

The Netherlands



Care Work with Older People

Da Vinci College
Waerthove centrum voor verpleeghuisorg

Care of Older People in The Netherlands

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Dear Student,

Welcome to The Netherlands! We are pleased you are doing your work placement here and we hope it will be a productive and pleasant time.



The purpose of this booklet is to help you find your way in Dutch care for the elderly. It maps the history of health and social services from the past right up to the present and also includes ideas about future developments. On a practical level it outlines social services and networks that elderly people can apply for. The role and position of the care worker is also described.

Dutch welfare policy and an overview of elderly people in The Netherlands are described in Chapters 3 and 4.

You will get an overview of social security and the service system for elderly people in the Netherlands in Chapters 5 and 6.

Practical information about the actual work on the job is included as well. A client's day, the day of the care worker and helping the client are described in Chapters 7 and 8.

You can find information on employment in care and its levels, and the Dutch educational system for health care in Chapters 9 and 10.

The handbook contains a lot of information. It is best used as a reference book and guide. Please read the list of contents and use the relevant material you need at any particular time.

Lots of success during your work placement in the Netherlands. We are sure this Handbook is a helpful resource in understanding the Dutch system.

Good luck!

1. United Nations, European Union and Social Policy

1.1. United Nations' Second World Assembly on Ageing 2002:

Building a Society for All Ages

◆ An ageing population is a challenge to all societies. Global guidelines and principles are drawn to secure and enable older people's integration as full citizens in different societies. As an example of such global aims, the following United Nations' document presents United Nations' principles that are re-phrased on a European Union level.

Building on previous meetings of the United Nations Plenary Assembly in 1982 during which they formed an action plan and United Nations Plenary Assembly in 1991 when this action plan was passed a further meeting was convened in 2002.

To address challenges associated with the momentous demographic shift taking place in the older population, the United Nations' General Assembly decided to convene the Second World Assembly on Ageing from 8th to 12th April, 2002 in Madrid, Spain. An international action plan in this regard was passed on 12th April, 2002. Article 1 of this plan is expressed as follows:

We, the representatives of the governments, meeting at the second world assembly in Madrid, to address the fact of ageing, have decided to pass an international action plan to take into account the possibilities and challenges associated with older people in the 21st century.

We commit to ensure at all levels, including National and International, that this action plan is built on three solid foundations:

- ◆ Older people and their development
- ◆ Promotion of health and well being in advanced years
- ◆ Guarantee of a beneficial and supporting environment.

The Principles of the United Nations for the care of the older person such as:

- ◆ Independence
- ◆ Participation
- ◆ Care
- ◆ Self fulfilment and
- ◆ Dignity

Are now set in stone, with targets, measures, demands listed in 117 points on the charter. Special mention was given in the International network (point 109) to the words exchange - consultation - support. The United Nations Commission for Social Development will be responsible

for implementing and following up those Principles to ensure that action plans are carried out at National and International level.

Further information on the United Nations guidelines and principles may be had from:

<http://www.un.org/esa/socdev/ageing/waa/index.html>

<http://www.un.org/ageing/dpi2230.html>

1.2 United Nations Principles for Older Persons

(adopted by the UN General Assembly December 16, 1991 - Resolution 46/91)

”To add life to the years that have been added to life”

◆ The UN Principles aim to ensure that priority should be given to the situation of elderly persons. The UN Principles deal with the independence, participation, care, self-fulfilment and dignity of the elderly.

The General Assembly appreciates the contribution that the elderly make to their societies and encourages national Governments to incorporate the following principles into their national programmes whenever possible:

Independence

Elderly persons should:

1. Have access to adequate food, water, shelter, clothing and health care through the provision of income, family and community support and self-help.
2. Have the opportunity to work or to have access to other ways of earning an income
3. Be able to participate in determining when they will stop working and at what pace this withdrawal from the labour force takes place.
4. Have access to suitable educational and training programmes.
5. Be able to live in environments that are safe and that can be adapted to personal preferences and changing capacities.
6. Be able to live at home for as long as possible.

Participation

Elderly persons should:

7. Remain integrated in society, participate actively in the formulation and implementation of policies that directly affect their well-being and share their knowledge and skills with younger generations.
8. Be able to look for and develop opportunities for service to the community and to serve as volunteers in positions suitable to their interests and capabilities.
9. Be able to form movements or associations of elderly persons.



Care

Elderly persons should:

10. Benefit from family and community care and protection in accordance with each society's system of cultural values.
11. Have access to health care to help them to maintain or regain the optimum level of physical, mental and emotional well-being and to prevent or delay the onset of illness.
12. Have access to social and legal services to enlarge their autonomy, protection and care.
13. Be able to use suitable levels of institutional care providing protection, rehabilitation and social and mental stimulation in a humane and safe environment.
14. Be able to enjoy human rights and fundamental freedoms when living in any shelter, care or treatment facility, including full respect for their dignity, beliefs, needs and privacy and their right to make decisions about their care and the quality of their lives.

Self-fulfilment

Elderly persons should:

15. Get opportunities for the full development of their potential.
16. Have access to the educational, cultural, spiritual and recreational resources of society.

The UN Principles aim to ensure that priority attention will be given to the situation of elderly persons. The UN Principles address the independence, participation, care, self-fulfilment and dignity of older persons.

The General Assembly appreciates the contribution that older people make to their societies and encourages national Governments to incorporate the following principles into their national programmes whenever possible:

More information available at:

<http://www.aoa.gov/international/Principles/principle.html>

www.un.org/esa/socdev/iyop/iyoppop.htm

1.3. European Union and Social Policy

◆ The European Community Treaty enacted in Maastricht in 1992 emphasises connections between economic growth, employment and welfare. Social policy and social protection are seen as factors promoting economic growth.

The EU-level social policy decision making is restricted in drawing up general guidelines and principles that can be found in different Council's Recommendations and Charters agreed by Member States.

From an ordinary citizen's viewpoint the question lies more with the national social policy legislation: social policy is a core responsibility of the Member States. The EU has laid down only minimum standards and minimum rights.

The European Social Charter represents a consensus over basic economic, social and cultural rights. The rights guaranteed by the European Social Charter are as follows:

- ◆ The right to education
- ◆ The right to employment,
- ◆ The right to health,
- ◆ The right to housing,
- ◆ The right to non-discrimination and
- ◆ The right to social protection.

The European Social Charter defines the rights of EU-citizens on a general level. The implementation of these rights is executed by Member States. Under the Charter, states must guarantee the right to social protection i.e.

- ◆ The right to the protection of health,
- ◆ The right to social security
- ◆ The right to social assistance and
- ◆ Social services.

It lists the special measures, which must be taken for the older person. The revised Charter guarantees the right to protection against poverty and social exclusion. The European Social Charter defines the rights of EU citizens on a general level. The implementation of these rights is executed by Member States.

1.4. Social Protection of Older People - Social Charter

◆ The following additional protocol to the European Social Charter specifies older people's rights to social protection. As all Member States have ratified the Charter, it binds Member States and they are expected to adapt their social policy programmes and measures to meet the aims of the Charter. The additional protocol lays the guidelines for the social

protection of older people on a European Union level, in the following way:

Article 4 - Right of older persons to social protection:

With a view to ensuring the effective exercise of the right of older persons to social protection, the Member States undertake to adopt or encourage, either directly or in co-operation with public or private organisations, appropriate measures designed in particular:

1. Enable older persons to remain full members of society for as long as possible, by means of:
 - (a) adequate resources enabling them to lead a decent life and play an active part in public, social and cultural life;
 - (b) provision of information about services and facilities available for older people and their opportunities to make use of them;
2. To enable older people to choose their life-style freely and to lead independent lives in their familiar surroundings for as long as they wish and are able, by means of:
 - (a) provision of housing suited to their needs and their state of health or of adequate support for adapting their housing;
 - (b) the health care and the services necessitated by their state.

3. To guarantee older people living in institutions appropriate support, while respecting their privacy, and participation in decisions concerning living conditions in the institution.

Source: European Social Charter, Additional Protocol to the European Charter ETS No. 128.



It is the parties' (member states) of the rights of elderly responsibility to take effective measures to make sure that the rights to social protection of the elderly are met, either directly or in co-operation with public or private organisations.

2. Welfare Policy in The Netherlands

General introduction

◆ The care and welfare system wants people to feel well and aims to make it possible for them to function in their families, at work, at school and in their neighbourhoods.

The main goal for the national policy on elderly people is:

To let people in all circumstances and phases of life be independent and self-reliant as long as possible. It is essential to offer people who need care, such as the elderly, optimum choices and to improve the quality of their life and the care they receive.

The Dutch system of health care, care and welfare doesn't have a transparent structure. There are different criteria for classification. It's possible to distinguish health care, care and welfare. Care may also be divided according to target groups such as youth care, care for the mentally disabled, for the elderly and for the chronically ill.

