tot geheugen en denken, concentratie en motivatie.

Ten aanzien van *ADL* hebben de cliënten betreffende de kleine verzorgingstaken, het wassen en het aan- en uitkleden dagelijks behoefte aan hulp. Betreffende eten en drinken en de toiletgang bestaat bij de cliënten soms behoefte aan toezicht en stimulatie.

Ten aanzien van *mobiliteit* hebben de cliënten betreffende het verplaatsen binnenshuis soms hulp nodig (voor veel cliënten is bijvoorbeeld een rollator voldoende). Voor het verplaatsen buitenshuis hebben cliënten (naast eventueel de hulp van een rollator) behoefte aan toezicht en stimulatie.

In een beperkt aantal gevallen is sprake van *verpleegkundige* aandacht.

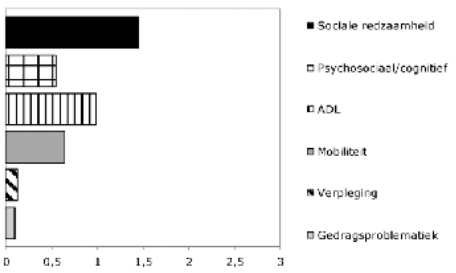
Bij deze cliënten is meestal geen sprake van *gedragsproblematiek* en ook geen sprake van *psychiatrische problematiek*.

De *aard van het begeleidingsdoel* is bij deze cliënten vaak stabilisatie of begeleiding bij achteruitgang. De zorgbehoefte kan in de tijd wisselend van aard zijn en er is behoefte aan zorg op meerdere momenten per dag. De *zorgverlening* is op afspraak en direct oproepbaar (bijvoorbeeld 24 uur per dag via een alarmeringssysteem) of voortdurend in de nabijheid te leveren. Het *beperkingenbeeld* van deze cliënten verandert langzaam.

De *dominante grondslag* voor dit cliëntprofiel is meestal een somatische ziekte/aandoening of een (beginnende) psychogeriatrische ziekte/aandoening.

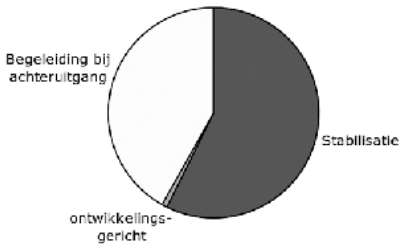
Voorbeelden van cliëntgroepen zijn:
De 'gemiddelde' bewoner van het verzorgingshuis (kan eventueel ook in het verpleeghuis wonen).
Tijdelijk verblijvenden in het verzorgingshuis ten behoeve van herstel na bijvoorbeeld ziekenhuisopname of als gevolg van een tijdelijk falend cliëntsysteem.

Gemiddelde scores beperkingen



Aard van de psychiatrische problematiek

Aard van het begeleidingsdoel



Functies en tijd per cliënt per week

Woonzorg				Dagbesteding	Behandelaars (BH)	Totaaltijd
Functie	BG	PV	VP	Is integraal onderdeel van het ZZP.	Bij de zorgverlening zijn geen behandelaars betrokken.	Inclusief dagbesteding: 5,5 tot 7,5 uur
	ja	ja	ja			

Verblijfskenmerken

Setting: beschut wonen.
Nachtdienst: wakende wacht.
Leveringsvoorwaarde: volgens afspraak en direct oproepbaar of voortdurend in de nabijheid.

ZZP 3 VV	Beschut wonen met begeleiding en intensieve verzorging

Cliëntprofiel

Deze cliëntgroep heeft vanwege omvangrijke somatische problematiek behoefte aan begeleiding en vooral ook intensieve verzorging, in een beschutte woonomgeving.

De cliënten hebben ten aanzien van *sociale redzaamheid* hulp nodig betreffende deelname aan het maatschappelijk leven, besluitnemings-/oplossingsvaardigheden, uitvoeren van eenvoudige taken en dagelijkse routine. Betreffende de communicatie is veelal toezicht of stimulatie nodig. Betreffende het uitvoeren van complexere taken en het huishoudelijke leven moet vaak overname van zorg plaatsvinden. Er is vaak sprake van een beginnend verlies van regie over het dagelijks leven.

De cliënten hebben vanwege het verlies aan geestelijke spankracht ten aanzien van verschillende *psychosociale/cognitieve functies* vaak hulp, toezicht of sturing nodig; het betreft concentratie, geheugen en denken, motivatie en psychosociaal welbevinden.

Ten aanzien van *ADL* hebben de cliënten op verschillende terreinen hulp nodig, het betreft de kleine verzorgingstaken, de zorg voor tanden, haren, nagels en huid, het wassen en kleden en de toiletgang. Bij het eten en drinken is vaak toezicht en stimulatie nodig.

Ten aanzien van *mobiliteit* binnenshuis en het bewegen/maken van transfers (opstaan/zitten, in/uit bed) hebben cliënten regelmatig behoefte aan hulp. Betreffende de mobiliteit buitenshuis is vaak hulp of overname van zorg nodig.

Cliënten kunnen een kwetsbare gezondheid hebben vanwege een chronische ziekte die voortdurende *verpleegkundige aandacht* vereist.

Bij deze cliënten is meestal geen sprake van *gedragsproblematiek*.

Bij deze cliënten is meestal geen sprake van *psychiatrische problematiek*.

De *aard van het begeleidingsdoel* is bij deze cliënten gericht op begeleiding bij achteruitgang of op stabilisatie.

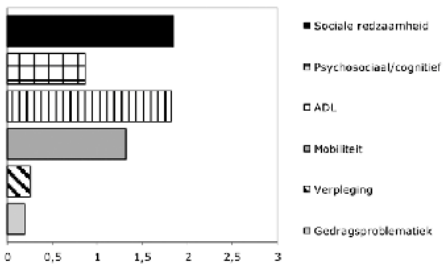
De *zorgverlening* is voortdurend in de nabijheid te leveren en wordt op meerdere momenten per dag geboden.

Het *beperkingenbeeld* van deze cliënten verandert langzaam tot snel.

De *dominante grondslag* voor dit cliëntprofiel is meestal een somatische ziekte/aandoening.

Voorbeelden van cliëntgroepen zijn:
Bewoners somatische meerzorg in het verzorgingshuis.
Lichte somatische bewoners in een verpleeghuis.

Gemiddelde scores beperkingen



Aard van de psychiatrische problematiek

Aard van het begeleidingsdoel

Functies en tijd per cliënt per week

Woonzorg				Dagbesteding	Behandelaars (BH)	Totaaltijd
Functie	BG	PV	VP	Is integraal onderdeel van het ZZP.	Bij de zorgverlening zijn behandelaars betrokken.	Inclusief dagbesteding: 9,5 tot 11,5 uur
	ja	ja	ja			

Verblijfskenmerken

Setting: beschut wonen.
Nachtdienst: wakende wacht.
Leveringsvoorwaarde: voortdurend in de nabijheid.

ZZP 4 VV	Beschut wonen met intensieve begeleiding en uitgebreide verzorging

Cliëntprofiel

Deze cliëntgroep heeft intensieve begeleiding gecombineerd met uitgebreide verzorging in een beschutte omgeving. De reden hiervoor kan verschillend zijn.

De cliënten hebben ten aanzien van hun *sociale redzaamheid* betreffende veel aspecten hulp nodig, zoals bij de communicatie, het nemen van besluiten, communicatie en het uitvoeren van taken. Ze kunnen niet of nauwelijks zelfstandig deelnemen aan het maatschappelijk leven.

De cliënten hebben ten aanzien van alle *psychosociale/cognitieve functies* behoefte aan hulp, toezicht of sturing, omdat de cliënten veel beperkingen hebben met betrekking tot met name denken en geheugen, oriëntatie en concentratie.

Ten aanzien van de verschillende aspecten van *ADL* hebben de cliënten veelal toezicht en stimulatie nodig, omdat de cliënt beperkingen heeft waardoor er ondersteuning nodig is bij kleine verzorgingstaken, wassen en kleden.

De cliënten hebben ten aanzien van *mobiliteit* veelal toezicht of stimulatie nodig. Binnenshuis kan de cliënt zich beperkt zelfstandig bewegen. Betreffende het verplaatsen buitenshuis is in het algemeen hulp of overname van zorg nodig.

Cliënten kunnen een kwetsbare gezondheid hebben vanwege een chronische ziekte die voortdurende *verpleegkundige aandacht* vereist.

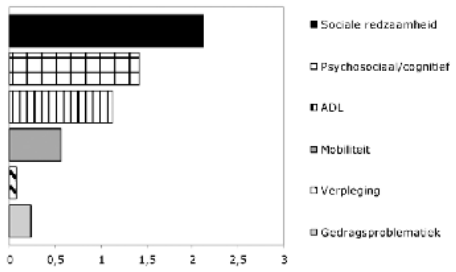
Bij deze cliënten kan sprake zijn van enige *gedragsproblematiek* waarbij af en toe hulp, toezicht of sturing nodig is. Bij deze cliënten kan ook *psychiatrische problematiek* voorkomen, vooral passief van aard.

De *aard van het begeleidingsdoel* heeft vaak betrekking op begeleiding bij achteruitgang, maar kan ook stabilisatie zijn. De cliënten hebben een structurele behoefte aan zorg, op meerdere momenten per dag. De *zorgverlening* is voortdurend in de nabijheid te leveren. Het *beperkingenbeeld* van deze cliënten verandert langzaam tot snel.

De *dominante grondslag* voor dit cliëntprofiel is meestal een psychogeriatrische of somatische ziekte/aandoening (zie voorbeelden).

Voorbeelden van cliëntgroepen zijn:
Cliënten met een matig dementieel syndroom.
Bewoners met PG meerzorg in het verzorgingshuis.
Cliënten die door ouderdom een verzorgingsbehoefte hebben gekregen naast reeds bestaande langdurende psychiatrische problematiek.
Personen die in samenhang met de fysieke verzorgingsbehoefte extra begeleiding nodig hebben vanwege ernstige zintuiglijke beperkingen (doof- en/of blindheid op latere leeftijd).

Gemiddelde scores beperkingen



Aard van de psychiatrische problematiek

Aard van het begeleidingsdoel

Functies en tijd per cliënt per week

Woonzorg				Dagbesteding	Behandelaars (BH)	Totaaltijd
Functie	BG	PV	VP	Is integraal onderdeel van het ZZP.	Bij de zorgverlening zijn behandelaars betrokken.	Inclusief dagbesteding: 11,0 tot 13,5 uur
	ja	ja	ja			

Verblijfskenmerken

Setting: beschut wonen.
Nachtdienst: wakende wacht.
Leveringsvoorwaarde: voortdurend in de nabijheid.

ZZP 5 VV	Beschermd wonen met intensieve dementiezorg

Cliëntprofiel

Deze cliëntgroep heeft vanwege ernstige dementiële problematiek behoefte aan intensieve begeleiding en intensieve verzorging, in een beschermende woonomgeving. De cliënten zijn (bijna) geheel zorgafhankelijk.

De cliënten hebben ten aanzien van hun *sociale redzaamheid* op alle aspecten in ieder geval hulp en vaak overname van zorg nodig. Er is bij deze cliënten sprake van vergaand verlies van zelfregie. Er kan sprake zijn van zwerfgedrag. De cliënten hebben geen greep meer op hun eigen doen en laten.

Ze hebben ten aanzien van de verschillende *psychosociale/cognitieve functies* continu hulp, toezicht en sturing nodig, omdat de cliënten veel beperkingen hebben met betrekking tot oriëntatie, concentratie en geheugen en denken. Er is sprake van volledige desoriëntatie naar tijd, plaats en persoon.

Ten aanzien van *ADL* is betreffende alle aspecten hulp of overname van zorg nodig, waaronder eten en drinken, kleine verzorgingstaken, de persoonlijke zorg voor tanden, haren, nagels en huid, de toiletgang, het wassen en het kleden.

Ten aanzien van *mobiliteit* hebben de cliënten vaak hulp of overname van zorg nodig. Binnenshuis kan de cliënt zich zeer beperkt zelfstandig bewegen, buitenshuis kan dat helemaal niet.

Als gevolg van de kwetsbare gezondheid is *verpleegkundige aandacht* noodzakelijk (o.a. voorkomen van decubitus en infecties).

De cliënten kunnen soms *gedragsproblematiek* vertonen. Dit betreft dan met name dwangmatig gedrag, ongecontroleerd/ontremd gedrag of reactief gedrag met betrekking tot interactie.

Bij een deel van de cliënten komt *psychiatrische problematiek* voor, vooral passief van aard.

De *aard van het begeleidingsdoel* heeft meestal betrekking op begeleiding bij achteruitgang.

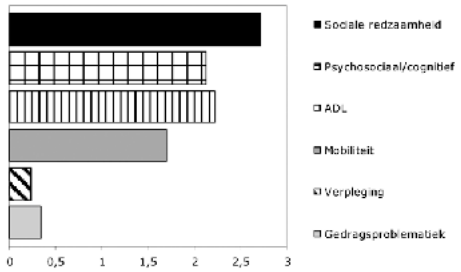
De cliënten hebben een structurele behoefte aan zorg, op meerdere momenten per dag. De *zorgverlening* is voortdurend in de nabijheid of 24 uur per dag direct te leveren.

Het *beperkingenbeeld* van deze cliënten verandert langzaam tot snel.

De *dominante grondslag* voor dit cliëntprofiel is meestal een psychogeriatrische ziekte/aandoening.

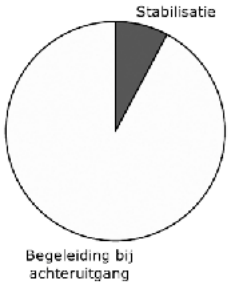
Voorbeelden van cliëntgroepen zijn:
Cliënten met een ernstige mate van dementie zonder veel gedragsproblematiek.

Gemiddelde scores beperkingen



Aard van de psychiatrische problematiek

Aard van het begeleidingsdoel



Functies en tijd per cliënt per week

Woonzorg				Dagbesteding	Behandelaars (BH)	Totaaltijd
Functie	BG	PV	VP	Is integraal onderdeel van het ZZP.	Bij de zorgverlening zijn behandelaars betrokken.	Inclusief dagbesteding: 16,5 tot 20,0 uur
	ja	ja	ja			

Verblijfskenmerken

Setting: beschermd wonen.
Nachtdienst: wakende wacht.
Leveringsvoorwaarde: voortdurend in de nabijheid of 24 uur per dag direct aanwezig.

ZZP 6 VV	Beschermd wonen met intensieve verzorging en verpleging

Cliëntprofiel

Deze cliëntgroep heeft vanwege ernstige somatische beperkingen op veel momenten van de dag behoefte aan begeleiding, intensieve verzorging en verpleging, in een beschermende woonomgeving.

De cliënten hebben ten aanzien van hun *sociale redzaamheid* een begeleidingsbehoefte betreffende het begrijpen wat anderen zeggen, het begrijpelijk maken naar anderen. Soms is hierbij toezicht en stimulatie nodig. Betreffende de overige aspecten van sociale redzaamheid is in het algemeen hulp bij of overname van zorg nodig, hieronder vallen initiëren en uitvoeren van eenvoudige en complexe taken. De cliënt is niet zijn zelfregie kwijt.

De cliënten hebben ten aanzien van de *psychosociale/cognitieve functies*, betreffende concentratie, motivatie en psychosociaal welbevinden, vaak of continu hulp, toezicht of sturing nodig, vanwege een combinatie van fysieke en psychische moeilijkheden (zoals snel vermoeid, minder controle over armen en benen, vertraagd denkvermogen).

De cliënten hebben ten aanzien van de verschillende aspecten van *ADL* in het algemeen overname van zorg nodig. Betreffende eten en drinken kan toezicht en stimulatie in sommige situaties voldoende zijn (de cliënt is meestal goed in staat om zelf te bepalen welke hulp nodig is en hoe hij die hulp wil krijgen).

De cliënten hebben zowel binnenshuis- als buitenshuis op het gebied van *mobiliteit* overname van zorg nodig (vaak met behulp van een rolstoel).

De cliënt heeft continu behoefte aan *verpleegkundige aandacht* (o.a. wondverzorging, pijnbestrijding).

Van *gedragsproblematiek* is bij deze cliënten in het algemeen geen sprake.
Bij deze cliënten kan ook *psychiatrische problematiek* voorkomen, vooral passief van aard (bijvoorbeeld depressiviteit).

De *aard van het begeleidingsdoel* heeft meestal betrekking op begeleiding bij achteruitgang maar kan ook gericht zijn op stabilisatie.

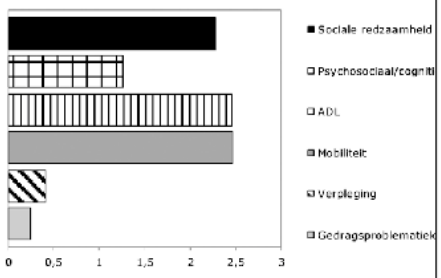
De cliënten hebben een structurele behoefte aan zorg, op meerdere momenten per dag. De *zorgverlening* is voortdurend in de nabijheid of 24 uur per dag direct te leveren.

Het *beperkingenbeeld* van deze cliënten verandert vaak snel.

De *dominante grondslag* voor dit cliëntprofiel is meestal een somatische ziekte/aandoening.

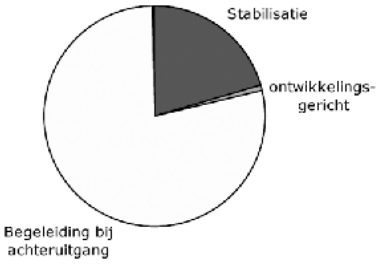
Voorbeelden van cliëntgroepen zijn:
Cliënten met ernstige somatische beperkingen (bijvoorbeeld blijvend hersenletsel, Parkinson, chronisch hartfalen, spierziekte).
Cliënten met complexe ziekten in een nog niet vergevorderd stadium en/of zonder gedragsproblematiek.

Gemiddelde scores beperkingen



Aard van de psychiatrische problematiek

Aard van het begeleidingsdoel



Functies en tijd per cliënt per week

Woonzorg				Dagbesteding	Behandelaars (BH)	Totaaltijd
Functie	BG	PV	VP	Is integraal onderdeel van het ZZP.	Bij de zorgverlening zijn behandelaars betrokken.	Inclusief dagbesteding: 16,5 tot 20,0 uur
	ja	ja	ja			

Verblijfskenmerken

Setting: beschermd wonen
Nachtdienst: wakende wacht
Leveringsvoorwaarde: voortdurend in de nabijheid of 24 uur per dag direct aanwezig.

