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**Urgency coding as a dynamic tool in management of waiting lists
for psychogeriatric nursing home care in the Netherlands**

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Abstract

Criteria are used to prioritise patients on waiting lists for health care services. This is also true for waiting lists for admission to psychogeriatric nursing homes. A patient's position on these latter waiting lists is determined by (changes in) urgency and waiting time. The present article focuses on the process and outcome of an urgency coding system in a fair selection of patients. It discusses the use of urgency codes in the daily practice of waiting list management and the related waiting times. Patients and their informal caregivers were followed from entry on the waiting list to admission to a nursing home. Caregivers were interviewed during the waiting period and after their relative's admission to a nursing home, and the formal urgency codes on the waiting list were monitored. Seventy-eight of the initial 93 patients were admitted to a nursing home. High urgency codes were commonly assigned and the waiting times were shorter for patients with higher urgency codes. Negative consequences of an urgency coding system, e.g., patients with less urgency not being admitted at all and patients not being admitted to the nursing home of their choice, could not be demonstrated. Patients without higher urgency codes were admitted after a mean waiting time of 28 weeks. It may be questioned whether this long waiting time is problematic, because satisfaction of the caregivers with regard to waiting times was not influenced by the actual waiting times. An urgency coding system enables health care professionals to react to changes in the situation of both patients and caregivers by adjusting urgency codes to influence the length of time until nursing home admission.

Introduction

Waiting lists and waiting times in health care remain a topic of concern and discussion in The Netherlands despite the extra money spent to address the problem. This is also true for the waiting lists for psychogeriatric nursing home care. In 1997, for example, the mean waiting time to admission to such a nursing home in The Netherlands was 17.5 weeks¹, a period of time that is generally considered too long.

Waiting lists are used to justly distribute the 'burden' of waiting and the possible health risks of the listed persons. Three criteria are often used to obtain a fair distribution among the scarce health care facilities: 1) "first-come, first-serve" criterion, which aims at a fair *procedure* of allocation; 2) priority for urgent cases, which aims to prevent extra damage caused by longer waiting times – i.e., deterioration in health status during the waiting period may result in an irremediable condition or in death; and 3) those with the highest chance of success are selected first. In the case of organ transplantation, for example, priority is given to those patients who have a higher tissue match with the donor organ. Such a distribution will reduce the risk of transplant rejection.² The balance between these three criteria and their meaning depends on the type of health care service needed.³ The first two criteria are used for the waiting lists for admission to a psychogeriatric nursing home, the waiting list is organised according to urgency and the distribution within urgency categories is dependent on the length of the waiting period. Urgency codes are used in these lists to take into account not only the suffering of the patient, but also the limits of his/her social situation (informal caregivers, formal home care possibilities).^{4,5} The severity of the disease, therefore, does not necessarily determine the urgency code. A balance between the three criteria may, however, be attended by negative results. For instance, there is a risk of selecting only highly urgent patients when the waiting lists are too long. This has as a consequence that the duration of the waiting period of the less urgent patients only increases. Another side effect of selecting just urgent patients may be that they are not allowed to await a vacancy in the nursing home of their choice.

This article focuses on the process and outcome of an urgency coding system in a fair selection of patients waiting for admission to a psychogeriatric nursing home. The procedure of nursing home admission is explained below. Questions addressed in this article are: How often are higher urgency codes given? What are the reasons for the high(er) urgency? Do higher urgency codes result in shorter waiting times? Are non-urgent patients ever admitted? Is the preference for a specific nursing home taken into account? Are informal caregivers

satisfied with the waiting times? This research on an urgency coding system is part of a larger Waiting List Project, which studies the health status course of both patients and their caregivers during the waiting period for psychogeriatric nursing home care. This present longitudinal observational study includes several measurement points from patient entry on the waiting list to admission to the nursing home.

Method

Setting

There are more than 300 nursing homes in the Netherlands that provide care for (mainly) elderly people with complex needs due to chronic somatic and/or psychogeriatric problems. The latter problems generally concern individuals with dementia.⁶ The nursing homes can be categorised into three types: somatic nursing homes, psychogeriatric nursing homes, and combined nursing homes with separate departments for patients with either somatic or psychogeriatric problems. There are no financial constraints for nursing home admissions in the Netherlands since all citizens are insured for this type of care. However, a formal indication for admission to a nursing home is required from a Needs Assessment Committee. These committees are organized at the municipal level. In Amsterdam, for example, the Regional Institutions for Ambulatory Mental Health Care (RIAGG) are involved in the indication for admission to a psychogeriatric nursing home. The RIAGG assigns indications to patients living at home and in residential homes, and only to those hospitalised patients who were known to the RIAGG prior to hospitalisation.