There are also other methods to make classifications (way of financing, national/ regional/ local)

This handbook contains a classification based on target groups.

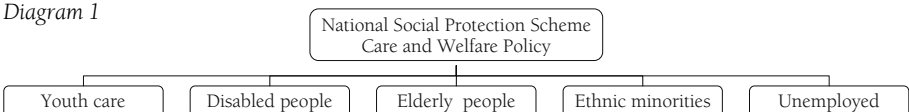
There are many people who need daily professional help. For them it's possible, on certain conditions, to go to facilities where they receive care. The assessment of the needs of the elderly and the admission to care is described in chapter 4.

The area of care and welfare is divided into several categories and is arranged into five main sectors, namely youth policy, care for the disabled, care for the elderly, care for ethnic minorities and the unemployed.

Approximately 400,000 professionals are working in the field of care and welfare in The Netherlands. Many of these people, for example those working in home care, have part-time and/or short-term contracts.

Most people work either in care for the elderly or the disabled. Some 25,000 people have jobs in youth care and about the same number of people work in local, municipal social services.

Diagram 1



3. Older People in The Netherlands

3.1. Developments in Demand for Nursing and Care

◆ Since 1990 the population of the Netherlands has grown by 6.5 %; every year there is a growth of the population of 0.6 %. It is expected that the growth of the Dutch population will not end until the year 2004. Because of this, the demand for nursing and care will continue to increase.

The composition of the population will also have its influence on the demand for care. The demand for nursing and care will be influenced mainly by the ageing of the population. Whereas in 1990 12.8 % of the population was over 65, in 2000 this was 13.6 %, which is an increase of 250,000 elderly persons. From this age-group 70 % had chronic diseases. It is expected that the percentage of people of over 65 will increase to 14.8 % in 2010 and to 22.9 % in 2040.



The percentage of the chronically ill has increased in The Netherlands, partly as a result of ageing: from 36 % in 1990 to 41 % in 2000, which is an increase of well over 100,000 persons.

In general people of Turkish, Moroccan and Surinam origin, living in the Netherlands, are more often ill than the Dutch. The Netherlands has 1.4 million inhabitants of non-Western origin, which is almost 9 % of the population. It is expected that in 2015 about 12.5 % of the Dutch population will be of non-Western origin, and that most of them will live in the bigger cities.

The number of single households will also have its influence on the demand for care because in general the health of single persons is worse than that of persons living together. It is known that 15 % of all elderly persons living on their own uses health-care facilities and 9 % of the elderly that live together. In 2000 the percentage of single households was 33.3 %; in 1990 this was 29.9 %. In ten years' time this is an increase of single households of more than 450,000. It is expected that in 2010 the percentage of single households will have increased to 36.8 % (which means an increase of about 450,000 single households as compared to 2000).

”Umbrella care”, which means ”care given by children, relatives and neighbours”, is already of great influence on the admission to formalised care. Numerous developments are responsible for putting more and more pressure on ”umbrella care”, such as the ageing of the population, the

growth of the number of chronically ill persons, more single households, waiting-lists in health care and an increasing number of women who have got a job. As a result of these developments facilities for supporting ”umbrella care” will become more important.

3.2. Diagrams

Diagram 2

Demographic Indicators 1998 and 2010 on ageing of the population

	1998	2010
Deaths per 1.000 of the population...	9	9
Life expectancy at birth (years).....	78.0	79.5

Diagram 3

Midyear population, by age and sex: 1998 and 2010

(Population in thousands)

AGE	1998			2010		
	TOTAL	MALE	FEMALE	TOTAL	MALE	FEMALE
TOTAL	15.731	7.792	7.939	16.242	8.071	8.171
00-04	951	486	464	723	370	353
05-09	992	507	485	836	428	408
10-14	936	478	458	936	479	457
15-19	921	471	451	1.014	518	495
20-24	972	495	477	987	503	484
25-29	1.257	640	617	946	483	463
30-34	1.325	681	644	979	501	478
35-39	1.295	662	634	1.169	595	574
40-44	1.192	605	586	1.338	687	651
45-49	1.143	583	561	1.330	681	649
50-54	1.094	558	536	1.215	616	599
55-59	819	415	405	1.110	560	550
60-64	705	348	357	1.103	553	550
65-69	644	303	341	788	387	401
70-74	550	239	311	621	290	332
75-79	436	172	265	486	207	279
80-84	278	93	184	346	128	218
85+	219	56	163	315	87	229

Source: U.S. Bureau of the Census; International Database. (<http://www.census.gov>)

Explanation:

Comparing 1998 with 2010 shows that an increase in numbers of the total population will occur.

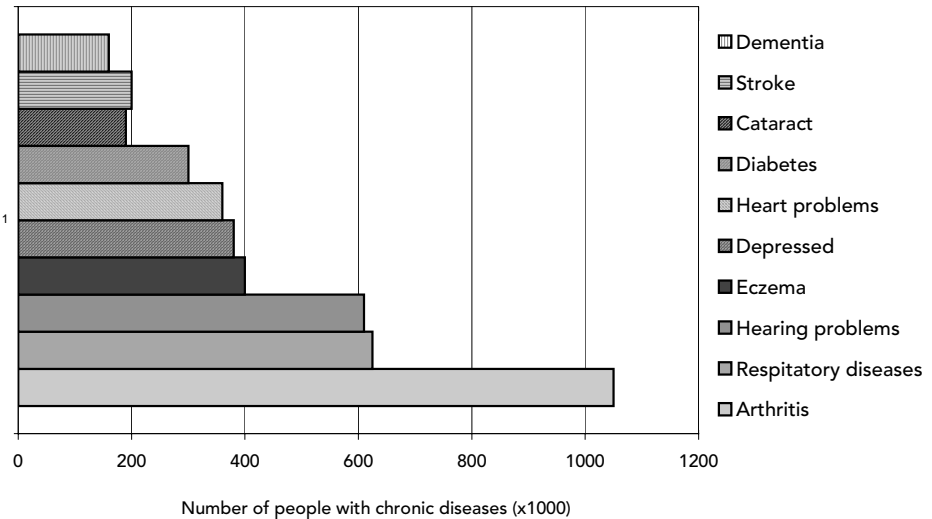
An increase of all population groups will occur, starting from group 40-44 and beyond. This means that in future there will be many more elderly persons and that they will live longer.

In both scales (1998 and 2010), women will live longer than men.



Diagram 4

More chronically ill people in 2010



Explanation:

As a result of ageing of Dutch population in future, more and more people will be suffering chronic diseases, limitations and impediments. Arthritis and rheumatism will occur most in future. Estimated figures in 2010 are presented here.

Source of this diagram with estimated figures is The Dutch Foundation for chronic diseases. (2001)

4. Services for Older People in the Netherlands

4.1. Care of Older People as It Was since 1900

◆ Between 1900 and 2002 we have experienced changes in public health: people have recognised the importance of hygiene, the number of babies and the number of elderly people who die have both increased.

A number of social changes have also taken place: the industrial revolution and protective guild rules (social system dating from the Middle Ages) do no longer exist.

As a result of these developments people who had got a job found themselves in a vulnerable position. People of over 40 were often made redundant in order to be replaced by cheaper and quicker younger people and for the elderly who were physically no longer able to work, poverty began. People had to rely on charity.

People from socially higher class and middle class groups often had better health, and were able to find a new job. To make sure that "old equals poor" did not apply anymore, it was essential to introduce reforms within the existing

system of relief for both the poor and the elderly people:

1912 Poor Law

1913 Old Age Pensions Act

These Laws laid the foundation for financial independence of the elderly and improved the position of old people's homes. In 1919 the law stated that everybody had to be insured against old age and disablement. The contribution was partly paid by the employer and partly by the government.

This situation continued until after the Second World War. But there was criticism because of the small support and the dependence on charity. This resulted in new Laws after the Second World War.

1941: Public Health Insurance Decree

1947: Provisional Senior Citizen's Bill

1957: General old Age Pensions Act

1962: Housing Act

1970: Senior Citizen's Bill (Senior Citizen's pass for participating in social life)



Because of all these new laws the financial situation of the elderly improved a lot.

Other developments:

1980-1990: In connection with the increase of the ageing population, the question is whether Old Age Pension can continue to be financed.

The nineties: Emphasis on the quality of care

4.2. Care of Older People as It Is Now

Introduction

◆ The central issue in care for the elderly is the integration of the elderly into society. Elderly people should be able to participate in public life as much and for as long as possible. The elderly should be able to live on their own for as long as possible, with extra help when necessary. Elderly people who can no longer take care of themselves and who need more than family or home care, may be admitted into a nursing home or a residential home for the elderly. In addition to these government-supported homes, there are various private services for the elderly. Local social organisations offer a lot of different activities and services for the elderly.

