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Titel draft - report

Subtitel Sno-Dutch Programme on Elderly Care and Community Health
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**Sino-Dutch symposium on Elderly Care and Community Health Care Reform
Suzhou, 8-10 October, 2002**

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Introduction

The People's Republic of China –with one-fifth of the world population- has seen major and rapid changes during the last generation. The changes will be equally considerable, if not more so, for the years to come.

One generation ago the Cultural Revolution swept through China. Currently, strong economic growth is sustained for more than ten years, the country recently extended compulsory education to a nine-year period, special funds are being made available to promote the ownership of one's own house among ordinary people, and gradually unemployment provisions and benefits, previously available only in urban areas, start to be provided in rural areas as well. Opening to the west and reforms, from a planned economy to a market economy and increased mobility of people are other changes in China.

Ageing is a worldwide phenomenon and also affects China. It creates many challenges for all societies and countries. How to maintain or develop a meaningful role for elderly people in society, how to organise care and how to sustain financially a growing proportion of inactive elderly people in society are questions to which answers are looked for globally. In recent years, China has given particular attention to this and started to look for experiences and policies in other countries.

Simultaneously, the development of Primary Health Care is a topic of importance in China. Its hospital oriented Health Care system is too heavy, expensive and does not sufficiently address the health concerns of the population. A new system needs to be built. While initiating health reforms, the government of China decided to look across the borders and try to learn from policies and practices elsewhere.

Initiated in 1996 during a visit to China by Mrs Erica Terpstra, then State Secretary for Health, Welfare and Sports in the Netherlands, contacts and exchanges between Dutch and Chinese officials and experts have led to a Sino-Dutch programme on the topics of Elderly Care and Primary Health Care, concentrated on the cities of Qingdao and Suzhou. Under the umbrella of an official Memorandum of Understanding between the two governments, civil and health authorities, health planners, managers and health professionals have paid study visits to each other's countries and training courses have been given in the Netherlands for Chinese professionals.

This book summarises the activities, roles and contributions of the different Chinese and Dutch partners during the initial contacts and the more than four-year programme: from 1999 well into 2003. It provides for some insight in the approach taken by the Chinese authorities for the development of their Health Care and Care systems and highlights the results of these several years of collaboration. It also gives insight in how the cultural differences could enrich rather than hinder the collaboration and how the learning process was both ways.

This book is a testimony to solidarity and effective collaboration between two countries. It provides for a fine example of how problems that occur globally can be addressed locally.

Preface

When my predecessor State Secretary Mrs Eric Terpstra offered to her counterpart of the State Development Planning Commission Mrs Hao Jiangxiu, in 1996, assistance to the reform of Health Care and Elderly Care in China, she assumed that Dutch non-governmental organisations would be willing to help to implement the commitment taken by the Dutch Government.

She has not been disappointed. On a voluntary basis, staff members of several Dutch hospitals, primary care and Elderly Care organisations and teaching institutions have invested many hours in sharing their knowledge with their Chinese counterparts, both in the Netherlands and in China. This project shows that, in a period that the Dutch systems of Care and Health Care are confronted with budgetary and organisational constraints and also are involved in a reform process, they did not lose the vitality needed to sustain a longer term collaboration with Chinese partners.

The Chinese partners eloquently describe in this book the results of the collaboration and show that, across cultures, an exchange between professionals from countries as far apart as the Netherlands and China can effectively contribute to the development of a new system of care and healthcare.

Being personally familiar with China and the Chinese language and culture, I appreciate the close relationship and confidence that developed between persons and institutions in both countries. This book illustrates that the transfer of knowledge is not one way traffic and that the benefits of the project are on the Dutch side as well, for example through reflection and feedback on our policies and systems.

While the Ministry of Health, Welfare and Sports was at the basis of the collaboration, it is good to read that the implementing Dutch and Chinese partners take the initiative to consolidate and continue their exchanges, capitalising on earlier investments.

I wish them a fruitful and effective collaboration.

Clémence Ross - van Dorp
State Secretary for Health, Welfare and Sports

China in brief

China's total population is approximately 1.280 billion people.

The large majority of the population lives in the southern and eastern parts of the country.

Especially the so-called southern rim, bordering the Chinese Sea, is a prosperous area with approximately 400 million people.

Sixty percent of China's population lives in rural areas, where living standards are much lower than in the urban areas. Although China's economic growth is overwhelming, with near-double digit figures, in some areas, especially rural, growth is minimal or even contraction is taking place. In these conditions, migration from rural to urban areas is a natural phenomenon.

The administrative structure of China is complex, due to the geographical and demographic variations. Basically, there are 31 provinces, autonomous regions and municipalities, each with its own government. There are 34 cities with more than one million inhabitants and among them are Qingdao and Suzhou.

Four municipalities reside directly under the central government in Beijing: Beijing, Shanghai, Tianjin and Chongqing. They all have more than 10 million inhabitants.

Cities can have urban and rural areas. The urban area is subdivided in districts, which can have a population of several hundreds of thousands. A district is subdivided in streets, which can have up to 20.000 population. In rural areas towns and villages can be found, whether or not they belong to a city.

In Qingdao and other cities, health centres are developed at street level.

The government

The State Development Planning Commission (SDPC) co-ordinates budgeting and targeting of the different National Ministries in China. It has delegations at the level of the government of provinces, municipalities and cities. In the current project, the SDPC is the formal counterpart of the Ministry of Health, Welfare and Sports in the Netherlands with which it has signed a Memorandum of Understanding.

The currency in China is the Yuan, also called the Renminbi (RMB).

1 RMB = € 0,12

1 € = 8,5 RMB

The Sino-Dutch programme, a general overview

Background

From the early nineties on, the challenges to China in the field of Health Care and Care for the elderly became a topic on intense discussion. The Dutch State Secretary of Health, Welfare and Sports, Mrs Erica Terpstra, visited China in 1996. Among the topics of discussion was the intention of the Chinese authorities to develop Primary Health Care and Elderly Care and reform the health system. It was thought that the Dutch with their experience in these issues could deliver a meaningful contribution to the Chinese plans. Therefore, two Chinese delegations visited the Netherlands later in 1996, in order to build up some understanding on the Dutch approach to Elderly and Primary Health Care. Amongst others, they visited the nursing homes of Zorg Spectrum in Nieuwegein.

These visits led to the wish to maintain a longer-term collaboration between the two countries. Early 1999 a Memorandum of Understanding (MoU) was signed between the Dutch Ministry of Health, Welfare and Sports (Ministry of VWS) and the Chinese State Development Planning Committee (SDPC) covering a three-year period, 1999 – 2001. Later, it was extended to include 2002. The MoU stipulated the purpose of the collaboration: the exchange of knowledge and experiences. The transfer of hardware or capital goods was not going to be an important component of the collaboration. The cities of Qingdao and Suzhou were chosen to be the locations for the implementation of the project, under supervision of the SDPC in Beijing.

Programming

At the request of the Ministry of VWS, the International Centre of the Netherlands Institute for Care and Welfare takes upon itself the coordination. It appoints a programme coordinator who had been involved in the development of Elderly Care in the Netherlands and who had previous international experience. The programme coordinator makes an initial visit to Suzhou and Qingdao of 6 weeks in spring 1999, in order to familiarise with the counterparts and to get a clearer picture of the situation in both cities. Through discussions with policy makers, managerial and medical staff, a picture concerning the present and the desired situation starts to emerge. The chapters on Qingdao and Suzhou provide for more detail on the situation and intended developments in both cities. All in all, it is evident that profound reforms in several sectors of society are taking place in China, and that Elderly Care and Primary Health Care are among the reform priorities.

At that point in time, mid-1999, it is clear that the Chinese counterparts are looking for practical examples of how Primary Health Care and Elderly Care can be organised, and for an opportunity to train some of their policy makers

and implementing staff. This leads to the idea to organise a group of Dutch institutes and organisations, which can function as knowledge-providers. So indeed, from mid-1999 on, a number of Dutch institutions get involved in the project: training-institutes and organisations for Health Care and Elderly Care. Gradually, seven regular partners emerge and the programme coordinator initiates group meetings, which are held several times over the years. Chapter 3 contains a description of each of the partners, including the specific contribution to the programme.

Activities

There are several components to the programme:

- In order to involve a large number of authorities and health staff, group delegations from Qingdao, Suzhou and Beijing pay visits to the Netherlands, during the years 1999 – 2002. The schedule invariably contains brainstorm sessions and visits to the Dutch partner organisations and is, each time, adjusted to the specific composition and focus of each delegation. When necessary, other institutions are involved as well. The last visit in 2002, for example, includes a visit to the University of Professional Education in Amsterdam, hitherto not involved in the programme. During the four years, 10 visits take place with an average of 10 Chinese visitors each.
- Several Dutch partners undertake individual visits to their Chinese counterparts, from which longer-term bilateral collaboration originates in some cases.

In spring 2000, a team from the GDVV visits Suzhou, as part of the support to the

Suzhou Welfare House. In February 2001, the GDVV group organises a small symposium in Suzhou for staff of the Suzhou Welfare Home and for staff of homes

for the elderly in the city. A further GDVV visit to Suzhou takes place in November

2002, on invitation of the Suzhou Welfare House. New plans for exchanges are

made at that point in time.

In July 2000, a 2-person delegation of the Hieronymus Bosch Hospital (then: Bosch

Medi Centrum) spends several days in Qingdao. The Second People's Hospital is

interested to reflect on the necessary hospital changes, once Primary Health Care will develop.

In April 2000, a Dutch GP and a NIZW adviser visit Qingdao to discuss general

practice.

In August 2000 and May 2001, director and staff from the HealthCare group Almere

visit Suzhou and Qingdao, for discussions on the development of family practice.

