

# Access to long-term care: perceptions and experiences of older Dutch people

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## Abstract

**Purpose** – Despite the current focus on demand-based care, little is known about what clients consider important when they have a request for formal long-term care services. The paper aims to discuss this issue.

**Design/methodology/approach** – Questions about the access process to care services were added to the “Senior Barometer”, a Dutch web-based questionnaire that assesses the opinion of older people about different aspects in life. The questionnaire surveyed both people who already requested care services (“users”), and people that did not (“future clients”).

**Findings** – The results show a significant difference in what people expect to be the first step from what users actually did, when requesting formal care services. In addition, there was a significant difference on how “users” and “future clients” rated several access service aspects.

**Research limitations/implications** – The results give valuable information on how both “users” and “future clients” value the access process. The findings also provide valuable input for organizations providing long-term care for older clients about the important issues that have to be considered when organizing the access process.

**Originality/value** – This study shows what older people in the Netherlands find important during the access process to care and this has not been explored before. The difference between what “users” and “future clients” find of importance in the care access process suggests that it is difficult for people to foresee what will be important once the need for care arrives, or where they will turn to with a request for care services.

**Keywords** Long-term care, Older people, The Netherlands, Access to care, Request for care, Web-based questionnaire

**Paper type** Research paper

## Introduction

At some point, many older people need professional long-term care due to chronic illness, or because they become disabled. Clients in general prefer to live in their own homes as long as possible and require care and services that suit their wishes and needs (Swartz, 2013). If care at home is no longer possible, clients are admitted to a long-term care facility such as a residential home or nursing home. Care providers nowadays are challenged to provide services that match the individual needs of their clients (De Blok *et al.*, 2009; VWS (Dutch Ministry of Health, Welfare and Sports), 2013).

As a consequence, the focus of long-term care for older clients is shifting to a more client-centred approach. This calls for a well-organized access process to these services. Several studies are available providing information on quality of long-term care for frail older adults in residential facilities and/or nursing homes, as well as for older people receiving care at home (e.g. Francis and Netten, 2004; Zimmerman *et al.*, 2005; Hoe *et al.*, 2006; Kane *et al.*, 2007; Zuidgeest *et al.*, 2012).

In contrast to the availability of studies on the quality of long-term care, remarkably little is known about the process that leads towards the actual provision of care. This is the step in which the client makes a request for care, after which a care package is specified to match his or her

individual needs (Gulliford and Morgan, 2003; De Blok *et al.*, 2010). The client specifies his or her needs, while at the same time receiving information from the care provider about the services and procedures (Goddard and Smith, 2001). In this respect, the care and service access process can be considered as an important step in the total process of care provision.

Access to care has been found to be one of two dimensions that patients consider of importance when valuing their care experiences, the other being provider performance. Access encompasses issues associated with patient-caregiver interaction and actual care provided and received by the patient (Tucker and Adams, 2001). The direct interactions with clients during the first contact influence the experiences and emotions that subsequently follow in the actual care process. When the initial interaction goes well, a positive cycle between the customer and the organization starts. When it turns out poorly, it might be difficult to recover (Kenagy *et al.*, 1999).

From earlier research it is known what aspects organizations take into consideration to shape the access process to long-term care for older people (Schipper *et al.*, 2013, 2015). However, considering what older clients themselves value in this process is essential to make sure that the important first step in the care process works out well. Despite the emphasis on demand-based care (Swartz, 2013; Van Campen and Woittiez, 2003), little is known so far about what older people ("future clients") themselves consider important during this access process or about to whom they would address their requests for care.

### ***Access to care: the three A dimensions***

Access can be described by three dimensions: availability (appropriate service at the right time and place), affordability (fit between the costs of the service and the ability to pay for it) and acceptability (expectations of provider and client and their attitudes to each other): the three A's (Penchansky and Thomas, 1981; Sinha and Kohnke, 2009; McIntyre *et al.*, 2009; Schipper *et al.*, 2015). The access process to care needs to match expectations of "future clients" on these three A's. In addition, information on what current clients of care and services ("users") found important when reflecting on the access process might be useful to further improve the process. Therefore, it would be valuable to know if clients who already made a request for care ("users") consider the same elements to be important when they reflect on the access process. The difference in what people expect they would find important in the access process and what "users" actually found of importance once they made a request are both relevant for evaluating or designing the access process.