A patient's name is entered on a regional waiting list once the need for admission to a nursing home has been established by the municipal committee. The position of a patient on the waiting list is dependent on the urgency code and the waiting time (i.e. the date of indication). The urgency code is determined by a geriatrician and a social psychiatry nurse from the RIAGG; they judge the severity of the situation at home and the urgency for nursing home admission. The criteria for the urgency codes are broadly defined and the allocation of urgency codes is discussed among the team of health care professionals. Urgency codes may change during the waiting period: patients may be registered as having 'normal' urgency and then become highly urgent or vice versa. Patients are given the highest urgency code ('1A') when they must be admitted at very short notice and, as a result, their preference for a

particular nursing home is disregarded. A high urgency code ('1B') is given to those patients who have to be admitted quickly, but then to the nursing home of their choice. Patients who are inappropriately staying in hospitals or observation clinics are given urgency code '2'. Their preference for a particular nursing home is limited. Patients with a 'normal' urgency code (code '3') have to be admitted to a nursing home within the foreseeable future, but are allowed to wait for an opening in the nursing home of their preference. If a patient is highly urgent at the moment of entry on the waiting list, the reasons for the higher urgency code are registered in the patient's files. If the urgency code is upgraded during the waiting period, the regional admissions office is informed by means of a mutation form. This form includes information on the change in urgency code and reasons for the change. In Amsterdam, all indications and urgency codes for nursing home admissions are registered at the Admissions Office, where a computerised waiting list is managed. When the Admissions Office is notified of a vacancy in a nursing home, an office manager will determine, which patient has to be selected from the waiting list. The manager takes into account the type of vacancy in the nursing home (place for a male or a female and whether the ward is for mildly or severely demented patients), the preference of patients for a particular nursing home, the urgency codes, and the waiting times. Patients with the highest urgency codes are usually considered first to see whether they "fit" the type of vacancy, then the other criteria are weighed. This procedure has been described in more detail elsewhere.⁷