In September 2000, a delegation from Care Spectre Nieuwegein visits both cities to

discuss on rehabilitation.

- On request of the Chinese partners, a specific training of 3 months for health planners and health managers from Qingdao and Suzhou is organised. Fontys School for Social Work in Eindhoven provides these trainings: from 1999 on, seven courses for 10 Chinese participants each are provided, the last of this series taking place early in 2003.
- In 2001, the King William 1 College in Den Bosch provides for a 6-week course for 20 nurses from both cities. This is a “Train the Trainers” course for home care teachers.

Before the course, staff from the College visits the two cities to make an assessment

of training needs and design the training format. After the course, in April 2001, a

delegation of four persons of the Dutch teaching staff visits the two cities again, to

discuss with the participants the degree to which the newly acquired knowledge

could be put into practice.

- During spring 2001 equally, a group of ten general practitioners from both cities receives a six-week training by the Healthcare group Almere. The training focuses on the role and position of the General Practitioner and the relationship between the GP and his patients.
- In October 2001, a symposium is held in Suzhou, with a large Dutch and Chinese participation. There is lively interest from other cities in China as well. Chapter 4 summarises the proceedings of the conference.

During the mutual visits, strong relationships develop between some of the Dutch partners and the corresponding Chinese Institutions. This leads to bilateral agreements and visits, as is evident from the GDVV activities. E-mail contacts between the Dutch training institutes and their former students continue.

How the collaboration developed

Over the years, the Chinese partners get to understand better what the Netherlands has to offer – and what not.

As far as the Dutch partners are concerned: from the start they realise that, in this programme, there is no question for the Chinese of copying the Dutch models. Rather, the Chinese partners seek inspiration in the Netherlands and look for principles of Primary Health Care and Elderly Care that can be applied in a Chinese manner. This leads to a frank exchange of information and ideas, which does not commit one or both sides to direct implementation.

By way of example: the development of systems of Primary Health Care and Elderly Care in China takes place in a complex context. A minority of the population in both cities has got a health insurance, although the number of insured persons rapidly increases. Hence, there is no question that the health insurance companies play the same role as they do in the Dutch system. However, the Chinese students who follow courses in Eindhoven, Den Bosch and Almere, use their knowledge and insight to propose models of care and a process of change to their superiors back home: they write the proposals during their course in the Netherlands. Since the students partly are senior managers in both cities, they have the required background information to do so.

The combination of general orientation of health managers and professionals and specific courses for a number of them has, in both cities, resulted in a high level of motivation and skills among those responsible for the development and implementation of Primary Health Care and Elderly Care.

The programme is not entirely one way traffic. Without exception, the Dutch partners benefit from the collaboration as well. They feel that the relationship with China enriches their own staff and institutes, due to the confrontation with other cultures and views. In general, the staff of the Dutch partner organisations appreciates the visits from China. For the organisations as a whole, their involvement in the Chinese programme may feel as a burden but this is eclipsed by the non-material rewards. The institutes are proud to be partner in a longer-term programme of collaboration with China.

Financial aspects

In agreement with the MoU, both the Dutch and Chinese sides financially contribute to the programme. Accommodation and local expenses in China for the Dutch visitors are provided for by the Chinese counterparts. International flights for the Chinese visitors to the Netherlands are equally paid for by the Chinese.

The Ministry of VWS covers the expenses of the Chinese visitors to the Netherlands, the travel of the Dutch counterparts, the coordination and other general costs. The training by the Fontys School on Social Work and the Healthcare Group Almere is funded by the Ministry of VWS as well. The total financial contribution from the Ministry of VWS in the period 1999-2003 is more than €500.000.

The training by the Koning Willem I College in 2001 has been funded by the so-called Asia facility of Senter, an agency of the Ministry of Economic Affairs in the Netherlands.

When receiving Chinese delegations, the Dutch counterparts provide their time for free. Since most of the Dutch institutions receive Chinese visitors quite regularly, their contribution in time represents a considerable value. When

they pay visits to China the Dutch partners mostly make their time available for free as well.

Further plans for the future

At the end of 2002, the MoU between the two countries finished, and with that the agreed upon programme of collaboration. However, both the Dutch partners as well as those in charge in Qingdao and Suzhou, and the SDPC in Beijing, intend to continue the collaboration. The newly developing models of Elderly Care and Health Care require the training and retraining of many health professionals and health managers. The existing training capacity in both cities is not yet sufficiently developed, in terms of the availability of curricula and teaching staff.

After discussions on the modalities of support from the Dutch partners to the training capacity in both cities, the first courses are provided early in 2003. The courses concern health management, nursing and Primary Health Care. These trainings are also seen as the start of a Sino-Dutch Knowledge Centre on Healthcare.

The NIZW International Centre maintains its coordinating role, and is in charge of fundraising for the coverage of the programme.

The further development of this expertise centre is one of the main challenges for the coming years.

The development of Community Health Services in Qingdao

Qingdao is situated in Shandong province, approximately 600 km north of Shanghai. The city itself has 1.4 million inhabitants in 6 urban districts.

The system as it was

The starting point in Qingdao in terms of care and healthcare is identical to other cities in China: a large number of hospitals of different size that developed in an unplanned and uncoordinated manner. There are smaller clinics, either with or without beds, with a varying number of doctors and nurses and with varying specialities. Some of these clinics function as a first line facility but there is no coherent network, there are no standards. Most of the doctors in these clinics are medical specialists. Especially the smaller hospitals are underfunded and underused: the population prefers the bigger and better equipped hospitals. As a consequence, even for minor illnesses people visit the large hospitals. Hence, the system is top heavy and expensive. There is no community care to speak of. Isolated institutions for the elderly exist and some home care activities, but again, there is no general coverage, there are no quality standards and services are irregular and erratic and there is no functional relationship between institutions. The picture in healthcare is part of the wider phenomenon that the growth of the population and the developments in society at large during recent years were not matched by concomitant government policies.

In Sifang district, population 430.000, there were 16 first level hospitals, 4-second level and 2 third level hospitals, 52 private clinics, one epidemic station and one health centre for women and children. They did not form a system, there were no standards of performance or quality, although there were a number of formal regulations to comply with.

The new system, some principles and practices

In 1999, a start was made with the development of community Health Care. This was part of a general national policy to adopt a community approach, which has started in 1997. This includes community administration, community public security, community culture, community service and community Health Care.

In 1999, the establishment of a steering group by the municipal government, the earmarking of funds and the selection of Sifang district for piloting the development of community Health Care were the first steps. Sifang district also takes part in other pilot activities to develop a community approach, which are initiated at national level.

A Qingdao Community Health Service Experimental Working Plan established some basic principles and targets.

The main principle is: "first line treats common disease, hospital treats serious disease". At district level, a system with three layers was designed: primary, secondary and tertiary level. At the top of the triangle is a hospital. In the

case of Sifang district this is the Second People's Hospital, to become a centre of medical expertise, training and research. The middle level is formed by the functions of day-care, long-term care and rehabilitation, for in and outpatients. The lower level is the Community Health Centre, which functions as a gatekeeper of the health system and as first contacts for patients with the health system. There are six functions of community care that need to be organised: health protection, health education, family planning, treatment of common and minor diseases, treatment of chronic diseases and rehabilitation.

The street level is the lowest organisational level for (health) care, so each street has its own community health centre. The General Practitioner (GP) can be based in the community health centre but frequently he works in an easily accessible facility or clinic, depending on the situation in the street. He mostly works in a small group of GP's. The community care centre comprises a home care organisation, including nursing staff, an alarm post and ambulance service. The GP has a family orientation and uses patient files. The patient can choose his own permanent GP and a GP can have up to 2500 patients, he conducts home visits. The GP's refers patients to the district hospital when necessary. A diagnostic centre, physically located elsewhere, complements the community care approach: it is used for examinations of patients of GP's – which previously was not possible.

Working on the change, and the results

The change from the previous to the new system required a number of measures.

At the start, Sifang district reserved funds from its own budget for the health sector development, in addition to the municipal funds and a project group was set up.

Later, Shinan district offered itself as well and was included in the pilot.

First, an inventory of existing health providers and health facilities and a plan for conversion of existing facilities were made. The development of further principles and standards for care was initiated. For example, the referral system would not (yet) be set up like in the Netherlands, since the health insurance system does not allow for that. It is through quality and convenience that GP's will attract their patients. Quality standards for community health services and for health staff were formulated.

Secondly, managers in Health Care were trained and criteria for organisations, that were to be recognised as part of the community services, were established. Among them are many private organisations (clinics for example). At street level – a street may count up to 20.000 inhabitants – an administration was set up and staff was trained.

In the middle of 2002, more than 100 clinics have been transformed in a GP clinic. Other clinics were closed and illegally working doctors had to stop practising.

GP training was set up by Qingdao Medical School, inspired by the GP training in the Netherlands.

Initially, medical specialists are retrained, later recently graduated doctors will be trained to become GP's.

At the end of 2002, more than 700 doctors have been trained as a GP.

In Sifang district, four rehabilitation centres new style have been established by mid 2002. They are part of the system, but their role, activities and skills need to be further studied and developed.

Also, four diagnostic centres have been converted into community diagnostic centres, which means that a functional relationship of previously existing diagnostic centres is established with the GP clinics.

An important part of the introduction of the new system is the information to the population. Information sessions, exhibitions, distribution of booklets and many more activities have been undertaken. An opinion poll in 2001 indicated that a large part of the population is aware of the new system and favours the changes.

What was the role of the Dutch ?

Exchange with Dutch experts and visits to the Netherlands helped to define the above mentioned community Health Care model. Tens of health managers and civil authorities from street, district and municipal level have visited the Netherlands over the years to get acquainted with the Dutch philosophy and principles on Primary Health Care and the model used. Thirty-eight managers, GP's, nurses and teachers went to the Netherlands for various types of training by the Koning Willem 1 College, the Fontys University and Healthcare group Almere. Amongst others, 10 GP's received additional training in the Netherlands.