### ***Research questions***

In order to explore this subject further, the following main research questions are addressed in this paper:

- RQ1. What do people of 55 years of age and older expect to be important when they would make a request for long-term care ("future clients")?
- RQ2. What did people of 55 years of age and older find important once they made a request for long-term care ("users")?
- RQ3. Is there a difference between the two groups?

### ***Research setting***

Long-term care for older people in the Netherlands includes home care as well as long-term institutional care and is covered by a separate insurance scheme, the Exceptional Medical Expenses Act. The amount and type of care needed (and paid for) under the Exceptional Medical Expenses Act, is determined by an independent body, the Care Assessment Centre. Traditionally welfare services also were included in long-term care. However, these are nowadays organized through municipalities, based on the Social Support Act. Most municipalities set up a department in their offices that receives and handles requests for services under this Social Support Act. Parts of these services, like domestic services or mobility services, previously covered by the Exceptional Medical Expenses Act now fall under the scope of the Social Support Act (VWS (Dutch Ministry of Health, Welfare and Sports), 2013, 2014).

## Method

To address the research questions, information was needed from a large sample of older people, following a quantitative research design. For this purpose, specific questions were added to the “Senior Barometer”.

The Senior Barometer is an initiative of Tilburg University (2014) and is a web-based questionnaire for people over 50 years of age. It assesses yearly the opinion of older people in the Netherlands about different aspects in life, including life events in the past year, experienced health, satisfaction and well-being. Adding specific questions gave the opportunity to get answers on the research questions mentioned from a large panel of older people. The questionnaire was set out for the first time in 2008. People are invited to participate in the panel through the web site [www.seniorenbarometer.nl](http://www.seniorenbarometer.nl) or via an announcement made on the web sites of associations and unions for older adults. Furthermore participants that attended computer training courses for older people given by a large educational institute in the Netherlands were approached to join the panel. Those who register to participate can fill in the questionnaire anonymously and without obligations. Anyone who registered to participate in a certain year, is invited to participate the following year as well. The panel changes yearly due to people dropping out and new participants who registered to participate. For this study, data were used from the Senior Barometer that was set out in May 2012. A total of 1,078 people registered to participate for the 2012 questionnaire.

At the time this questionnaire was set out, no specific ethical approval was needed for this type of surveys, as people were free to participate and could stop participating at any time. Also participation is anonymous.

The first question added to the questionnaire was set up to be able to distinguish between “future clients” and “users”. Furthermore, questions referring to the following items were added:

1. To whom do “future clients” expect they would turn first when they would have a request for care?
2. To whom did “users” turn with their actual request for care?
3. Which service aspects during the access process do “future clients” expect to be important, in case they would have a request for care?
4. Which service aspects during the access process did “users” find of importance when they actually had a request for care?
5. Are “users” satisfied about the way their request for care was handled?

To find out to whom “future clients” would, or in the case of, “users” did turn with their request for care, respondents could choose one of the following options: family doctor, municipality, Care Assessment Centre, district nurse, home care organization, care home or nursing home or “otherwise” with the (open) option to further explain their answer.

An expert team formulated nine access service aspects, based on a literature study and the three A’s mentioned in the introduction (Schipper *et al.*, 2015). To measure the perceived importance of these nine access-related service aspects, a five-point Likert scale was used with answer options ranging from not very important to very important. The aspects added to the questionnaire can be found in Table III. A five-point Likert scale was used, because this was also used for the other questions in the Senior Barometer.

To find out if “users” were satisfied about the way their request was handled, seven items were added that could be rated on a five-point Likert scale, ranging from very dissatisfied to very satisfied.

## Analysis

Questionnaires of people under 55, as well as questionnaires in which the questions added for our research were not completed, were excluded from the analysis. In total 912 questionnaires of the 1,078 registered respondents were included in the analysis. First, age and gender of

participants were described and compared to age and gender of the general population in the Netherlands of 55 years and older. The information needed for this, was retrieved from the Dutch Central Bureau of Statistics in February 2014 (CBS, 2014), which regularly publishes information about the demographics of the Dutch population. The respondents were grouped in four age categories (55-64, 65-74, 75-84 and 85+) to be able to compare the age of respondents with the age groups provided by CBS. The five-point scales were recoded to three-point scales in order to get enough observations per category in the analysis.

To find out if there was a statistical difference between what “future clients” thought is important and what “users” actually found important,  $\chi^2$  tests were performed.  $\chi^2$  tests are mainly used to compare answers between two groups, when a normal distribution of the answers is not likely to occur.  $\chi^2$  tests were also used to find out if answers were significantly different across age groups, by gender, by marital status, by having none or one or more children and by level of education. All statistical analyses were conducted using SPSS 19.0.