The traditional three-level-system

◆ *The first level of care for the elderly consists of residential homes for the elderly.* From the sixties onwards The Netherlands have created a large number of residential homes for the elderly ("verzorgingshuizen") within the public sector. These homes are evenly distributed over towns and villages and have a "homely" atmosphere, with small private one-room apartments, with shower and kitchenette, grouped along internal corridors. Originally these residential homes for the elderly were primarily meant as serviced residential provisions. Because a lot of houses were destroyed during the Second World War, these residential homes for the elderly were built. By letting the elderly move into these residential homes lots of houses became available to others. Meanwhile the residential homes have changed through the eighties and nineties into care institutes for frail elderly people with an average age of 85.

◆ *The second level of care for the elderly consists of nursing homes.* The traditional nursing home ("verpleegtehuis") is a rather large institute with at least 120 beds, based on the hospital model, with rooms containing 4-6 beds and very little privacy. In addition to their original function as institutes for post-clinical nursing and rehabilitation, it has become a home for the very old, where people with serious somatic and cognitive disorders spend the last years of their lives. The capacity for elderly persons suffering from dementia is still

being expanded. Because of new privacy regulations, nursing homes must now restructure their buildings so that they offer the elderly single or double rooms.

The difference between the residential home for the elderly and the nursing home has become smaller. For this reason both types of homes have recently gained the same legal status, which means that they have been put into one legal and financial framework.

By the year 2000, the nursing homes had a capacity of about 55.000 people and residential homes about 110.000, the total volume of institutional care covers about 9 % of the population over 65, which is still the highest figure in Europe. At the moment there are still long waiting lists for nursing homes as well as for residential homes.



Both nursing homes and residential homes are financed under the General Act on Exceptional Medical Expenses (AWBZ). All elements like care, services, full board and the buildings are financed in this system. Residents pay a contribution according to their income; those with a low income have their social allowances paid directly to the home and receive a monthly amount of "pocket money".

◆ *The third level, which is expanding rapidly in the Dutch system, is the so-called extramural care system, as opposed to the intramural care in institutional homes.* The core of this system is the regional home care and home help service. Professional home care is all care, nursing, supervision and monitoring of people who require assistance at home. Home care used to be carried out by organisations for family care, maternity care and district nursing.

Currently, the number of large home care organisations that combine these three areas of work is increasing. Home care usually consists of relatively "light" help, such as domestic help for a couple of hours a week, or some caring or nursing assistance. The disabled and the elderly may also require assistance with common daily activities such as (un)dressing and washing. Terminally ill people are offered more extensive home care. People can also apply to home care organisations to borrow or buy all sorts of (medical) aids.



Welfare organisations for the elderly are also part of the extramural system. These are not part of the care insurance system, but of a municipal service. These welfare organisations offer a lot of different services, such as meals-on-wheels and activities that stimulate participation in society, such as social events and physical exercise courses. Some communities develop extra initiatives, for instance odd-job services and transport services, which are offered to the elderly at relatively low prices. All services offered by welfare organisations rely largely on the commitment of volunteers.

Sheltered housing schemes for elderly people, with a total of about 130,000 houses, consist of newer and older flats and "alms houses", most of them built and managed by not-for-profit housing corporations. The newer ones are built to "lifetime standards" and are well-equipped three-room apartments. About 40,000 units have been built as "sheltered houses", close to residential homes for the elderly, which can provide emergency services and social services.

A regulated market-system of housing and care

◆ At the beginning of the nineties the housing corporations, like the nursing homes, residential homes and the home-care organisations, were essentially still government agencies with very limited freedom as to how they were run.

In the mid-nineties, ties were loosened and the housing corporations turned into social entrepreneurs with their own management responsibility. They were legally turned over to private bodies. These operations resulted in small housing corporations that later on merged into larger professional organisations.

In the early nineties, a parallel effort was made by the Secretary of Health and Welfare to introduce a regulated market system in the care sector. At that time the effort failed, but because there was a growing list of people that needed care, efforts were made to find new ways of providing and funding care.

At a small scale, personal care budgets were introduced as an alternative to institutional care, but only for the disabled, and as an alternative to the regular home-care organisations. The organisations for elderly and disabled people lobbied for more personal care budgets so that they could give the money directly to the user instead of to the organisations. Legal procedures were also started in order to force the care insurance agencies to attribute care to those who were legally

entitled to it according to the regional need assessment agency (RIO). During recent trials, judges have declared that an insurance- based system must not contain limitations in supply in the budget for care.

In the year 2000 a report was published that recommended the total reform of the care system into a regulated market system, which would be financed by people with personal care budgets. Since 1 April 2003 the General Act on Exceptional Medical Expenses (AWBZ) has been changed. The underlying idea is that care is given in relation to the demand for care and not on the basis of the supply of care. Because of the reconstruction of the General Act on Exceptional Medical Expenses, competition has increased and management based on functions has become more important than management based on supply. In 2008 the new system should be operational for the whole care sector.

These new developments will make the traditional three-level system and the borderline between intramural and extramural care and welfare disappear. The present care system reform will create a large and level playing field for all providers, as care budgets will increasingly be linked to persons, and not to institutes.

”Umbrella care” (care given by family and neighbours) will become more and more important in the future. At the moment about 3.5 million people are already



involved in ”umbrella care”. As about 75,000 people, involved in ”umbrella care”, are overburdened, there will always be the need for specialised services such as 24-hour care and interval home care. These types of care will survive, but will be provided by complementary functional neighbourhood teams.

Assessment of the needs of clients

◆ Admission to home care, residential homes and nursing homes is determined by assessment of need. Until 1998 home care carried out its own need assessment, and the assessment for institutional care was done by a separate agency. Nowadays, however, we have independent and integrated need assessment agencies in The Netherlands, which cover both home care and institutional care admission. They are organised at a regional level. Therefore they are called regional need assessment agencies (RIO). There is not a nation-wide protocol in use for assessment, but 91 % of all 85 RIOs

use the model of the BIO protocol (*see appendix, number 1). The BIO protocol was developed by BIO, which stands for Wide-range Assessment Council. This BIO protocol is a form that can be filled out for an independent, objective and integral manner of assessing housing, care and well-being. Its purpose is to support assessment advisors in analysing the needs of clients and to produce an assessment advice and later on take an assessment decision.

The BIO protocol and its procedures used by regional need assessment agencies (RIOs) are based on the International Classification of Impairments, Disabilities and Handicaps (ICIDH), which was developed by the World Health Organisation as an instrument to systematically order the aspects of the functional health situation of a person in relation to health care problems. For assessment in case of (suspected) dementia very often the regional community mental care organisation (RIAGG) is called in. In this assessment a social geriatrician or a specialised psychologist might be involved. In the near future regional need assessment agencies (RIOs) will also be charged with the assessment of disabled people.

The decision of the need assessment agency is the framework for supply of care to the patient by the care provider as well as for funding the care provider under the General Act on Exceptional Medical Expenses (AWBZ).

The so-called "Zorgkantoor", to be translated as "Care Office" is responsible for the execution of the General Act on Exceptional Medical Expenses. This Office makes agreements between care providers and insurance companies about the care and provisions offered in relation to calculated prices.

Municipalities are responsible for welfare services offered locally. There are local differences in the welfare services offered, because of the difference in which the costs are covered by the municipalities.

4.3. Care for Older People as It Will Be in the Future

New arrangements of housing and care

◆ The population of The Netherlands is ageing rapidly. This development is expected to reach its peak in about 40 years from now. In addition, average life expectancy is rising and the group of people of advanced age who need intensive daily care is growing quickly. Medical progress is also making it possible for people with a chronic illness to live longer. As a result of these developments, pressure on services will increase continuously. The Dutch policy aims to relieve this pressure by encouraging older people to live on their own as long as possible and by paying special attention to informal care and voluntary care.

The new dynamics on the market of housing and care will make the traditional three-level system unimportant within 10 years' time. Residential homes are increasingly providing care to clients who are on the waiting list for a nursing home. Some nursing homes offer clients a choice between nursing at home and stationary nursing in the regional home, whenever the circumstances make this possible.

Residential homes for the elderly are providing extramural care and social services to older people in the surrounding area, mostly in co-operation with home-care organisations. Since 1987, housing corporations have built about 40,000 apartments in housing-and-care-estates (woonzorgcomplexen). One third of the residents receive extramural care from residential homes or nursing homes, and another one third from home-care organisations. This new type of sheltered housing is increasingly popular among elderly people, as it combines the full quality standard of self-supporting life-time housing with warden services, common facilities and alarm systems plus optional care packages delivered by the local residential home.