ZZP 7 VV	Beschermd wonen met zeer intensieve zorg, vanwege specifieke aandoeningen, met de nadruk op begeleiding

Cliëntprofiel

Deze cliëntgroep heeft op grond van een chronische ziekte specifieke begeleiding nodig in combinatie met zeer intensieve verzorging en verpleging in een beschermende woonomgeving.

De cliënten hebben ten aanzien van hun *sociale redzaamheid* volledige begeleiding nodig, overname van taken is noodzakelijk. Met name bestaat er sterke behoefte aan het bieden van dagstructurering. Ze kunnen niet of nauwelijks zelfstandig deelnemen aan het maatschappelijk leven, communiceren, zelfstandig besluiten nemen, complexe taken initiëren en regie voeren over hun eigen leven. Deze cliënten hebben behoefte aan een vaste structuur en hulp bij het organiseren van de dag.

De cliënten hebben ten aanzien van de *psychosociale/cognitieve functies* continu hulp, toezicht of sturing en begeleiding nodig, omdat er onder andere sprake is van beperkingen op het gebied van oriëntatie, geheugen en denken, concentratie en motivatie. Daarnaast kan extra begeleiding nodig zijn om familieleden te leren omgaan met de veranderde persoon.

De cliënten hebben ten aanzien van de verschillende aspecten van *ADL* veel hulp nodig. Met name bij kleine verzorgingstaken, de persoonlijke zorg voor tanden, haren, nagels en huid en bij het wassen kan ook behoefte zijn aan overname van zorg.

De cliënten hebben ten aanzien van *mobiliteit* binnenshuis veelal hulp nodig. Ten aanzien van mobiliteit buitenshuis is overname van zorg nodig (er is altijd een begeleider nodig). *Verpleging* is nodig om de chronische ziekte in de gaten te houden en eventueel passende maatregelen te nemen.

Er is bij deze cliënten vaak sprake van *gedragsproblematiek*, waardoor in die situaties vaak of continu hulp, toezicht of sturing nodig is. De aard van de gedragsproblematiek is divers, maar reactief gedrag met betrekking tot interactie en verbaal agressief gedrag komen in veel situaties voor. Een deel van de cliënten vertoont *psychiatrische problematiek*, zowel passief als actief van aard.

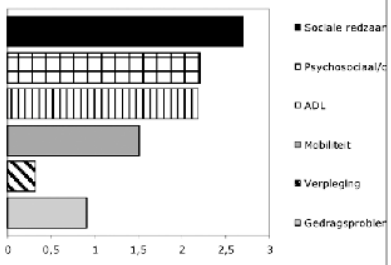
De *aard van het begeleidingsdoel* heeft meestal betrekking op begeleiding bij geleidelijke achteruitgang. De cliënten hebben een structurele behoefte aan zorg, op meerdere momenten per dag. De zorgverlening is voortdurend in de nabijheid of 24 uur per dag direct te leveren.

Het *beperkingenbeeld* van deze cliënten verandert vaak langzaam.

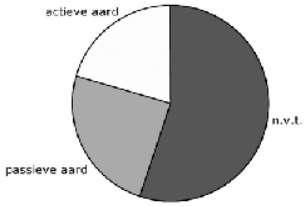
De *dominante grondslag* voor dit cliëntprofiel is meestal een somatische ziekte/aandoening of een psychogeriatrische ziekte/aandoening.

Voorbeelden van cliëntgroepen zijn:
Volwassenen met ernstig en blijvend niet aangeboren hersenletsel.
Cliënten met een ernstige mate van dementie in combinatie met gedragsproblemen (vooral voorkomend bij jong dementerenden).
Mensen met de ziekte van Korsakov.
Ouderen met complexe lichamelijke problematiek in combinatie met actieve psychiatrische problematiek.
Ouderen die als gevolg van doofblindheid op latere leeftijd specifieke zorg nodig hebben.

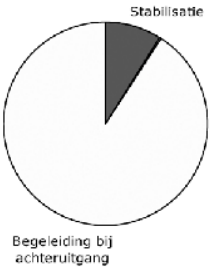
Gemiddelde scores beperkingen



Aard van de psychiatrische problematiek



Aard van het begeleidingsdoel



Functies en tijd per cliënt per week

Woonzorg				Dagbesteding	Behandelaars (BH)	Totaaltijd
Functie	BG	PV	VP	Is integraal onderdeel van het ZZP.	Bij de zorgverlening zijn behandelaars betrokken.	Inclusief dagbesteding: 20,0 tot 24,5 uur
	ja	ja	ja			

Verblijfskenmerken

Setting: beschermd wonen.
Nachtdienst: wakende wacht.
Leveringsvoorwaarde: voortdurend in de nabijheid of 24 uur per dag direct aanwezig.

ZZP 8 VV	Beschermd wonen met zeer intensieve zorg, vanwege specifieke aandoeningen, met de nadruk op verzorging/verpleging

Cliëntprofiel

Deze cliëntgroep heeft op grond van een ernstige somatische aandoening/ziekte behoefte aan specifieke en zeer intensieve verzorging en verpleging in combinatie met begeleiding in een beschermende woonomgeving.

De cliënten hebben ten aanzien van hun *sociale redzaamheid* volledige begeleiding nodig, overname van taken is noodzakelijk. Deze begeleiding komt voort uit beperkingen die de ziekte met zich meebrengt en meestal niet uit het ontbreken van zelfregie. Met name bestaat er sterke behoefte aan het bieden van dagstructurering. Ze kunnen niet of nauwelijks zelfstandig deelnemen aan het maatschappelijk leven, complexe taken initiëren en regie voeren over hun eigen leven.

De cliënten hebben ten aanzien van de *psychosociale/cognitieve functies* overname nodig als gevolg van beperkingen op het gebied van concentratie en motivatie. Mede vanwege veranderingen in karakter en persoonlijkheid kunnen ook de partner en/of kinderen behoefte hebben aan begeleiding.

De cliënten hebben ten aanzien van alle aspecten van *ADL* ten gevolge van hun specifieke aandoeningen/ziektes minimaal hulp dan wel overname van zorg nodig.

De cliënten hebben ten aanzien van *mobiliteit,* zowel binnenshuis als buitenshuis, behoefte aan hulp of overname.

De cliënten hebben ten gevolge van de specifieke aandoeningen/ziektes continu behoefte aan veel (gespecialiseerde) *verpleegkundige aandacht* (voorkomen van decubitus, infecties, longontsteking).

Van *gedragsproblematiek* is bij deze cliënten in het algemeen geen sprake. Bij deze cliënten is meestal geen sprake van *psychiatrische problematiek.*

De *aard van het begeleidingsdoel* heeft meestal betrekking op begeleiding bij achteruitgang van de zorgsituatie.

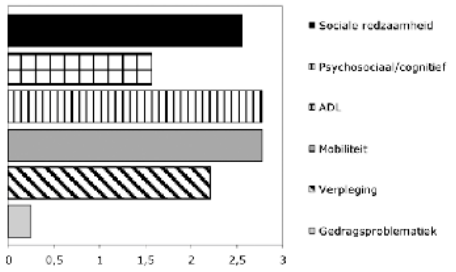
De cliënten hebben een structurele behoefte aan zorg, op meerdere momenten per dag. De *zorgverlening* is voortdurend in de nabijheid of 24 uur per dag direct te leveren.

Het *beperkingenbeeld* van deze cliënten verandert vaak langzaam.

De *dominante grondslag* voor dit cliëntprofiel is meestal een somatische ziekte/aandoening.

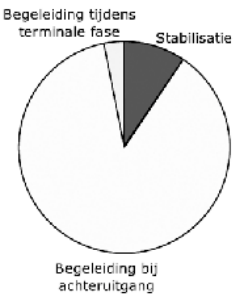
Voorbeelden van cliëntgroepen zijn:
Cliënten in de laatste (terminale) fasen van de ziekte, zoals Huntington, ALS, MS of zware reuma.
Cliënten met Korsakov in een fase van volledige zorgafhankelijkheid.

Gemiddelde scores beperkingen



Aard van de psychiatrische problematiek

Aard van het begeleidingsdoel



Functies en tijd per cliënt per week

Woonzorg				Dagbesteding	Behandelaars (BH)	Totaaltijd
Functie	BG	PV	VP	Is integraal onderdeel van het ZZP.	Bij de zorgverlening zijn behandelaars betrokken.	Inclusief dagbesteding: 24,5 tot 29,5 uur
	ja	ja	ja			

Verblijfskenmerken

Setting: beschermd wonen.
Nachtdienst: wakende wacht.
Leveringsvoorwaarde: voortdurend in de nabijheid of 24 uur per dag direct aanwezig.

ZZP 9 VV	Herstelgerichte behandeling met verpleging en verzorging

Cliëntprofiel

Bij deze cliëntgroep heeft medisch-specialistische diagnostiek/interventie plaatsgevonden waarbij doorgaans sprake is geweest van een opname. Voorafgaand aan de interventie ontvingen (vrijwel) alle cliënten uit deze groep reeds behandeling in combinatie met verblijf. In aansluiting op de interventie is behoefte aan herstelgerichte behandeling die aanvullende integrale en multidisciplinaire aanpak vereist. De medisch-specialistische diagnostiek/interventie is afgerond. Naast de aandoening waarvoor de cliënt (aanvullende) behandeling ontvangt heeft de cliënt ook andere problemen in de zin van kwetsbaarheid en comorbiditeit (zoals problemen met de bloedsomloop, psychogeriatrische aandoeningen, het bewegingsapparaat en/of metabole stoornissen), hetgeen leidt tot instabiliteit, complicaties en verminderde leer- en trainbaarheid. Herstel tot het niveau van functioneren van vóór de acute aandoening wordt nagestreefd.

Aanvullend op de herstelgerichte behandeling kan functionele diagnostiek noodzakelijk zijn. Deze aanvullende functionele diagnostiek is vooral gericht op het beperkingenniveau van de cliënt, het onderzoeken welke behandeldoelen haalbaar zijn en het onderzoeken van behandelmogelijkheden (verbeteren van het functioneren van de verzekerde voor zover mogelijk, voorkomen van verergering van beperkingen en het zo lang mogelijk handhaven van zelfstandigheid).

De cliënten hebben ten aanzien van sociale redzaamheid op alle aspecten in ieder geval hulp en vaak overname van zorg nodig. Er is bij deze cliënten sprake van vergaand verlies van zelfregie. Er kan sprake zijn van zwerfgedrag. De cliënten hebben geen grip meer op hun eigen doen en laten.

Cliënten hebben ten aanzien van de verschillende psychosociale/cognitieve functies continu hulp, toezicht en sturing nodig, omdat de cliënten veel beperkingen hebben met betrekking tot oriëntatie, concentratie, geheugen en denken. Er is vaak sprake van desoriëntatie naar tijd, plaats en persoon.

Ten aanzien van ADL hebben cliënten op alle aspecten hulp of overname van zorg nodig, waaronder eten en drinken, kleine verzorgingstaken, de persoonlijke zorg voor tanden, haren, nagels en huid, de toiletgang, het wassen en kleden.

Ten aanzien van mobiliteit hebben de cliënten vaak hulp of overname van zorg nodig. Gedurende de verblijfsperiode vermindert de mobiliteitsproblematiek substantieel.

In het kader van herstel is verpleegkundige aandacht nodig.

De cliënten kunnen soms gedragproblematiek vertonen. Dit betreft met name dwangmatig gedrag, ongecontroleerd/ontremd gedrag of reactief gedrag met betrekking tot interactie.

Meestal is geen sprake van psychiatrische problematiek.

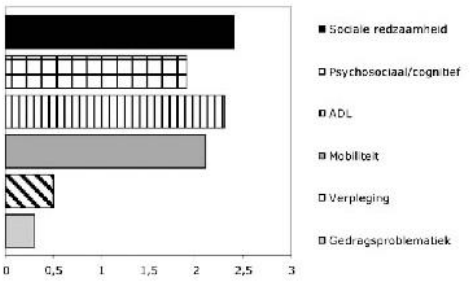
De aard van het begeleidingsdoel is veelal gericht op stabilisatie, soms op ontwikkeling of begeleiding bij achteruitgang.

Het beperkingenbeeld van de cliënt verandert langzaam.

De cliënten hebben een tijdelijke behoefte (2-6 maanden)aan extra behandeling en zorg, op meerdere momenten per dag. De zorgverlening is voortdurend in de nabijheid te leveren. Bij deze cliëntgroep is sprake van een multidisciplinaire inzet van behandelaars, waarbij specialistische deskundigheid op het gebied van ouderengeneeskunde noodzakelijk is.

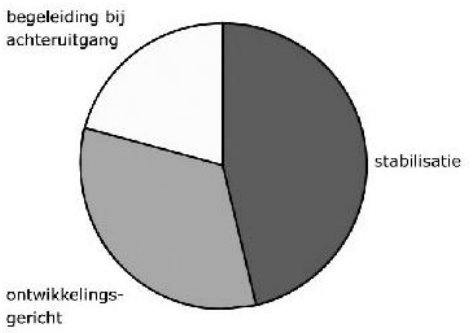
De dominante grondslag is meestal een somatische of psychogeriatrische ziekte/aandoening.

Gemiddelde scores beperkingen



Aard van de psychiatrische problematiek

Aard van het begeleidingsdoel



Functies en tijd per cliënt per week

Woonzorg				Dagbesteding	Behandelaars (BH)	Totaaltijd
Functie	BG	PV	VP	Is integraal onderdeel van het ZZP.	Bij de zorgverlening zijn behandelaars betrokken.	Inclusief dagbesteding: 18,0 tot 22,0 uur
	ja	ja	ja			

Verblijfskenmerken

Setting: beschermd verblijf.

Nachtdienst: wakende wacht.

Leveringsvoorwaarde: voortdurend in de nabijheid

ZZP 10 VV	Beschermd verblijf met intensieve palliatief-terminale zorg

Cliëntprofiel

Deze cliëntgroep verblijft kortdurend (doorgaans niet langer dan drie maanden) in het zorghuis in verband met een naderend overlijden, in een situatie van beschermd verblijf.

In verband met de terminale fase van het leven is er sprake van een intensieve zorgbehoefte ten aanzien van *psychosociale/cognitieve functies*, de *sociale redzaamheid*, de *mobiliteit* en de *ADL*. In het algemeen is sprake van noodzaak tot overname van zorg op al deze aspecten. De mate waarin de cliënt beperkingen ondervindt op het gebied van psychosociaal welbevinden kan sterk verschillen. De begeleiding is gericht op zowel de cliënt als zijn naasten (verwerking).

Bij deze cliënten is in veel gevallen (gespecialiseerde) *verpleegkundige aandacht* aan de orde.

Er is bij deze cliënten meestal geen sprake van *gedragsproblematiek*.

De *aard van het begeleidingsdoel* is begeleiding in de terminale fase van het leven.

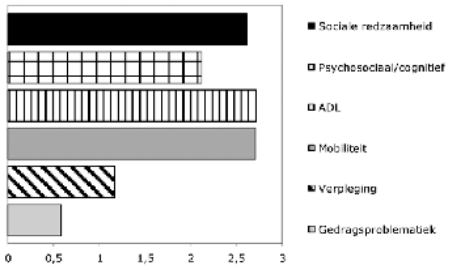
Bij deze cliënten kan sprake zijn van *psychiatrische problematiek*, zowel passief als actief van aard.

De cliënten hebben een structurele zorgbehoefte, op zowel geplande als op niet geplande tijden. De *zorgverlening* is voortdurend in de nabijheid of 24 uur per dag te leveren.

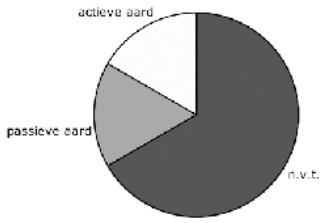
Het *beperkingenbeeld* van deze cliënten verandert eigenlijk niet tijdens de verblijfsperiode, er blijft sprake van zeer veel stoornissen.

De *dominante grondslagen* voor dit cliëntprofiel kunnen vaak zowel een somatische ziekte/aandoening als een psychogeriatrische ziekte/aandoening zijn.

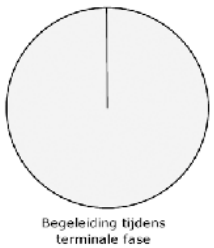
Gemiddelde scores beperkingen



Aard van de psychiatrische problematiek



Aard van het begeleidingsdoel



Functies en tijd per cliënt per week

Woonzorg				Dagbesteding	Behandelaars (BH)	Totaaltijd
Functie	BG	PV	VP	Is integraal onderdeel van het ZZP.	Bij de zorgverlening zijn behandelaars betrokken.	Inclusief dagbesteding: 26,5 tot 32,5 uur
	ja	ja	ja			

Verblijfskenmerken

Setting: beschermd wonen.
Nachtdienst: wakende wacht.
Leveringsvoorwaarde: voortdurend in de nabijheid of 24 uur per direct aanwezig.

Appendix III | Interview questionnaire

In this appendix the structure, the interview questionnaire, for the interviews is given. The interview is divided into several parts, each of the parts is introduced by the interviewer (the author).

Introduction

I am currently working on my master graduation thesis at the Eindhoven University of Technology, specialisation Construction Management & Engineering, which is a mix between the departments of 'Built Environment' and 'Industrial Engineering'. For this I am doing research on how health care (aimed at the elderly care) perceive the changing environment in which they are currently active (changing governmental regulations, aging of the Dutch population). By performing interviews with several parties I will try to compare the practical relevance with the framework as sketched in the theoretical orientation. With the interviews I hope to find out what is currently happening in the healthcare sector regarding financing and strategic real estate management. What are the problems those institutions face and what kind of internal policies do these parties have to be able to deal with these changes?

1. **Can you introduce yourself?**
   - Education
   - Work experience
   - How long employed at …*(name institution)*…
2. **Job definition**
   - Work proceedings

Substantive part

Since 2006 the Dutch government has been working on redesigning the financing related to the health care sector. The introduction of the ZVW, changing the AWBZ, funding through ZZP are just a few of the changes. By introducing these changes, the Dutch government wanted to create a more cost-conscious, competitive health care sector which is more efficient. The results is the ability to reduce the money spent on care.