Any change is confronted with obstacles and resistance. In this case, the challenge is to get lasting support within the health system for the shift from hospital oriented care towards Primary Health Care. The visits to the Netherlands are enlightening and motivating and have contributed to the consolidation of the vision behind the changes among so many people concerned.

The need is felt, in Qingdao, to continue some form of collaboration between the Dutch and Chinese partners from 2002 on, in order to sustain the changes. Implementation in Qingdao is only halfway and needs further support.

Rehabilitation is one focus, the development of disease control by GP's, for example on diabetes, is another one. Also, programmes on women's health and children still need to be embedded in the system, as well as health education and promotion. A professional organisation of GP's is needed, in order to sustain their development.

The development of Elderly Care in Suzhou

Suzhou is situated in Jiangsu province, at approximately 100-km south west of Shanghai. It is an ancient city and enjoys strong economic growth and prosperity.

The urban area of Suzhou has 1.06 million inhabitants, of which 11.7 % over 65 years and 15.8 % over 60 years in the year 2000. There are three urban districts. The larger Suzhou area counts more than 5 million inhabitants, in the rural area of the region ageing is slightly less advanced. Projections are that by 2010 the proportion of urban elderly over 60 and 65 will have risen to respectively 22 % and 14.5 %.

Several years ago the city initiated a three level system for Elderly Care, at municipal, district and street level. By the end of 1998, at the start of the project, there were 20 Elderly Care institutions of all kinds and 1000 geriatric beds, which is 10 per 1000 elderly people. There were 23 community care centres, 330 elderly activity rooms, 28 elderly rehabilitation clinics and more than 4000 volunteers. Impressive as these figures may be, these facilities did not form a coherent and well-organised system and the actual capacity and quality of the facilities were insufficient. Virtually no home care was developed and there was no leading organisation or central policy development.

By that time, two surveys revealed that in total, 28 % of the elderly lives in institutions while 72 % lives at home. Of those who do not live in institutions, 38 % lives with children or relatives and 62 % lives alone. This pointed to a great need for home care or community care. Having assessed the situation in other cities, the authorities became convinced that the family will continue to play an important, albeit declining, role in Elderly Care. The family will need support from community services, and need for community care or institutional care for the elderly will increase.

From 1999 on, a number of visits to the Netherlands were made, studying the Dutch approach to Elderly Care. The comprehensiveness of the system is very instructive: income (pensions, social security), housing, Health Care and social aspects are all regulated by laws and acts; organisations and institutions are organically integrated. The extramural part plays an important role; 80 % of expenditure is spent on intramural care, the rest on extramural care. The shift in orientation from intramural to extramural care that took place some time ago in the Netherlands provides for an interesting learning point for the Chinese side. Given the scarce resources in Suzhou, extramural care is easier to realise. The Dutch example showed that there was a need to overcome administrative divisions, if an effective network is to cover the whole city. It was concluded that the concrete services need to be developed at street level and that one leading agency should be identified, which was to become the Municipal Social Welfare House.

Slowly, a model for provision of Elderly Care emerged in Suzhou based on two starting points: the focus needs to shift from intramural to extramural services, which are client oriented and not bureaucracy driven, and comprehensive services that have broad coverage need to be developed.

The basic unit for provision of the different forms of care and services is the street level: home services, day care, residential care, rehabilitation, Health Care and welfare services like opportunities to meet other people. At the district level residential care is provided and support is given to the street level. Studies on needs and demands of the elderly are done and used for policy development.

At municipal level, the Suzhou Social Welfare House, next to offering residential nursing care, focuses on rehabilitation and combines with health education and provides for training of professionals. It initiates policy development and has, for example, established a list of 18 services items that need to be provided or to be available, among which are emergency treatment, Health Care, security, home help, shopping, police support, law counselling etc. This list by now has been approved by the State Civil Administration Bureau and is known as the Suzhou model.

How does the change take place from the previous to the new situation ?

Jinchang district was chosen as the pilot area. At street level, new residential homes were constructed and old ones were rehabilitated. Pre-existing community centres were remodelled and re-equipped, so that they became multifunctional. In Jinchang district there are now seven elderly homes, of which five have an auxiliary facility. The number of geriatric beds rose to 17 per thousand elderly; there are 92 activity rooms for the elderly, 23 facilities that provide for psychological support, 63 home beds and 38 community health stations. Also in the two other districts the reform started. A plan to cover the whole city with these services is being implemented.

The Suzhou Welfare House, operated by the Suzhou Civil Affairs Bureau, was founded in 1710. It was an institution for orphans, handicapped and elderly. In the last ten years it opened a municipal geriatric hospital and a day care centre. Presently, there are 600 beds, of which 350 geriatric beds. Managerial and care staff numbers 253 and medical staff 180.

The Suzhou Social Welfare House is being remodelled, for which considerable funds – more than 10 million RMB – had to be reserved. From the previous standard institution with a large number of beds and a hospital like atmosphere it develops into a multifunctional home. The orientation is changing from a medical to a more social perspective. The day care centre recently opened. A school has been affiliated to the Welfare House, which provides for courses for the elderly. With the assistance from the Dutch, a number of lectures for Elderly Care workers has been given.

Particular mention needs to be made of the alarm system, in use since July 2001. It enjoys quick popularity and is called the intelligent nurse. It is

connected with the alarm system of the public security and of the emergency system of the municipal hospitals.

A survey was done, designed by a Sino-Dutch team, on the qualifications of the staff, working with the elderly. More than 70 % of staff has only primary level education, 25 % middle school and only 4 % secondary school or higher. To provide for the comprehensive and demand oriented community care that is being developed, the professional skills of the care workers needed to be improved. After training in the Netherlands, 10 professionals from Suzhou wrote a training book with 10 chapters covering all the details of Elderly Care. More than 400 staff has received an additional training by now, on nursing and home care.

Many measures need to be taken in order to come to high quality services with a good coverage. Further training of staff is necessary. Also, more regulations, criteria and standards are needed for resources allocation and provision of services.

In order to ensure a parallel development of community Health Care, a number of Health Care administrators and Health Care professionals have received training in the Netherlands, together with their colleagues from the elderly services. The previous absence of exchange between the Elderly Care and Health Care systems has been partially remedied by that. The concept of community Health Care has been introduced and a series of initiatives has been taken for its implementation. It started with the establishment of a community Health Care committee, of which the mayor is in charge and most of the municipal government departments are members. The committee drew up the following model: a community health centre for 200.000 – 300.000 people has several residential functions: as a nursing home for the elderly, as a rehabilitation centre and as an elderly home. Under the jurisdiction of this centre come the community health stations, covering 15.000 – 20.000 persons. Here the 6 basic functions of Primary Health Care are exerted. Retraining of medical staff is required for this new system and Suzhou Health School offers 400-hour courses to doctors and nurses in the city. By the end of 2001 some 300 have been retrained and most of them work in the community health stations, of which by now more than 100 are functioning. A three-year training of general practitioners is being set up as well. Provision of medical care to elderly people in nursing homes or homes for the elderly as an outreach activity takes place in an experimental way in some areas. This needs to be systematically done, but the constraint is the lack of resources. A textbook on community nursing practices is being written by the trainees who have been studying in the Netherlands.

Other changes are urgently required as well: a social security system needs to be created. Because Suzhou's economy has been developing rapidly, it is neither desirable nor necessary to wait for a national policy. A district based social security system will be completed as soon as possible. Next to this, an

Elderly Care fund will be created from tax revenues, inspired by the pension funds elsewhere.

Some services will be provided on basis of out-of-pocket payments.

Finally, collaboration with the Health Care sector, with the transport department and with the housing department needs to be intensified in order to develop really comprehensive services.

Sino-Dutch symposium on Elderly Care and Community Health Care Reform Suzhou, 8-10 October, 2001

This symposium brought together the Chinese and Dutch partners in the project, along with a number of Chinese representatives from more than 15 provinces and several cities. The intention of the symposium was to consolidate and discuss the achievements of the project and to look at the agenda for future action. Sharing the information and ideas with colleagues from other parts of China was to give additional value to the efforts undertaken by the partners in the project from the two countries.

The 33 persons strong Dutch delegation was headed by Mr. Hans Smons, chairman of the board of the NIZW and Mr. Peter Pennekamp, director general of the Ministry of Health, Welfare and Sports. All Dutch partners in the project participated in the symposium. Several Dutch companies, like Estafette (specialised in home alarm systems) and the international Dräger Homecare company took part as well. The joined home care providers in the Netherlands have set up a national support organisation called W.DTM, which was represented as well.

The consul general of the Netherlands in nearby Shanghai, Mr. Heinsbroek, attended and addressed the symposium equally.

The 92 Chinese participants were led by Mr. Yu Guangzhou, vice chairman of the SDPC and Mr. Yang Qingwei, Director General of the Department of Social Development of the SDPC. The vice Governor of Jiangsu province and the vice-Mayor of Suzhou both addressed the conference. Among the participants were many of the partners from Suzhou and Qingdao, officials from the SDPC and more than 50 representatives from other provincial governments and city administrations.

The presentations by several national Chinese authorities summarised the situation of the ageing population in China and the challenges created by the rapid increase of the number and proportions of elderly people and the gradual weakening of the family support system due to small families and increasing mobility of the younger generations. The worldwide trend has reached China already: 6.96 % of the population is aged 65 and over and this will increase to more than 20 % in 2030. The differences between rural and urban areas and eastern/coastal China compared to western and northern China were emphasised: in terms of general economic levels, individual income and family composition the situation varies. Hence, there are variations in the need – and the possibilities – for social security systems, services and institutions for elderly people. The encouragement of migration from rural to urban areas was mentioned as an approach that deserves further study. In 1949 the pension age for men was set at 60 years, for women at 55 years. In view of increasing longevity these age limits need to be reconsidered. In 2000, the government decided to address the ageing problem more actively, and action has been included in the tenth five-year plan on the National Economic and Social Development. New ways need to

be found to generate funds for services for the elderly, and the Starlight project is seen as an important contribution: the revenues of a so-called welfare lottery.