## Results

In total, 63 per cent of the respondents were male ( $n = 572$ ). The majority (69 per cent) lived with a partner, 83 per cent had one or more children and the mean age was  $72.6 \pm 7.4$  years, ranging from 56 to 102 years. Table I shows the gender and age of the respondents. The characteristics of the respondents differed from the general 55+ population in the Netherlands, as presented by the Central Bureau of Statistics of the Netherlands (CBS, 2014) and, these are shown in Table I by the percentages between brackets. More men than women filled in the Senior Barometer, whereas the majority in the general 55+ population is female. Furthermore, almost 80 per cent of our respondents fell in to the age category 65-84. In the general population this group is about half of the 55+ group.

### Point of first request

The majority of the respondents (82 per cent) reported not having requested any care services under the Exceptional Medical Expenses Act or Social Support Act. This group was called “future clients”. If they would need such care, 66 per cent said they would first go see their family doctor. About one-quarter would go to their municipality office. The other answer possibilities like Care Assessment Centre, home care or the local nursing or residential home were less often mentioned as a first place to turn to. About 4 per cent did not know who to turn to first, or suggested other options, like consulting the internet or their children (see also Table II). Even though older people and males were more likely to turn to their family doctor than other groups, these differences were not statistically significant.

**Table I** Gender and age of respondents

Age group	n	% <sup>a</sup> (% CBS) <sup>b</sup>	Gender			
			Male		Female	
			n	% <sup>a</sup> (% CBS) <sup>b</sup>	n	% <sup>a</sup> (% CBS) <sup>b</sup>
55-64	129	16.3 (43.4)	61	12.1 (46.2)	68	23.6 (41.0)
65-74	402	50.7 (32.2)	250	49.5 (33.5)	152	52.8 (31.1)
75-84	225	28.4 (17.8)	164	32.5 (16.1)	61	21.2 (19.3)
85+	37	4.7 (6.5)	30	5.9 (4.2)	7	2.4 (8.6)
Total	793	100	505	63.7 (44.7)	288	36.3 (55.3)
Missing	119					

Notes: <sup>a</sup>% of respondents in Senior Barometer; <sup>b</sup>% in general 55+ population

**Table II** Point of first request

	Who would you turn to first? "Future clients" (n = 671)		Who did you turn to first? "Users" (n = 119)	
	n	%	n	%
Family physician	442	65.9	34	28.6
Municipality	163	24.3	36	30.3
Care Assessment Centre	10	1.5	11	9.2
Home care organization or professional	28	4.2	20	16.8
Residential or nursing home	0	0	1	0.8
Otherwise	28	4.2	17	14.3

**Note:** Significance  $p < 0.001$

About one-fifth of the respondents (157 persons) reported that they or someone else in their family had requested one or more services reimbursed by the Exceptional Medical Expenses Act or Social Support Act ("users"). The services requested mostly involved care of low complexity: these services do not require highly skilled staff or complex technology and are provided by a single professional caretaker. In most cases services were delivered at home and in most cases several services were combined. About half of the "users" requested domestic care (housekeeping) (52 per cent) and/or mobility services, such as electrical bikes or wheelchairs, adaptations to the car or a taxi pass (45 per cent). Other services reported were requests for medical devices (38 per cent), adjustments in the home (e.g. stair lift or adjustments in bathroom or kitchen; 31 per cent), personal care at home (19 per cent), nursing care at home (9 per cent), use of meals-on-wheels services (9 per cent), visiting day care or day treatment facility (3 per cent). Another 8 per cent reported requesting other services, such as nursing home care.

Table II also shows who "users" actually first turned to when they had a request for care. About 30 per cent went to the municipality with their request for care, while 29 per cent first turned to their family doctor. "Users" that checked the answer possibility "other", often mentioned the hospital or a medical specialist.

"Users" living without a partner more often turned to a (representative of a) home care organization ( $p < 0.05$ ). "Users" with children were more likely to turn with their questions to the municipality, while "users" without children were more likely to turn to the family doctor. Older "users" (age categories 75-84 and 85 and older) were more likely to turn to their family doctor, a home care organization or professional with their request for care than the younger age groups, but these differences were not significant.

Fewer "users" than "future clients" turned first to the family doctor when they requested care (29 vs 66 per cent), but more "users" than "future clients" went, respectively, the municipality, the Care Assessment Centre or a home care organization or professional with their request for care. When the two groups ("future clients" and "users") were compared, the differences in where "future clients" thought they would turn to with their request for care and where "users" actually made their request (see Table II), was statistically significant.