3. **Where these changes needed to achieve the goals of the government in your opinion?**
4. **What is your opinion about these changes?**
   - Positive / negative

Concerning everything I have studied so far, I believe that care institutions should keep a closer eye on trends and the needs of care recipients. This way, they will be able to compete

with other institutions in a better way. Trends such as small scale living, can be seen and more extramural care will be delivered in the future.

5. **Are there any other trends in the V&V sector?**

Part of these changes are also served at the financing of real estate in the health care sector, the introduction of the NHC is an example for that. This will force institutions to start a renewed strategic real estate management plan.

6. **Does …*(name institution)*… have a real estate strategy for being able to adapt to these changes?**
7. **What is the particular strategy that …*(name institution)*… has regarding its real estate management?**
   - Outsourcing
   - Risks (which for themselves and which by others)
   - Will you keep in your own hands
8. **Do you expect more private parties to get involved in the Dutch health care sector? And if so; which role will they fulfil?**
   - Bigger role for project developers or investors
   - Maybe even new parties

<u>Closure</u>

9. **What can external parties, in your opinion, do better?**

Appendix IV | Information of interviewees

In this appendix more extensive information of the institutions which were interviewed is given. The information in this appendix is in Dutch, all summarised information of the institutions can be seen in English in the report (see paragraph 6.3).

Stichting Habion

Bron: (Stichting Habion, 2012) & (Stichting Habion, 2011)

Algemene informatie	
Naam	Stichting Habion
Adres	De Molen 94
Postcode	3995 AX
Plaats	Houten
Telefoonnummer	+31 (0)30 – 220 47 04
Website	http://www.habion.nl

Organisatie

Habion, opgericht in 1952, is een landelijk operende woningcorporatie die zich richt op woonvormen voor de gezondheidszorg. Daarbij werkt Habion samen met lokale partners om woonvormen voor service en zorg, gericht op ouderen, te ontwikkelen, realiseren en beheren.

Kernactiviteiten

Habion ontwikkelt, bouwt en beheert dus huisvesting voor senioren. Dit doen zij in samenwerking met locale partners (de klanten), de type woonvormen die Habion aanbied zijn; verzorgings- en verpleeghuizen, aanleunwoningen, woonzorgcomplexen, levensloopbestendige appartementen, mediche praktijken en wijkservicepunten. Bij het ontwikkelen van huisvesting voor senioren houdt Habion trends in de ouderenzorg goed in de gaten zodat senioren huisvesting ook in de toekomst zal voldoen aan de eisen die senioren hebben.

De vastgoedportefeuille van Habion ziet er als volgt uit:

Woning type	Eenheden
Zelfstandige woningen	4.528
Zorgeenheden	5.116
Overige eenheden	110
Totaal aantal eenheden	**9.754**

- Zelfstandige woningen

De zelfstandige woningen die Habion in haar bezit en beheer heeft zijn grotendeels aanleunwoningen die in de nabijheid van een zorgcentrum zijn gesitueerd. Het kleine deel hiervan zijn zelfstandige seniorenwoningen in een woonwijk.

- Zorgeenheden

Zorgeenheden zijn voor het grootste gedeelte appartementen en kamers die zich in verzorgingshuizen bevinden. Het kleine gedeelte bevindt zich in verpleeghuizen. Om in aanmerking te komen van zo'n dergelijke woning dient de partiënt te beschikken over een zorgindicatie van het CIZ.

- Overige eenheden

De overige eenheden zoals aangegeven in de tabel, zijn verhuureenheden zoals garages en winkelruimten.

Voor de zelfstandige woningen heeft Habion goedkope, betaalbare en dure huurwoningen in haar portefeuille. Dit zodat Habion huisvesting kan aanbieden aan alle lagen in de samenleving.

Huurklasse	Aantal	%
Goedkoop (tot en met €357,37)	262	6
Betaalbaar (van €357,37 tot en met €548,18)	3.511	77
Duur (vanaf €548,18)	755	17
Totaal	**4.528**	**100**

Werkgebied

Zoals al eerder aangegeven, heeft Habion een werkgebied dat zich uitspreid over geheel Nederland. En heeft Vastgoed in zo'n 70 gemeenten. Over het werkgebied verspreid heeft Habion circa 50 zorginstellingen die Vastgoed huren bij Habion.

Stichting Palet

Bronnen: (Stichting Palet, 2012) & (Stichting Palet, 2012a)

Algemene informatie	
Naam	Stichting Palet
Adres	Badweg 1
Postcode	8934 BW
Plaats	Leeuwarden
Telefoonnummer	+31 (0)58 – 234 39 43
Website	http://www.paletgroep.nl

Organisatie

Stichting Palet is een zelfstandige eenheid binnen de Stichting Kwadrantgroep. Deze stichting is een holding waaronder verschillende zorginstellingen uit de provincie Friesland zelfstandig werkzaam zijn. Deze zorginstellingen zijn:

- Stichting Palet
- Stichting Zorgverlening De Friese Wouden
- Stichting Zorggarant
- Zorggroep Friesland BV

Het dagelijkse bestuur van de stichting Palet, alsmede de eindverantwoordelijke voor deze organisatie binnen de stichting kwadrant, is dhr. K.H. Koops. Eén van de twee leden uit de Raad van Bestuur van de stichting Kwadrantgroep.

Kernactiviteiten

De stichting Palet levert verpleging, verzorging in verschillende zorginstellingen. Voor al deze zorginstellingen geldt dat zij zich toeleggen op het leveren van ouderenzorg. Daarnaast wordt er in sommige situaties ook zorg aan dementerende, doven en revaliderende patiënten geleverd. Verder heeft Palet een zorgcentra van waaruit thuiszorg wordt geleverd.

Naast het hierboven beschreven AWBZ gefinancieerde zorg, levert Palet ook zorg vanuit de Wmo. Daarvoor faciliteert Palet huishoudelijke hulp.

Bovenstaande gegevens resulteert in het volgende overzicht:

AWBZ	
Aantal intramurale cliënten	597
Aantal extramurale cliënten (inclusief cliënten met dagactiviteiten)	1.028
Aantal personeelsleden	1.760
Aantal FTE's	771

Werkgebied

Het werkgebied van stichting Palet is Noordwest Friesland.

Over het werkgebied verspreid heeft Palet 6 verzorgingshuizen, 1 verpleeghuis en 5 kleinschalig wonen groepen.

Zorginstelling	Locatie
De Hofwijck (vzh)	Leeuwarden
Greunshiem (vzh)	Leeuwarden
Sint Jozef (vzh/ksw)	Leeuwarden
Swettehiem (ksw)	Leeuwarden
Parkhove (vph)	Leeuwarden
Het Nieuwe Hoek (vzh)	Leeuwarden
Nij Statelân (vzh/ksw)	Menaam
Skilhiem (vzh/ksw)	Stiens
Petterhústerstate (ksw)	Stiens
vzh = verzorgingshuis, vph = verpleeghuis, ksw = kleinschalig wonen	

Stichting De Stouwe

Bron: (Stichting De Stouwe, 2012) & (Stichting De Stouwe, 2012a)

Algemene informatie	
Naam	Stichting De Stouwe
Adres	Reestlaan 2
Postcode	7944 BB
Plaats	Meppel
Telefoonnummer	+31 (0)522 – 498 498
Website	http://www.destouwe.nl

Organisatie

Stichting De Stouwe is in 1997 ontstaan na een fusie tussen drie bestaande zorgaanbieders en is aanbieder van de combinatie wonen, zorg en welzijn. De hoofdvestiging van waaruit alle ondersteunende afdelingen werkzaam zijn, huisvest zich in Meppel.

Naast de zorgstichting is de Stichting De Stouwe Beheer actief als beheerder van alle zorgcomplexen die De Stouwe in haar bezit heeft. Stichting De Stouwe Thuis coördineert de thuiszorg activiteiten van De Stouwe.

Kernactiviteiten

Stichting De Stouwe richt zich op de ouderen en heeft daarvoor een verscheidenheid aan woon & zorgoplossingen paraat. De Stouwe levert zoal ondersteuning, (verpleeghuis)zorg en/of wonen. Daarnaast heeft Stichting De Stouwe enkele aanleunwoningen voor ouderen die zelfstandig willen en kunnen blijven wonen, echter wel kunnen terugvallen op de hulp van De Stouwe. Verder is De Stouwe sinds 2010 actief in de thuiszorg en sinds 2012 heeft De Stouwe ook een verpleeghuis waar dementerende ouderen verzorgd kunnen worden.

AWBZ	
Aantal intramurale cliënten	324
Aantal cliënten dagactiviteiten	0
Aantal extramurale cliënten	140
Aantal personeelsleden	635
Aantal FTE's	244

Werkgebied

Stichting De Stouwe is een klein schaligere zorgaanbieder die actief is in Meppel en directe omgeving (regio's Zuidwest Drenthe en Noordwest Overijssel). In het werkgebied heeft Stichting De Stouwe zeven woonzorgcentra, inclusief het verpleeghuis voor dementerende ouderen.

Zorginstelling	Locatie
ABC	Meppel
Irene	Meppel
Reestoord	Meppel
De Kaailanden	Meppel
't Vonder	Ruinerwold
Het Kerspel	Nijeveen
Dunninghe	De Wijk

Stichting Zorggroep Tellens

Bron: (Stichting Zorggroep Tellens, 2012) & (Stichting Zorggroep Tellens, 2012a)

Algemene informatie	
Naam	Stichting Zorggroep Tellens
Adres	Gasthuissingel 22
Postcode	8701 BL
Plaats	Bolsward
Telefoonnummer	+31 (0)515 – 570 870
Website	http://www.zorggroeptellens.nl

Organisatie

Zorggroep Tellens is in 2004 ontstaan uit een fusie tussen twee zorgaanbieders in Friesland, in 2009 is daar nog een derde zorgaanbieder uit Friesland bijgekomen en heeft Tellens de structuur gekregen zoals die momenteel is. De hoofdvestiging van Tellens is gevestigd in Bolsward.

Kernactiviteiten

Tellens is actief in de ouderenzorg en doet dit door verschillende diensten in de ouderenzorg aan te bieden. Zo is Tellens actief in het aanbod van zorg, wonen, welzijn en diensten, dit doet zij door ondersteuning (thuiszorg) te leveren en levert het zorg in kleinschalige woon-zorg complexen. Deze woon-zorg complexen bieden onderandere aanleunwoningen, waarbij service binnen handbereik is en intramurale verpleeg en verzorgingshuis zorg. In samenwerkingsverbanden biedt Tellens ook specialistische zorg ten behoeve van psychogeriatrische cliënten en ouderenpsychiatrie.

Bovenstaande gegevens resulteren in onderstaand overzicht:

AWBZ	
Aantal intramurale cliënten	690
Aantal cliënten dagactiviteiten	278
Aantal extramurale cliënten	658
Aantal personeelsleden	1.569
Aantal FTE's	772

Werkgebied

Het werkgebied van Tellens is Zuidwest Friesland, in de gemeenten Franekerdeel, Tytsjerksterdiel, Littenseradiel en Súdwest-Fryslân heeft Tellens 16 woon-zorg complexen.

Zorginstelling	Locatie
Avondrust	Makkum
Aylva State	Witmarsum
Bonifatiushuis	Sneek
Frittemahof	Sneek
Huylckenstein	Bolsward
It Menniste Skil	Bolsward
Martenahiem	Tzum
Nij Dekama	Weldum
Nij Mariënacker	Workum
Nij Stapert	Wommels
Noorderhoek	Sneek
Saxenoord	Franeker
Talma state	Heeg
Teatskehûs	Blauwhuis
Dr. Wumkeshûs	Sneek
Skewiel Trynwâlden	Oentsjerk

Appendix V | Elaboration of the performed interviews

In this appendix the performed interviews with the institutions are elaborated. Each interview is classified according the formulated questions which can be seen in appendix III. The elaboration of each interview is in Dutch because each interview is performed in Dutch, the report of all the interview data is given in English in paragraph 6.3.

- Stichting Habion (see page 117)
  - Interviewee: Mr. drs. R. *(René)* Lolkema
  - Interviewed on May 7, 2012 in Houten

- Stichting Palet (see page 123)
  - Interviewee: Mr. M. *(Machiel)* Talsma MBA
  - Interviewed on May 2, 2012 in Leeuwarden

- Stichting De Stouwe (see page 129)
  - Interviewee: Mr. drs. P.G. *(Peter)* Visch
  - Interviewed on May 15, 2012 in Meppel

- Stichting Zorggroep Tellens (see page 135)
  - Interviewee: Mr. A. *(Arend)* Schenkel
  - Interviewed on May 23, 2012 in Bolsward

Uitwerking interview

Geïnterviewde	: René Lolkema (RL)
Bedrijf	: Stichting Habion
Interviewer	: Gerard Tesselaar (GT)
Datum	: 7 mei 2012 (14.16u – 15.01u)
Locatie	: Houten, De Molen 94 (kantoor Stichting Habion)

Eventuele opmerkingen : Omdat Habion zelf geen zorginstelling is, echter een 'woning corporatie' is die zich richt op ouderenhuisvesting. Is vraag 6 weggelaten omdat deze niet relevant is. En is de formulering van vraag 7 aangepast.

Uitwerking interview

<u>Introductie</u>

RL/GT Het interview begint met achtergrond informatie over Habion. GT gaat bij zijn introductie al in op het feit dat Habion geen zorg levert, echter zich alleen richt op de huisvesting. RL geeft aan dat Habion een 'woning corporatie' is die zich exclusief richt op de ouderendoelgroep. Zo heeft Habion 10.000 verhuurbare eenheden die ongeveer fifty-fifty verdeeld zijn over eigen woningen en kamers in tehuizen. Habion is een jaar of 50 – 60 geleden opgericht. Daarbij werkt Habion samen met verschillende zorginstellingen, tegenwoordig huurt Habion ook direct aan de eindgebruiker (de oudere), echter het gros wordt verhuurd aan een zorginstelling.

<u>1 – Zou u uzelf willen voorstellen</u>

RL Werkt drie jaar bij Habion, heeft daarvoor 5 jaar bij een landelijke corporatie gewerkt en daarvoor werkzaam in de advies wereld, waar hij door gemeenten, ontwikkelende aannemers en ontwikkelaars werd ingehuurd.

<u>2 – Functieomschrijving</u>

RL René Lolkema is ontwikkelingsmanager bij Habion, waarbij hij acquisitie van nieuwe projecten doet en deze projecten dan meeneemt naar de initiatief en definitie fase. Daarnaast is hij verantwoordelijk voor de nieuwe samenwerking die Habion kort geleden is aangegaan met de Amaris Zorggroep. Bij deze samenwerking gaat Habion zeven huisvestingslocaties herontwikkelen van Amaris, van oude voorzieningen naar nieuwe voorzieningen die weer jaren mee kunnen.

GT Leidt verder in naar het inhoudelijk gedeelte van het interview.

3 – Zag u deze veranderingen als benodigd voor het behalen van de doelstellingen van de overheid?

RL Vind de vraag wel wat breed gesteld, echter wat je wel kan zien dat er beter wordt nagedacht. Vroeger deed de directeur vaak het vastgoed gedeelte erbij. En door de veranderende regelgeving zien ze wel beter in dat ze moeten veranderen, wat een vooruitgang is.

4 – Hoe kijkt u tegen deze veranderingen aan?

RL Het zal ongetwijfeld ook op andere manieren hebben gekund, kijk het model van; als je dit bouwt krijg je 40 jaar lang geld van de overheid vindt ik persoonlijk niet goed. Dat idee is nu natuurlijk weg, wat ik een gezonde ontwikkeling vindt. Je maakt zorginstellingen bewust over het vastgoed, dat er nagedacht gaat worden over al het geld dat erin gestoken wordt. In de huidige tijd kon de 'oude' situatie ook niet meer. Het is beter om daar, zoals nu, wat zakelijker en kritischer naar te kijken. Zorginstellingen doen door die veranderende omgeving marktonderzoek, iets wat ze 10 jaar geleden echt nog niet deden.

GT Leidt in dat hij ziet dat er verschillende trends gaande zijn in de zorgsector.

5 – Zijn er nog andere trends te herkennen in de zorgsector?

RL Pillen tegen dementie is er eentje. Er wordt een beetje gekscherend over gedaan, echter lijkt het erop dat er over een aantal jaar toch een medicijn tegen dementie is. Hierdoor zullen wij als Habion dus verdraaid goed moeten kijken wat voor huisvesting wij specifiek voor die doelgroep hebben neergezet. Als door zo'n pil die hele doelgroep weg valt, dan heb je toch echt een serieus probleem.
Verder natuurlijk dat het rijk steeds verder afstand gaat nemen van de zorg, dat kan er ook een zijn. Dat we als partijen (zorginstellingen, beleggers, zorgverzekeraars, enz.) met elkaar zorg moeten gaan dragen voor de zorgsector.

GT Zijn er trends waar jij je zorgen over maakt?, bijvoorbeeld die pil tegen dementie.

RL Naja, natuurlijk wel een beetje. Als die pil er komt, moeten wij heel goed gaan kijken wat we met de specifieke huisvesting voor dementerende moeten. Zorg wordt zo duur, en in de toekomst nog duurder door de vergrijzing die eraan komt, dus er zal iets moeten gebeuren om patiënten of het rijk meer voor zorg te laten betalen.

RL/GT Geeft aan dat hij tijdens interviews verschillende achtergronden meekrijgt (begonnen als verzorger en nu ontwikkeling). RL ziet ook dat hij zaken doet met personen met verschillende achtergronden. Vaak komt de ontwikkeling op het bordje van de directeur. Echter tegenwoordig specialiseren zorginstellingen zich steeds meer.

GT Vraagt of RL dit als een probleem ziet, was er daardoor minder kennis?

RL RL komt inderdaad zorginstellingen tegen die te weinig verstand hebben van vastgoed. Vroeger werd er alleen uit de gedachte van de gebruiker gekeken, ze zien nu wel in dat ze verder moeten professionaliseren en meer kijken naar de kosten. Er word meer nagedacht over wat er allemaal nodig is en welk budget ze hebben.

GT Leidt het gedeelte in naar de te voeren strategie voor zorginstellingen.

7 – Welke strategieën zijn er momenteel gangbaar bij zorginstellingen m.b.t. het vastgoedbeleid?

RL Je ziet veel meer dat zorginstellingen hun vastgoed nu aan een partij als Habion aanbieden, zodat een zorginstelling zich weer meer kan gaan richten op het bieden van zorg.