With the introduction of new neighbourhood services and housing-and-care-estates, new promising developments have started. Examples of these new developments are:

- ◆ Small group homes for demented elderly people, clustered in "service areas" within the neighbourhood.
- ◆ "service areas" (woonzorgzones) are being developed with a mix of regular housing and about 5 % adapted housing for special needs groups, including the elderly and the disabled, with neighbourhood care and service centres within walking distance (inspired by the Danish neighbourhood model). These new dwellings are planned as living areas in which people can stay their whole lives and offer a good mix of care and welfare provisions.
- ◆ Systematic upgrading of existing flats towards life-time standards, with sheltered housing arrangements with the local residential home, which provides ICT-based safety and alarm systems, direct care guarantees and social services.

Strategic alliances between providers

Because of all the new arrangements, mentioned above, at least two providers are required: a care provider and a housing corporation. The national union of nursing and residential homes (Arcares) and the union of the not-for-profit housing corporations (Aedes) have decided to establish a strategic alliance.

For this reason, the union of nursing and residential homes (Arcares) is planning a second strategic alliance with the national union of home-care and home help organisations. On a regional level, more and more relations between different types of intra- and extramural providers will be established.

New strategic alliances will also be established between the care sector and the municipal welfare sector. The providers of care for elderly people, the mentally and physically disabled and chronically



psychiatric patients, are developing "multi-sector" projects in some places in The Netherlands. Joint night-watch services and day-activity programmes are organised.

What should be done?

◆ To make these new developments work in the future, a few major obstacles will have to be removed. The major ones are: the situation of those using care, the cost of the care system and the shortage of personnel. The lack of "umbrella care" (care given by children and neighbours) will also result in a demand for more professional staff.

The position of the users on the market will be reinforced by the general introduction of the system of personal care budgets. These users will only be able to exercise their power when the market is transparent. This will only be possible when there's more than one provider on the local level and when the users get support and advice from professional "brokers" on the market of housing and care. The users are becoming more emancipated and critical, demanding the care they need in their personal situation.

Because of the present and expected shortage of care and welfare staff it will be necessary to develop new organisational models and to invest more in infrastructure and technological aids. Campaigns to recruit more staff in combination with good education and good conditions of employment and fringe benefits (extras such as for example) company cars, will bring down the shortage of staff.

All these factors, the shortage of staff, the necessity of investments in infrastructure and technology and the general rise of quality standards in housing as well as in care, will create a tendency towards rising costs and will force providers to merge into ever larger regional concerns.

As long as there is a shortage in care and housing where people can stay for the greater part of their lives, the market will function in an imperfect way, and the control of the public sector will still be necessary.

5. Support Systems for Older People

5.1. The Dutch Social Security System in Relation to Care for Older People

◆ Note: The information offered here can be found on the website of ZZW, Information Centre for Social Security: www.ZZW.nl, linking to button "100 jaar Sociale Zekerheid" to "Internationaal", next to "English summary". On this website the schemes and diagrams concerning the Dutch Social Security System are shown. In this chapter we only explain the laws concerning social security for elderly persons.

Who qualifies as an elderly person according to the Dutch Social Security System?

There is not a formally set age limit for the purpose of defining the category of elderly people or senior citizens, but for social security a person is called an elderly person when that person is 65 or over. In The Netherlands these people are categorised as over 65 (65+).

As far as responsibility is concerned it is important to distinguish between the care-office (zorgkantoor) and the municipality (gemeente). The care-office is responsible for the execution of the General Act on Exceptional Medical Expenses. All care providers make

agreements on performance they will achieve. The municipality is responsible for welfare (i.e. meal services, job services etc.). They provide all kinds of welfare institutions with money.

What Acts are crucial, concerning elderly people?

The first two Acts mentioned here are part of the *National Insurance Schemes*, which consists of four acts in total. Contributions to these national insurance schemes are based on income. The higher the income, the higher the contribution. There is a limit to contributions, however, just as there is for the benefits. The contributions to the national insurance schemes are collected by the tax authorities.

1) *General Old Age Pensions Act (AOW, Algemene Ouderdomswet)*

This provides all insured persons who have reached the age of 65 with an old age pension. For each year of residence in The Netherlands a person is entitled to 2% of the full retirement pension. If a person has been insured from his 15th to his 65th birthday, he is entitled to his full pension. A person's income or assets do not affect the rate of the benefit. This act is implemented by the Social Insurance Bank.

People who have retired early and who have been employed by a company or

have been civil servants for the Government, will in general, receive a pension. This means that people can start living off their pension even before they have reached the age of 65. They receive the retirement pension from a special pension fund, for which both the employers and the Government are responsible. These people receive a retirement pension in addition to the old age pension.

2) General Act on Exceptional Medical Expenses (AWBZ, Algemene Wet Bijzondere Ziektekosten)

This Act ensures the entire population of The Netherlands of a number of health-care provisions. This includes home care and exceptional medical risks such as admission to a residential old people's home or a nursing home. People will have to pay a contribution according to their income from the age of 18. At the moment the lowest contribution is €100* a month. The highest contribution may reach a maximum of €1,665* a month.

This Act is implemented by the Health Insurance fund and specific private insurance companies. The Health Care Insurance Board and Association of Dutch Health Insurers can provide more information on this Act.

3) The Health Insurance Act (ZFW, Ziekenfondswet)

The Health Insurance Act (ZFW) is part of the Employee Insurance Schemes and provides health insurance for employees whose salary is below a certain limit. For 2002 this limit is set at €30,700* a year. The partners and children of employees may be insured as well. A person whose income is above this limit must take out a private health insurance.

The Health Insurance Act covers expenses for medical services such as the family doctor (GP), medical specialist, pharmacy, dentist, physiotherapy, maternity care, special medical treatment.

Under certain conditions, elderly people of 65 or older are also covered by the Health insurance Act (ZFW).

4) Disablement Provision Act (WVG, Wet Voorzieningen Gehandicapten)

The Disablement Provision Act belongs to the group of Social Provisions that are implemented by the municipal authorities and are paid from tax revenues. Under this Act a municipality must ensure that disabled persons of any age, including elderly disabled people, have certain provisions such as additions to their homes and provisions for transport.

**All figures mentioned above are based on information from the year 2002*

5.2. Health Care Insurance for Older People



◆ Health care in The Netherlands is funded almost entirely through a system of public and private health insurance. *There is no special insurance system for poor or elderly people. The system is a general one and includes all citizens.* Some elderly people may benefit from special regulations for reduced premiums. The system for insurance has three compartments. It should not be confused with the traditional three-level-system of care for the elderly, as described in paragraph 4.2

The first compartment includes insurance for medical care of excessive costs. These costs cannot reasonably be paid for by individual persons, nor can they be covered by a private health insurance in an adequate way. These costs are sometimes called "uninsurable risks" and are covered by the General Act on Exceptional Medical Expenses (AWBZ, Algemene Wet Bijzondere Ziektekosten), as mentioned above.

The second compartment includes insurance for a wide range of more "regular" medical care, such as family doctor(GP), physician consult(in hospital), dental care for minors and regular check-ups for adults, hospital care (first year), and prescription of medicine. The costs of this kind of care are covered by public or private health insurance. The public insurance is covered under the Health

Insurance Act (ZFW, Ziekenfondswet), as mentioned above. The self-employed and workers receiving annual wages above €30,700 (2002) will have a private insurance. Under certain conditions elderly people of 65 or over are covered under this Act.

Please note that in the future the first and second compartments will be fused into a joint compartment where "care" and "cure" will be combined. The difference being made now, meaning that the AWBZ is meant for "care" and the ZFW is meant for "cure", is an artificial one and is undesirable from the perspective of patients. The way the ZFW functions now, should be included. Only part of the services provided under the AWBZ should be included in the new Act for insurance of "care" and "cure".

The third compartment includes insurance for additional medical care that is not included in the first or second compartments. This additional care is considered less necessary, such as dental care and care beyond the limits set in the second compartment, like additional physiotherapy or special treatments. The insurance in this compartment is optional and private. Insurance companies are free to offer a package of coverage.

On a micro level, this system of insurance for health care and social provisions could mean that an individual elderly person uses provisions that are covered by different insurance Acts and regulations at the same time. For example, an elderly person receiving AWBZ funded home care, might have his/her treatment by a family doctor (GP) funded by The Health Insurance Act (ZFW), modifications to

his house, necessary because of his/her disability, covered by the Disablement Provision Act (WVG) and in addition this person may receive a state pension covered by the General Old Age Pensions Act (AOW). The Acts mentioned here are described above.