The need for introduction of Primary Health Care is felt all over China and supported by the majority of the population, according to surveys. The epidemiological transition – decrease of infectious diseases, increase of chronic diseases -, the inefficiency of the current hospital oriented health system, the strong annual increase of medical expenses and the inaccessibility of the health system for many people, especially the elderly, all point to the need to develop Primary Health Care. In 1997 already the government initiated the policy on health reform and in 1999 issued some guidelines on the development of Urban Community Health Service. The slogan “common disease to be treated by community health service and complex diseases at hospital level” summarizes the vision behind the reform. Six functions are foreseen for the community health services: health protection, health education, family planning, treatment of common and minor diseases, treatment of chronic diseases and rehabilitation. However, there is a lot of informational work to do among authorities and medical staff to implement the policies.

Care for the elderly and Primary Health Care are developed in an era during which the reorientation from a planned economy to a socialist market economy takes place. This creates new challenges, like the redefinition of the role of the state and its organs. The state should withdraw from implementation tasks and limit itself to creating conditions, regulation and control. To ensure financial accessibility to both Elderly Care and Primary Health Care is an immense task. Social security, health insurance and pension systems currently only cover a part of the urban populations and hardly the rural populations. The design and funding of systems for the very diverse situations in the different parts of the country requires a great effort. New opportunities arise as well: China's membership of the WTO, the economic growth and the development of civil organisations.

Presentations from several Chinese cities described the approach taken to implement the policies set at national level.

In **Shanghai**, population 13 million, ageing is already in an advanced stage: it has the largest proportion of elderly people in China: 14.2 % of the city's total population is over 65 with 12.6 % of them being over 80. These figures are double the national average. Already in the early nineties programmes on Elderly Care were developed. A Shanghai Municipal Old Age Working Committee has been established to coordinate between the different sectors and local government departments. The development of private organisations that run homes for the elderly is encouraged, resulting in an increased percentage of privately run homes: 26 % in 2000. Once the network of institutions for the elderly starts to have a wide coverage, now the development of day care and home care has been taken at hand: home nursing, meal deliveries, performance of household tasks etc. The Starlight

lottery functions already in Shanghai and is expected to contribute at least 80 million RMB in the city per year.

In **Chengdu**, capital of the province Sichuan, with 10.13 million inhabitants, the population aged 65 and over is much less than in Shanghai: 895,000 or 8.8 % of the total population and the over 60 population is 12.5 %. Emphasis has been put on the income of the elderly: A social security system with different compartments is being developed: basic insurance, supplementary insurance and individual private insurance. In total, 1.7 million people were insured in 2000. An elaborate system of reimbursement of medical expenses made for the elderly to the hospitals has started. In addition, support is being developed for Chengdu's large rural population, especially to the poorest households: supply of basic commodities and support to decent housing. A series of other policies and programmes are under development and elderly are encouraged to make active use of their rights and for that purpose the "Law on Rights of the Elderly" will be widely publicised.

Jinan city, located in Shandong province, covers an area of ¼ of the Netherlands and counts 6 million inhabitants.

In 1996, the establishment of community Health Care started and attracted nationwide attention through a national community Health Care conference in November 1997.

The government of Jinan included the community Health Care policies and implementation plans in its economic and social development plans, which guaranteed cooperation and involvement of other sectors. At district and county level, the governments developed plans of their own, integrating community Health Care in the overall community development plans. At this level, the coordination committee comprises, amongst others, the health, education, civil affairs, financing and labor departments. At street and town level, corresponding committees exist. The reform resembles the approach taken in other cities: the existing health institutions are restructured: primary hospitals turn into community health centers of which one is planned in each street; several community Health Care stations per street are set up in resident committees. Health centers and stations employ doctors and nurses. One doctor plus a nurse serve 1500-2000 residents, which contract them. A training school for general practitioners has been established.

Health research has a prominent place: some pilot interventions have been researched, like a diet and sport programme, without drug treatment, for persons with diabetes, hypertension and obesity. In Huaiyin district basic data and information on chronic diseases were collected among 170,000 residents, as part of a national non-infectious disease control programme.

Zhenjiang Municipality, in Jiangsu Province, started the introduction of community health in 1998.

As a result, currently seven Health Centers are operating around the clock, each covering 30,000 – 50,000 population, within 15 to 20 minutes' ride and the network is expanding. At the start, each Health Center surveyed the community it serves and established health files of the residents. There are no stations foreseen under the level of the Health Centers. The former neighbourhood clinic is cancelled. A training programme for the staff of

Health Centers is developed and the staff works in a more proactive way than before.

Among the challenges for the new system is the need to strike a better balance between workload and activities of the staff of the health centers and the income for the services supplied.

Against the background of this nationwide picture, the project-partners from Qingdao and Suzhou gave several presentations. They described the principles and practices developed over the past 3 years, inspired by the exchange with the Dutch partners. *More information can be found in the chapters on the two cities.*

Several presentations by the Dutch participants summarised their contributions to the collaboration with the Chinese partners:

Piet Driest, who coordinated the project for three years on the Dutch side until recently, was the first of the Dutch speakers. He started with expressing his appreciation for the fact that this conference is a milestone in the Sino-Dutch collaboration. He highlighted the similarities between the two countries by giving concrete examples of the physical needs of elderly people in China and in the Netherlands and by showing that the response needed was different in organisational terms but identical in practical terms as far as the elderly persons themselves are concerned. The same applies for Primary Health Care: he expects that, in both countries, patients ask for the same quality and accessibility of care when they have the chance to express themselves. The collaboration between the partners from the two countries was a learning process, he underlined. The dedication and sense of purpose of the partners overcame the cultural differences. The challenge ahead is to consolidate the collaboration but in new ways.

Hans Simons summed up the factors that made this Sino-Dutch collaboration to a success:

- The involvement and good collaboration between the governments of China and the Netherlands gave a valuable impetus to the project
- The coalition that has been formed between the Dutch partners among themselves and between the Dutch and Chinese partners proved to be a stable setting. This allowed for the gradual building of confidence between the parties.
- The realistic timeframe of the project – step by step, but not too slow – was helpful to achieve goals in the period of time which was agreed upon.
- Both parties supplied a reasonable financial contribution, which showed commitment and created the necessary material conditions for the implementation of the project.
- A further factor was the process of regular adjustment and evaluation of the programme. In this way, justice was done to the growing understanding of each other's situation, needs and intentions.

- Finally, the project and its results can be reproduced; it does not need to be a single experience.

Hans Simons also mentioned some recent developments of importance to the Dutch systems of Care and Health Care:

Decentralisation and privatisation are themes not only in China but in the Netherlands as well: it impacts on the implementation of the care system and requires a new role of the government. The development of the European Union brings with it a slow but permanent process of convergence towards certain approaches, values and standards in care. Although the European Union in its legislation and regulations does not influence the care system as such, many of its elements are subject to European policies, like the harmonisation of diplomas for professionals and the development of standards for quality of care.

As in most European countries, the Netherlands is confronted with an increase in costs of healthcare, which seems to escape control. This does require new ways of budgeting and asks for new views on which care is essential and which is not.

Medical technology, finally, does create new possibilities and challenges: the development of new ethics on gene technology amongst others.

Peter Pennekamp emphasised that one of the pillars of a policy on ageing is the development of a coherent and flexible pension system. Taking the system in the Netherlands as an example, he suggests that there are three components:

The government guarantees a minimum income for all aged persons (in the Netherlands above 65 years), which is funded from general taxation. The second component is a company based pension fund, to which both the employer and the employee contribute. Self-employed people can adhere to special pension funds. Thirdly, people can use private savings to add to their old age income. A point of discussion is the question under what conditions the entire population can be covered by pension funds.

In general terms, he asked attention for Mental Health as one of the increasing health concerns in the world: according to the World Health Organisation in the coming decade mental illnesses will increase substantially. He also mentioned the relationship between employees and employers that influences health and wellbeing of the former. In the Netherlands this is an issue of considerable debate. Finally he stressed that proper housing adjusted to their needs is a condition for elderly people to remain full and participating members of society; it should be avoided that elderly people are locked away from mainstream society.

Han van Oosterbos, director of the Almere Healthcare group and Daan van de Meeberg, director of the GDVV group, one of the care providers in The Hague, described the functioning and organisation of their respective institutes. They underlined that their clients are central and that the organisation should follow the clients in their needs and demands and that clients should not be hindered by bureaucratic red tape. *More information on*

the two organisations can be found in the chapter with the descriptions of the individual partners.

Pieter Huijbers, at this point in time coordinator of the programme, in his address asked attention for hardware for home services for the elderly: alarm systems, respiratory support systems, rehabilitation devices. They help to sustain elderly people in their home environment and reduce the need for institutionalisation.

He also emphasised the chain-approach in health and care: the system should function in such a manner that patients or clients during the different phases of the period that they need care or Health Care, easily find access to the care they need. This requires good collaboration and fine-tuning between the different layers of the care system. For example, home care, the Primary Health Care level and the secondary and tertiary level should coordinate their services, so that individuals do not run into problems when they need a shift in care from level to the other, or when they need care from several services at the same time.