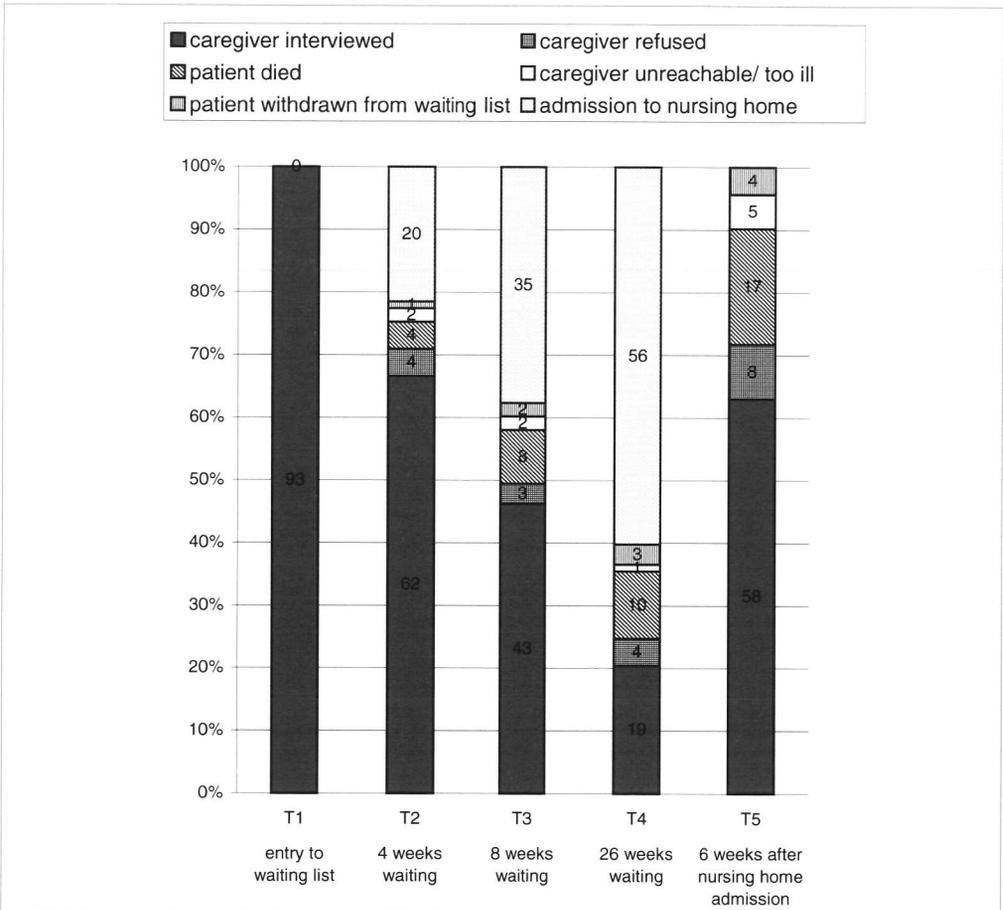
Subjects and procedure

Pairs of patients and their informal caregivers were recruited from two (out of five) RIAGGs in Amsterdam. Inclusion criteria for the Waiting List Project were an indication for admission to a psychogeriatric nursing home, non-acute admission to a nursing home, presence of an informal primary caregiver, and caregiver's ability to participate in an interview. Informal caregivers of patients who had received an indication for admission to a psychogeriatric nursing home in the period March 1997 (October 1997 at the second RIAGG) until August 1998 received a letter describing the Waiting List Project and requesting their participation. The study consisted of, among other things, a number of interviews (see Measures). One hundred and thirty informal caregivers were contacted when their relative was enrolled on the waiting list. Thirteen caregivers (9.9%) were excluded because their relatives either

* The names of these codes have been adjusted for the sake of clarity. In daily practice 1A and 1B are denoted A1 and A2, respectively.

died (n=4) or had been admitted to a nursing home (n=9) before the first interview could be conducted. Of the remaining 117 caregivers, 22 refused to participate (18.8%) and two were lost because of practical reasons. The remaining 93 caregivers (79.5%) were interviewed when their relative was registered on the waiting list.

Figure 1. Scheme of interviews and dropouts of patients/respondents per interview



Note: At T2 4 persons died: 3 patients and 1 informal caregiver; at T3 the number of refusals was one less than at T2, because at T3 this respondent's relative died.

Respondents could choose to be interviewed at their homes, at our department, or elsewhere. Not only were the respondents asked structured questions in a face-to-face interview, but they were also given self-report questionnaires to fill in. The mean duration of the interviews was 97 min. The scheme of the initial and follow-up interviews is shown in Fig. 1.

The figure also presents information on participation and dropout during the follow-up interviews. A total of 11 people died during the waiting period (one is not included in the Figure because death occurred after T4). One patient was still on the waiting list at the closure of the data-collection period (1 January 2000). Four patients were withdrawn from the waiting list, two had been offered places in nursing homes; but the informal caregivers were not ready to have them admitted; two had moved out of the area and were being cared for by informal caregivers not known to the investigators. Fifty-eight (62.4%) caregivers were also interviewed 6 weeks after their relatives had been admitted to a nursing home (T5). By that time, 17 people had died (11 during the waiting period and six within 6 weeks of nursing home admission).

Characteristics of patients and informal caregivers

Mean age of the patients was 83.2 years (range 51-96). Most (75.3%) were women. Almost one third (31.2%) were living alone, 45.2% lived in an institution (old people's home or hospital), and 23.7% lived with their spouse or a relative. The most common cause of dementia was Alzheimer's disease (54.8%); other causes included vascular disease, Parkinson's disease, or combinations of diagnoses. The severity of dementia, expressed as the amount of psychogeriatric care needed at T1, was mild in 32.3%, moderate in 60.2%, and severe in 6.5%.

Mean age of the informal caregivers was 57.3 years (range 24-89). Most (61.3%) were women. Seventeen percent were the patient's spouse, 36.6% were daughters, and 21.5% were sons. Twenty-four percent co-resided with the patient. The median duration of caregiving before the patients were registered on a waiting list was 3 years.