Diagram 6

Scheme of Dutch Health Care Insurance System

The financing of medical care takes place within a mixed system of public and private insurance. The system is divided into three compartments:

First compartment	Second compartment	Third compartment	The future
<p>AWBZ (1968): General Act on Exceptional Medical Expenses:</p> <ul style="list-style-type: none"> • Nursing home • Care for disabled • Home care • Care for mentally ill <p>All inhabitants must participate</p>	<p>(ZFW) Health Insurance Act:</p> <ul style="list-style-type: none"> • Basic medical care • Physicians • Hospital care • Medicines • Physiotherapy • Dental treatment for children <p>Employees with an income below the level of €30,700 (2002), their partners and their children, people over 65, up to the level of €19,550, recipients of social insurance benefits, the self-employed, up to the level of €20,500 and their partners and children.</p>	<p>Supplementary insurance, which can be taken voluntarily as an addition to the statutory health insurance fund or the standard package policy. The contents of these packages vary greatly as does the premium and one's own risk cover.</p>	<p>In 2001 the Dutch Government agreed on making changes in the health care insurance system. In the future there will be General Health Care Insurance for all inhabitants of The Netherlands. With this change the borderline between facilities covered by the Health Insurance Act (second compartment) and supplementary private health care insurance (third compartment) will disappear.</p>
	<p>Private medical expenses insurance: Insured on basis of the Access to Health Insurance Act. This package is largely the same as the statutory health insurance package.</p>		

6. Concepts of Working in the Care for Older People

6.1. General Goals of the National Policy on Older People

◆ The main goal for the national policy on elderly people is:

Maintaining the independence and self-reliance of people in all circumstances and phases of life for as long as possible.

It is essential to offer people who need care, including the elderly, optimum choices and to increase the quality of care and life.

The integration of the elderly into society is the central issue in the field of care for the elderly. Elderly people should be able to participate in public life as much and for as long as possible. The elderly should be able to live on their own for as long as possible, with additional assistance when necessary. Elderly people, who can no

longer take care of themselves, may be admitted to a nursing home or a residential home for the elderly. In addition to these government-supported homes, there are various private services for the elderly. Finally, local social organisations offer a lot of different activities and services for the elderly.

There is a question of expanding extra-mural care in the home situation as well as in the service areas and in housing and care estates. The number of people in self-supporting homes, especially meant for the elderly, has increased from 175,000 in 1990 to more than 450,000 in 1998. This development was parallel to a decrease in the number of elderly persons in nursing and residential homes. The quality of nursing homes and residential homes has improved.

6.2. The Aims and Principals of Nursing and Care Work

◆ 1. Assumptions for acting as a professional care worker

Assumptions for acting as a professional care worker are professional ethics, based on the professional profile. This professional profile describes what is meant by caring professionally:



The care worker provides attendance where and when addition is needed in the primary environment of a care seeker..

A care worker will stimulate, support and compensate the independence of the care seeker in the somatic and psycho-social sphere.

2. Legislative framework

A few aspects of acting as a professional care worker are regulated by law. The "Wet Geneeskundige Behandelingen Overeenkomst" (WGBO, April 1995)" (Medical treatment Act) sees to the rights of care seekers. Besides these rights, care seekers have a possibility to complain, which is regulated by the "Wet Klachtrecht Clienten Zorgsector (WKCZ, August 1995)" (Law Right of Complaints Health Care). Care workers should be aware of these equal possibilities for care seekers.

3. Professional Ethics

Professional ethics are primarily meant for care workers. Their acting as professionals is tested according to the standards and values as have been described in professional ethics.

Professional ethics contain four clusters:

1. *Assumptions in relation to professional practice*
2. *A carer in relation to the care seeker*
3. *A carer in relation to colleagues and others*
4. *A carer in relation to society*

Two examples of each cluster will be described as it would be too much to work out the whole professional ethics.

1. Assumptions in relation to the professional practice

1.1 *A care worker approaches each individual care seeker with respect*

Every care seeker has a right to be taken care of by carers without being discriminated against based on ethnic origin, nationality, age, being a man or a woman or sexual preference of the care seeker.

Apart from this ideological and political conviction, lifestyle or social status must not influence the right to receive care.

1.2 *A care worker supports initiatives and undertakes actions that contribute to the development of the profession of care worker*

To be able to develop the profession of care worker to a higher standard and to guarantee the quality of care, many initiatives are taken by several care organisations. These initiatives are for example improving professional competence, bringing the professional profile to a higher level, improvement of the professional image and the development of methods.

A care worker is expected to participate in, be involved in and support the initiatives that are being taken.



2. A care worker in relation to the care seeker

2.1 Regarding care, a care worker puts the interests of the care seeker in the centre of his / her actions as a professional

In the context of the profession of caring, "interests" include everything that contributes to the well-being of a care seeker. The need for care of the care seeker is the main object and the care given should be based on the assessment of the needs of a care seeker. This also means that the care worker will stimulate a care seeker to be responsible for his or her own well-being, taking the possibilities and impairments of the care seeker into account.

2.2 A care worker will never accept gifts from a care seeker

By accepting gifts from a care seeker, a care worker could give the (wrong) impression that extra care can be bought. It could also promote the (wrong) idea that only this specific care worker will have a positive influence on the process of providing care. When a care seeker or his relatives insist on giving something to show that they are grateful, it could be suggested to give a donation that will benefit all staff of the organisation or to give a donation to a charity organisation.

3. A care worker in relation to colleagues and others

3.1 A care worker is prepared to carry out temporary tasks for a colleague when it is necessary.

When it is known that a colleague is temporarily unable to provide care of a certain kind, a carer should be loyal to his/her colleagues, and offer help or to take over tasks. Here one may think of cases in which colleagues have a lack of competence or when they are bothered by occupational diseases. When a colleague experiences private problems a care worker is also supposed to take over parts of the job of this colleague.



4. A care worker in relation to society

4.1 A care worker uses the means that have been put to his / her disposal in a responsible way.

A care worker is jointly responsible for matching the needs of a care seeker regarding the supply of care as much as possible. A care will use all available means and materials in a careful, an efficient and accurate way.

4.5 When care workers work to rule or when care workers are on strike, a care worker will always provide all care that is required to prevent injuries to the health of care seekers.

When actions are taken to improve the status and position of the occupational group of care workers and work is stopped for a certain time, care workers will still have to provide the care that is required at that time. Care seekers must not be left without the elementary care, while the occupational group is taking action for improving working conditions and bringing their job to a higher standard.



7. Responding to the Needs of Older People

◆ As explained in other chapters, the care for elderly people is expanding rapidly. The variety of working methods and facilities that elderly people can make use of is expanding as well.

As an example of the working life of a care worker below you will find a description of a day in a nursing home and also the care plan that is drawn up for a client, Mrs. Jansen

ing, her working day starts. She reads the reports, and her colleague from the nightshift tells her what has happened during the night. At a quarter to 8 the first residents are washed and dressed. Sometimes a resident rather has a long lie in. Unfortunately, it may occur that a resident stays in bed longer than he/she actually wants to.....

7.1 A Worker's Day Combined with a Client's Day

◆ Maria works as a care worker at a unit with psycho-geriatric residents. Today Maria has the daytime shift. When she arrives at half past seven in the morn-

Thirty residents live in the unit, and in the morning Maria works with 5 colleagues: this means a ratio of one carer to 5 residents, so they cannot afford a sick colleague. When there is no replacement they have to work even harder. At 9 o'clock the volunteer who takes care of the residents' breakfast, coffee and much-needed extra attention arrives.

Diagram 7

Timetable of a care worker

7.30- 10.30	<ul style="list-style-type: none"> • Take care of residents: wash and dress them • Give breakfast • Have coffee yourself (in the mean time another care worker supervises the residents)
10.30- 12.00	<ul style="list-style-type: none"> • A number of residents are taken to club activities • Other residents are taken care of
12.00- 13.00	<ul style="list-style-type: none"> • Give lunch to the residents • Have lunch yourself (in two shifts)
13.00- 14.30	<ul style="list-style-type: none"> • Help residents to the toilet • Let residents have a rest in bed or chair
14.30- 16.00	<ul style="list-style-type: none"> • Undertake activities with residents • Consultation if any • Have tea • End of duty

Today Maria will take care of Mrs. Jansen. She was taken into the ward where Maria works, a few months ago. She is 78 now and has taken a turn for the worse very quickly over the last three years after the death of her husband. She could no longer live on her own. She regularly forgot to switch the heating of her house on and off, and she was unable to take care of herself. Mrs. Jansen is still able to fulfill most of her general daily activities of selfcare, but Maria has to tell Mrs. Jansen what to do next. If Maria did not do that, Mrs. Jansen would put on her clothes in the wrong order. Mrs. Jansen would also forget to wash, if she was not told to.

After being taken care of, it Mrs. Jansen regularly wants to go home. She asks Maria and other care workers to help her get on the bus. Mrs. Jansen gets angry and frustrated when nobody listens to her demands.

In the afternoon Mrs. Jansen takes a nap. Then she is often sad and depressed. She cries over her children and her husband who are no longer with her. Maria is unable to comfort her at such moments. This ritual is often repeated when going to bed in the evenings.