GT Vraagt welke rol Habion hierin speelt, ontwikkelen en dan weer verkopen of ontwikkelen ze alleen als ze ook de verhuur voor haar rekening kan nemen?

RL Je kan Habion beter zien als een ontwikkelende belegger, een belegger kijkt meer naar de lange termijn winst van een object waardoor er eigenlijk alleen wordt verhuurd.

GT Kijkt Habion hierbij ook naar de vraag in een bepaalde regio?, of is het zo dat er gerealiseerd wordt puur gedreven op de vraag van zorginstellingen?

RL Nee, Habion kijkt ook naar wat voor specifieke vraag er is. Wat wil de toekomstige bewoner. Vroeger was dat geen onderwerp van discussie, alleen tegenwoordig wordt er veel beter ingezien dat er moet worden gekeken naar wat de toekomstige oudere wilt hebben, ook door zorginstellingen. Ze worden zich bewust dat ze verantwoordelijk worden voor de leegstand in hun instelling.

GT Dus jij ziet in de branche dat zorginstellingen, door die prikkels van de overheid, een strategie aan het ontwikkelen dan wel bijstellen zijn?

RL Nou, kijk als je naar vroeger kijkt dat je kon gaan bouwen met toestemming van het CBZ en de komende tientallen jaren een vergoeding zou krijgen, en met het tekort voor ruimte, dan komen die ouderen van zelf wel en ga je meteen bouwen. En kijk, als ze nu alleen een vergoeding gaan krijgen als die kamer ook daadwerkelijk is gevuld, wat jij dus de prikkel noemt, zorgt er natuurlijk wel voor dat een zorginstelling er uiteindelijk op een andere manier in gaat zitten.

GT Maar is het niet zo dat zolang zorginstellingen nog niet precies weten waar ze aan toe zijn (doordat nog steeds niet helemaal duidelijk is hoe de regelgeving er exact uit gaat zien), dat ze voorlopig ook nog geen risico durven te gaan nemen?

RL Als je kijkt naar de overgangsregeling waar we tot 2018 in zitten, is het financieel aantrekkelijker om tot die tijd een ‘oud’ gebouw te hebben. Als je nu een nieuw pand gaat ontwikkelen wordt je volgens de nieuwe regelgeving gefinancierd, je kan dus beter nog even met je oude pand doen om zo wat vet op het bot te kweken zodat er in 2018 betere investeringen gedaan kunnen worden.

GT Is er één generaliserend beeld te herkennen in de strategie van zorginstellingen? Of zijn er toch nog verschillende tactieken?

RL Je ziet in ieder geval dat er grotere eenheden worden gebouwd, dit om de aantrekkelijkheid wat te vergroten, ook voor het geval het bijvoorbeeld leeg staat, dan kan je het makkelijker aan andere partijen verhuren. Met de zorginstellingen waarmee ik samenwerk zie je dit nu, zei het met horten en stoten, steeds meer ingevoerd worden.

GT Ziet dat ze graag intramurale zorghuisvesting zelf ontwikkelen en eigen beheer houden omdat ze zelf graag de regie houden i.v.m. gespecialiseerde groep.

RL Ziet inderdaad dat zorginstellingen zelf de regie willen houden op hun huisvesting. Je ziet echter nog wel verschil bij grotere en kleinere zorginstellingen. Hoe groter de zorginstelling, des te meer staf deze hebben om het beheer zelf te kunnen faciliteren. De kleinere hebben daar toch minder middelen voor.

GT Welke rol speelt flexibeler bouwen hierin?

RL Die speelt een grote rol hierin. Een casco van een gebouw gaat 50-100 jaar mee. Tot op heden is de cultuur in de zorg dat aangezien de financiering in 40 jaar het gebouw heeft afgeschreven er naar 40 jaar gesloopt en nieuwbouw wordt gedaan. Intern zal er echter vaker verbouwd moeten worden omdat dit simpel weg minder lang meegaat. Dus Habion denkt nu zo goed mogelijk na over het casco, zodat het met zo min mogelijk verbouwingen voor zoveel mogelijk doelgroepen kan worden gebruikt. Dat als het scheiden wonen-zorg verhaal doorgaat van de overheid, er gewoon een bruikbare woning beschikbaar is die door veel doelgroepen gebruikt kan worden.

GT Jullie spelen dus eigenlijk nu al in op de periode na 2040?

RL Ja, te verwachten is natuurlijk dat er na die tijd leegstand komt, dus nu al zodanig nadenken zodat huisvesting ook voor andere doelgroepen geschikt is. Je zal dus moeten inzetten op kwaliteit.

<u>8 – Verwacht u dat private ondernemers een grotere rol gaan spelen in de zorg, zo ja; hoe ziet die rol er dan uit?</u>

RL Dat ziet RL zeker gebeuren. Ze krijgen (als kleine ontwikkelende belegger) concurrentie van meerdere partijen. Vooral beleggers zien mogelijkheden om deze groep te gaan huisvesten en kijken naar goede mogelijkheden om in deze markt te kunnen stappen. Maar ook de private zorginstellingen, echter is dat een andere tak van sport.

GT Maar jij ziet ze dan vooral nog als financier in het hele verhaal?

RL Vooral in de financiering zie je tegenwoordig dat grotere beleggers met projecten aan de haal gaan. Daarnaast zie je steeds vaker samenwerkingen tussen zorginstellingen, beleggers, corporaties en zorgverzekeringen. Daar zal echt wel het nodige gaan gebeuren de komende tijd, hoe dat er precies gaat uitzien zal de toekomst moeten gaan uitwijzen. Wellicht staat er in de toekomst wel een zorggebouw van een willekeurige zorgverzekeraar.

GT Zal het zover gaan dat bijvoorbeeld een pensioenfonds gaat beleggen in de huisvesting van een zorginstelling en daarbij het recht heeft dat een verzekerde van hun als eerste recht heeft op een kamer in die zorginstelling?

RL Ja, wie weet. Het klinkt eigenlijk nog niet eens zo heel gek. Zou zeker kunnen.

RL Kijk zorginstellingen zullen toch naar andere mogelijkheden gaan kijken voor de toekomst. Daarbij zullen banken nog een beetje huiverig zijn om te investeren in zorginstellingen, omdat ze simpel weg nog niet zoveel vet op het bot hebben. En daarnaast is het nog steeds niet helemaal duidelijk hoe de uiteindelijke regelgeving er nu uitgaat zien.

9 – Wat kunnen externe partijen volgens u beter doen?

RL Ze zijn nog heel erg aan het worstelen hoe om te gaan met het nieuwe beleid van de overheid. Er zal een cultuur omslag moeten plaats vinden, dat nieuwe besef zal beter moeten komen. Momenteel staat dat erg in de kinderschoenen.

Uitwerking interview

Geïnterviewde	: Machiel Talsma (MT)
Bedrijf	: Stichting Palet
Interviewer	: Gerard Tesselaar (GT)
Datum	: 2 mei 2012 (11.06u – 12.07u)
Locatie	: Leeuwarden, Badweg 1 (kantoor Stichting Palet)

Eventuele opmerkingen : n.v.t.

Uitwerking interview

Introductie

MT/GT Het interview start met informatie over de Paletgroep (onderdeel van de Stichting Kwadrantgroep). Voor de regio Friesland (Noord-West) geldt dat er alleen de combinatie intramurale / extramurale zorg wordt aangeboden, ze dekken daarbij ongeveer 2/3 van de provincie Friesland. Daarnaast zijn de ondersteunende diensten gehuisvest in Apeldoorn en wordt er in die regio door Palet ook thuiszorg geleverd. Dus echt de focus van huisvesting voor zorg is echt alleen in de provincie Friesland aanwezig. De Kwadrantgroep heeft een jaarlijkse omzet van ongeveer €230 miljoen en bijna 6.000 werknemers. Terwijl de Paletgroep een omzet heeft van ongeveer €60 miljoen en ongeveer 1.500 werknemers.

1 – Zou u uzelf willen voorstellen

MT Machiel Talsma is van huis uit timmerman, metselaar, ziekenverzorger, verpleegkundige en manager. MT heeft in 2011 nog een MBA studie afgerond. En werkt sinds 1994 bij de Paletgroep. Doordat MT ook in de daadwerkelijke zorg heeft gewerkt weet hij goed waar hij over praat, iets wat van pas komt bij zijn huidige functie.

2 – Functieomschrijving

MT Is projectdirecteur wonen en dienstverlening bij Paletgroep, heeft deze functie sinds 2002. Daarbij is MT verantwoordelijk voor het vastgoed, niet alleen de ontwikkeling, maar ook het beheer. Echter kijkt hij ook naar de pragmatische kant van de huisvesting, herkend als er iets veranderd (b.v. vraagstelling zoals voor GT zijn onderzoek), en hoe moet Palet daar mee omgaan. Dus eigenlijk het concept ontwikkelen. Sinds januari 2011 is MT verantwoordelijk voor de huisvesting van de gehele Stichting Kwadrantgroep. Echter geldt niet dat MT verantwoordelijke is voor het technisch beheer van de huisvestingen, hiervoor heeft Palet een aparte afdeling. Met zijn functie is MT de schakel met externe partijen (zoals de bouwers) en verbind alles door met de rest van de stichting.

GT Leidt verder in naar het inhoudelijke gedeelte van het interview.

3 – Zag u deze veranderingen als benodigd voor het behalen van de doelstellingen van de overheid?

MT Heeft correctie, niet zozeer bezuinigen, maar eerder meer mensen helpen met zo min mogelijk groei van het budget.

MT MT is echter heel duidelijk, het doel van de overheid had ook op een andere manier gehaald kunnen worden. Overheid wil scheiden van wonen en zorg, waardoor het woon gedeelte voor rekening van de patiënt komt. Als men intramurale zorg wil ontvangen zal men het gehele inkomen (AOW, pensioen) moeten inleveren, en krijgt daarvoor een beetje zakgeld terug. Het wordt als het ware, kost en inwoning. De nieuwe wetgeving zorgt er eigenlijk alleen voor dat de geldstromen zijn veranderd. Kijk, hierdoor zullen patiënten wellicht alleen langer thuis blijven wonen, en daardoor belasten ze de maatschappij niet. Het is wellicht wel besparen, echter alleen dan meer voor de lange termijn.

MT Echter kijk eens waar het heen gaat, een verzorgingshuis (waar Palet er enkele luttele van in eigendom heeft). Een appartementje (40m2) voor het woon gedeelte heeft daarbij een kostprijs van €700,-, dat komt door ondersteunende faciliteiten zoals liften, gezamenlijke ruimten e.d. De appartementjes verhuren, zo wordt er in feite thuiszorg (extramurale zorg geboden), dit type zorg heeft ook weer eigen bijdragen van de patiënt en andere vergoedingen vanuit de overheid. Het is dus eigenlijk alleen maar schuiven tussen de ministeries en met geldstromen. Maar hierdoor zullen zorginstellingen geen eigen huisvesting meer in beheer hoeven hebben.

MT/GT De winst zit er dan eigenlijk in dat er geen huisvesting meer gefinancierd hoeft te worden en de zorg weer echt de zorg kan worden? MT beaamt dit.

MT Zo zal Palet nooit meer appartementjes van 40m2 laten bouwen, dit kan je na een periode van 30 jaar echt niet meer verhuren, en al helemaal niet voor die prijs. Er wordt op zo'n manier naar gekeken dat het na die periode ook nog bruikbaar is. Het kleinschaliger maken op wijk/dorps niveau van een zorghuis, met kamers waar een ouder echtpaar samen kan wonen, echter waar ook goede zorg kan worden verleend, alleen dan op kleine schaal. Mocht het om een of andere reden niet vol zitten, dan kan het alternatief worden aangewend.

MT Maar MT eigenlijk probeert te zeggen, de korte winst zit hem tussen het schuiven van de ministeries. Op de lange termijn het niet meer hoeven financieren van de huisvesting en het na 30jaar moeten slopen omdat het niet meer vol te krijgen is, want dat is kapitaal vernietiging.

4 – Hoe kijkt u tegen deze veranderingen aan?

MT In een woord prachtig. MT is ook erg blij met de crisis, 'onder hoge druk wordt alles vloeibaar'. De crisis maakt dat er druk is om veranderingen door te voeren, vandaar dat het ook allemaal kan wat de overheid wilt. Het biedt ook gewoon kansen. De handen tussen de verschillende facetten in de zorg worden veel meer ineen geslagen, en dat is vooruitgang.

GT Leidt in dat hij ziet dat er verschillende trends gaande zijn in de zorgsector.

5 – Zijn er nog andere trends te herkennen in de zorgsector?

MT Ja zeker, vroeger hadden we nooit kunnen bedenken in hoeverre we nu samenwerken. Iedere partij (corporatie, zorgaanbieder, dorpsbelang) deed zijn eigen ding. Nu hebben we de handen ineen geslagen, anders redden we het allemaal niet. Samen gebruik van ruimtes. In de dagopvang zoals wij die hebben wordt bijvoorbeeld 's avonds gebruikt door het dorp om te klaverjassen.

GT Komt dit deels door de veranderingen van de overheid (het wordt nu gestimuleerd), of komt dit al voort uit eigen initiatief en inzicht?

MT Deels wordt het door de overheid gestimuleerd of wordt je in die richting geduwd, echter is Palet daar zelf uit eigen beweging ook al mee bezig (sinds 2001).

MT Vroeger werden oudere echtparen uit elkaar gehaald, de een moest voor haar zorg in de stad gaan wonen. Terwijl de ander nog terecht kon in het dorp, daardoor moesten er weer allemaal andere dingen gefaciliteerd worden (vervoer, mantelzorg, familie). Dat is niet wat je wilt. Voorbeeld van Stiens, waar een kleine zorginstelling is gerealiseerd waar oudere echtparen samen kunnen wonen. Die woonhuizen krijgen ook budget mee en kopen alles zelf in bij supermarkten uit de buurt. De hele samenleving wordt dus als het ware betrokken bij het zorgdragen. Dit kan ook makkelijker omdat de ouderen dichter in hun eigen omgeving kunnen blijven wonen.

Daarnaast zal de zorg meer wijk & buurt gericht gaan worden.

GT Leidt gedeelte in naar de te voeren strategie voor zorginstellingen.

6 – Heeft Palet een strategie om te kunnen inspelen op deze veranderingen?

MT Ja zeker.

7 – Welke strategie heeft Palet m.b.t. het vastgoed beleid?

MT Tot 2006 had Palet een eigen corporatie die voor de huisvesting zorgde van alle typen zorg, in 2006 is deze corporatie gefuseerd met Habion en die partij zou voor Palet gaan bouwen en beheren. Echter, door de veranderingen willen we weer terug in eigen beheer gaan ontwikkelen en beheren. Het in eigen beheer bouwen komt ook weer omdat de huidige corporaties die voor hun zouden moeten gaan bouwen niet de wensen kunnen vervullen die Palet heeft, dus zit Palet weer om de tafel met beleggers e.d. Met die beleggers gaan we een huur contract aan voor de lange termijn en nemen dan zelf een leegstandsrisico. Dit geldt overigens alleen voor de intramurale zorghuisvesting. Dit omdat we deze zo specifiek vinden dat we die graag in eigen beheer willen ontwikkelen. Voor de overige vormen leggen we dat weer meer bij derden.

MT Daarnaast monitoren we tegenwoordig zelf waar de vraag zit. Dus gaan we met een corporatie en gemeente kijken waar de specifieke vraag zit, wat er ontbreekt en analyseren of Palet daar een concept voor heeft. Geen van de partijen heeft namelijk iets aan leegstand, dus bouwt Palet tegenwoordig alleen nog maar waar vraag naar is.

GT Nemen die gemeente en corporatie dan ook een deel van het risico voor hun rekening? Of draait Palet hier als enigste voor op?

MT De ene kant wel, maar aan de andere kant niet. Palet heeft gemonitord (voorbeeld project), dat er de komende 20 jaar in die gemeente een zorgvraag ligt. Dus met de corporatie hebben wij een huurtermijn van 20 jaar afgesproken, mocht het ons na die tijd niet meer bevallen of de vraag is er niet meer. Dan vertrekken wij uit dat pand, in die 20 jaar heeft de corporatie dat pand echt nog niet afgeschreven, dat is hun risico.

GT Vraagt hoe die prikkel komt voor investeren in duurzaamheid, door overheid of uit eigen initiatief?

MT Investeringen in duurzaamheid maken het tegenwoordig wel fijner door de veranderende regelgeving. Vroeger gebeurde het ook wel, maar als je als voorbeeld neemt de energierekening. Als je een jaar lang hard aan het stoken was, werd het door na calculatie toch wel vergoed, mocht je bezuinigen op je energiekosten, dan ging dat via diezelfde na calculatie weer terug, of te wel, je werd niet gemotiveerd om daarover na te denken.

GT En omdat je tegenwoordig je 'winst' natuurlijk in eigen zak kan steken, en daarnaast je restwaarde op je gebouw mag houden, wordt er beter nagedacht over investeringen?

MT Inderdaad.

GT Vat het geheel even samen;

- Een gedeelte van de activiteiten wordt geoutscourced.
- Een deel van de risico's worden bewust voor eigen rekening genomen, terwijl andere juist bij derden worden gelegd.
- In alle huisvesting houdt Palet wel zelf de regie.

MT Dat klopt. Dat we de regie in eigen hand willen houden is overigens niet omdat we zelf 'de baas' willen zijn, maar omdat we te maken hebben met kwetsbare groepen.

GT Als er een contract met een corporatie voor huur wordt gesloten, MT gaf net aan dat ze zelf de domotica regelen, wat is de verhouding daarin. Wat wordt er besteed aan huur en hoeveel blijft er dan nog over voor domotica?

MT Dat gaat anders, van de omzet die Palet jaarlijks maakt wordt 2% van apart gezet om te gebruiken voor innovatie zoals dat genoemd wordt binnen Palet. Daarna wordt gekeken waar dat aan besteed gaat worden.

MT Grootste probleem in de zorgsector gaat worden dat er zo meteen geen mensen meer zijn die in de zorg willen werken. Dan heb je niks aan zo'n mooi pand. Vandaar dat er nu ook al wordt gekeken naar de locatie van zo'n dergelijk pand, is het makkelijk te bereiken (OV), dat scheelt allicht voor het personeel.

