Health Care for Older Persons, A country Profile: The Netherlands

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HEALTH CARE SYSTEM

In the Netherlands, there are four medical specialties — clinical geriatrics, nursing home medicine, social geriatrics, and geriatric psychiatry — that focus primarily on geriatric care. Nevertheless, and despite a high rate of institutionalization (8% of older people are in residential or nursing homes), the general practitioner continues to act as the gatekeeper for additional intensive medical care services in most geriatric situations. The objective of this paper is to describe how medical care for older people functions in the Netherlands.

Facts And Figures

The Netherlands has a population of 15.6 million people, and, with 447 inhabitants per km^2, it is one of the most densely populated countries in the world. Approximately 2.1 million (13.4%) of these inhabitants are aged 65 years and older, and 0.6 million (3.1%) are aged 80 years and older (see Table 1). Life expectancy at birth is 75.2 years for men and 80.6 years for women,[1] figures that are very similar to the European average.[2] Health care expenditure in the Netherlands (8.6% of the gross national product) is 1% higher than the mean European expenditure (7.5%).

The vast majority of people in the Netherlands have healthcare insurance, which covers the costs of primary care and medication as well as the costs of in-hospital and outpatient treatment. In addition, every Dutch citizen is insured under the Exceptional Medical Expenses Act (AWBZ). The AWBZ provides the general public with insurance for health risks not covered by normal healthcare insurance, such as admission to nursing homes and residential homes and the costs of home care and ambulant psychiatric treatment.

Eighty-two percent of the Dutch people aged 65 years and older live independently in the community; the remainder live in adapted housing (10%), residential homes (5.5%), and in nursing homes (2.7%). Almost everyone is registered with a general practitioner, who is the first person to be consulted in connection with health problems. The responsibilities of the general practitioner are examination, advice, treatment, and, if necessary, referral. In the Netherlands, more than 90% of healthcare problems are dealt with in primary care (e.g., general practitioner, homecare organizations).

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General practitioners can refer patients to 143 hospital with almost 60,000 beds (3.8 per 1000 inhabitants). The average duration of hospitalization is 9 days, but for older people it is often longer. Only 17 hospitals, however, have geriatrics departments, with approximately 500 beds. Older patients with multiple pathologies are referred to these departments by general practitioners, nursing home physicians or hospital specialists and are admitted for short-term examination and treatment. Diagnosis takes place on an inpatient outpatient, or day clinic basis. Admission is restricted to patients with mobility problems, inadequate support at home, or specific nursing requirements. Treatment is provided under the supervision of a clinical geriatrician.

There are 330 nursing homes in the Netherlands, with a total of 57,000 beds (27 per 1000 inhabitants aged 65 and older) and day clinic places for 4800 patients. The Dutch nursing home is a healthcare institution for chronically ill persons needing permanent medical and paramedical attention and complex nursing care and is comparable to skilled nursing facilities in the US. It differs from nursing homes in other countries in that the staff includes nursing home physicians (1 full-time doctor per 100 patients) and physical therapists, occupational therapists, speech therapists, and psychologists (together equalling 6 per 100 patients), all of whom are employed by the nursing homes. Nursing homes have separate wards for rehabilitation, long-term physical care, and patients with Alzheimer's disease. One in three patients (primarily those with orthopedic problems or stroke) is discharged home after rehabilitation. Many nursing homes also provide crisis intervention and respite care at the request of the general practitioner. The patient population consists mainly of older people (average age 81.5 years), but younger patients (10% of residents) are also admitted.

There are 1425 residential homes in the Netherlands with a total of 117,500 beds (55 per 1000 inhabitants aged 65 years and older). A residential home is primarily a housing facility for older people who need ongoing help with activities of daily living. Residents have their own apartments with a small kitchen/bathroom. Medical care is provided on request by general practitioners and supported by nursing home physicians.

Finally, general practitioners can refer older people who live at home and have complex psychogeriatric problems to a social geriatrician, who will organize and monitor the necessary care at home. The social geriatrician is affiliated with a Regional Institution for Ambulatory Mental Health Care.