Sometimes Maria and some colleagues set off on a trip with a group of residents, travelling by a specially adapted bus. They drive past places the residents still remember from the past. The residents appreciate this a lot, and also like having lunch somewhere. When the residents return to the ward, the faces of some of

them are radiant in contrast to those who have obviously already forgotten the trip.

It may also happen that during the afternoons Maria takes work-shops or courses, or that she attends a discussion of progress. Of course there is sufficient care and attention for the residents who are in the unit then.

At 4 o'clock Maria's working day ends and care is handed over to colleagues. It is a rewarding and challenging job and every day is different.

On an average working day Maria meets other professionals that visit the unit as well:

- ◆ The swallow team: dietician, speech therapist and ergotherapist: because of swallowing problems the demented elderly and residents with a CVA (cerebrovascular accident) may be having.
- ◆ The behaviour therapist: for the coaching of staff in learning how to handle specific behavioural problems of residents.
- ◆ Psychologist: to coach residents, relatives and sometimes staff as well
- ◆ Physiotherapist: because of the resident's posture in bed and wheelchair
- ◆ Nursing home physician: drawing up multidisciplinary plans for care
- ◆ Activity coaches: to give advice on how to plan the day

Besides there are regular staff consultations:

- ◆ Work consultation: once every 6 weeks
- ◆ Discussions with trainees about learning progress
- ◆ Supervisor's consultation: once every 6 weeks
- ◆ Consultation about quality and working in project groups (occasionally)
- ◆ Multidisciplinary consultation with other professionals



Diagram 8

Formation overview of nursing and care staff of a psycho-geriatric care unit with 30 residents at a Dutch nursing home (2001)

Function	Formation / staff-client ratio
Area Manager	0.255
Head of Department/circuit	0.666
EVV's (care worker primarily responsible)	
Nursing/Care	9.615
Pool	0.241
Activity supervision	1.000
Behavioural therapist	0.208
Employees	3.537
Melkert jobs (Government subsidised jobs)	0,851
Subtotal of nursing staff	19.188
Practical supervision	0.258
Trainees 3 rd year	0.572
Trainees 2 nd year	1.247
Trainees 1 st year	1.758
Subtotal of trainees	3.862
	23.050

7.2. Example of a Care Plan

Maria takes care of Mrs. Jansen according to a care plan especially made for her. In The Netherlands data are gathered about residents according to a special method, after which these data are put into a care plan. This care plan is structured with the following items: care problem, care goal, nursing actions and evaluation moments. In this example, aspects of the method according to Virginia Henderson are being used. In this care plan we only show three aspects Maria has to deal with, namely: food and drinks, personal care and communication and interaction.

We would like to emphasise that this example only shows part of the care plan for Mrs. Jansen.

Diagram 9

	CARE PROBLEM	GOAL	EVALUATION	ACTION
Food and drinks	<ul style="list-style-type: none"> - Mrs. J. forgets to eat and drink 	<ul style="list-style-type: none"> - Mrs J. gets enough liquid and food 	<ul style="list-style-type: none"> - Daily 	<ul style="list-style-type: none"> - Observe and report the intake of liquid and foods - Offer food and drinks according to a regular scheme - Try to make Mrs. J adopt the habits of eating and drinking.
Personal care	<ul style="list-style-type: none"> - Mrs. J. does not pay attention to hygiene and care of body and clothing - Mrs. J. dresses in the wrong order - Mrs. J. is not able to wash in a logical order 	<ul style="list-style-type: none"> - Mrs. J. is able to take care of herself in a responsible way 	<ul style="list-style-type: none"> - Daily 	<ul style="list-style-type: none"> - Give guidance to Mrs. J., show her what to do in the right order
Communication and interaction	<ul style="list-style-type: none"> - The communication With Mrs. J. is obstructed by her thinking in a confused way and by disturbances in her memory 	<ul style="list-style-type: none"> - Mrs. J. interacts with her environment and the people around her 	<ul style="list-style-type: none"> - Every week 	<ul style="list-style-type: none"> - Guide Mrs. J. to reality- and orientation training in small groups - Stimulate Mrs. J. to have contact with other residents - Stimulate Mrs. J. to take part in activities - Let activities relate to earlier experiences

8. Employment in the Care of Older People

8.1. Facts, Figures and Trends about the Labour Market in the Field of Care

◆ *Volume of the occupational group for nursing and care*

In the year 1999 almost 390,000 people were working in nursing and care. This number represented some 6 % of the entire labour force of The Netherlands. About 288,000 of them were qualified at levels 2 to 5. The remainder didn't have any specific education in nursing or caring.

In the nineties there has been a growth in the number of workplaces in nursing and care that were occupied. In 1999 this stopped, but now (2002) there is a slight increase of numbers again.



Because of shortage on the labour market the growth of the number of people working in nursing and care has been smaller than in the years before. Moreover the number of qualified staff (the ones who were trained and educated to be qualified on levels 2 to 5) is decreasing now. It is expected that these two trends will continue in the next few years.

Indeed, there is a larger budget available for institutions that provide care, which could be used for caring and nursing, but the labour supply of qualified staff will be smaller than the demand for it. This may be explained by the fact that there has been a decrease in the number of students taking up nursing and care over the last few years. After a rise from 1997 till 2000, there has been a decline in the numbers of students in health care education since 2000. All levels of qualification show a drop in numbers. At the moment (2002) there are some 50,000 students in nursing and care education. Until 2003 the number of students that will graduate will show a slight increase, but as a result of fewer students who enrol at the moment, the number of graduates will drop in the future.

◆ *Composition of the occupational group*

Caring and nursing is still a profession carried out by women. Some 90 % of the care workers are female. This number is increasing slightly. Over the last few years the average age in the occupational

group has increased from 32.8 (1993) to 36. This number is expected to increase to 37.5 in 2005. From then on the increase of the average age will slow down. In the next few years the proportion of care workers of over 50 will rapidly increase: 10 % now up to 18 % in 2010. As a result of ageing of the entire occupational group the costs of salaries will rise with 1.4 % until 2005.

As far as workplaces for nursing and care are concerned, a relatively great number of people are needed because of the fact that many care workers have part-time jobs. About 180 people were needed to fill 100 workplaces in nursing and care in 1999. The number of full-time workers in nursing and care has decreased from 40 % in 1993 to 24 % in 2000.

Working in health care, leave or stay?

Nursing and care workers increasingly switch jobs. In 1994 there was a percentage of 5.6 %; in 2000 this had increased to 10.9 %. The reasons for this career change were the need for a different occupation and the desire to do something else. Time spent travelling and the financial reward are becoming more and more important. The lack of opportunities for individual development and the lack of perspective for a career are important factors. Lower wages as compared to those of other jobs are also a reason for people to leave health care. Work-related stress and occupational diseases (physical and mental) play a role in this too.

Sick-leave amongst nursing and caring staff has risen sharply. For the labour force as a whole, this trend could also be seen, but sick-leave for the occupational group of caring and nursing showed a higher percentage on average. Maternity-leave, prior to and after the birth of a

Diagram 10

Statistics of the total amount of staff in health care (students not included)

	1990	1995	1998	Average growth 90-95	Average growth 95-98
Hospitals	58.240	68.706	75.165	3,4 %	3 %
Psychiatric care	17.047	21.361	24.287	4,6%	4,4%
Mentally disabled	22.670	31.091	37.380	6,5%	6,3%
Elderly care	80.823	96.773	106.236	3,7%	3,2%
Homecare	115.760	126.670	134.402	1,8%	2%

Source: Calsbeek e.a. 2000, uit Trendrapport Vraag naar arbeid in zorg en welzijn)

baby, without including the national percentage for sick-leave, is 5.5 %, for caring and nursing this is 8.7 %.

In hospitals the percentage of sick-leave is the lowest, 7.0 %. But for home care the percentage is 10.0 %. Sick-leave for a period longer than two weeks is called long-term sick-leave. Almost 40 % of the people in this group say that their illness is caused by their work. Physical strain is the main reason, especially in residential homes and nursing homes. Work-related stress is shown by 20 % of the people on sick-leave.

8.2. Recruitment and Labour Market in the Field of Care

◆ *Job structure*

In the years to come nurses, care workers and care helpers will be needed. Professional nursing can be found in the area of individual health care. The people who comply with the terms specified

in Article 3 of the Law for professions in individual health care (Wet BIG) are registered as nurses.

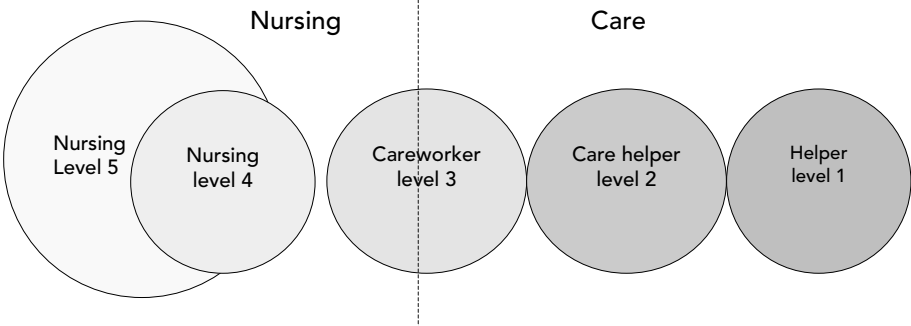
The profession of a health care worker consists partly of individual health care and partly of care.