MT/GT Zorg is dus eigenlijk alleen maar complexer geworden? MT beaamt dat, er word tegenwoordig naar meerdere factoren gekeken.

<u>8 – Verwacht u dat private ondernemers een grotere rol gaan spelen in de zorg, zo ja; hoe ziet die rol er dan uit?</u>

MT Ja, die zijn er zelfs al. Tegenwoordig zit ik met pensioenfondsen om de tafel. Vroeger moesten we niks van elkaar hebben. Die zaten vroeger op marges van 12%-15%, tja, dan heb je niks te zoeken in de zorgsector. Tegenwoordig zijn die marges gezakt tot op corporatie niveau, dan komen ze hier wel. Daarnaast natuurlijk wat ik al eerder aangaf in het interview ontwikkelaars en beleggers.

MT/GT Dus door die crisis maakt het, het nu mogelijk om met andere partijen aan tafel te gaan. Daaruit blijkt maar weer wat voor stabiele factor de zorgsector is en in de toekomst naar alle waarschijnlijkheid zal blijven.

GT Die pensioenfondsen komen die alleen nog maar langs voor de financiering? Of gaat dit al een paar stappen verder?
MT Nu alleen nog maar financieren, echter zit er wel meer aan te komen.

9 – Wat kunnen externe partijen volgens u beter doen?
MT Heb begrip voor elkaars wereld.

Uitwerking interview

Geïnterviewde	: Peter Visch (PV)
Bedrijf	: Stichting De Stouwe
Interviewer	: Gerard Tesselaar (GT)
Datum	: 15 mei 2012 (9.41u – 10.31u)
Locatie	: Meppel, Reestlaan 2 (woonzorgcentrum ABC; kantoor Stichting De Stouwe)

Eventuele opmerkingen : n.v.t.

Uitwerking interview

Introductie

GT Begint het interview met introductie over het afstudeeronderwerp, wat is het doel en waarom afleggen van interviews. Wat gebeurd er daarna met de informatie die uit de interviews naar voren is gekomen.

1 – Zou u uzelf willen voorstellen?

PV Peter Visch, werkt sinds 1 april 2011 bij De Stouwe als directeur/bestuurder.

GT Uw achtergrond, komt u uit de zorg of uit het vastgoed wereldje?

PV Komt uit de zorg, gezondheidswetenschappen gestudeerd in Maastricht. Dat is zeg maar de bedrijfskunde van de gezondheidszorg. Begonnen in de ziekenhuiszorg, daarna bij zorgverzekeraar en via de thuiszorg in de ouderenzorg terecht gekomen.

2 – Functieomschrijving

PV Geeft introductie over De Stouwe, bestaat uit twee onderdelen, het zorg gedeelte enerzijds en het beheer gedeelte anderzijds. In het beheer gedeelte valt het vastgoed. Formeel is PV van beide stichtingen (‘onderdelen’), directeur/bestuurder.

GT Leidt in naar het inhoudelijke gedeelte.

3 – Zag u deze veranderingen als benodigd voor het behalen van de doelstellingen van de overheid?

PV Dat had zeker ook op andere manieren gekund. PV denkt dat de overheid deze maatregelen als enigste middel zag om de enorme kosten stijgingen te kunnen dempen. De prestatie bekostiging in de ouderenzorg heeft er in ieder geval voor gezorgd dat het beter inzichtelijk is geworden, omdat de zorginstellingen toch meer als bedrijven zijn gaan functioneren. Echter staat de zorg nu wel op een cruciaal punt, rommelen we door op wat we in gang hebben gezet een aantal jaren geleden, of durven we toch om te buigen. PV denkt wel dat als er door gerommeld wordt de zorg in de toekomst onbetaalbaar wordt. Indien dat gebeurd zal de overheid er weer voor moeten zorgen dat de zorg betaalbaar wordt, dit zal gebeuren door hogere eigen bijdragen en/of hele uitgeklede basispakketten in de zorg.

PV Kijk het kan inderdaad anders, dat betekend alleen dat er meer ruimte geschonken zal moeten worden aan de sector zelf. En niet zoals nu gebeurd dat er door de politiek op elk incident weer een nieuwe wet of regelgeving wordt geschreven, dat verstikt de markt. In de huidige situatie hebben we contracteer vrijheid, maar vervolgens wordt er budgettair wel een vast bedrag bepaald. Dus een patiënt is vrij om te gaan en te staan waar hij/zij wilt, maar vervolgens is er door het CIZ wel bepaald welke zorg wij zo'n patiënt moeten bieden. Als er bij ons iemand komt die opeens een hogere zorgindicatie heeft, moeten wij dus meer productiviteit gaan leveren als dat wij bedacht hadden en dan geldt dat hele marktwerking principe niet meer.

GT Dus aan de ene kant werkt de gedachte van de overheid wel, maar aan de andere kant bemoeid de overheid zich er dus nog teveel mee waardoor het nog niet optimaal werkt.

PV Ja, er wordt gesuggereerd dat er een markt is, maar aan de andere kant houden ze die budgettair wel in de hand. De gedachte gang is dus ergens halverwege blijven hangen. Ik snap het ook wel weer, want als je de markt echt zijn werk laat doen…marktpartijen zijn natuurlijk vooral marge en omzet gedreven, waardoor het natuurlijk ook de pan uit kan rijzen. Misschien moet het breder worden getrokken en moet het idee van de zorgindicatie worden afgeschaft, dat is echter alleen tegen de natuur van de politiek in want dan moeten ze loslaten en gaan vertrouwen.

GT De politiek zit hier natuurlijk in een spagaat, ze willen de controle toch een beetje houden omdat zorg goed moet gebeuren. Echter belemmeren ze de zorginstellingen daarin om echt als ondernemer te gaan acteren.

PV Beaamt dit, dit komt omdat het gemiddelde kamerlid niet in staat is om niet op incidenten te reageren.

GT Er moet dus zekerheid over de toekomst komen en vertrouwen worden gegeven? Dat zijn nou eenmaal de consequenties.

PV Ja, kies iets. Nationaliseer de gehele zorg of laat het los en kader het anders in.

<u>4 – Hoe kijkt u tegen deze veranderingen aan?</u>

PV Toch wel gematigd positief. Maar dat is denk ik ook persoonlijk. Het oude stelsel (goed keuring van het CBZ, rekening naar VWS en vergoeding krijgen van de NZa) dat werkt natuurlijk niet. De nieuwe bekostiging daagt zorginstellingen om goed te gaan nadenken wat de markt exact wilt en hoe die markt zich gaat ontwikkelen. Dat is top.

GT Leidt in dat hij ziet dat er verschillende trends gaande zijn in de zorgsector.

<u>5 – Zijn er nog andere trends te herkennen in de zorgsector?</u>

PV Nee, niet echt grote of speciale trends. Met wat jij aanhaalt, extramuralisatie en kleinschaliger gaan wonen heb je de belangrijkste eigenlijk wel gehad. Wel zal je zien dat woon-zorgcomplexen in de toekomst echt een belangrijkere rol gaan innemen in de wijk, voor jong en oud. Commerciële partijen zullen hierbij een rol gaan spelen en het zal veel meer flexibeler worden ingezet.

PV In PV zijn opinie is de toekomst van de zorg: dat zorginstellingen die een breed pakket hebben, lokaal goed geworteld zijn en lokaal snel kunnen schakelen en herkend en erkend worden de toekomst hebben. De Stouwe is daar een voorbeeld van.

GT Leidt gedeelte in naar de te voeren strategie voor zorginstellingen.

6 – Heeft De Stouwe een strategie om te kunnen inspelen op deze veranderingen?

PV Ja, die is net klaar.

GT Betekend dat dat jullie in de oude situatie geen vastgoed strategie hadden?

PV Ja wel, maar beperkt. Die was veel globaler; hoe de demografische ontwikkeling eruit zag en waar zullen we als De Stouwe eens wat gaan realiseren.

PV Met de invoering van de NHC (wat jij net ook al aangaf), moesten we voor de jaarrekening van 2011 ons vastgoed herwaarderen. Toen werd besloten om het dan maar meteen grondig aan te pakken, aangezien toch al het vastgoed al werd nagelopen. De huidige situatie heb je dan toch in beeld, dan is het een kleine slag om een analyse en nieuw vastgoed beleid te schrijven. Dus we hebben ons compleet vastgoed bestand nagelopen, hoe ziet het eruit (zowel qua bouwkundige staat als qua boekhouding), van daaruit is een analyse gemaakt van het beleid van gemeenten, demografische veranderingen en daarin zijn de (on)mogelijkheden van onze huidige gebouwen meegenomen. Dat heeft vorige maand geresulteerd in het opleveren van het strategisch vastgoedplan 2012-2020.

GT Dus er is ook gekeken naar de periode na de overgangstermijn tot 2018?

PV Ja, dat is bewust gedaan.

7 – Welke strategie heeft De Stouwe m.b.t. het vastgoed beleid?

PV In het vastgoedplan is meegenomen voor de zes locaties (de zevende locatie die net nieuw is, is daar niet zozeer in meegenomen omdat je daar de komende jaren toch niet zoveel aan kunt veranderen), wanneer er op welke locatie gaat worden (her)ontwikkeld. Plus wat er her en der kan worden ontwikkeld, plus wat er dan interessant is om te ontwikkelen. Dus is het een hele complete leidraad voor wat er de komende acht jaar gaat gebeuren op het vastgoed gebied bij De Stouwe.

GT Je kan het strategisch vastgoedplan dus opdelen in twee delen; één deel een markt analyse van welke vraag er in welke regio is (of in de nabije toekomst komt) en kan De Stouwe daar een product gaan leveren en één deel met een plan voor het huidige vastgoed.

PV Klopt.

GT Wat zijn nu de doorslaggevende factoren om juist wel, of juist niet, te gaan bouwen? Alleen economisch gedreven of juist gedreven op die te verwachten vraag.

PV Het plan is puur vraaggericht ontwikkeld, daarbij kunnen wij het ons permitteren om niet economisch gedreven te kijken. De verzorgingshuiszorg gaat verdwijnen, dus zullen wij de periode zoals omschreven in het strategisch vastgoedplan moeten benutten om die verzorgingshuiszorg (waar wij voor 95% uit bestaan) om te bouwen naar aanleun of beschermd wonen, hetzij meer te bouwen richting de verpleeghuiszorg. Je ziet in de wachtlijsten terug komen dat er meer vraag komt naar extramurale zorg.

PV Kijk, de vraag veranderd niet. Het is alleen het systeem dat we veranderen. De kunst is dat wij met de vraag mee ontwikkelen, rekening houdend met het veranderende systeem. De behoefte van de mensen veranderd niet zo als dat in het systeem wordt bedacht, dat mensen langer zelfstandig blijven wonen. Maar wat is nu zelfstandig wonen? Het enige verschil tussen de intramurale zorg en de aanleunwoningen is eigenlijk dat bij intramurale zorg betaal je geen huur, bij de aanleunwoning wel, bij de intramurale zorg heb je geen eigen keukentje en in een aanleunwoning wel. Mijn kritiek op het systeem is dat er voor die mensen is gedacht, maar niet met die mensen over is nagedacht of gesproken. Wat vinden zij nu belangrijk.

GT In jullie vastgoed strategie hebben jullie natuurlijk ook meegenomen welke risico's jullie zelf bereid zijn om te nemen en welke worden geoutsourcet.

PV Ja. Het vastgoed wat we zelf hebben (De Stouwe heeft zes woon-zorgcomplexen (het nieuwste complex voor dementerende even buiten beschouwing gelaten), drie grotere zijn in eigendom van De Stouwe en drie kleinere worden gehuurd van Actium) houden we in eigen beheer. Met het vastgoed wat we vanaf nu gaan ontwikkelen doen we in samenwerking met een woningcorporatie of een projectontwikkelaar. En dat is omdat het systeem zo ingewikkeld aan het worden is, dat ik vindt dat we niet meer voldoende expertise in huis hebben. Dan kan je natuurlijk die expertise gaan inhuren, maar het is denk ik toch beter om te gaan kijken naar de kernactiviteiten. Dus gaan we het vastgoed gedeelte afbouwen.

GT Dat is om zelf geen risico's meer te hoeven dragen, of is dat kennis gedreven?

PV Dat is kennis gedreven. Wat ik nu probeer is om samen met een andere partij samen iets te gaan proberen, we kunnen wel onder het mom van huurovereenkomst gaan bakkeleien wie het leegstandsrisico op zich neemt. Maar wat is mooier als in termen van een joint venture gaan denken. Waarbij je bij zowel bij aanvang van het project, de realisatie als bij de exploitatie, gezamenlijk verantwoordelijk bent en blijft voor zo'n complex. Dan heb je allemaal gelijke belangen bij dat er eens heel goed wordt nagegaan wat de wensen van de klant zijn, daar kan de bouw namelijk nog wel wat leren, en wordt er beter nagegaan hoe de dienstverlening en zorg nog beter kan worden geleverd, iets waar de zorg naar mijn mening nog iets van kan leren. Op die manier breng je het beste van beiden samen.

GT Iedereen moet dus weer terug gaan naar de kern van zijn eigen kwaliteiten?

PV Ja dat klopt. De Stouwe gaat zich weer focussen op de zorg en een corporatie of projectontwikkelaar gaat zich weer focussen op de realisatie en exploitatie van het vastgoed complex.

GT Jullie hebben niet zoiets dat jullie juist bepaalde zaken in eigen regie willen blijven uitvoeren?

PV Nee, dat moet je juist uit handen geven. Een kwestie van vertrouwen. Dat nieuwe zorgcomplex, waar we zojuist al even over gehad hebben, is wat mij betreft het laatste project dat we in eigen regie hebben uitgevoerd. Daar hebben we ons bijna aan vertild.

GT Financieel gezien, of op het gebied van kennis?

PV Beiden. Kijk dan zijn we dus bouwbegeleider, terwijl we daar eigenlijk net niet genoeg verstand van hebben. Waar het mooiste is, ik ben er van overtuigd dat het werkt, gaan realiseren in een gezamenlijk belang. Met elkaar eerst heel goed gaan nadenken en praten wat nu echt de wensen van het pand zijn.

8 – Verwacht u dat private ondernemers een grotere rol gaan spelen in de zorg, zo ja; hoe ziet die rol er dan uit?

PV Ja en nee, de crisis gooit wel een beetje roet in het eten. Er wordt door verschillende partijen natuurlijk wel gekeken naar de zorg. Met name bouwpartijen, die zien ook dat de zorg een van de weinige sectoren is waar de komende tijd nog wel gebouwd zal gaan worden. En ook een aantal beleggers die in de zorg betere perspectieven zien als in andere sectoren. Het wordt voor mij drukker met projectontwikkelaars. Maar het werkt ook omgekeerd, zorginstellingen zien ook dat de financiering aan het veranderen is, banken zijn iets minder happig, dus zorginstellingen gaan ook kijken naar andere mogelijkheden.

GT Zie jij private partijen vooral nog als financier, of ook met andere functie?

PV Nee, ik zie het niet gebeuren dat ze een andere rol als financier zullen aannemen.

9 – Wat kunnen externe partijen volgens u beter doen?

PV Laat de bouw eens vraaggericht gaan bouwen in plaats aanbod gericht. Het enige lichtpunt van de bouwcrisis van het moment, is dat bouwpartijen ook weer veel kritischer gaan kijken naar wat er daadwerkelijk nodig is, wat voor vraag is er.

Uitwerking interview

Geïnterviewde	: Arend Schenkel (AS)
Bedrijf	: Stichting Zorggroep Tellens
Interviewer	: Gerard Tesselaar (GT)
Datum	: 23 mei 2012 (9.28u – 10.46u)
Locatie	: Bolsward, Gasthuissingel 22 (kantoor Zorggroep Tellens)

Eventuele opmerkingen : n.v.t.

Uitwerking interview

Introductie

GT Begint het interview met een introductie over het afstudeeronderwerp, wat is het doel en waarom afleggen van interviews. Wat gebeurd er daarna met de informatie die uit de interviews naar voren is gekomen.

1 – Zou u uzelf willen voorstellen?

AS Arend Schenkel werkt sinds 2001 bij Tellens, als voorzitter van de raad van bestuur. Economie gestudeerd in Groningen. Vanaf 1976 tot 2001 gewerkt voor de overheid, bij provincies en ministeries. Begonnen op ministerie van economische zaken en daarna ministerie van binnenlandse zaken.

2 – Functieomschrijving

AS Tellens heeft een tweehoofdige raad van bestuur, waarvan AS er één is. Is begonnen bij een van de recht voorgangers van Tellens.

GT Want Tellens is ontstaan uit een fusie van drie bestaande zorginstellingen toch?

AS In het begin hadden we acht verzorgingshuizen, in 2002 hebben we een klein verzorgingshuis overgenomen, in 2004 met een verzorgingsinstelling in Sneek en omstreken en in 2008 een failliete zorginstelling overgenomen. Zo zijn we een beetje gegroeid, van 400 medewerkers in 2001 naar 1.600 nu. En daarbij 'bestuur' ik.

GT Dan gericht op het vastgoed?, of over de gehele zorggroep breed?

AS We hebben niet echt een portefeuille verdeling, maar ik zit iets meer in het vastgoed dan mijn collega.

GT Komt dat door uw achtergrond?

AS Dat is gewoon toeval, daar zit geen idee achter.

GT Leidt in naar het inhoudelijke gedeelte.

3 – Zag u deze veranderingen als benodigd voor het behalen van de doelstellingen van de overheid?

AS Ziet wel dat het nodig is om de kosten in de zorg te beheersen. Alleen de maatregelen die daarvoor worden genomen werken wat mij betreft precies averechts. Vroeger kregen we namelijk geld per bewoner, de overheid reguleerde de capaciteit en daarmee dus ook de kosten. Nu heb je ZZP's, hoe zwaarder de ZZP, des te hoger is het prijs kaartje wat eraan vasthangt. En dat kan je als overheid niet beheersen, dus wat je ziet gebeuren (anders als dat de overheid dat wilde), een toename in de kosten in plaats van een afname. Het is überhaupt nog maar de vraag of de kosten kunnen worden beheerst, AS vraagt het zich in ieder geval af.

4 – Hoe kijkt u tegen deze veranderingen aan?