Another issue of attention is the needs assessment: in order to assure timely and adequate care for the elderly, a quick and standardised needs assessment has to be put in place, with good communication with the providers of the services. In the Netherlands, for this purpose independent bodies, the so-called regional organisations for needs assessment, have been developed. As one of the cornerstones of the system, their challenge is to avoid bureaucracy and delays for the patients and clients and to provide for transparent assessment conclusions and recommendations.

As his closing remark Mr. Huijbers mentioned that it takes time to learn to collaborate and he wishes to appreciate the investment of the Chinese partners in the process of working together.

The Dutch partners in the programme

Netherlands Institute for Care and Welfare in Utrecht

The **Netherlands Institute for Care and Welfare** / NIZW is a non-governmental organisation which targets innovation and improvement in the care and welfare sector. It provides information and support to many organisations and more than 400,000 professionals and volunteers working all over the country in fields as varied as child care, social services, community work, care and services for the elderly, youth care, shelter, nursing homes, home care and services for disabled people.

Also organisations outside the care and welfare sector, but providing care and welfare services, such as schools, provincial and municipal authorities and housing associations, regularly make use of NIZW's services. The activities of the Institute are grouped around a number of themes: information and infrastructure, child and youth care and welfare, caring and nursing, organisation of care, and local social policy. Within these frameworks nearly 400 staff are committed to developing and implementing new methods and information materials, matching supply and demand of service delivery, and expertise building. Concrete products include research and study reports, conferences, education and training programmes, books, brochures, databases, websites, CD ROMs, videos and an information telephone / help line.

NIZW has an **International Centre** (IC), which contributes to the improvement of the health, care and welfare sectors both in the Netherlands and abroad. The IC stimulates and co-ordinates co-operation and exchange of knowledge and information between Dutch and foreign organizations, it monitors international developments in health, care and welfare that are of importance to the Dutch field, and it offers expertise and information on internationalisation. The IC seeks to establish links between the Dutch field of health, care and welfare and the relevant Dutch authorities, and between the Netherlands and other countries. In addition, the IC ensures contacts with international organizations, both inter-governmental and non-governmental. The International Centre has as its four priority areas of work: youth, public health, care, and social policy.

The NIZW International Centre has been particularly involved in reform of the health, care and welfare sector in the countries of Central and Eastern Europe. It involves the Dutch organisations in policy developments in the European Union and took part in the preparation of several UN summits, like the Madrid 2002 summit on Ageing.

The International Centre manages the Sno-Dutch Project on Social Development and Health Care. It has been requested to do so by the Ministry of VWS. The role of NIZW/IC is to plan, organise and co-ordinate the implementation of the programme. Therefore it maintains contact with the

Ministry of VWS and with the implementing partners in the Netherlands and in China. Over the years, the NIZW/IC also has hosted visits from other areas and authorities in China.

The GDVVgroup in The Hague

The GDVVgroup is one of the care providers in the city of The Hague. In its four nursing homes, five homes for the elderly, the Dr. W. Drees nursing home and 900 individual sheltered homes, the GDVVgroup cares for more than 2500 elderly people and has 1300 staff and 750 volunteers working for it.

The organisation is currently undergoing a process of modernisation, with more care being provided to clients in their own homes. This is in fact one of the trends in the development of care in the Netherlands today: from intramural to extramural. The care is thus organised in a more need-orientated way. Combined with changes in the care system where person-related budgets are being introduced into care for the elderly, the GDVVgroup will focus more on the wishes of clients. The use of ICT too, both internal and in communication with the customer, will occupy an increasingly important place.

Besides the attention and care that the homes of the GDVV group give to their residents, they also offer support to residents in their own neighbourhoods. For instance, locals can come to these homes for day care and ergotherapy.

In line with the trend that people want to remain living in their own homes as long as possible, more and more care is provided at home. A good example of this is providing emergency help to occupants of sheltered homes. Each sheltered home has an alarm connection with the home for the elderly or nursing home. The alarm is received by the reception desk, and then a carer is sent to the sheltered house to offer help. Residents of sheltered homes may also make use of a range of other services, such as the meal service and a variety of recreational activities.

If the stage is reached where a resident in sheltered homes does require more care, or even nursing care, in some cases it is still possible to continue living at home. The Moerwijk home for the elderly and Vrederust-West nursing home have started a new project where they provide home nursing care for residents in sheltered homes. The other GDVV houses will also offer this kind of care in the future.

The GDVV also has much to offer local residents who can still look after themselves perfectly well and have no need of sheltered accommodation. The Moerwijk home for the elderly is the first GDVV house to start up a new care subscription scheme for locals. As from November 2001, home care subscriptions will also be offered to occupants of two apartment buildings in the vicinity of the Vrederust-West nursing home. Home care subscribers live independently in their own homes, but have a special telephone with an alarm button. This means that in the case of an emergency they can contact the reception of the home for the elderly or nursing home, and a carer will come straight away to see what the problem is and what help is needed. Complete independence is thus combined with the security of knowing that

help is always close at hand. In addition, local residents with a care subscription may use a range of other services provided by the nursing home at a reduced rate, such as the hairdresser, pedicurist, meal service and participation in organised activities.

Since December 1999 the GDVV group has been involved in a collaboration project in China, with the Suzhou Social Welfare Home (SSWH) and the care for the elderly in the JinChang district. Visits were made to the Welfare Home, homes for the elderly in the city, private homes lived in by elderly people and a (traditional) hospital.

A number of delegations from Suzhou have also visited the GDVV and three members of staff at the SSWH have had a short period of work experience in the homes of the GDVV group.

The GDVV group has a number of elderly Chinese people among its residents, which gives the collaboration with the city of Suzhou a reciprocal character. For the Chinese residents in our institutions, a number of provisions have already been made to make their time with the GDVV group even more comfortable.

In February 2001, the GDVV group organised a small symposium in Suzhou for staff of the Suzhou Welfare Home and for staff of homes for the elderly in the city.

The central theme of this symposium was the stimulation of co-operation between the various disciplines. In addition, the opportunities for day treatment and day care as an addition to extramural provision were highlighted.

The role of home care here is an essential condition. The provision of alarm systems was discussed in this respect, whereby the Thuiszorg Den Haag (The Hague Home Care) looked into possibilities for this.

During the coming years, the GDVV group will be available to intensify the collaboration with Suzhou.

We would like to welcome staff from Suzhou to give them some experience of care for the elderly in the Netherlands. Together with Thuiszorg Den Haag, the GDVV group is also willing to support the development of home care and alarm systems.

The Hieronymus Bosch Hospital (in Dutch: Jeroen Bosch Ziekenhuis) in Den Bosch

This hospital organisation is a result of the merger on January 1, 2002 between the Bosch Medicentrum (Bosch Medical Centre) and the Carolus-Liduidina Hospital.

The new hospital has been given the name of the most famous inhabitant of Den Bosch: the fifteenth century artist and painter, Hieronymus Bosch. His grand imaginative powers and supreme skills still attract the people of the 21st century and inspire the management to develop and sustain a high quality of care.

Until a new accommodation will be realized in 2007 or 2008, the present five locations of the original two hospitals will continue to serve as they have in the past years. The hospital serves a population of 360.000 in Den Bosch and the region around it.

The Hieronymus Bosch Hospital is a teaching hospital providing a large variety of treatment and care. The hospital has 4000 employees and 200 medical specialists. In accordance with the new national regulations on the number of allotted hospital beds (2 beds per 1000 inhabitants), the new hospital will have approximately 700 beds in the future. There are nearly 28.000 admissions per year and 200.000 outpatient visits.

The Hospital offers specialised medical diagnosis, treatment as well as para-medical and nursing care. Presently, the hospital has only one so-called top-reference treatment facility, that of the kidney dialysis centre. In the future, ambitions go out to attaining permits for perinatology treatment and care as well as the status of a neurosurgery sub-centre.

During 2001, much energy and thought went into the development of a new and innovative policy for the total hospital organisation. One of the key aspects is the personal touch for every one of the patients that trust themselves to our care. The larger scale of the new hospital may not stand in the way of customer (patient) orientation and coherence of care. The hospital policy also has a number of other prominent topics, like improving quality, the further development of the teaching hospital and the acquisition of other very specialised top-clinical services. It strives to maintain its position among the best hospitals of the country.

One of the more recent delivery systems that prove to be an excellent example of this philosophy is the Multi-disciplinary Oncology Centre (MOC). Here, the medical specialists come to the patient instead of the other way around. The treatment and care are organised around the patient, so to speak. The quality of care is not limited to the professional aspects of the care delivered. Efficiency and effectiveness of the organization of care are also of high importance. Therefore, we also strive to shorten the length of stay to a safe and acceptable minimum. To achieve this, it is evident that Cupertino with other Health Care providers, like home care agencies and other primary and tertiary Health Care providers must be further developed, which leads to so-called chain care.

Hence, the Hieronymus Bosch Hospital maintains excellent relationships with other stakeholders in Health Care, including specific patient groups, general practitioners, nursing homes, rehabilitation centres, psychiatric care facilities, facilities for the mentally and physically handicapped as well as with the Health Care insurance companies and local, provincial and national government.

High quality hospital care goes hand in hand with high quality education and training facilities. This applies to both the training of young medical specialists as well as nurses and para-medics. 1.700 nursing students were trained in our hospital in the course of 2001. The hospital has an accreditation to train young medical doctors to become specialists and accreditation for 15 different specialisations, among others those of intensivists, internal medicine and clinical physics.

Hieronymus Bosch Hospital and China

Since six years, we receive numerous visits from China. The Fontys Institute of Social Work and the King Willem 1 College as part of a specific training initiate some of the visits. Other visits are delegations from Beijing, Qingdao and Suzhou.

Also we facilitate visits of delegations to other partners in our network (including nursing homes, various other institutions as well as a Health Care Insurer, CZ Insurance's in Tilburg). Presently we are investing in a more permanent relationship with the Municipal Health Bureau of Suzhou. There are plans for exchange of more vital information and training of people from Suzhou.