#### *Important elements when requesting care*

"Future clients" were asked to rate how important they found nine aspects of the care access process, if they would have a request for care and services under the Exceptional Medical Expenses Act or Social Support Act. Almost all respondents (95 per cent) not only found it important that their personal preferences were heard, they also wanted information about the possibilities of care (95 per cent), waiting lists and waiting times (95 per cent) (Table III). These three aspects rank first, second and third when comparing the responses.

There were statistically significant differences on most items between male and female respondents. For most items, female future clients were more likely to score the items in the questionnaire "very important or important" ( $p < 0.05$ ). For several items there was also

**Table III** Important aspects when requesting care

Addressed issues	<i>(Very) important in case of a request for care</i> "Future clients" <i>n</i> = 715		<i>(Very) important when request for care was done</i> "Users" <i>n</i> = 150		Significance <i>p</i>
	<i>in %</i>	<i>Rank</i>	<i>in %</i>	<i>Rank</i>	
<i>General information</i>					
Receiving information about procedure on first contact	94.1	4	80.7	3	< 0.001
Receiving information about possibilities of care on first contact	94.8	2	81.3	2	< 0.001
<i>Availability</i>					
Being able to ask question in municipality I live in	87.3	9	75.3	6	< 0.001
Being able to ask question to organization that will provide the requested care	89.3	8	78.0	5	< 0.001
Being able to ask all questions at one spot	92.2	6	84.0	1	= 0.003
<i>Affordability</i>					
Quickly receiving information about mandatory excess	92.4	5	74.0	7	< 0.001
<i>Acceptability</i>					
Being listened to	95.1	1	79.3	4	< 0.001
Receiving information about waiting lists and waiting times	94.5	3	64.0	9	< 0.001
Having a dedicated advisor from the start	91.9	7	72.0	8	< 0.001

a noticeable difference across age groups, marital status or level of education. Older age groups (85+,  $n = 24$ ) found it less important to be able to request care to the organization that will provide the requested care ( $p = 0.05$ ) and to receive information about the possibilities of care on first contact ( $p = 0.05$ ). Respondents from the 85+ age groups, as well as people living alone considered it more important to have a dedicated advisor ( $p = 0.03$  resp.  $p = 0.02$ ). People that lived alone, and people with lower level of education found it more important to quickly receive information about the mandatory excess/personal contribution ( $p = 0.03$ ). Furthermore, people living alone highly valued information about waiting lists and waiting times ( $p = 0.04$ ). Table IV shows an overview of the items that significantly differed across gender, age groups, marital status, having children or educational level.

Also "users" were asked to rate how important they found the nine aspects of the care access process, when they requested care and services under the Exceptional Medical Expenses Act or Social Support Act. Most respondents (84 per cent) found it important to be able to ask all questions in one spot. Also receiving information about the possibilities of care as well as about the procedure was rated as important or very important by 81 per cent of "users" (Table III). These three aspects rank first, second and third when comparing the responses.

For "users" there were no statistical differences across gender, marital status or level of education in the responses on any access service aspects. For two items there was a significant difference across age groups. Older age groups (85+) found it less often important to receive information about the procedure on first contact ( $p = 0.05$ ) and to receive information on waiting lists ( $p = 0.08$ ). Furthermore, people without children found it less important to quickly get information about the possibilities of care ( $p = 0.05$ ) but more important that they were being listened to ( $p = 0.03$ ) (see Table IV).

For "users" all the access service aspects mentioned were important, but compared to "future clients", they answered on all issues less often that these were important or very important. Again, the differences in answers between "future clients" and "users" were statistically significant. The aspect scored most often to be important or very important by respondents who requested care, was to be able to ask all questions regarding care at one spot. In all, 44 per cent scored this issue important or very important. Other issues in the top three service aspects of "users" were receiving information about the procedure at first contact as well as about the possibilities of care (both 81 per cent). "Users" rated information about waiting lists and waiting times as less important than the other aspects when requesting care (Table III).