AS Over het idee van bezuinigen in de zorg ben ik best positief. Alleen hoe ze het aangepakt hebben is in mijn optiek minder handig. Tegenover de ZZP ben ik negatief. Bezuinigen en efficiënter gaan werken wil ook nog niet zeggen dat de rijksuitgaven zullen dalen. In de AWBZ gaat ongeveer 24 miljard euro per jaar om, het eigen vermogen van alle zorginstellingen in de AWBZ is ongeveer 15% van de omzet (dus 3,5 miljard euro) waar in wezen dus niks mee gebeurd. Of te wel, het geld beter proberen in te zetten van de overheid, dan had dus eerst het eigen vermogen van zorginstellingen omlaag gegaan. Dus als er door efficiënter te gaan werken zorginstellingen het eigen vermogen kunnen opbouwen, helpen de maatregelen van de overheid niet.

AS Kijk waar ik wel weer positief tegenover sta is de NHC. Zoals het vroeger gebeurde dat je alles kon indienen bij de overheid, de partij die het beste met de overheid kon onderhandelen ging er met de poen vandoor. Dat is niet goed.

5 – Zijn er nog andere trends te herkennen in de zorgsector?

AS Het kleinschaliger gaan wonen is in ieder geval een mode verschijnsel. Onderzoek toont aan dat het welbevinden niet samenhangt met het kleinschalig wonen van patiënten. Het kon in ieder geval niet worden aangetoond.

AS Het zou nog wel eens zo kunnen zijn dat het spel tussen zorginstellingen niet meer gespeeld gaat worden om de patiënt maar om het personeel. Ook weer dankzij de vergrijzing zal het voor instellingen in de toekomst moeilijker worden om personeel te kunnen aantrekken.

GT Leidt gedeelte in naar de te voeren strategie voor zorginstellingen.

6 – Heeft Tellens een strategie om te kunnen inspelen op deze veranderingen?

AS Dit klopt wel wat je zegt (strategie vastgoed benodigd om te kunnen concurreren met andere zorginstellingen). Enigste punt van aandacht is dat de ouderen wel blijven komen, dankzij de vergrijzing. Tellens is wat dat betreft uniek omdat we als ons vastgoed huren, er is niets in eigendom (behalve het hoofdkantoor dan). Voor al die locaties hebben we lang lopende huurcontracten.

7 – Welke strategie heeft Tellens m.b.t. het vastgoed beleid?

AS Aangezien de regelgeving flink is veranderd, zullen we ons de komende periode vooral richten op het vernieuwen/renoveren van het bestaande woon bestand. En heel voorzichtig zijn met nieuwbouw projecten. Verder is het een dunbevolkt gebied waar wij actief zijn, dus werkt het simpel weg niet om zomaar nieuwe vestigingen te openen.

GT Zit er ruimte in de contracten met de corporaties voor het vernieuwen/renoveren van het bestaande vastgoed?

AS In de contracten met de corporaties is dat allemaal vastgelegd. Echter doet dat nog niets met de functionaliteit van een gebouw, dat kan je niet meer veranderen.

GT Zijn jullie zelf de verhurende partij aan de ouderen of gaat dat via de corporatie?

AS Nee, het is een all-inclusive pakket voor patiënten, dus daar zit het wonen bij in. Het leegstandsrisico is voor mij. Wij zijn de huurder van de corporatie.

AS Kijk wat betreft outsourcing, maakt het geen zak uit of je voor langere termijn huurt of dat je voor een langere tijd een hypotheek hebt lopen.

GT Alleen dat je via huur bepaalde risico's kan uitsluiten voor jezelf.

AS Ja, dat is waar. Enigste wat je kunt zeggen is dat als je het in eigendom hebt je op een bepaalde manier kunt profiteren van de waardestijging. Het grootste nadeel is dat je dan ook die kennis in huis moet hebben om dat vastgoed te kunnen beheren.

GT En dat is wat er nog een beetje aan ontbreekt in de zorgsector?

AS Zelf hebben we ook wel enige kennis, echter de rest zit bij de huur baas. Kijk mensen denken altijd dat alles wat ze uitbesteden, daar zijn ze dan weer mooi vanaf. Echter dat is niet zo, je zult als instelling toch altijd moeten kunnen blijven beoordelen of het pad dat je aan het bewandelen bent nog steeds de juiste is.

AS In de ouderenzorg is het gewoon erg ongewis wat er gaat gebeuren de komende periode. Het rare is dat de overheid nooit risico scenario's schetst voor zichzelf. Niet van als we dit doen, wat zullen instellingen dan gaan doen. Maar alleen van wat er verwacht wordt, maar dat is meestal nooit ergens op gebaseerd.

GT Of te wel, de overheid kijkt eigenlijk alleen naar de positieve 'scenario's'?

AS Dat is dus alleen maar geloven over wat er gaat gebeuren, dat werkt niet. Je zou eigenlijk verwachten dat je als je in een sector bezig bent waar zoveel geld in omgaat. Dat er eens beter zal worden gekeken naar hoe de instellingen daarop reageren.

AS Bij marktwerking hoort dat de overheid voor een langere periode met de handjes op de rug toekijkt. En niet op elk incident gaat reageren.

GT Dus dat er meer vrijheid wordt gegeven.

AS Zolang de ouderen blijven komen dwingt dit een instelling nog niet tot het verbeteren van de kwaliteit van onroerend goed. In een stad met meerdere zorgaanbieders denk ik dit op den duur wel, daar kiezen de mensen voor de betere kwaliteit. Zeker als het de patiënt niets extra's kost, een mooi en goed verzorgingshuis kost evenveel als een slechter verzorgingshuis. Maar op het platteland, daar is gewoon geen keuze, dus daar gaat dat trucje niet op. Wat niet is kan nog komen, dat is zeker waar. In de steden zie ik dit in de toekomst zeker nog wel gebeuren, alleen op het platteland mogen ze al blij zijn als er één is door het lage "aanbod" van patiënten. Ik zal dus geen instellingen aanraden om de concurrentie met ons aan te gaan. Dus voor de steden geldt inderdaad dat zorginstellingen meer aandacht zullen moeten besteden aan de kwaliteit van hun zorgvastgoed. Echter kan het ook omgekeerd, dat de oude meuk geëxploiteerd blijft worden, het verschil tussen de lasten en de inkomsten vanuit de NHC in eigen zak steken, toevoegen aan die 3,5 miljard euro eigen vermogen.

AS Er komt een tsunami aan van oudere mensen, waardoor die al blij mogen zijn als wij zorginstellingen plek hebben. Hierdoor zullen ze wellicht minder eisen kunnen stellen aan het vastgoed. Wat ook vaak de situatie is, dat die mensen acuut naar een zorginstelling moeten, dus ze hebben dan ook minder te kiezen. Voor de nieuwere locaties heb je meestal al langere wachtlijsten.

AS De politiek neemt eerst meer afstand, en vervolgens gaan ze zich er toch weer mee bemoeien als er een incident plaats vindt. Kijk dat werkt niet.

GT Is dat niet juist het probleem? Dat de overheid te wispeltreurig is?

AS Ja. Het lastige is dat je als bestuurder probeert een strategie te ontwikkelen voor de komende 15 – 20 jaar. En dat ondertussen de overheid voortdurend de spelregels veranderd. Kijk als je naar de demografische trends kijkt zou je zeggen, begin maar met bouwen en we zien het wel. Echter als je dat doet loop je een flink risico omdat de overheid voortdurend die regels aan het veranderen is. En wat ik nu zie is dat veel zorginstellingen nog even de kat uit de boom blijven kijken. Er wordt dan ook, als ik even om me heen kijk, vrij weinig gebouwd in de wereld van de zorginstellingen. Of je een gebouw nu in eigendom hebt of huurt, je neemt een investeringsbeslissing voor minimaal 20 jaar. Maar als je vanuit de overheid maar zekerheid krijgt die van jaar tot jaar veranderd…

GT Dan kan je dus over een jaar of vijf opeens heel bedrogen uitkomen met je contract voor 20 jaar.

AS Precies. Daarom potten zorginstellingen nu geld op, zodat als ze zo meteen moeten gaan bouwen ze bij banken kunnen laten zien dat ze die lasten aankunnen. Dus als overheid zou je eigenlijk een concessie moeten doen voor een lange termijn, zodat zorginstellingen naar een bank kunnen gaan en aantonen wat de spelregels zijn voor de komende tijd. Dat maakt dat je als zorginstelling erg voorzichtig moet zijn.

AS Ik moet ook eerlijk toegeven dat ik vroeger sneller en makkelijker investeerde in nieuw vastgoed, tegenwoordig ben ik daar wat voorzichtiger in en kijk ik beter naar de risico's.

GT En dat niet alleen door de crisis?

AS Nee, in tegendeel. In tijden van crisis kan je goed zaken doen. Aannemers schrijven scherp in op projecten en de grond is erg goedkoop.

GT Door de NHC zal er dus beter nagedacht moeten worden over het vastgoed. Als er een gebouw neergezet kan worden dat 60 jaar meegaat, dan zou je theoretisch dus meer geld overhebben voor betere kwaliteit.

AS Dat is dus de vraag. Als je vanuit de techniek redeneert klopt dat wel, alleen vanuit gebruik geredeneerd dus niet. Ik denk dat je dus gebouwen moet neerzetten die je in 20 jaar afschrijft. Als je kijkt naar de vergrijzing, die zal zijn hoogtepunt in 2035 – 2040 bereiken, dus als je nu een nieuw gebouw neerzet zou dat betekenen dat je hem in 25 jaar zou moeten afschrijven. Alleen als er nu wordt overgestapt van het ene op het andere, dat zal financiële gevolgen hebben.

GT Want daar is de NHC nu niet op berekend.

AS Inderdaad. In wezen zit de zorgsector met hetzelfde probleem als de projectontwikkelaar met zijn kantoorpanden nu.

GT Of te wel, de kantoren markt kan voor jullie een leermarkt zijn, hoe gaan ze daar met die leegstand om? Want dat is ook te verwachten voor de zorgsector.

AS Precies.

GT Betekend dit dat er ook beter wordt gekeken naar flexibiliteit? Zodat het pand ook na 2035 – 2040 kan worden ingezet.

AS Dan zal de overheid de regelgeving even moeten aanpassen. Bijvoorbeeld, het gros van de ouderen is doof, toch geldt dezelfde regelgeving voor geluidsisolatie als voor bijvoorbeeld studentenhuisvesting. De stichtingskosten voor een appartementje van 45m2 in een zorginstelling zijn ongeveer €180.000,--. Theoretisch bouw je hier natuurlijk een hele woning voor. De hoge kosten komen door de domotica, technische installaties en gemeenschappelijke ruimten. Dit maakt het lastig om er een andere bestemming aan te geven. Verder valt het buiten de huurtoeslag, want die appartementjes hebben geen eigen keuken.

<u>8 – Verwacht u dat private ondernemers een grotere rol gaan spelen in de zorg, zo ja; hoe ziet die rol er dan uit?</u>

AS Michel van Schaik van de Rabobank heeft aangegeven dat de financieringsbehoefte in de zorg (dus inclusief de ziekenhuizen) ver boven de mogelijkheden van de banken gaat komen. Dan is het dus onontkoombaar dat andere partijen mee gaan doen in de zorg.

GT Maar hier bestempel jij private partijen dus al als financier?

AS Ja, of de sector moet zijn financieringsbehoefte aanpassen aan de mogelijkheden van de banken, of er moeten buiten de banken andere partijen investeren in de sector om die investeringsbehoefte te kunnen dekken. Dan kun je denken als pensioenfondsen, verder wordt ik momenteel helemaal suf gebeld door projectontwikkelaars. Die blijven maar grond aanbieden waar ik kan bouwen of projecten waar ik in kan stappen. Die partijen kijken alleen naar rendement, logisch, alleen is dat rendement niet te halen in de zorg.

GT Maar ziet u private partijen niet andere functies gaan vervullen als financier?

AS Dat zie ik niet gebeuren. Het heeft denk ik voor de pensioenfondsen niet zoveel waarde omdat te gaan doen.

GT Dus voorlopig alleen nog als financier?

AS Ja.

9 – Wat kunnen externe partijen volgens u beter doen?

AS Kijkend naar de overheid; eens duidelijke regels maken en dan 20 jaar met de handen op de rug gaan toekijken.

GT Dus de overheid moet als het ware een contract maken met de instellingen over hoe de regeltjes er de komende 20 jaar uit zien.

AS Ja, dan leg je een soort van basis zekerheid in die sector. Dan kunnen instellingen zich ook gaan bezig houden met nieuwbouw, omdat ze dan ook naar een bank kunnen stappen en laten zien wat de regeltjes voor de toekomst zijn.

AS Anders bijvoorbeeld, net als in het openbaar vervoer, ga per werkgebied het recht voor ouderenzorg beschikbaar stellen aan één partij voor bijvoorbeeld een periode van 10 of 20 jaar.

AS Als sector kunnen wij het beter doen door de bevolking beter te informeren wat we doen.

Appendix VI | Research method: scenario planning

In this appendix background information about the applied research method, scenario planning, is given. In chapter 7 the scenarios are designed, background information on which the scenarios are based on can also be found.

VI.1 History of scenario planning

Scenario planning is originally adapted and generalized from a classic method used by the U.S. Air Force during World War II, in which was tried to imagine what its opponents might do and prepare alternative strategies. In the 1960s scenario planning was developed by Herman Kahn, who had been part of the U.S. Air Force, at the RAND corporation. In 1961 he founded the Hudson Institute were he expanded his research and refined scenarios as a tool for business prognostication, and started to publish scenario planning concepts. In the 1970s his research method reached new dimensions when scenario planning was picked up in the business world, the first large company using scenario planning was the planning department of Royal Dutch Shell. They used scenario planning for determining their long-term strategy in the oil shock of 1973. From that moment Herman Kahn became America's top futurist. The use of scenario planning by more and more large companies all over the world led to the development of more practical techniques that supports this long-range forecasting. Research of Diffenbach (1983) showed that scenarios are the third most popular technique for long-range forecasting used by 68% of the large organizations he surveyed. At the moment lots of different companies use scenario planning, e.g.; American Express, Nokia and Nissan (Schwartz, 1996).

VI.2 What are scenarios?

Now that a brief history of scenario planning has been given, it is time to find out what the actual content of scenario planning is. Other commonly used words are; 'scenario thinking' and 'scenario analysis', these are the words mostly used.

Scenario planning can be used for organizations, companies or governments to make flexible long-term, strategic, plans for their future. A general mistake is that scenario planning is a 'prediction-tool', which it certainly is not. Scenarios give an array of a set of images / stories about how future ways of living might evolve, these sets of images / stories are called "scenarios". Besides scenarios can be helpful to stretch our thinking about the opportunities and threats that the future might hold, and to weigh those opportunities and threats carefully. These images / stories are based on political environments, social attitudes, regulations and economic situation. The aim of scenarios is to eliminate the uncertainty of the future as far as possible by using plausible situations and problems that could occur in the (near) future (Godet & Roubelat, 1996) & (Scearce & Fulton, 2004).

The process of scenario planning can be applied in different disciplines, such as; business, transport, political, social or economic environments. This way, scenarios will allow to

address an array of possibilities about the future, which can be *good and bad* or *expected and surprising* (Schwartz, 1996).

For companies scenario planning can contribute to:

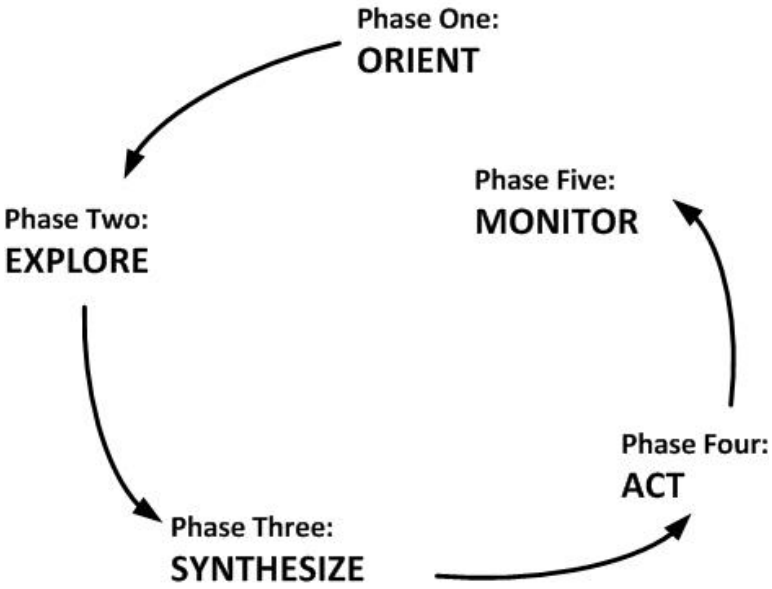
- Stimulating strategic thought and communication within companies;
- Improving internal flexibility of response to environmental uncertainty and providing better preparation for possible system breakdowns;
- Reorienting policy options according to the future context.

VI.3 The scenario thinking process

Because scenario planning is a practitioner's art and it developed over the years and in several disciplines, you can therefore say that it is more a craft than a science. Over the years several general principles about how to apply scenario planning are developed. When comparing several of these general principles a general trend in how to approach the scenario thinking process is concluded. (Scearce & Fulton, 2004) Describing that the scenario thinking process consists of five basic phases (see figure 10), these phases are;

- Phase one: Orient;
- Phase two: Explore;
- Phase three: Synthesize;
- Phase four: Act;
- Phase five: Monitor.

Figure 10 | The basic five-phase scenario thinking process



Source: (Scearce & Fulton, 2004)

Phase one: Orient

The first phase of scenario planning is to orient on the field of research, the issues from the orientation will be used as device throughout the remaining four phases. The first phase is the basis of starting a scenario planning. The process starts with learning about how the environment works and which organizations are involved in it and what the future perspectives are within the environment.

Phase two: Explore

Within the second phase of scenario planning, the "driving forces" will be determined 'explored'. These driving forces are influenced from outside the 'viewpoint' (see paragraph 1.3.1) of the research that will shape the future dynamics in predictable and unpredictable

ways. Driving forces can either be “predetermined elements” or “uncertainties”. Predetermined elements are forces that are almost certain to happen in the given future timeframe, such as; demographic change, political change and spendings. Uncertainties are unpredictable but have an important impact on your area of interest, such as; public opinion and governmental role.

Phase three: Synthesize

The driving forces that have been explored in phase two will be synthesized and combined in phase three. Each of the determining driving forces will be explained and discussed, for each driving force it means that a clear image of its impact is given. Within this phase a good overview of all driving forces can also be given.