Mrs Rosemary van der Avort – Lier has been involved in the China programme for many years now: “We find working with the Chinese very inspiring and meaningful. It helps us to reflect on our own situation, teaching us new values and giving us insight and reflection about our own system. China is a booming nation with many ambitions. We have learned from their eagerness. The country is filled with positive energy, something we miss at times in the Netherlands. Change doesn't seem to be a threat to China, but a means to reach their goals of becoming one of the leading nations in the world. I have been impressed by the ingenuity of our partners. They know very well what they want and use our experience and information in a careful and critical way. For example, they understand our individualism and need for privacy, but do not aspire to go as far as we go, in that respect. On the other hand, it is very helpful for us when we know some more of the Chinese culture.”

HealthCare group Almere in Almere

Almere is a growing town on reclaimed land, the like of which is unknown in the rest of the Netherlands. In just over 25 years, Almere has grown from the first single inhabitant to a town of more than 160,000 residents. Over the next 25 years it is expected that the population of Almere will more than double to reach a total of 350,000 residents, whereas in the same period the number of elderly persons will increase fourfold.

Almere is growing and the healthcare provision is growing with it. Much has been achieved during the past 25 years. The co-operating care providers have succeeded in providing every new resident with a broad and well-organised care provision in their own neighbourhood. For the care provision in Almere, this has meant a growth from a small group of pioneers to a sector with more than 5000 employees. Due to a permanent building programme the infrastructure for care provision developed from the first temporary building to 40 buildings, scattered around the town.

A new town with a new view of healthcare. A step towards an integrated healthcare supply chain where residents and patients are offered the right care at the right moment.

Over the past 25 years, Almere has introduced a range of developments directed towards greater regional coherence and collaboration between care providers. The reasons for this stem from the following observations: that the number of elderly and chronically ill is increasing, the demand for care is changing and becoming more complex, the patient no longer accepts the inconvenience caused by bureaucratic barriers between different parts of the healthcare supply chain, professionals wish to concentrate on their core tasks without being burdened by bureaucratic red tape; and finally that developments in medical and information technology are opening up new forms of coherent care provision.

Today, Almere is also an example of coherent local provision, transmural care and healthcare supply chains. It is a strong intention in Almere to share our experiences with others. This is not in order to be copied literally elsewhere but rather to facilitate the application of some principles concerning a patient/care consumer-oriented and integral provision of residential care, care and social services.

Almere is a continuous test bed in the areas of care organisation and care renewal.

Since 1999, Almere has been involved with the China project. A number of delegations has visited different locations of the Healthcare group Almere. The main focus for most of the delegations was the organisation of the primary care in Almere in local Health Centres and especially the role of the general practitioner in the chain of care. The general practitioner in Holland plays an important role as a gatekeeper for the hospital and other health

institutions. About 90% of the health problems in Holland are effectively treated by the GP. In the Health Centre he works closely together with other primary care workers like home care nurses, pharmacists, physiotherapists, midwives and social workers. The delegations visited also residential homes and nursing homes for elderly and the local hospital as part of the chain of care.

Apart from the different delegations one group of ten GP's from Suzhou and Qingdao has been the guest of Health Care group Almere for 6 weeks in 2000. This group has gone through an intensive program mainly about the role of the GP and his Cupertino with others. After that visit one GP from Almere has visited Qingdao and Suzhou and has shared some of his experience. For Almere it is also very useful to have a close collaboration with our Chinese friends. On one hand we like to share our experience and our model in which we strongly believe, on the other hand we are most impressed by the effective ways in which our Chinese friends are developing their own vision and implement important changes in their health system in an unbelievable short time. What we mostly have in common is being pioneers in our different countries and our aim to provide the best care we can.

The Flevo Hospital in Almere

Almere is a young city built on reclaimed land, the so-called *polderland*. Every year the city welcomes 7000 new inhabitants and thus the Flevo Hospital is located in a rapidly growing city, which is a unique situation for the Netherlands since, elsewhere, there is no space for expanding, not for cities nor for hospitals. Consequently, the Flevo Hospital sees its number of patients increasing day by day. In 1991, when the Flevo Hospital opened its doors for the first time, Almere counted 70.000 inhabitants and now, ten years later 160.000 people are living in Almere.

Finally, the Flevo Hospital is located in the city centre, which is, again, unique for the Netherlands. For many years hospitals have been banished to the suburbs, far away from the inaccessible city centre.

Taking this all into account, it can be said that the Flevo Hospital is a unique hospital located in the pounding heart of a unique city.

In Almere the Flevo Hospital, healthcare centres, nursing homes and ANOZ, a medical insurance company, have been co-operating very closely in order to fine-tune all activities in the area of Health Care, which is of great importance since an expanding city continuously asks for keeping up, anticipation and co-ordination from all actors in the field.

The efficient way in which the so-called Primary Health Care (including general practitioners, district nurses, physiotherapists) is organised in Almere, has resulted in a kind of hospital differing from other hospitals in the Netherlands. Health Care, such as the reception of emergency cases, care for chronically sick patients and aftercare, are not taking place in the Flevo Hospital but in health-care centres. This enables the Flevo Hospital to focus mainly on specialist medical care provided by its physicians and trained nurses.

Since September 2001 75 physicians have been working in disciplines ranging from internal medicine, paediatrics, surgery, dental surgery, rheumatology and oncology. Patients also can enter the Flevo Hospital for specialist dental care (Centre for Special Dentistry), plastic surgery, IVF and pain control.

At this moment there are 240 beds, including 7 incubators, 8 intensive-care beds, 12 medium-care beds and 5 surgeries.

For 2001, 70.000 first visits by outpatients, 100.000 repeated visits, 5600-day care treatments, 11250 admissions and 65000 patient-days have been planned. The 2001 budget of the Flevo Hospital amounts to 50 million Euro.

To optimise the organisation of healthcare and subsequently its quality, the Flevo Hospital in collaboration with its partners ANOZ and the *Care Group Almere*, continuously invests in the supply of Health Care. According to this, the *Medical Co-ordination Centre Almere* has been established to improve the realisation of innovative projects. The majority of these projects are focused on the co-ordination and fine-tuning of Health Care supplied by the *Healthcare Group Almere* on the one hand and the care supplied by the

Flevo Hospital on the other hand. Examples of this kind of projects are home nursing of thrombosis patients, collective treatment of CVA patients, deliverance of medicine to the home of patients who were recently released from hospital.

Another example of the above mentioned co-operation is *The Patient Service Point*, located in the Flevo Hospital. Here patients are informed on the hospital, their illness and its treatment as well as on patient associations and insurance matters.

Since a few years the Flevo Hospital has been too small to satisfy the needs for medical care of a fast growing city in the usual way. Therefore, the hospital has been forced to organise its internal and external processes of healthcare as efficient and effective as possible. Consequently, job requirements at the hospital are extremely high. Besides being qualified, employees need to be creative, committed and ambitious in their care for people in Almere. Plans for enlargement of the Hospital are being made.

The hospital has received many visits from the Chinese partners in the project, too many to recall. Especially the guests from Qingdao have been interested to see how the relationship between the Primary Health Care level and the hospital works out. The hospital staff is used to foreign visitors and has a welcoming attitude. The visits reinforce the feeling among staff that they work in a unique setting and have something to share with others.

The Carespectrum Foundation (in Dutch: Stichting Zorgspectrum) in Nieuwegein

Is a modern organisation with over 800 staff members and six nursing and residential homes in the towns of Nieuwegein, Houten and Vianen, in Utrecht area.

Further the Carespectrum Foundation has a rehabilitation/stroke unit in a general hospital in Nieuwegein with 32 beds. With day-care facility, day-treatment and extramural care projects the Carespectrum foundation provides a complete spectrum of care.

The capacity in the homes is as follows:

Residential care centre Zuilenstein	75
Residential care centre Vreeswijk	120
Nursing home De Geinsche Hof	200
Residential care centre Het Haltna Huis	77
Nursing home Het Houtens Erf	95
Residential care centre Batenstein	107

The budget of the Carespectrum foundation is about 33 million Euro annually.

The individual resident is central to the Carespectrum Foundation. The residents request care tuned in to the individual, corresponding to the person's own life style. They themselves want to choose where, when and how they receive the care they need. They are even prepared to pay extra for additional services. In short, the residents become clients.

All these developments require a clear view on our work. The care provided is geared to the resident's personal needs to the largest possible extent. With that, customising care and improving the quality of care are given top priority. This is reflected in the architectural design of our homes and residences: the recently built ones are more adapted to nowadays views on how our clients wish to spend their time. Practically speaking, this means for example that the trend to accommodate the wish for privacy from our clients leads to providing individual rooms for them, within the possibilities. When new residences are built, the architect includes individual rooms in the design. The Carespectrum Foundation is actively involved in developing the care of the elderly in the Netherlands, in general, and in the Utrecht area, in particular, by taking part in the policy and planning process in several advisory bodies.

Between 1996 and 2002, we have four times received a one-day visit of Chinese policymakers and planners. During the first visit we intended to show the level of residential care as part of a general orientation to Mrs. Hao Jianxiu, Vice-Minister of the State Development Planning Commission and other officials from the SDPC. The following delegations were composed of SDPC officials and representatives from several cities in China and from Qingdao and Suzhou. Several of our locations were visited and the care process was discussed, including the competencies of our staff and their training and the concept of integrated care. Other issues of interest were the

architecture of the buildings and the way an organisation on 6 different locations is managed. In total Carespectrum received 30 visitors from China. The chairman and two staff members of Carespectrum have taken part in visits to Qingdao and Suzhou.