**Table IV** Level of significance by gender, age, marital status and level of education on rating aspects

<i>Addressed issues</i>	<i>Female</i>		<i>Age &gt; 85</i>		<i>Living alone</i>		<i>Having no children</i>		<i>Lower education</i>	
	<i>F</i>	<i>U</i>	<i>F</i>	<i>U</i>	<i>F</i>	<i>U</i>	<i>F</i>	<i>U</i>	<i>F</i>	<i>U</i>
	<i>p =</i>	<i>p =</i>	<i>p =</i>	<i>p =</i>	<i>p =</i>	<i>p =</i>	<i>p =</i>	<i>p =</i>	<i>p =</i>	<i>p =</i>
<i>General information</i>										
Receiving information about procedure on first contact	0.001			0.05						
Receiving information about possibilities of care on first contact			0.05				0.05			
<i>Availability</i>										
Being able to ask question in municipality I live in	0.002									
Being able to ask question to organization that will provide the requested care	0.014		0.05							
Being able to ask all questions at one spot	0.03									
<i>Affordability</i>										
Quickly receiving information about mandatory excess	< 0.001				0.03					0.03
<i>Acceptability</i>										
Being listened to	0.02							0.03		
Receiving information about waiting lists and waiting times	0.05			0.08	0.04					
Having a dedicated advisor from the start			0.03		0.02					

**Notes:** *F*, “future users”, *n* = 715; *U*, “users”, *n* = 150

### Satisfaction

Furthermore, “users” were asked how satisfied they were about several service aspects during the access process. In total, 70 per cent were satisfied or very satisfied with the response time needed to answer their questions. The majority valued the service (68 per cent), availability (66 per cent), quality of the information received (66 per cent), expertise of the front office staff (63 per cent) and the offer for care they received (62 per cent). A smaller group, but still the majority of respondents (59 per cent) was satisfied or very satisfied about the way their background and specific wishes were taken into consideration. For these items there were no statistical differences across gender, age, marital status, having or not having children or level of education.

### Discussion and conclusion

This study shows what people aged 55 years and older in the Netherlands report being important during the access process to care. To our knowledge, this has not been explored before. The possibility for this study to use the Senior Barometer gave an opportunity to ask a large panel of seniors about their perceptions. Furthermore, it made it possible to compare people who had already experienced the access to care services (“users”), with people who had not done that yet (“future clients”). From other areas of research it is known that with respect to receiving professional care, expectations beforehand may differ from the actual experiences looking back. A more specific example is provided by a study about volunteer support in palliative care, that showed that caregivers beforehand are reluctant to make use of volunteer support during care of terminal clients. However, people who made use of support by volunteers were very positive about this experience (Luijckx and Schols, 2009).

For both groups the family practitioner appeared to provide an important first step in the access process to long-term care. However, our study indicated a significant difference between what people expected their first step would be and what their actual first step was. “Users” more often made use of other means, compared to what future clients indicated they would do. Most notable was their use of the fairly new municipality care offices. Municipalities have organized care offices once they became responsible for Social Support Act services in 2007. According to a recent study of clients requesting care under the Social Support Act, these municipal care offices are

already known by more than half of people with disabilities (Feijten *et al.*, 2013). These care offices are particularly developed for people who need care provided under the Social Support Act, and this is primarily intended for people that require mainly care of low complexity. This applied for the majority of the “users” that responded to this questionnaire and might explain why so many of the respondents turned to these offices with their request for care.

Furthermore, Feijten *et al.* (2013) reported that people who found their way to the municipality’s office are often suggested to use this route by family or health care professionals. This is also supported by our finding that “users” with children or a partner were more likely to turn to the municipality. However, people without a partner were more likely to turn to a home care organization or professional, suggesting that people living alone are already known and/or visited by home care organizations.

There is also a significant difference between “users” and “future clients” in what they consider to be important during the actual (“users”) or future request (“future clients”) for care. The importance of all issues was not only valued less high by “users”, but the issues were also ranked differently, with the exception of receiving information about the possibilities of care. This issue was ranked second by both groups.

### ***Importance of the three A dimensions***

The elements included in the questionnaire were based on the three A dimensions. From the results it seems that the A of availability is the most important access dimension for “users”. Especially more practical aspects like being able to ask all questions at one spot and quickly receiving information about the procedures seem most important for the “users”. This suggests that once people have a request for care, they prefer to get practical information at one entry point about the next steps in the access process.

In contrast, “future clients” value issues addressing the A of acceptability as more important. On some specific items we found statistical differences across age groups, marital status, having children or not and level of education. The results suggest that people in the older age groups put more value on acceptability items and therefore have less need for concrete information, but do stress the importance of a dedicated advisor.