The profession of a care worker (provided the terms are complied with in the Law for professions in individual health care(wet BIG)) is to be regulated under article 34. The profession of a care worker consists of offering care.

Nursing workers.

◆ Nursing workers are responsible for independent planning of nursing activities. They organise and supervise individual beneficiaries(their clients). They consider the contact with the beneficiary the most important element in their jobs. This direct contact is part of the nurse's interventions and the basis of health provision. On top of that, nursing workers perform a number of pre-conditional tasks, such as quality care and promotion of expertise. Nursing workers carry out their job alone and/or work in

Diagram 11



a team. In their profession the nursing workers are often confronted with ethical questions. These ethical questions may be of great importance in recognising, monitoring and executing care requirements.

Two levels can be distinguished in the profession of nursing workers. Work is divided according to professional competence, not functional dependence. Nursing workers at the first and second levels of expertise carry out activities in the primary process of nursing.

Besides, working nurses at the first level are capable of:

- Giving consultations and setting examples: giving advice in all stages of nursing, making a diagnosis, interventions and results, providing care.
- Providing care, especially in cases when standard procedures are not available.
- Supervising care and organising.
- Determining which interventions have to be carried out, in what order and by which professionals (indication proposition).
- Assigning beneficiaries.
- Supervising all activities concerning care, which involves a number of disciplines.
- Creating conditions to improve the primary nursing process for example quality control, and improvement of standards, procedures and protocols.
- Promotion of expertise.

Care Workers

◆ Care workers offer help when and where the beneficiary requires additional help in his/her living environment. The basic assumption is to maintain and stimulate the beneficiary's self-help. In those cases where there are limited possibilities for self-help because of somatic or psycho-social reasons the care workers will stimulate, support or offer compensation.

The tasks of care workers are:

- Drawing up an individual care plan
- Execution of care
- Reporting any changes in health and well-being
- Marginal tasks connected with the organisation and the profession (supervision, consultation, adjustment to others, quality care)

The profession of care workers in individual health care also has a number of nursing aspects.

Assistant Care Worker

◆ As a rule, assistant care workers carry out their work in the beneficiary's personal living environment. This may be the beneficiary's own home or a substitute residence. Their job is to stimulate and support the beneficiary's ability for self-help with an emphasis on domestic work and personal care.

Care helpers

◆ The care helper provides domestic care and everyday tasks. Using a care plan, the care helper encourages self-help in household tasks, while at the same time reporting any changes in the beneficiary and in his/her living condition

NOTE:

The job structure as shown above, relates to the Qualification structure in social and health care education as shown in chapter 9. The structure of the educational system is based on this job structure.

8.3. Advertising

As an example for recruiting new staff, we supply a fictitious recruitment advertisement for a vacancy at a nursing home in The Netherlands.

Who wants to lend us a helping hand?

Our nursing home is located in Sliedrecht, a small town south-east of Rotterdam. We take care of mainly elderly people for short as well as for longer periods. Care is given in a pleasant, homelike atmosphere. There are 70 beds for clients with somatic needs and 170 beds for clients with psycho-geriatric disorders. Besides that we have a transition ward and in our region we provide day care treatment for clients with somatic and psycho-geriatric needs. Well over 500 employees give all their attention to our clients, day in and day out.

We are looking for an enthusiastic colleague, qualified as Care Worker IG (Individual Health Care), level 3

What we ask from you:

You are experienced in working with clients with somatic and/or psycho-geriatric needs.
You are capable of giving physical care and are able to contribute to carrying out a care plan.
You have the following qualities to offer:

- talent for improvising
- independence
- enthusiasm
- social skills

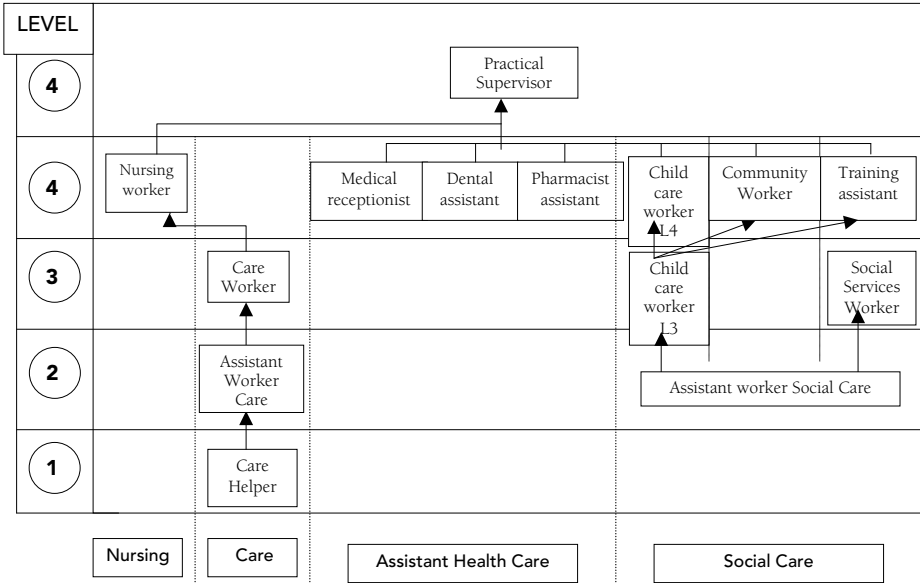
What we offer you:

Besides providing excellent payment, we take your personal wishes into account when working schedules are being made. All staff are offered personal opportunities for studying. We offer possibilities for child attendance. Apart from all this, we have a P.C. private project, a tax-free salary saving possibility and a very active club for staff.

9. Vocational Education

Diagram 12

QUALIFICATION STRUCTURE HEALTH AND SOCIAL CARE EDUCATION



On the next pages you will find a description of the qualifications of nursing and care. You can find a description of the qualifications of social care, in the package of childcare in The Netherlands.

The description will focus on the job description, responsibility, complexity and transfer of each qualification. After that you will find the partial qualifications of Nursing and Care Education

9.1. Job Description

Qualification Care Worker, level 3

Responsibility

- *Care planning and execution*
The care worker is capable of bearing responsibility or is able to draw up an individual care plan, to report changes in the health and well-being of beneficiaries and to evaluate the care plan. In addition, he/she may be responsible for the execution of care indicated in cluster 1. The emphasis is mainly on maintaining, stimulating and supporting the beneficiary's self-help capabilities and the relevant comprehensive care. Psycho-social guidance is linked to these care activities.
He / She is also capable of activities with regard to prevention, health information and education (GVO) and general information (cluster 2).
- *Individual health care (IG)*
The care worker working in individual health care is capable of carrying out a number of nursing and specific psycho-social activities. This is indicated with "IG" in the overview of activities and actions.
- *Co-ordination and organisation*
The care worker is responsible for organising his/her own work activities and for consultation and adjustment to others. The care worker reports any changes in the beneficiary's care requirements or

environment to the family doctor (GP) who assigned him/her to the beneficiary, if these go beyond his/her ability or responsibility (cluster 3).

- *Basic conditions*
The care worker is responsible for a number of basic tasks such as those indicated in clusters 5 and 6. He / She is also capable of providing work guidance to trainee practitioners in advanced vocational training (cluster 4).

Complexity

The care worker is capable of working according to routines, standard procedures and combinations of (standard) procedures.

Transfer

The care worker possesses the required knowledge and skills connected to the job in hand in addition to knowledge and skills specific to the profession.

Qualification Nursing Worker, level 4

Responsibility

- *Care planning and execution*
The nursing worker is responsible for the independent planning of nursing activities and actions and interpreting and registering their subsequent effects. The diagnosis used to choose which nursing action should be taken is based on standards. The nursing worker is also responsible for carrying out these activities and actions (cluster 1) and for activities concerning

prevention, health information and education and general information (cluster 2).

- *Co-ordination and organisation*
The nursing worker is responsible for the organisation of care for individual beneficiaries. He/ She can consult his/her own discipline and the disciplines of others. He/She consults the family doctor (GP) who assigned his/her to the beneficiary if there are changes in the beneficiary's care requirements or environment that are beyond his/her ability or responsibility (cluster 3).
- *Basic conditions*
The nursing worker is responsible for basic tasks indicated in clusters 5 en 6. He/She is also capable of providing work guidance to beginners and advanced participants in vocational training programmes (cluster 4).