Maarten Dekker, chairman of Carespectrum, says:

“We have appreciated the visits to our organisation. It has stimulated us to engage in more international exchanges. We are proud of our Carespectrum and like to share our views and experiences with foreign partners. Foreign visitors are not only nice and friendly: they challenge us by asking questions that we are not asking ourselves, and they help us to be aware of our blind spots. Language is an important issue: the better one speaks English, the better is the quality of the exchange and the depth of the analysis and discussion.”

The King William I College (in Dutch: Koning Willem 1 College) in Den Bosch

The Koning Willem I College is one of 45 Regional Training Centres (ROC) in the Netherlands. It is situated in Den Bosch, in the southern part of The Netherlands (60 miles south of Amsterdam). The various educational departments are separately housed. The college has 13.000 students, of whom several hundreds of foreigners, and 1100 employees. It offers courses in the field of welfare, healthcare, hospitality, business/administration, adult education, Dutch and second language courses, engineering and courses in the technical field.

The Department of Health Care organises basic vocational programs for nurses, health-care workers, health-care assistants etc. and has 1200 students, presently.

In addition to these educational programmes, specialist courses and other courses in the field of continuing education are presented.

The Train the Trainers course

As a part of the joint development programme on healthcare and Elderly Care, the Department of Health of the Koning Willem I College designed a Train the Trainers programme for teachers in healthcare. Twenty teachers from Qingdao and Suzhou, were our guests for 6 weeks in October and November 2000.

Aim of the course.

To give the trainees the tools to create a curriculum for different professional workers in community care or/and in the Elderly Care. The result had to be a CD-ROM. As such these trainers could use the programme for different kinds of training that would need to be developed in the future for the new community healthcare organisations.

These care workers have the following profiles:

Community nurse;

Home nurse;

Home help.

Characteristics of the course.

The focus of the course was on giving optimal information to our Chinese guests.

This information should not be copied, but needs to be transferred into a practical body of knowledge in the Chinese situation.

The educational vision of our institute consists of coaching the student to learn in an active way. Linking the practice of a health-care worker to the theoretical background is essential for this process.

The contents of the programme focused on competence oriented learning: to make the connection between knowledge, skills, insight and attitude in the professional practice. Therefore, case studies were presented from the Chinese background in both cities and used as keynote for several educational parts of the programme.

In addition to that, a week of working in the Dutch Home-care organization was included.

During the last week the knowledge and skills obtained were consolidated by designing core curricula for staff in the different home care or Elderly Care settings in both cities.

Global contents of the course.

- Practical and cultural information about The Netherlands
- Dutch Healthcare system
- The Dutch educational system
- Methods of education, in relation to the programme and creating a CD-ROM
- Community Care, theory and practice
- Care for the elderly people, Rehabilitation
- Organization and Finances
- Ethics
- Education, new concepts of learning, teaching
- Analysing the professional background and formulating profiles
- Vocational training for adults

Oda Terwindt, head of the Health Care department:

“Looking back to this experiment, all of us are happy with the result. During a visit in April 2001, we observed that our students had done a wonderful job. Qingdao developed a course and they were training 200 health-care nurses. The Suzhou students were writing a book (at least 9 chapters) that was meant to be the main tool for the future training.

But: not only the results were positive. Also our contacts with the individual Chinese guests gave us many happy and valuable memories. On several occasions, like dinner-parties, cooking together, celebrating birthdays, excursions, and the daily contact of six weeks, we shared much and learned from each others cultures.”

Home care Den Bosch region (in Dutch: Thuiszorg regio Den Bosch) in Den Bosch

Thuiszorg regio Den Bosch is a home care organisation in the southern part of the Netherlands. We focus our activities on the 260,000 inhabitants of the city of Den Bosch and almost every municipality in the vicinity. Approximately 1600 employees provide on a daily basis a wide range of products in order to enable clients to remain at home as long as possible and to maximise the quality of life at home. All our employees are professionally trained. Whether you are a home-helper, home carer, auxiliary nurse, district nurse, dietician or doctor in a child health clinic. Our services comprise nursing, support and counselling related to illness, recuperation, disability, old age and death. It also includes help, advice and care to the young family. Together with the general practitioner we play a key role in the Primary Health Care system of our region. We also work together with the hospitals to assure that patients don't stay in hospital unnecessary. A new trend in the care for elderly people is a more intense co-operation between home care, nursing homes and elderly homes, in order to develop new arrangements in care which connect in a better way the needs and demands of this fast growing category of clients.

The home care services of Thuiszorg regio Den Bosch are:

- **Community nursing**
Mainly person-oriented nursing care; set out medication, administer oral medicine, give injections, wound care, catheterisations, care for urine drainage systems, maintenance and control of fluid therapies, control of essential body functions etcetera.
- **Home help services**
Assistance which is provided during the day and includes all activities which are necessary to keep the household independent, such as cleaning, washing and ironing, messages and cooking meals. Sometimes in combination with low and middle complex personal care, assistance in moving, bathing, eating, (un)dressing, visiting the lavatory.
- **Alpha help**
Home help services during a limited number of hours a week, in which the client is the direct employer of the alpha help.
- **Maternity care**
Pre-natal gymnastic classes, assistance by delivering a baby at home, nursing care, prevention and health promotion and household support at home in the first week after delivering a baby.
- **Child health clinics**
Clinics to monitor and promote the health and development of young children in the age from zero to four years. Also vaccinations for babies and infants.
- **Prevention & health promotion**
To prevent illness, to promote health by information and education for groups.

- Dietician services
Diet advice in the Primary Health Care.
- Day care ward
A number of clients are looked after in groups outside the home. Clients who are mentally or physically handicapped or whose continual care is too heavy for their immediate surroundings are eligible for this type of care.
- Social alarm system
A necklace with an alarm button which can be used to connect a telephone alarm service when necessary.
- Meal service
Meal service delivers chilled meals to clients who are unable to shop or to prepare nutritious hot meals for themselves.
- Several transmural services as:
 - A sheltered hostel for patients with Alzheimer disease
 - Use at home of residential nursing technology
 - Liaison nurses
- Home care shop to borrow, rent or buy nursing appliances

In the last few years several delegations from Qingdao and Suzhou visited Thuiszorg regio den Bosch. We also co-operated in the Train the Trainers course of the college "Koning Willem I" in the autumn of 2000. One of our staff members visited Qingdao and Suzhou in March 2000 to study the Chinese situation in order to develop this training programme. In this train the trainer course. We organised the practical training for the Chinese students and offered them, together with three other home care organisations, a week of practical training to experience the meaning and possibilities of home care in the Dutch Health Care system. Also several of our specialists gave lectures to the students.

Some impressions of the Chinese students during their practical training.

"COPD patients can live in their home with the help of a long oxygen tube and the help of home care. They can do anything they want at home."

"The nurse and home help communicate very easily with the clients and their family, They sit there to discuss how to help them and how to handle problems, just like a member of the family"

"I saw many different appliances in the homes, electronic wheelchairs, an electronic lift to go up and downstairs, an patient-elevator, a special bath-chair and a *rollator* which is very helpful to walk stable and on which you can sit safely when you are tired."

“In most cases home care is not spectacular, but I discovered that their support is very important for the patients well-being.”

Fontys Institute of Social Work
Fontys University of Professional Education in Eindhoven

The Fontys Institute of Social Work is one of the 33 institutes of the Fontys University of Professional Education. Fontys represents the largest educational institution in the Netherlands, providing 180 different courses and education programmes (full time and part-time) for over 33.500 students. In total, the organisation employs 3.500 staff members and it has an annual budget of about €240 million.

The Fontys Institute of Social Work focuses its teaching on both social work and social services and on social and cultural development. Both are organised for full-time or part-time students. In addition to this, we offer an internationally recognised degree of Master of Arts in Social and Community Studies. In total, the Institute provides regular courses for 950 students and employs 100 staff members.

Our unit specialises in training, research, development and consultancy projects in the area of social services and social policy. In these, we combine the perspective of citizens, professionals, managers and policy makers. We operate on a local and national, as well as international level. Our clients are cities and ministries and we support institutes in several countries in Central and Eastern Europe. We take part in some European programmes like Leonardo. Some of the more specific areas of our expertise include labour market issues, care for the elderly, social aspects of the information society, research methodologies, team building and multicultural work.

Our contribution to the project is the organisation of intensive social development training for professionals of the People's Republic of China. Between 1999 and 2001, five programmes were implemented for a total of 100 students from Qingdao and Suzhou, with a duration of 12 weeks each. In 2002 and 2003 two more will be run.

The objectives of the programmes on Health Care reform and Elderly Care are:

The participants:

- Understand the Dutch way of thinking about, and working in care and welfare.
- Know the central theories and applications of working methods.
- Can compare the Dutch and the Chinese way of thinking and doing and can transfer the Dutch concepts to the Chinese context.
- Contribute to the innovation projects of Elderly Care in Suzhou and community Health Care Qingdao.

The main subjects of the training are:

- Introduction in the Netherlands (Dutch culture, policy, paradigms)
- Social Policy
- Theory and practice in Care and Welfare (with excursions)
- The Dutch educational system

- Working in projects
- Teambuilding
- Theory of management

The training consists of group discussions, free study, classroom teaching and visits to care-organisations like hospitals and home care organisations.

Computer technology is extensively used.

For the Dutch teachers and the Chinese students the training is very useful for the intercultural exchange and experience. In three months it is possible to learn from each other and to better understand each other's behaviour, expectations and experiences.

One of the elements of the programme the participants appreciate most is teambuilding. On the one hand it is not surprising because they are eager to learn about this approach that is very new for them. On the other hand this way of working together makes the differences between both cultures very visible. It asks for behaviour that the Chinese students are not accustomed to, but they rather easily adjust to our cultural rules about intimacy and equality when working together. They have drawn the conclusion that such a close co-operation in groups, without hierarchy but with attention for the value of each single team member, would be of great added value in the Chinese context: "Our managers should do this training!"