The A of affordability is considered important by almost all “future clients” and about three quarters of the “users”, however, it does not rank high for both groups. This is consistent with earlier findings (Schipper *et al.*, 2015) and is most likely related to the way the Dutch health care insurance system works. In the Netherlands, pay for care is not determined by the chosen services, but based on income.

Furthermore, female “future clients” were more likely to value items in the questionnaire as very important compared to male “future clients”. This could mean that females are more involved in care processes.

Generally, people living alone or with lower education are financially more vulnerable and have less resources, including informal care options (De Klerk, 2004). This might explain why these respondents put more value on issues concerning affordability and acceptability and quickly want to receive information about their mandatory excess, why people living alone find having a dedicated advisor more important and quickly want information about waiting lists and waiting times and why people without children find it more important that they are being listened to.

However, these results are not consistent across “future clients” and “users”.

During the access process, being listened to is considered as very important. This is also known from results of an earlier study of older clients that regularly see physicians. They want to be heard and acknowledged in their interactions with care providers. Good listening and a caring attitude are mentioned as reasons for either choosing or leaving a physician (Bayliss *et al.*, 2008).

The respondents highly value having a dedicated advisor, even though “users” find that significantly less important than “future clients”. Earlier research showed that long-term care

organizations that provide care services for older people, often arrange the access process around a care advisor, who is dedicated to handle the request of a client, even though this was not based on clients experiences or wishes (Schipper *et al.*, 2013). Studies evaluating client satisfaction found that patients receiving regular care, value easy access to their care providers. This goes for both the physical access process and access by phone (Kenagy *et al.*, 1999) and counts for appointments as well as for seeking or receiving follow-up information (Bayliss *et al.*, 2008). From our study it can be concluded that the same may hold for clients with a request for care. A dedicated advisor can play an important role during the access process.

### *Implications for practice*

The difference between what “users” and “future clients” find of importance in the care access process suggests that it is difficult for people to foresee what will be important once the need for care arrives, or where they will turn to with a request for care services. The differences between “users” and “future clients” can be explained by the specific context; most people do not engage in care processes until the situation arrives that it is needed to take the steps leading to care. Reflecting on what is important during the process, when asked, does not necessarily reflect what people consider to be important when the need for care arrives. When older people request care, they often have become frail and the situation in which the need for long-term care arrives, often goes hand in hand with strong emotions and uncertainty. Therefore, both perspectives are important to consider when organizing the access process to care. The care access process should be organized in such a way that future clients trust their preferences will be heard. Furthermore, organizations should use information from current clients (people that already requested care services) to improve their access process.

The ranking of the issues from our questionnaire gives valuable input for organizations that provide long-term care for older clients about the important aspects to consider when organizing their access process. The further development of the three A dimensions could help organizations to focus on what their future clients find important, for example, giving information about the possibilities of care on first contact as well as information about waiting lists and waiting times. For “users” the ability to ask all questions at one care entry spot seems most important, which implies the need to organize a central service department for clients.

Generally, respondents who had already requested care were satisfied with the process and services provided before the actual provision of the care itself. Nonetheless, accounting for the background and specific wishes of clients’ needs further improvement.

### *Limitations and future research*

The results of this study are based on a web-based questionnaire, which was filled in on a voluntary and anonymous basis. Further research on how both “users” and “future clients” value the access process from a more representative group of respondents is necessary to obtain results that are more generalizable. Where people turn to (or think they would turn to) is specific to the Dutch long-term care setting. However, the importance of the highest ranked acceptability issue in this study, being listened to, might apply in other countries as well, as suggested by other studies (Bayliss *et al.*, 2008; Kenagy *et al.*, 1999). Also, other issues that ranked highly in this study, might apply in other countries.

Furthermore, the respondents of this questionnaire who requested care services, in most cases requested care of low complexity. It is possible that people receiving more complex care, like 24-hour care or nursing home care, find other issues of importance in the care access process than people receiving services of a lower complexity and intensity. Given the diversity of the respondents labelled as “users” in this survey, it is recommended to use qualitative research methods to get more enriched information from clients that are using or have used care. Also qualitative research might be helpful to deepen our understanding of the found differences between “users” and “future clients” and could help reflect on the actual behaviour of clients during the access process, which is not accounted for in this study.

However, the results of this study are of interest and can already be used to improve the care access process, given the current lack of information on what people consider important when

making a request for care. Nevertheless, this also implies that issues in this area be considered a subject for further research. These include the importance of the issues in other care sectors, or other countries, as well as exploring in more depth, the motivations of clients' preferences and the role of informal care during the access process.

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