Non-respondents

The Admissions Office revealed that the 130 patients whose informal caregivers participated in the Waiting List Project represented 52.2% of the patients registered on the waiting lists in the two regions during the study period. No detailed information was available on the percentage of patients who did not meet the inclusion criteria. The mean waiting time of our respondents (21 weeks) was comparable to that of patients living at home or in residential homes in Amsterdam in 1997.⁸

Measures

Data collection consisted of interviews with informal caregivers and analysis of patient files at the RIAGG. Informal caregivers were interviewed when the patient was enrolled on the waiting list (T1) and were followed up, provided that the patient was still on the waiting list, at fixed points in time during the waiting period (T2=4 weeks waiting, T3=8 weeks, T4=26 weeks) and again 6 weeks after nursing home admission (T5). Measurement instruments on the health status of patients and informal caregivers are presented in Table 1.

Table 1. Health Status and caregiver burden measurement instruments and reliability coefficients (current study, N=93).

	Items	Cronbach's alpha
Patient		
IDDD	11	0.81
RMBPC memory problems	7	0.61
RMBPC depressive symptoms	9	0.77
RMBPC disruptive behaviours	8	0.63
Informal caregiver		
SPPIC	9	0.83
CES-d	20	0.92
MOS health perceptions	5	0.82
MOS physical functioning	6	0.79
MOS mental health	5	0.88
MOS role functioning	2	0.79
MOS social functioning	1	

IDDD: Interview for Deterioration in Daily Living Activities in Dementia⁹;

RMPBC= Revised Memory and Behaviour Problem Checklist^{10,11};

SPPIC= Self-Perceived Pressure from Informal Care scale¹²;

CES-d= Center for Epidemiologic Studies Depression Scale¹³;

MOS= Medical Outcome Study^{14,15}.

Information on the waiting status was gathered from the patient files at the RIAGG. Data were collected on indication date, date of admission to the nursing home, urgency codes, and (reasons for) changes in urgency codes during the waiting period.

Analyses

Descriptive analyses were performed on all relevant measures. Differences between patients with 'normal' urgency codes and those with higher urgency codes were tested with Chi-squared tests and *t*-tests. ANOVA was used to test the differences in waiting time according to the urgency codes. All analyses were performed with SPSS 8.0.

Results

Dynamics in urgency codes

Table 2. Urgency coding at registration on the waiting list and on admission to a nursing home.

Urgency code	Registration waiting list		Admission nursing home	
	N	(%)	N	(%)
1A: Highest	19	(20.4)	37	(47.4)
1B: High	8	(8.6)	18	(23.1)
2: Residence ^a	4	(4.3)	3	(3.8)
3: 'Normal'	62	(66.7)	17	(21.8)
Missing	-		3	(3.8)
Total	93	(100.0)	78 ^b	(83.9)

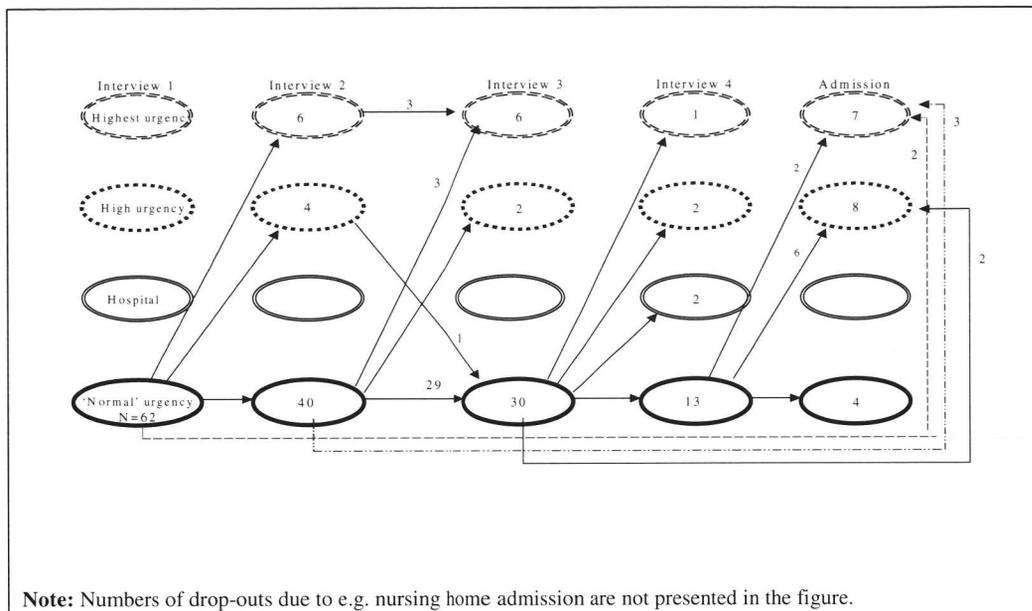
^a Residence: inappropriate stay in hospital or observation clinic.