JAGS 48:214–217, 2000

0002-8614/00/$3.5

Table 1. The Dutch Health Care System Profile in Numbers (1997)[1]

Total population	15.6 million	
Men	7.7 million	
Women	7.9 million	
Percentage of total population aged 65+ years	13.4%	
Men	5.4%	
Women	8.0%	
Percentage of total population aged 80+ years	3.1%	
Men	0.9%	
Women	2.2%	
Life expectancy at birth		
Men (years)	75.2	
Women (years)	80.6	
Life expectancy at age 60		
Men (years)	14.7	
Women (years)	18.8	
Life expectancy at age 80		
Men	6.3	
Women	8.3	
Total health care expenditure (% of gross national product)	8.6%	
Physicians (number/100,000 inhabitants)	253	
General practitioners (number/100,000 inhabitants)	57.6	
Nursing home physicians (number/100,000 inhabitants)	9.4	11.8
Clinical geriatricians (number/100,000 inhabitants)	1.1	
Social geriatricians (number/100,000 inhabitants)	1.3	
Registered nurses (number/100,000 inhabitants)	1251	
Acute care hospital beds (number/1000 inhabitants)	3.8	
Nursing home beds (number/1000 inhabitants > 65 y)	27	
Beds in residential homes (number/1000 inhabitants > 65 y)	55	

*See reference 1 for all numbers.

A Brief History Of Geriatric Care

Geriatric care in the Netherlands has developed along two separate lines. The first nursing home ("hospital for the chronically ill") was established in 1929 and provided care for patients with long-term illnesses such as neuromuscular disorders, tuberculosis, and cancer. After 1950, the number of nursing homes increased rapidly, especially with the implementation of the AWBZ insurance program in 1968, which provided a sound reimbursement basis for nursing homes. Hospitals also began to develop geriatric programs and geriatric departments, mainly after the recognition of clinical geriatrics as a medical specialty in 1982.[3]

CULTURAL AND SOCIAL HIGHLIGHTS

In the Netherlands, as in other western, industrialized countries, the number of older people is increasing rapidly. The population group aged 65 years and older is expected to increase from its present 13.4% to 17.8% in 2010 and to reach a maximum of 23.3% of the total population in the year 2025.[4] The number of very old (aged 80 and older) will increase from 3.9%, to 4.9%, to a maximum of 6.8%.[5] There will be very few regional differences in these percentages.

Although children sometimes support their parents over long periods of time, older persons, as well as their children, count more on professionals as the main providers of care. The average number of children in a family in Holland is now less then two, and many of these children have families of their own and are employed in a part of the country away from their parents. The number of women involved in the employment process has risen from 26% in 1960 to 63% in 1999. It is very unusual for parents to live with their children.

At the same time, the decreasing number of young people and the negative image of nursing among them has made it increasingly difficult for institutions to recruit sufficient staff. This makes it particularly difficult to provide a proper quality of care level in the home and in healthcare institutions. These developments have been especially influential in the large cities in the western region of the Netherlands but have been felt to a lesser extent in rural areas.

EDUCATION OF GERIATRICIANS

Clinical geriatrics and nursing home medicine have been officially recognized as specialties by the Royal Dutch Medical Association since 1982 and 1990, respectively. Clinical geriatric training is a 5-year program consisting of 2 years of internal medicine, 2 years on a geriatric ward, and 1 year of psychogeriatrics. At present there are 80 qualified clinical geriatricians and 120 residents working in hospitals and treating patients for short-term evaluation on an inpatient, outpatient, or day clinic basis.

The vocational training program for nursing home physicians takes 2 years and consists of practical training 4 days a week in a teaching nursing home under the supervision of a senior colleague and theoretical training 1 day a week at the university. There is capacity for 84 new residents each year. At present there are approximately 1000 qualified nursing home physicians, most of whom are involved largely in daily

patient care in nursing homes; a few also having management tasks.

In addition, there are 140 physicians practicing social geriatrics. Social geriatrics is the care of patients, living in their own home or residential home, who have primarily psychological or social problems that can threaten their ability to live independently. Social geriatrics is not an officially recognized medical specialty, but the Vrije Universiteit Amsterdam provides a 2-year training course.

Geriatric psychiatry is included in the basic psychiatry training. The interest of psychiatrists in this domain is increasing, and recognition as a subspecialty is under consideration. Two universities have already created the position of Professor of Geriatric Psychiatry.[4]

GERIATRIC CARE FROM THE PATIENTS PERSPECTIVE

The principal elements of Dutch government policy with regard to care for older people, as represented in the memorandum "Modernizing Care for the Elderly" (1996), are: (1) increasing the responsibility of insurance companies and care providers at local levels (decentralization and deregulation), (2) intensifying home care so that older people can live independently for as long as possible, and (3) improving collaboration between the various services by bringing the various healthcare services for older people under the same reimbursement schemes. The first step was taken in 1997 by adding residential homes and homecare organizations to nursing homes under AWBZ insurance coverage. In order to qualify for these facilities, patients must have a medical indication designated by an independent municipal indication authority.