Phase four: Act

Now the scenario framework has been made in the third phase, in phase four a start will be made with the design of scenarios, using the driving forces from the third phase. While designing scenarios, continuous keep in mind whether the critical uncertainties produce believable and useful ‘stories’ of the future. The set of scenarios should represent a range of alternative futures, not simply a best, worst, and most likely world. (van der Heijden, 1996) Describes the next rules for designing scenarios;

- At least two scenarios are needed to reflect uncertainty. More than four has proven organizationally impractical;
- Each of the scenarios must be plausible. That means that they must grow logically (in a cause/effect way) from the past and the present;
- They must be internally consistent. That means that events within a scenario must be related through cause/effect lines of argument which cannot be flawed;
- They must be relevant to the issues of concern to the client. They must provide useful, comprehensive and challenging idea generators and test conditions, against which the client can consider future business plans, strategies and directions;
- The scenarios must produce a new future and original perspective on the client’s issues.

Except for the general rules shown above (van der Heijden, 1996) claims there is a total flexibility in deciding how the scenarios will be built, what aspects will be used in each of the scenarios.

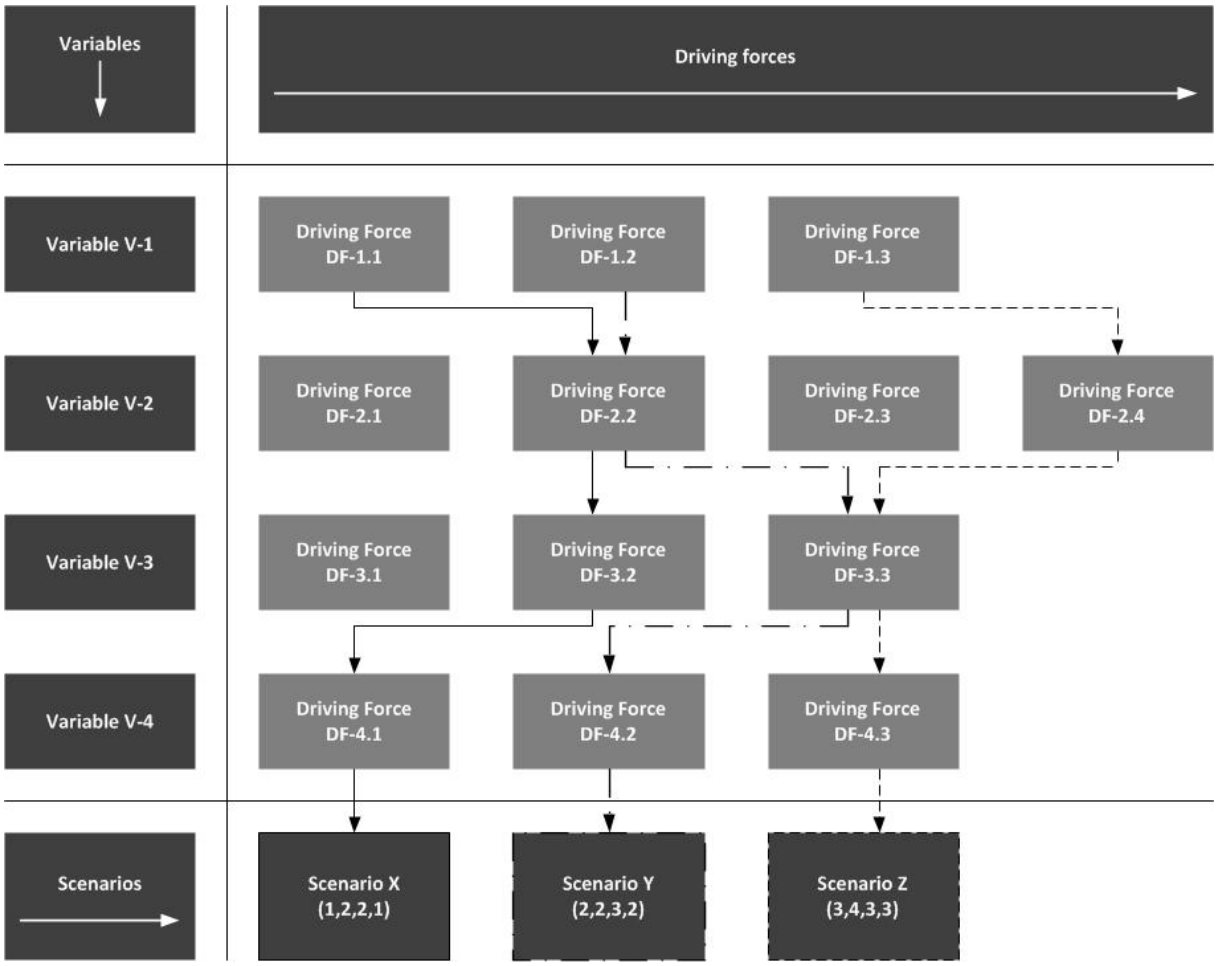
Phase five: Monitor

In the last phase organizations create mechanisms to shift in the changing environment and adjust its strategy to it. While scenarios are ‘stories’ of what might happen in the (near) future in the research environment. It is obvious that the one scenario has a bigger chance to act compared to another scenario. It is worthwhile to monitor and identify indicators that will tell you if a particular scenario is starting to unfold. Monitoring offers the opportunity to respond to the emerging reality.

VI.4 Morphological analysis

For scenario planning in research environments in which there are a lot of driving forces that determine the research environment, it is possible to apply 'morphological analysis'. Which is a tool for scenario planning to handle such a high amount of driving forces. Another side effect which causes morphological analysis to be useful is the clear and structured way of presenting each driving force. In the article of (Godet, 2000) it is described how this tool can be applied, in figure 12 an example of the model can be seen.

Figure 12 | Morphological scenario analysis [example]



Source: (Godet, 2000)

In the left vertical column it is possible to list variables (V-1 till V-4) that are of high tide on the research environment. A variable can be seen as a 'key-question' in a certain area for the environment. For each variable it is possible to give driving forces (DF-1.1 till DF-4.3) that determine the research environment (shown in the biggest cell). By designing the scenarios it is possible to 'choose a path' through the driving forces for enabling the content of each scenario. Because the high amount of possible paths, in this example there are 3x4x3x3=108 possible resulting scenarios. This will force the researcher to think logically and also in interactions amongst the variables (if V-1 is acting like this, how will V-2 react on it, and so on), this will be needed to limit the amount of scenarios.

Appendix VII | CME summary paper

In this appendix the 'CME summary paper' that will be published in the CME graduation book is given.

TIME FOR CARING FOR THE CONSTRUCTION INDUSTRY

A scenario-approach for determining the future contractor's position within the Dutch nursing and care sector.

Author: ing. G.W.M. *(Gerard)* Tesselaar

Graduation program:
Construction Management & Urban Development 2011-2012
Business Engineering

Graduation committee:
prof. dr. ir. W.F. *(Wim)* Schaefer (TU/e)
dr. Q. *(Qi)* Han (TU/e)
ir. W.F. *(Erik)* Schot MRE (Van Wijnen)

Date of graduation:
July 26, 2012

ABSTRACT
In the upcoming years, demographic aging in The Netherlands will lay an enormous social and financial pressure on the Dutch health care sector; an increasing demand for care spaces will arise. To be able to control this enormous pressure, the Dutch government started restructuring the regulation for the health care sector in 2005. This newly formed regulation causes that nursing and care institutions become self-responsible for all their activities; including their real estate financing and management. Within this research it is analysed what the strategy of nursing and care institutions will be concerning their real estate management and how they see their new environment. For a construction company active in the nursing and care sector valuable information because they are also subject to the changes. Therefore a set of plausible scenarios about the possible future perspectives are elaborated for creating a better view on the new business environment.

Keywords: Dutch health care sector, construction industry, care homes, nursing homes, scenario planning

INTRODUCTION
The pressure on the Dutch health care sector will increase enormously in the upcoming years due to demographic aging (in 2040 almost 25% of the total Dutch population will be 65 years or older (CBS, 2012)), this will put an enormous social and financial pressure on the Dutch health care sector. Especially the nursing and care (V&V) sector will be affected by this; a growing demand for care spaces within a V&V institution will occur. To prepare the V&V sector for this growth the Dutch government started restructuring the regulation within the V&V sector. This newly formed regulation causes that V&V institutions become self-responsible for all its real estate activities, both financing and management. All these changing forces in the V&V sector will also influence the perspectives of a construction company which is active within this sector.

Within this research the future environment of a construction company active in the Dutch V&V sector is explored. The result provides an insight in the changing environment of the

V&V sector; what are the trends and what does the regulation change exactly content. A set of plausible scenarios about the possible future perspectives are designed, these scenarios concerning; governmental regulation, forms of housing, development organisation real estate and future role V&V institutions. Regarding the scenarios an advice towards construction company Van Wijnen (participating within the performance of this research) how to deal with the future perspective is given, preparing them for the future in the V&V sector.

METHODOLOGY

For elaborating this research and determining the future perspectives within the V&V sector, there has been made use of the scenario planning tool. Besides there will be explained how the research has been performed.

Scenario planning

Scenario planning is a tool for organizations, companies or governments to make flexible long-term, strategic, plans for their (near) future. Therefore scenarios give an array of a set of images/stories about how the future ways of living might evolve, these sets of images/stories are called scenarios. Regarding the V&V sector, lots of factors are changing or will change in the near future, for Van Wijnen scenario planning can be helpful to create a context which makes it possible to think about and discuss all the driving forces that are creating their V&V sector's environment. Within this context it is possible to consider the several opportunities that might occur, and consider for Van Wijnen how to (re)act on it (Schwartz, 1996) & (van der Heijden, 1996).

(Scearce & Fulton, 2004) Describing the process of scenario planning that has been applied in this research. They assume that the process of developing scenarios must be divided into five different phases. According to these phases scenario planning is applied within this research (see figure 1).

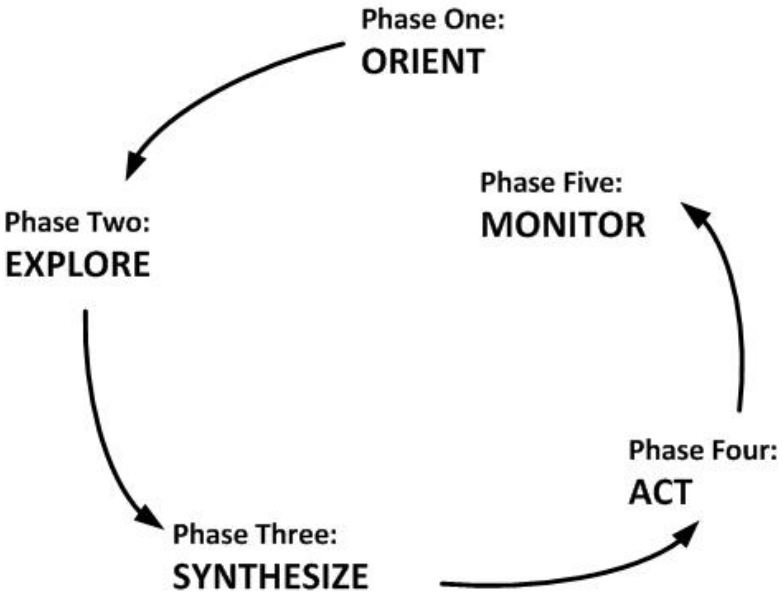


Figure 1 | The basic five-phase scenario thinking process
Source: (Scearce & Fulton, 2004)

In phase one the Dutch health care sector, construction industry and the overlap area involving both sectors are oriented. In phase two the research environment is explored by performing interviews with experts in the V&V sector. In phase three the driving forces influencing the V&V sector are classified and overviewed in a model. In phase four the scenarios are designed. In phase five an advice towards Van Wijnen is elaborated.

Due to the high number of determining driving forces that influence the V&V sector, it has been decided to apply a 'morphological analysis' (Godet, 2000) in phase three and four of the scenario planning method. Morphological analysis makes it possible to process a high number of driving forces and is useful for a clear and structured way of presenting each driving force. As a result, various combinations between the driving forces can be made and this enables the researcher to select the most probable scenarios (see figure 2).

In the left vertical column the variables (V-1 till V-4) that are of high tide on the research environment are listed. For each variable a set of possibilities per variable that determine the research environment are shown in the main cell, called driving forces (DF-1.1 till DF-4.3). By designing the scenarios it is possible to 'choose a path' through the driving forces for enabling the content of each scenario. For this example there are 3x4x3x3=108 possible resulting scenarios. This will force the researcher to think logically and also in interactions amongst the variables.

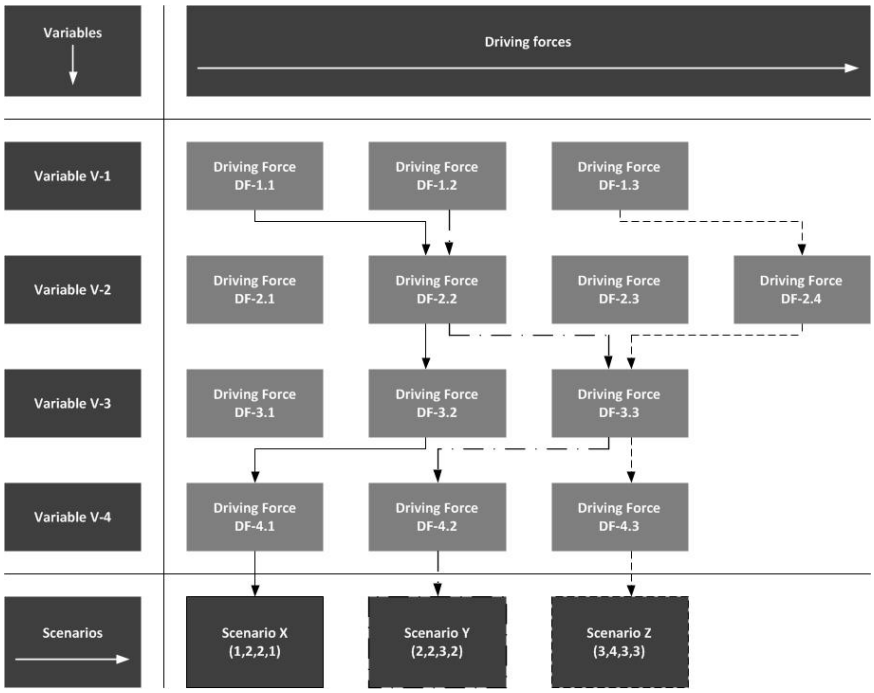


Figure 2 | Morphological scenario analysis [example]
Source: (Godet, 2000)

CONTEXTUAL ORIENTATION (PHASE ONE)

The contextual orientation elaborated by determining the Dutch health care sector, the construction industry and construction vs. health care, below these are defined.

Dutch health care sector

Within the total supply of care a distinction can be made between two specific types of medical care, namely 'cure' and 'care'. The specific focus of cure is on the healing and/or recovery of care recipients, institutions in the cure sector are for example hospitals, dentists and general practitioners. While the care sector focusses on the support and medical interventions of care recipients, relieve the symptoms and prevent complications. Institutions active in the care sector are for example V&V institutions, mental health care and disabled care. In figure 2 a comparison can be seen. Annually €87.1 billion is spent in the total Dutch health care sector, the Dutch government finances 83% of the total costs within the health care sector. The rest is financed by the users of care, amongst others through the health care insurance and companies. The V&V sector consumes almost 20% of the total costs (CBS, 2011).

Figure 3 | Cure vs. Care
Source: (Steegh, 2011)

Nursing and Care (V&V)
Care homes provides support for care recipients that cannot take care of themselves anymore, they will be helped with washing, dressing and eating, enabling care recipients in their everyday life. Nursing homes provide a more intensive type of care, care recipients will also be treated with major medical treatments. The living environment of care recipients receiving V&V care can be divided over three types; intramural, semi-mural and extramural. For intramural care the care recipient will actually live within the institution and have 24/7 access to care. Within an intramural care space living, care, supervision, services are provided. The semi-mural type can be seen as day care. The difference with intramural is that the care recipient will not stay overnight in the institution where they receive their care during the day. Extramural care will be delivered by care recipients own house (RVZ, 2001).

Dutch construction industry
The construction industry can be distinguished by three different sectors (B&U, GWW and A&O). The construction industry is characterized by the diversity of activities, complexity and extensive collaboration between many stakeholders. (Myers, 2008) Specifies the construction industry following five characteristics;

- Each project is regarded as a unique one of a kind product;
- The construction industry is dominated by a large number of relatively small firms;
- The general state of the economy influences the demand;
- Prices are determined by tendering;
- Projects are characterized by their 'lumpiness' in terms of their scale and expense.

In the Dutch construction industry, almost 115,000 companies are active. Specific for this industry is the high amount of 'small' companies (self-employed and companies with only a single person employed) of 70%. The annual turnover of the Dutch construction industry is about €87.7 billion annually (Bouwend Nederland, 2012).

Construction vs. health care
Up to 2006 V&V institutions did not face any risks concerning their real estate management, the capital costs of their property were fully reimbursed through calculation; this policy was not conductive to an entrepreneurial management of V&V institutions. In view of the growing pressure on the health care due to aging this policy was no longer desired by the government; V&V institutions should be 'rewarded' for their delivered care. To achieve these goals, the government changed the regulation of financing (AWBZ) within (amongst others) the V&V sector. Within the modernised AWBZ, the ZZP and NHC are introduced. The

ZZP regulates the financing of the delivered care, classified according to the intensity needs of the care recipient, for the V&V sector, ten ZZP's are composed. The NHC regulated the compensation of the real estate for intramural provided care of V&V institutions. This will cause that V&V institutions will consider their investments in real estate much better and be done more efficiency-driven (NZa, 2010) & (CVZ, 2011). Currently discussions are still on-going, the idea is to abolish the compensation for housing (NHC) in the future and make the care recipient responsible for accommodate their housing.

The goal of the transition is to create self-conscious health care institutions with an entrepreneurial attitude. This regulation change has consequences for the V&V sector. First of all the V&V institutions should learn to act in a 'real estate environment with risks', internally they need to become aware of their risks, adapt risk management and professionalize their organization concerning its housing. Within the legislation, institutions should make choices between ownership or rent of their real estate (Steegh, 2011).