^b Fifteen patients were not admitted to a nursing home for the following reasons: patient died during the waiting period (n=10); patient was withdrawn from the waiting list (n=4); and patient was still on the waiting list at the end of the study (n=1).

The distribution of the urgency codes during the first interview (registration on the waiting list) and on admission to a nursing home is presented in Table 2. At the moment of registration, 33% of the patients were given a higher than 'normal' urgency code. Seventy-eight patients were eventually admitted to a nursing home, 37.2% of whom had been given an urgency code that was higher than 'normal' at the time of registration. This percentage had increased to 74% by the time they had all been admitted to a nursing home.

The urgency code was changed to either a higher or a lower urgency code in only three of the patients (9.7%) who were given high or highest urgency codes at T1. In contrast, patients who were given 'normal' urgency codes at T1 showed the greatest variation: of the 62 patients assigned 'normal' urgency at T1, 36 (58%) experienced a change in urgency (see Fig. 2).

Figure 2. Dynamics in urgency codes for patients with ‘normal’ urgency at T1 (registration on the waiting list, n=62)



Reasons for higher urgency

Fifty-eight patients received a higher than ‘normal’ urgency code prior to nursing home admission. The reasons for these high urgency codes, as given by professional caregivers, are presented in Table 3.

Differences in health status between patients with high urgency codes (1A and 1B together) and patients with ‘normal’ urgency codes (code 3) were analysed (*t*-tests) at the moment of registration on the waiting list. The results are presented in Table 4. Differences were only found for performance in activities of daily living (IDDD): performance was worse for patients with higher urgency codes.

Table 3. Professional caregivers' reasons for higher than 'normal' urgency codes prior to nursing home admission.

Reasons	N	(%)
a) Decline health status patient	17	(29.3)
b) Exhaustion informal caregiver	9	(15.5)
c) Residential home can no longer meet patient's needs	5	(8.6)
Combinations of a, b, and c	15	(25.9)
Other reasons*	3	(5.2)
Missing	9	(15.5)
Total	58	100

* One informal caregiver moved abroad, one caregiver went on holiday after several years of caregiving, and one patient was inappropriately staying in a psychiatric hospital.

Table 4. Mean differences in health status and caregiver burden between situations with high/highest urgency codes (n=27) and 'normal' urgency codes (n=62) at registration on the waiting list.

	'Normal' urgency	High/highest urgency	t	Df
Patient				
IDDD	32.0	38.1	-3.30*	86
RMBPC memory problems	20.5	19.8	0.60	81
RMBPC depressive symptoms	11.2	11.7	0.30	86
RMBPC disruptive behaviours	4.6	5.0	-0.42	86
Informal caregiver				
SPPIC	5.4	5.8	-0.68	85
CES-d	11.2	12.2	-0.44	84
MOS health perceptions	64.8	61.0	0.70	84
MOS physical functioning	65.0	68.7	-0.50	83
MOS mental health	67.6	67.1	0.10	84
MOS role functioning	75.0	80.8	-0.64	84
MOS social functioning	83.7	89.2	-0.92	83