One of the first Dutch words the trainees learned was "overleggen", which means something like "negotiating". In contrast, we learned from them that in their huge country it is not possible to negotiate about everything with everybody, and also that in our country all that 'overleggen' is often inefficient.

Summary

China is going through a period of profound changes in society and reforms in many areas. One issue is the rapid ageing of China, a consequence of, amongst others, the one-family-one-child policy, initiated some more than a generation ago. Since the middle of the nineties, the Chinese authorities are looking for ways to deal with ageing, also with regards to care for the elderly. Healthcare is too heavy, with large hospitals and many medical specialists, as one meets in the countries of Central and Eastern Europe as well. The search for alternatives brings Primary Health Care in the picture.

After a visit to China by the Dutch state secretary of Health, Welfare and Sports (Ministry of VWS), Mrs Erica Terpstra, in 1996, a collaboration has been set up between the two countries, with the view to provide for Dutch support to the development of Elderly Care and Primary Health Care in China. Under the umbrella of a Memorandum of Understanding, between the Ministry of VWS and the State Development Planning Committee (SDPC) in China, a programme is being implemented since 1999.

The SDPC selected the cities of Qingdao and Suzhou as locations. In Qingdao emphasis is on Primary Health Care and in Suzhou on Elderly Care. The programme involves transfer of knowledge exclusively, there is no material component.

The programme coordination is entrusted to the International Centre of the Netherlands Institute for Care and Welfare, which created a group of 8 organisations in the Care and Health Care sector, which take part in the programme regularly:

- Flevo Hospital, Almere
- Fontys University, Eindhoven
- GDVV group, the Hague
- Hieronymus Bosch Hospital, den Bosch
- Homecare Den Bosch region, den Bosch
- King William I College, Den Bosch
- Care Spectrum Foundation, Nieuwegein
- Healthcare group Almere, Almere

These organisations all have received delegations from China for short visits, on a regular basis. From the two multi-million-inhabitants cities, a total of approximately 100 policymakers, managers of (health)care organisations and medical staff have been in the Netherlands, to get inspiration for an alternative to their present care system. Due to these visits, understanding for and acceptance of new systems of Primary Health Care and Elderly Care are widely spread. Obviously, the visitors do not try to copy the Dutch models, but their aim is to reflect on principles and conditions, in order to, subsequently, make their own analysis of the necessary changes in China. Many counter-visits to Qingdao and Suzhou by the Dutch organisations allowed for a deepening of the understanding of the Dutch partners of the current situation

and for discussions on the directions of change that are being considered. The Chinese counterparts warmly appreciate these opportunities to put their plans to the test.

Over the years, several training courses have been given to groups of Chinese students from the two cities: courses in the field of management of (health) care institutions by Fontys University, a train-the-trainers course for nursing and caretakers in home care by the King William I College and a course for future family practitioners by Healthcare group Almere. In some cases, a more or less autonomous bilateral programme of collaboration is developing between one of the Dutch partners and their counterpart in China. This proves the success of the formula of collaboration.

In both cities, the authorities have proceeded energetically with the implementation of the Primary Health Care and Elderly Care.

Modern, de-medicalised nursing- en caring homes in Suzhou and community based Primary Health Care centres and stations in Qingdao are witnesses to the rapid developments. Training courses have been or are being set up and the hospitals do have plans to adjust to the new situation.

Once the Memorandum of Understanding expires, at the end of 2002, the Chinese counterparts and the Dutch partners are motivated to continue some form of collaboration. During 2002, plans have been made for the support to the development and implementation of training courses in China, reducing the need for training courses in the Netherlands. Early in 2003, further decisions are to be taken.

Over the years, the Ministry of VWS has covered the material expenses of the programme, like travel expenses and the costs of preparing and implementing the formal training courses. The Dutch partners have provided their time for free. In view of the considerable time invested by them, this does represent a considerable value.

The visible effects in China make participation in this programme quite rewarding for the Dutch partners. Also, the organisations do feel that the contacts with the Chinese are stimulating and challenging: it gives food for thought on one's own situation.

Indeed, as the state secretary states in the preface, it is a proof of their vitality that the organisations participate in such an international collaborative programme, in a period that they are confronted with budgetary constraints and reform themselves.

Samenvatting in het Nederlands

China maakt een periode door van diepgaande veranderingen in de maatschappij en hervormingen op allerlei terreinen. Zo kent China een snelle vergrijzing, onder andere als gevolg van het een-kind beleid dat ruim één generatie geleden is ingezet. Sinds het midden van de jaren negentig zoekt de Chinese overheid naar manieren om de vergrijzing goed op te vangen, ook ten aanzien van de ouderenzorg.

De gezondheidszorg is topzwaar, met grote ziekenhuizen en veel medisch specialisten, zoals men dat in Midden en Oost Europa ook kende. Men is op zoek naar een alternatief en denkt aan het opzetten van een eerste lijnsysteem.

Naar aanleiding van een bezoek van staatssecretaris Erica Terpstra in 1996, is een samenwerking ontstaan tussen Nederland en China, waarbij Nederland helpt om de eerste lijnszorg en de ouderenzorg te ontwikkelen. Onder de paraplu van een Memorandum of Understanding, afgesloten tussen het Nederlandse Ministerie van Volksgezondheid, Welzijn en Sport (VWS) en de State Development Planning Committee (SDPC) in China, is sinds 1999 een programma in uitvoering. De SDPC heeft de steden Qingdao en Suzhou uitgekozen als locaties voor het programma. In Qingdao ligt de nadruk op hervorming van de eerste lijn en in Suzhou op de ontwikkeling van ouderenzorg. Het programma richt zich uitsluitend op kennisoverdracht, er is geen materiele ondersteuning mee gemoeid.

De coördinatie van het programma is gelegd bij het International Centre van het Nederlands Instituut voor Zorg en Welzijn (NIZW/IC). Vanaf 1999 is een groep gevormd van 8 instellingen in de Nederlandse zorg die regelmatig een bijdrage leveren aan het programma:

- Flevo Ziekenhuis, Almere
- Fontys Hogescholen, Eindhoven
- GDVVgroep, Den Haag
- Jeroen Bosch ziekenhuis, den Bosch (voorheen Bosch Medi Centrum)
- Koning Willem I College, den Bosch
- Stichting Thuiszorg Regio den Bosch
- Stichting Zorgspectrum Nieuwegein
- Zorggroep Almere

Deze instellingen hebben allemaal regelmatig delegaties uit China ontvangen. Aangezien het om twee miljoenen steden gaat, zijn vanaf 1999 ongeveer 100 beleidsmakers, managers uit de (gezondheids)zorg en (para)medici in Nederland geweest om zich te oriënteren op een alternatief voor hun huidige systeem. Inmiddels is daardoor het begrip voor en de acceptatie van nieuwe systemen voor eerste lijnszorg en ouderenzorg wijd verbreid. Uiteraard komen de bezoekers niet om het Nederlandse model te kopiëren, maar zij oriënteren zich vooral op principes en randvoorwaarden om vervolgens in China hun eigen analyse van de benodigde veranderingen

te maken. Veel tegenbezoeken door de Nederlandse organisaties hebben de gelegenheid gegeven om in Qingdao en Suzhou ter plaatse kennis te nemen van de huidige situatie en om de veranderingsrichtingen te bespreken. Deze toetsing van hun gedachtengoed wordt door de Chinese counterparts zeer op prijs gesteld.

In de loop der jaren zijn verschillende cursussen gegeven aan groepen studenten vanuit de twee steden: cursussen op het gebied van management van (gezondheids)zorginstellingen door Fontys Hogescholen, een cursus voor opleiders voor verpleegkundigen en verzorgenden in de thuiszorg door het Koning Willem I College en een cursus voor huisartsen-in-spé door de Zorggroep Almere.

In een enkel geval is een min of meer zelfstandige bilaterale samenwerking aan het groeien tussen een van de Nederlandse partners en hun specifieke counterpart in China, hetgeen opgevat kan worden als bewijs van het succes van de formule van samenwerking.

In beide steden zijn ouderenzorg en eerste lijnszorg zeer voortvarend aangepakt.

Moderne, gedemedeïseerde verpleeg- en verzorgingshuizen in Suzhou en wijkgebonden huisartsenpraktijken in Qingdao getuigen van de snelle ontwikkelingen. Opleidingen zijn of worden ontwikkeld en de ziekenhuizen hebben plannen om zich aan de nieuwe situatie aan te passen.

Na afloop van de Memorandum of Understanding, eind 2002, zijn de Chinese counterparts en de Nederlandse organisaties zeer gemotiveerd om door te gaan met een vorm van samenwerking. Gedacht wordt vooral aan ondersteuning van het opleiden van studenten in China zelf. Begin 2003 wordt besloten over plannen daartoe, die in 2002 zijn opgesteld.

Het Ministerie van VWS heeft in de loop van de jaren de materiële kosten vergoed, zoals reizen en verblijf, en de kosten van het organiseren van de formele cursussen. De inzet van de Nederlandse organisaties gebeurt voor het overige volledig pro deo. Gezien de (vrije) tijdsinvestering vertegenwoordigt dit een aanzienlijke waarde.

Het zichtbare effect in China is één van de factoren die participatie in dit programma lonend maakt. De instellingen ervaren de contacten met de Chinezen ook als uiterst stimulerend en uitdagend: het zet ook aan tot denken over de eigen situatie.

Zoals de staatssecretaris in haar voorwoord schrijft: het is een blijk van vitaliteit dat de zorginstellingen, in een periode waarin zij in Nederland zelf te maken hebben met financiële beperkingen en hervormingen, gedurende langere tijd aan een dergelijke internationale samenwerking deelnemen.

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