INTERVIEWING (PHASE TWO)

By performing interviews with experts in the field of the V&V sector, an attempt was made to compare the contextual orientation with the practical relevance. During each interview the goal was to find a strategy for the real estate management of each V&V institution. The data collected with the interviews helps determine the driving forces for the scenario planning. Four institutions active in the V&V sector are interviewed. Three of them are institutions providing care in the V&V sector, the other is a housing corporation that develops and manages real estate for V&V institutions.

The results

The interviews gave a good insight in the problems that V&V institutions have concerning their real estate, a diversity of struggle points became clear. The interviews are held with different 'types' (size, activities, etc.) of institutions; two smaller-scaled institutions, one large-scaled institution and a housing corporation focusing on the V&V sector. This variety of institutions gave insight in the diversity of problems within each different type of institution. All interviewees agreed that the regulation in the Dutch health care sector had to be changed (old situation), current regulation is just a slight progress but still needs to be fine-tuned to be able to succeed. Due to the aging in the upcoming years the battle of V&V institutions will not be to 'attract' care recipients, there will be plenty of 'potential customers', but to maintain a sufficient amount of staff to practice their activities, which could become a main issue in the Dutch health care sector. The goal of the government has already partially been achieved, each of the interviewed institutions has declared that since the regulation change a more intensive strategic real estate management plan has been made. The larger-scaled institutions will remain to develop and manage their real estate in-house, while the smaller-scaled institutions will outsource this activities to a project developer or housing corporation. It is also indicated that governmental uncertainty causes that institutions are not willing to make decisions concerning their real estate. The on-going discussion about the abolishing of the NHC. Besides private parties are carefully exploring the opportunities within the V&V sector. Most institutions see; investors, pension funds, health insurers and project developers are entering the V&V sector. Currently only as financer and do not fulfil any other role in the V&V sector.

VARIABLES INFLUENCING NURSING AND CARE SECTOR (PHASE THREE)

Data gained by performing interviews is used to determine the influencing variables and driving forces. Within this research a set of five variables are concluded, together these variables have 15 driving forces that determine the V&V sector. In figure 4 the collection of variables and driving forces can be seen.

Government

The government is a big influence on the V&V sector, they decide what the future regulation will look like; separate living and care (NHC), partially separate living and care and maintain living and care.

Forms of housing

The future demand of care recipients in combination with the regulation content of the Dutch government will determine the form of housing the future V&V institution has to deal with; intramural, independent on care site, wellness and home care.

Organisation V&V institutions real estate management

V&V institutions have to decide on how to adapt to the changing regulation of the Dutch government by choosing their real estate management strategy; ownership or rent.

Private parties entering the Dutch health care sector

Because the V&V sector is a growing market due to aging, private parties see business opportunities to make money. The type of private parties that might enter are; housing corporation, investor and project developer.

Future role V&V institution

Due to the changing environment in which a V&V institution is active, their role will change in the future. Possibilities of their future role are; regional, care oriented and social involvement.

SCENARIOS (PHASE FOUR)

Results from phase three make it possible to elaborate the actual scenario design. The combination of a set of driving forces for each scenario are determined by logically analysing the interaction amongst variables in the V&V environment. The combination of a set of driving forces for each scenario can be seen in figure 4.

Scenario A

The government has separated living and care to be able to control the costs of V&V care, therefore care recipients will remain to live at home and the focus of V&V institutions will mainly be on practicing home care. For the construction industry this will mean that the demand from the elderly people will mainly be small units; life-proof housing. Therefore the focus of V&V institutions will more and more be on renting, housing corporations will manage the real estate for V&V institutions, care recipients will rent direct from the housing corporation. The orientation of V&V institutions will be more regional. In this way V&V institutions will become better informed with the specific regional needs and will sooner see opportunities.

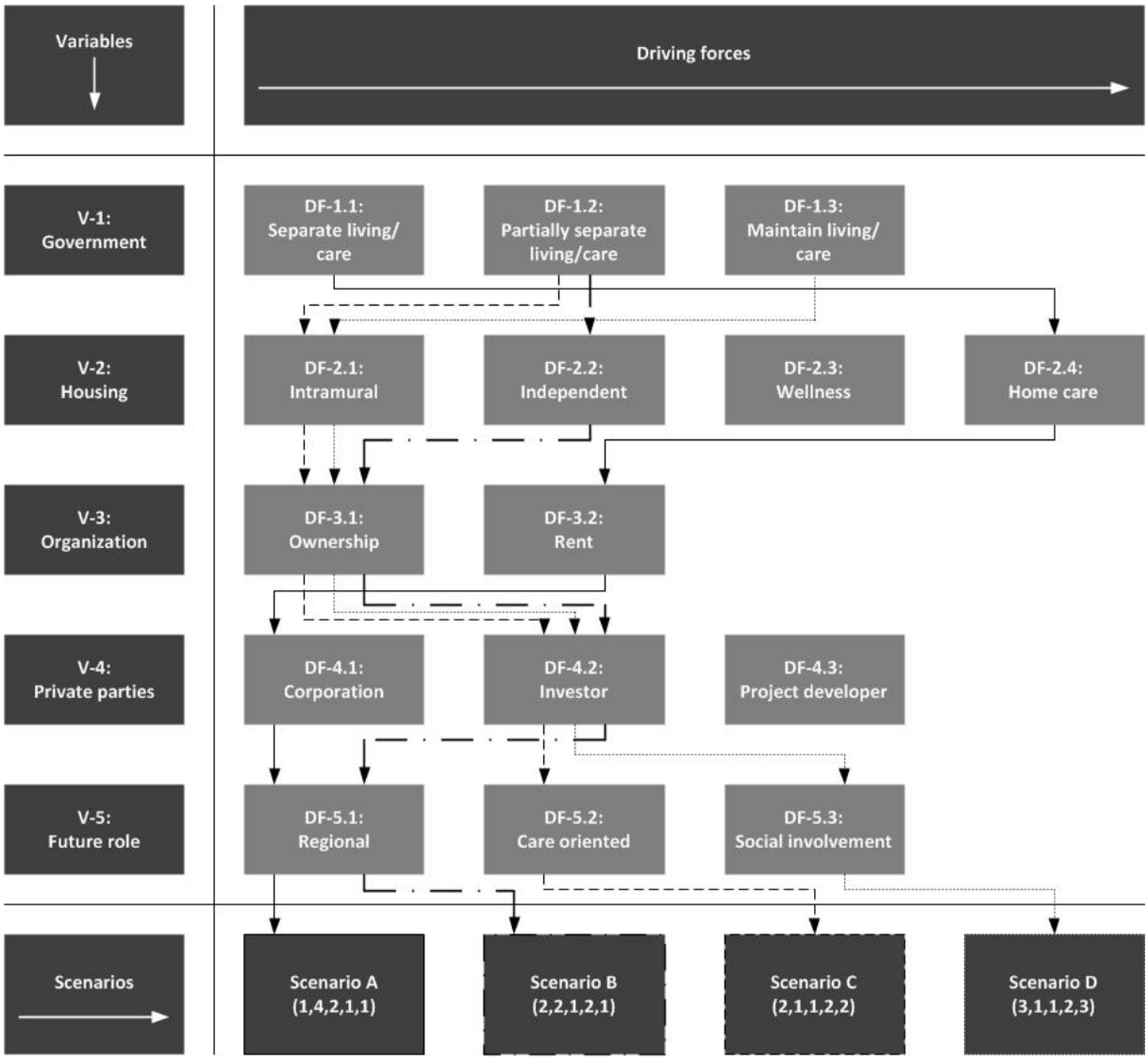


Figure 4 | Morphological scenario analysis [scenarios]

Scenario B

In this scenario living and care is just partially separated, this to control costs on V&V care on one hand, but on the other hand to be able to give care recipients with more intensive care needs the ability to live intramural. Therefore care recipients will live in a sheltered environment when they become in the first need of care, they will remain to live independently, but within the near reach of care. V&V institutions will develop and manage their real estate in-house, therefore capital needs to be established. Investors will be approached to realise their real estate plans. To better fulfil the needs of the care recipient, which can differ per region, the focus of V&V institutions becomes more on the regional area, which makes it easier for them to do business and determine the specific demands.

Scenario C

Also in this scenario living and care will be partially separated, to control the costs spent in the V&V sector on one hand, but on the other hand to be able to give care recipients with more intensive care needs the ability to live intramural. In this scenario the care will be provided intramural, this due the shortage of staff that occurs and intramural care is a more efficient type of delivering care to care recipients. V&V institutions will develop and manage

their real estate in-house. To make it possible to develop the real estate, investors are approached to do business with and to finance their real estate. The pressure on the V&V sector causes that V&V institutions are limiting their activities to the core business of a V&V institution, delivering care to care recipients.

Scenario D
In this scenario the government decides to maintain the living and care, aging and the thereby associated increase of demand for V&V care spaces makes that the government wants to control the V&V sector. Intramural type of care will the demand of care recipients, they are not encouraged to remain to live at home. Due to the growth in the V&V sector, V&V institutions decides to develop and manage their real estate in-house, again investors will be approached to finance the real estate developments. The pressure on the V&V sectors makes that the society will be involved by delivering the care. Commercial parties will assume to take over activities of the V&V institution so that V&V institutions by themselves can focus on delivering the care.

Conclusions
With the information gained during the elaboration of this research, together with the exploration with the performance of the interviews, an argued choice of which scenario is the most likely to act. Based on the growing pressure (both social and financial) on the V&V sector and at present day the first steps of the government towards a total separation of living and care has already been made. Therefore the most probable scenario that is likely to happen is scenario A. The advice is based upon this scenario.

ADVICE (PHASE FIVE)
Conclusions that are made together with the scenario planning leads to an advice for Van Wijnen. The advice can be used as appliance for determining the future activities of Van Wijnen in the V&V sector in the Dutch health care. The advice is based on the coherence of the variables and the probability of acting of the scenarios.

General advice
The environment as described in scenario A contains a variety of construction activities. While at first glance it might seem that for Van Wijnen there are no opportunities at all in the V&V sector, it becomes clear that; this is only apparent. The shifted focus in the V&V sector towards delivering home care does not mean that there will be no construction demands. Where in this scenario the care recipient becomes self-responsible for accommodate their own housing, in the first place the care recipients will try to remain to live at home as long as possible; in their own and trusted environment. The start of the elderly process starts with the pensioners, this group of ‘new elderly’ will prefer to live in a life-proof house, which is future proof for them. The growing demand for this type of housing makes that new developments within this sector needs to be constructed.

The focus of V&V institutions is shifted more and more to delivering home care; which does not mean that the intramural care will disappear. Only in first instance, when elderly people become care recipients of the first need of care those will remain to live at their own homes. In this early stage of being care recipient it is possible to remain to live at home. In a later

stage, when the care recipient becomes in the need of more intense care, the care recipient will transfer to live in an intramural V&V care place.

A V&V institution will orient more and more on renting their real estate. Because there will come more transition of care recipients from their home towards the intramural V&V institution. Those institutions will focus on practicing care and do not engage with the housing of their care recipients as well as the real estate management. Together with a housing corporation the real estate of a V&V institution will be developed. The separation of living and care makes that the care recipient will rent an intramural apartment in the institution from the housing corporation. Since the housing corporation will become the 'organiser' in the real estate activities, these are the parties that in the future will assign projects to construction companies such as Van Wijnen. Together with the more regional active oriented V&V institution makes that these three parties (the V&V institution, housing corporation and Van Wijnen) will analyse the specific needs and market opportunities within the specific region. Therefore Van Wijnen will seek for opportunities to collaborate with a housing corporation. Together with the housing corporation it might be possible to develop a 'standard' or general design which can be used on several locations, this 'standard' will be designed for more effectiveness on several aspects (development, management and ease of use). By doing so Van Wijnen can gain expertise with developing V&V real estate that is adjusted for more efficiency for the V&V institution.

CONCLUSIONS

The research that has been elaborated focusses on the aspects that influence the real estate affairs in the V&V sector. The research revealed that the future perspectives for the construction activities in the V&V sector can be determined by a group of variables; government, forms of housing, organisation V&V institutions real estate management, private parties entering the Dutch health care sector and the future role of a V&V institution. The combination between the possibilities of each variable (driving forces) make up a future perspective of the environment. With the design of four possible scenarios, four possible future perspectives for a construction company active in the Dutch V&V sector are elaborated.

DISCUSSION AND RECOMMENDATIONS

As this research has been spread out over a period of six months, already within this period some of the influencing actors were changed before the elaboration of this research could be completed. Therefore it would be interesting what the actual course of the Dutch government concerning the abolishment of the NHC would be, new insights would probably change way V&V institutions will handle. The 'housing corporation scandal' is very interesting for the V&V institutions, are housing corporations able to fulfil the assumed role as described within this research in the future? Within the 'stock of elderly people' there will be slight differences, one person is not like the other, this research only describes the gross and is thereby reflecting the 'general trend' that could occur in the V&V sector.

For future research an analysis of the future demand per region per year for V&V care compared with the current capacity of the V&V sector in that specific region. The gap will indicate the building production in that region. Also applying Quality Function Deployment

(QFD) to translate the preferences of the care recipient and market demands into design demands; knowing more precise what the actual preference of the care recipient will be.

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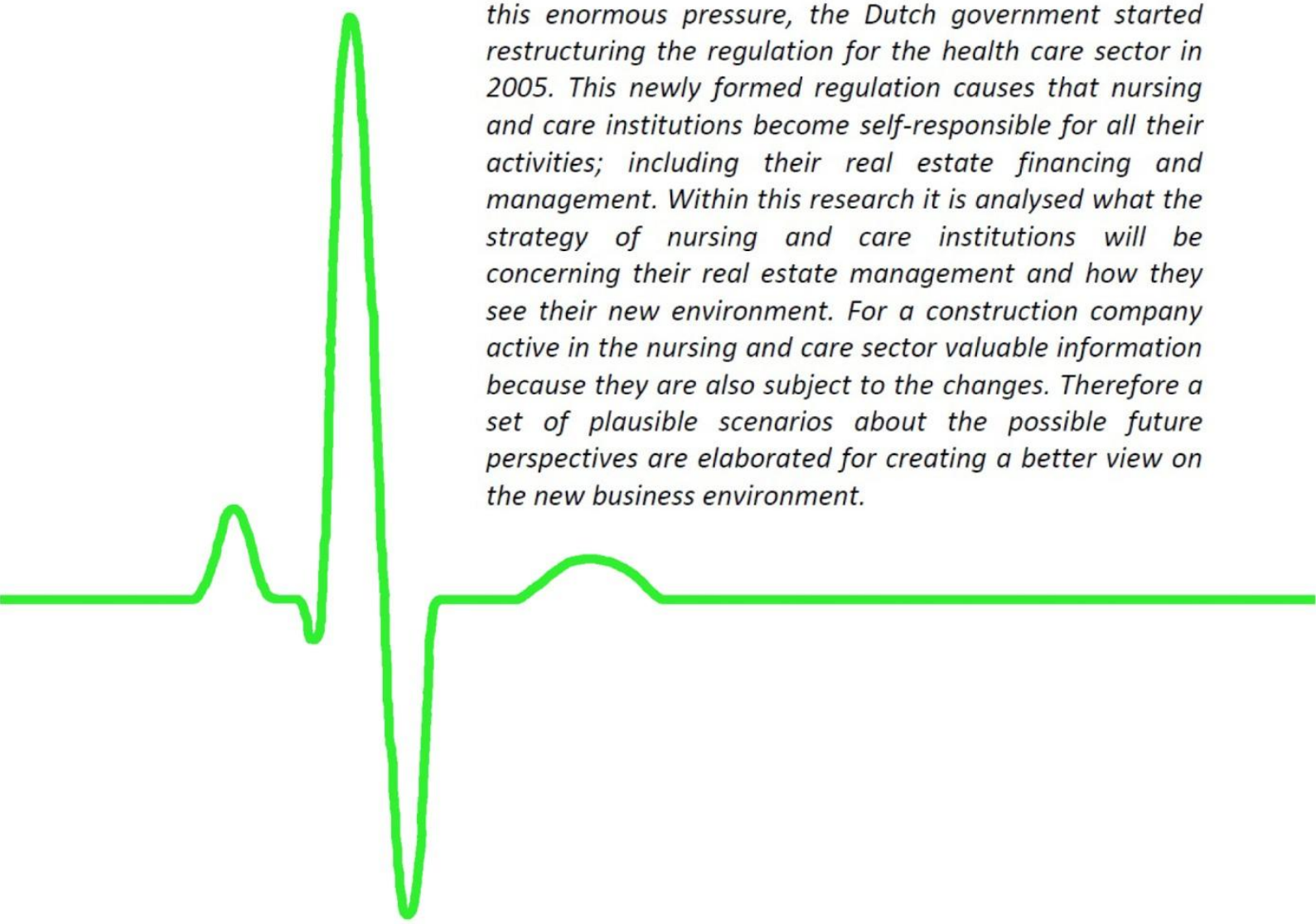
ing. G.W.M. *(Gerard)* Tesselaar

The saying *"he who knows the elderly, has the future in his hands"* is not just a saying. After completing this research, I (as a 'young' researcher) completely agree with this saying.

09.2005 – 06.2009	Bachelor of Built Environment, Hogeschool Inholland Haarlem
08.2006 – 02.2007	Internship at Van Wijnen, Haarlem
02.2008 – 06.2008	Internship at Heembouw, Roelofarendsveen
02.2009 – 06.2009	Graduation internship at Heembouw, Roelofarendsveen
09.2009 – 07.2012	Master Construction Management & Engineering, TU Eindhoven
03.2010 – 09.2011	Vice chairman of CoUrsE! Tour 2011 Brazil committee
06.2011 – 12.2011	Committee member annual CME Conference 2011
04.2012 – 07.2012	Graduation thesis at Van Wijnen Projectontwikkeling, Gorredijk

Where innovation starts

In the upcoming years, demographic aging in The Netherlands will lay an enormous social and financial pressure on the Dutch health care sector; an increasing demand for care spaces will arise. To be able to control this enormous pressure, the Dutch government started restructuring the regulation for the health care sector in 2005. This newly formed regulation causes that nursing and care institutions become self-responsible for all their activities; including their real estate financing and management. Within this research it is analysed what the strategy of nursing and care institutions will be concerning their real estate management and how they see their new environment. For a construction company active in the nursing and care sector valuable information because they are also subject to the changes. Therefore a set of plausible scenarios about the possible future perspectives are elaborated for creating a better view on the new business environment.



TU/e Technische Universiteit Eindhoven University of Technology