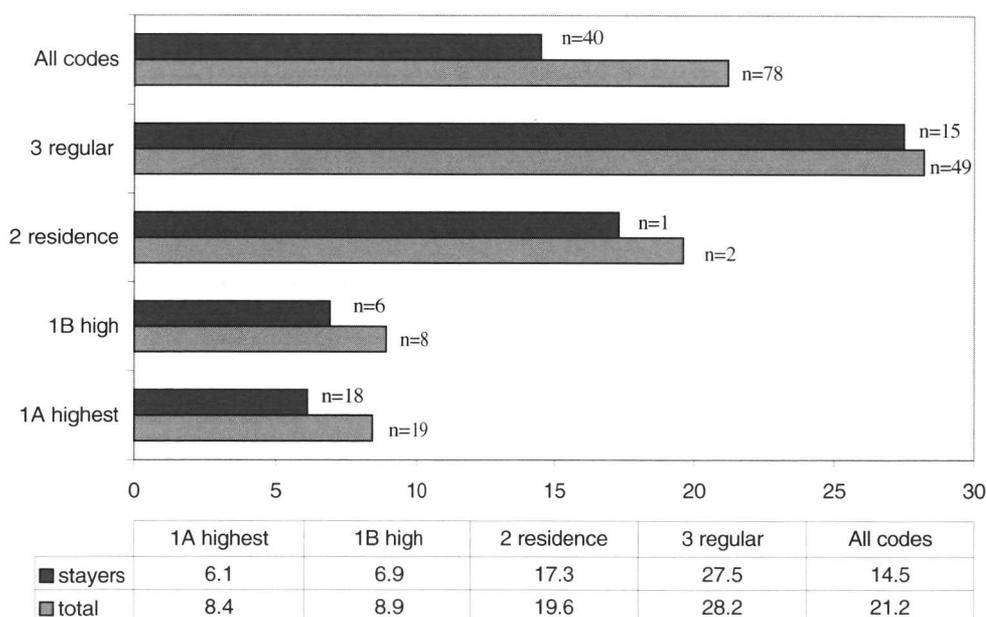
IDDD: Interview for Deterioration in Daily Living Activities in Dementia⁹; RMBPC= Revised Memory and Behaviour Problem Checklist [10,11]; SPPIC = Self-Perceived Pressure from Informal Care scale¹²; CES-d= Center for Epidemiologic Studies Depression Scale¹³; MOS= Medical Outcome Study.^{14,15}

* p < 0.01

Urgency codes and (satisfaction with) waiting times

Fig. 3 shows the results of the mean waiting times for the total number of patients admitted to a nursing home (n=78) and separately for patients who maintained a particular urgency code during the waiting period (the “stayers”). Waiting times were also specified for each urgency category and, within each category, for the stayers and the total number of patients. The mean waiting times for the stayers in the ‘normal’ urgency group, the high urgency group, and the highest urgency group differed significantly ($F=19.50$, $df=2$, $p < 0.001$). The mean waiting time after receiving a higher than ‘normal’ urgency code, at some moment during the waiting period, was 6 weeks (n=56, two missing).

Figure 3. Waiting time (in weeks) according to dynamics in urgency (urgency codes prior to nursing home admission).



Caregivers were asked their opinion of the waiting time 6 weeks after their relatives had been admitted to a nursing home. Ten (23.8%) caregivers of patients with higher than ‘normal’ urgency codes prior to nursing home admission considered the waiting time too long. Reasons for this included: caregiver was exhausted (one of them considered exhaustion the reason for his own admission to a sick-berth in a residential home after his spouse had been admitted to a

nursing home); the situation was too dangerous because of the patient's behaviour; the patient's condition deteriorated; and the care in the nursing home was considered so much better than that prior to admission that the caregiver wished the patient had been able to profit earlier from nursing home care. Of all the informal caregivers who were interviewed after their relative had been admitted to a nursing home, 22.4% perceived the waiting period as too long, 17.2% as too short, and 55.2 % as adequate (5.2 % had another or no opinion). There was no difference in mean waiting times between the caregivers who perceived the waiting period as too long, too short, or good ($F=0.812$, $df=2$, $p=0.45$). Moreover, this opinion did not differ between caregivers of patients with 'normal' urgency codes prior to admission to a nursing home and those of patients with higher urgency codes (Chi-square= 2.70, $df=2$, $p=0.26$).

Urgency codes and preferences for particular nursing homes

Of the 78 patients who were admitted to a nursing home, 29 (37.2%) were admitted to the home of their choice, 25 (32.1%) were not placed in the preferred nursing home, and 16 (20.5%) did not have a preference; information on preference was missing for the remaining eight (10.3%) patients. The fulfilment of preferences did not differ between patients with 'normal' urgency codes and those with higher urgency codes prior to nursing home admission (Chi-square= 0.563, $df=1$, $p=0.45$).

If a patient was not placed in the home of his/her choice, the possibility of transfer to another nursing home could be looked into. Twenty percent of the informal caregivers wanted their relative transferred, one respondent was undecided about a transfer, and 76% did not want a transfer. Reasons for the "no transfer" included too much commotion for the patients ("remove an old tree and it will wither to death") and satisfaction with the current nursing home.

Conclusions and discussion

The present study focussed on the use of an urgency coding system in the daily practice of managing a waiting list for admission to a psychogeriatric nursing home. All patients were assigned an urgency code at enrolment on the waiting list, which could be changed, if necessary, during the waiting period. At any point in time, the patient's position on the waiting list could be determined by the urgency code and -within this code- by the waiting time.