In 1980–1985 the percentage of the population aged 65 and older living in institutions (medical and nonmedical) was 11% in Holland, 4% in Japan, 6% in the US, 9% in Canada, 10% in Sweden, and 12% in Denmark (source: Socio Demographic Characteristics of Comparison Countries. International Health Statistics, Washington DC, November 1993). As a result of measures discussed above, the institutionalization rate in Holland decreased to 8.2 (2.7 in nursing homes and 5.5 in residential homes) in 1998, and it is expected to decrease further as a result of the government policy to keep older persons in their own environment as long as possible. The decrease will affect the capacity of the residential homes more than that of the nursing homes. Nonetheless, Holland continues to have one of the highest institutionalization rates in the world. Both institutions are funded by the Exceptional Medical Expenses Act, which means that patients/residents contribute according to their income (maximum 2200 Dutch guilders, i.e., $1100 dollar/month). Nursing homes and residential homes cooperate in funding nursing home units in residential homes so that people living in the residential home can remain there if they need nursing home care.

Collaboration is also enhanced by agreements made by nursing homes with hospitals to transfer older patients quickly to a nursing home for further rehabilitation, intensive care nursing, or postacute care. This results in an increase in the already strongly developed rehabilitation function of the nursing home. As a result of these government efforts, a broad range of support facilities is now available to keep patients at home for as long as possible. Meals-on-wheels, household help, district nurses, and medical aids on loan are available throughout the country. Housing development programs are also becoming increasingly aware of the needs of older people (wheel-chair access, safety provisions, alarm systems, proximity to facilities). Moreover, there are volunteer organizations and old peoples' centers throughout the country where keep-fit classes and other activities for older adults are organized.

Most nursing homes have day clinic facilities for psychogeriatric and somatic patients. They provide treatment for patients who have a medical indication for at least two types of therapy (physiotherapy, occupational therapy, speech therapy, and medical and/or psychological treatment). Departments of geriatric medicine in hospitals provide diagnosis, observation, care planning, and treatment on a short-term basis for patients with complex geriatric problems. The comprehensive assessment takes place on an inpatient basis or, whenever possible, on an outpatient basis in the geriatric day clinics. Screening is carried out by a multidisciplinary team consisting of a clinical geriatrician, paramedics, psychologists, social workers, and nurses. Patients admitted to observation units in nursing homes for short-term evaluation are primarily patients with nonacute psychogeriatric problems.

All of the facilities mentioned above are intended to provide optimal well-being for the patient, support for homecare organizations, and, possibly, relief for a healthy partner.

CRITIQUE

One of the major advantages of the healthcare system for older people in the Netherlands is the broad range of comprehensive treatment and care facilities offered both at home and in institutions. Nursing care and household help for older people living at home is provided by regional homecare organizations. Evaluation in the geriatrics departments of a hospital, rehabilitation in nursing homes, regional institutions for ambulant mental health, and permanent admission to a residential home or a nursing home complete the range of provisions. Another advantage is that these facilities are available to everyone, with a minimal contribution made according to income. Patients have easy access to geriatric medical care because it is provided by the 7000 general practitioners and supported by clinical geriatricians, social geriatricians, nursing home physicians, and geriatric psychiatrists. A final advantage is the low referral rate of nursing home patients to a hospital as a result of the presence of nursing home physicians.

A major disadvantage of the system is the waiting lists. The increase in the number of facilities can not compete with the increase in the number of (very) old people in the population, resulting in waiting lists for admission to residential homes, nursing homes, and home care; congestion in the hospitals is also a problem. In 1998, the waiting time between notification of an indication and admission was 40 weeks for a residential home, 7 weeks for a nursing home for physically disabled patients, and 17 weeks for psychogeriatric patients.[6] A second disadvantage is the increasing shortage of personnel in the nursing and care sectors. Because of the decreasing number of young people in the population, inadequate salaries compared with other professions, and a low level of interest in the profession, hospitals and nursing homes have had great difficulty recruiting qualified personnel. Maintaining the independence of older people is a noble concept, but, unfortunately, there is an increasing number of older people with high care needs in the community, who are sometimes

socially isolated, and this results in (too) great a workload for home care and the umbrella care network. Moreover, the policy of transferring hospital-based technology to the home-care system will infringe on the tasks of district nurses and general practitioners.

FUTURE PERSPECTIVES

Older people in the Netherlands want to live independently for as long as possible, and the government is spurring the development of care-innovation programs to make this both possible and financially feasible.[7] Medical and social care are becoming increasingly integrated as a result of the growing collaboration between homecare organizations, nursing homes, and residential homes. The number of geriatrics wards in hospitals and the number of clinical geriatricians is increasing, but there are still too few. In no other country in the world has medical care for older people, with its four specialties, developed as it has in the Netherlands. The availability and integration of these four specialties, and their collaboration with the general practitioner and other medical specialties, must be further developed in the near future. Evidence-based medical care for older people needs to be high on the research agenda in the Netherlands and in other countries as well.

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