There are several risks in using an urgency coding system. For example, 'normal' urgency patients may be passed by high urgency cases and, hence, will not be admitted to a nursing home or only after a very long waiting period. In addition, there is less chance of being admitted to the preferred nursing home when the situation becomes more urgent. The current study on waiting lists for admission to a psychogeriatric nursing home showed that high/highest urgency codes are frequently assigned. In fact, at the moment of registration, one third of the patients were given a higher than 'normal' urgency code, a percentage that increased to 74% by the time of nursing home admission.

Possible selection bias should be considered when interpreting these results. First, the study included only those patients who had both an informal caregiver and an indication from the RIAGG for admission to a nursing home. This resulted in an underrepresentation of patients living in institutions (hospitals, residential homes). Second, patients who were admitted at extremely short notice to a nursing home were not included in the study, because their caregivers could not be interviewed at enrolment on the waiting list. Thus, the number of highest urgency patients was in fact larger and the mean waiting time shorter.

The urgency coding system was effective in this study, because patients coded with high/highest urgency were indeed admitted sooner to nursing homes. Patients with 'normal' urgency codes often experienced an upgrading of their urgency code in order to hasten admission. Patients who maintained 'normal' urgency codes were also admitted to a nursing home, but with long waiting times. Long waiting times did not influence satisfaction with the waiting period. In fact, some caregivers even perceived the waiting period as too short. This highlights the fact that waiting lists for admission to a nursing home may be "special" in the sense that the people involved are ambivalent towards nursing home admission. The risk of admission with higher urgency might be that the preference for a nursing home cannot be honoured. This was the case in almost one third of our nursing home admissions. This number may be even higher because some caregivers no longer had a preference or had broadened their preferences because the situation needed an urgent solution. Nevertheless, admission to "not-preferred" nursing homes was not related to urgency prior to admission. After admission to a not-preferred nursing home a minority of informal caregivers considered transferring their relative to a nursing home of preference.

Reasons for higher urgency codes, according to the health care professionals, are often a decline in the health status of the patient and/or a decline in the capabilities of the informal caregiver. The latter reason was also found in a national survey among nursing homes.¹ Except for the performance in activities of daily life, the results of health status measurements did not show a difference between patients with higher and those with 'normal' urgency codes. Nor was such a difference found in the health status and experiences of burden of informal caregivers. This may have been caused by our study design: the measurement points were fixed so that actual crises in the caregiving situation may have been missed. This was true for the patients who received a higher urgency code after our last measurement during the waiting period. Also, an earlier study showed that health care professionals may have different opinions concerning the purpose of urgency coding, should it be used after a situation has escalated or should it be used to prevent escalation.⁷ In the latter situation, changes in health status may be hard to demonstrate. The reasons for higher urgency codes may also entail more than just health status. Criteria for assigning higher urgency codes have not yet been precisely defined in the field of psychogeriatric nursing home admission. Due to this, health care professionals can include combinations of other reasons for higher urgency such as the attitudes of caregivers towards nursing home admission and other social circumstances.

In general, balancing the criteria in order to make a fair selection between patients on the waiting list is considered a complex activity.^{2,16,17} Moreover, the desirability and possibility of developing standardised measures to prioritise patients and to assign "points for pain" are debatable.^{18,19} We mentioned earlier social factors such as the attitudes of informal caregivers toward nursing home admission and the willingness of informal caregivers to continue giving care. In order to accentuate the latter factor, the concept of a "duty to care" for one's relative must still be defined.²⁰⁻²² Some caregivers are ready to quit caregiving, while others resist nursing home admission and must be supported by health care professionals in the process towards nursing home admission.²³ These professionals must be alert to changes in the situation and make use of a dynamic urgency tool, which enables them to adjust urgency codes in order to hasten nursing home admission. Instead of accentuating the criteria, it may be more important to have a procedure in which the health care professionals have to account for and discuss their decisions.

In conclusion, the negative consequences of an urgency coding system, e.g., 'normal' urgency patients not being admitted to a nursing home and preferences for nursing homes not being met, could not be demonstrated. 'Normal' urgency patients do experience long waiting times; however, it is open to question whether this is problematic since the dissatisfaction of caregivers with the waiting times was not related to actual waiting times.

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