Complexity

The nursing worker quickly understands the beneficiary's care requirements and can provide the care efficiently and flexibly. The focus is on planning and executing care according to standard procedures and combinations of (standard) procedures. In addition, he/she can combine or design procedures for the provision of individual care.

Transfer

The nursing worker has the required skills and knowledge and also skills and knowledge not connected with the profession.

*In the case of qualifications at levels 2, 3 and 4, we refer to the clusters of activities and actions mentioned below. This summary should be regarded as a job description of assistant care worker, care worker and nursing worker:

- 1 Systematic professional activities
 - 1a Data collection and interpretation
 - 1b Care planning
 - 1c Care execution
 - 1c.1 Basic care (somatic and psychosocial)
 - 1c.2 Nursing action
 - 1c.3 Care of the environment
 - 1d Evaluation and reporting of care provided
- 2 Prevention, health information and education (GVO) and general information (only for levels 3 and 4)
- 3 Care co-ordination and organisation
- 4 Work guidance (only for levels 3 and 4)
- 5 Quality care (only for levels 3 and 4)
- 6 Promotion of expertise (only for levels 3 and 4)

9.2. Partial Qualifications Care Worker Level 3

BASIC PARTIAL QUALIFICATION	
Care worker (level 3)	
301	Care planning
302	Basic care
303	Prevention and health education
304	Nursing elements
305	Coordination of care 3
306	Quality assurance and promotion of expertise 3
307	Transfer qualification
JOB-SPECIFIC PARTIAL QUALIFICATIONS	
308	Nursing the chronically ill, physically handicapped and rehabilitation patients 3
309	Nursing geriatric residents – clients 3
310	Nursing the mentally handicapped 3
311	Nursing pregnant women, women in childbirth, new mothers and newborns
SPECIALISATIONS	
Care worker 3	
312	Differentiating short term care 3 vz
313	Differentiating maternity care 3 vz
314	Differentiating care for the elderly 3 vz
315	Differentiating in the care of the chronically ill 3-vz

9.3. Training Placement Profile Caring and Nursing

◆ Below you will find a training placement profile of the Care Worker level 3, made by the National Board of Secondary Vocational Education of Welfare, Health and Sports (OVDB). In this profile you can find the main attainment targets which

students have to achieve during their work placement periods. The OVDB uses these profiles to check if work placement organisations are able to educate the student adequately.

PARTIAL QUALIFICATION 301:

CARE PLANNING

- o Assessing residents/clients' need for care.
- o Outlining individual care plan on the basis of a model.
- o Recognizing changes in the need for care.
- o Evaluating a care plan and adjusting it as necessary (together with residents/clients and families and friends).
- o Providing oral and written reports.
- o Recording data in care file.
- o Passing on relevant data to family and friends.
- o Same to other disciplines.

PARTIAL QUALIFICATION 302:

BASIC CARE

- o Planning basic care.
- o Helping residents/clients with personal hygiene, eating and drinking, excretory functions, mobility problems, sleeping and waking patterns.
- o Making the bed (various kinds).
- o Monitoring vital functions (irregular levels).
- o Controlling use of medicines, handing out and registering them.
- o Administering medicines (oral, rectal, vaginal and via the skin and the mucous membrane).
- o Dressing inflamed and infected wounds.
- o Taking action in case of accidents and unforeseen circumstances.
- o Supporting residents/clients in leading independent lives, in their activi-

ties, in structuring time, in coping with change, in giving meaning to their lives, in accepting limitations and handicaps, in handling financial matters.

- o Supporting residents/clients' social network.
- o Help in coping with death.
- o Acting as intermediary.
- o Applying regulations.

PARTIAL QUALIFICATION 303: PREVENTION AND HEALTH EDUCATION

- o Giving information on health matters and health education.
- o Providing safe and hygienic surroundings.
- o Observing symptoms of disorders, limitations or handicaps.
- o Reporting the outcome of observation.
- o Recognizing reactions to disorders, limitations or handicaps.
- o Preventing negative effects arising from health problems.
- o Giving advice on adapting lifestyle.
- o Providing instructions for learning specific skills and/or maintaining behaviour codes and using aids and resources.
- o Giving advice on other means of assistance/welfare.
- o Providing information (on health problems, care institution, rights and obligations, the care itself, parent and patient organizations, complaints review service, social map, compensation for resources).

PARTIAL QUALIFICATION 304:
NURSING ELEMENTS

- o Administering drip-feed.
- o Looking after stomas and suprapubic catheters.
- o Administering medicines (see 302): through the bronchial tubes, by injection (subcutaneous, intramuscular).
- o Making up solutions and dilutions.
- o Dressing wounds (see 302): black wounds.
- o Applying bandaging techniques.
- o Looking after trachea cannulas and trachea stomas.
- o Catheterizing the bladder in both females and males.
- o Inserting and looking after gavages (gastro-tubes)
- o Administering oxygen
- o Administering heat or cold treatments
- o Draining oral cavity and pharynx.
- o Taking samples for diagnostic purposes.
- o Following nursing procedures with the chronically ill, physically handicapped, rehabilitation patients, geriatric residents/clients, mentally handicapped, maternal care and newborn babies.
- o Providing residents/clients with behavioural problems, gerontological-psychiatric problems and mentally handicapped with basic care.
- o Managing resources and measures

PARTIAL QUALIFICATION 305:
COORDINATION OF CARE 3

- o Taking part in unilateral and multilateral team discussions.
- o Requesting consultation and advice from other disciplines.
- o Calling up those responsible for care.
- o Assimilating agreements in care plan.
- o Ensuring discharge and transfer of residents/clients.
- o Drafting work schedule (time, priority).
- o Recognizing problems areas in care provision.
- o Suggesting solutions for problem areas.

PARTIAL QUALIFICATION 306: QUALITY ASSURANCE AND PROMOTION OF EXPERTISE 3

- o Helping to improve care at the point of delivery
- o Contributing to processes of change.
- o Consulting experts.
- o Using residents/clients' complaints to positive effect (at the point of delivery).
- o Recognizing problem areas in work climate.
- o Taking steps to solve problems.
- o Following in-service schooling and theme sessions.
- o Participating in colleague-support activities.
- o Reflecting on one's own actions.
- o Contributing to theme sessions.
- o Providing work supervision.
- o Working under the given terms (care

institution, profession, Working Conditions Act, Collective Bargaining Agreement / legal position

PARTIAL QUALIFICATION 308:
NURSING THE CHRONICALLY ILL,
PHYSICALLY HANDICAPPED AND
REHABILITATION PATIENTS 3

- o On behalf of and in consultation with a chronically ill patient, a rehabilitation patient and a physically handicapped resident/client:
 - drawing up a care plan;
 - providing domestic care;
 - providing basic care;
 - giving information, instruction, advice;
 - coordinating care.
- o Taking measures to relieve pain.
- o Supporting residents/clients suffering from anxieties over incurability of illness, fear of dying.
- o Providing terminal care.
- o Supporting young chronically ill, rehabilitating or physically handicapped residents/clients (and their parents/guardians).

PARTIAL QUALIFICATION 309: NURSING GERIATRIC RESIDENTS/CLIENTS 3

- o On behalf of and in consultation with a geriatric resident/client
 - drawing up a care plan;
 - providing domestic care;
 - providing basic care;
 - giving information, instruction, advice;
 - coordinating care.
- o Organizing a daily (activity) programme.

- o Providing support in adapting lifestyle.
- o Organizing memory exercises, vitality training, sense activation (snoozlen)
- o Supporting residents/clients with behavioural problems.
- o Handling physical aggression.
- o Supporting residents/clients in making contact in a group.
- o Assisting group with activities and interactions.
- o Handling conflicts.

PARTIAL QUALIFICATION 310: NURSING THE MENTALLY HANDICAPPED 3

- o On behalf of and in consultation with a mentally handicapped:
 - drawing up a care plan;
 - providing domestic care;
 - providing basic care;
 - giving information, instruction, advice;
 - coordinating care.
- o Outlining the role of parents/guardians in the care of young mentally handicapped.
- o Assessing range of care needed in a (social) group.
- o Preventing skin afflictions.
- o Assisting with toilet-training.
- o Organizing a daily (activity) programme.
- o Supporting residents/clients with behavioural problems.
- o Handling physical aggression.
- o Supporting residents/clients in making contact in a group.
- o Modelling social environment.
- o Assisting group with activities and interactions.

- o Organizing activities aimed at development.
- o Handling conflicts in a social group.
- o Lending assistance in implementing care plan in the home environment.

PARTIAL QUALIFICATION 311: NURSING PREGNANT WOMEN, WOMEN IN CHILDBIRTH, NEW MOTHERS AND NEWBORNS

- o On behalf of and in consultation with a new mother and her baby:
 - drawing up a care plan;
 - providing domestic care;
 - providing basic care;
 - giving information, instruction, advice;
 - coordinating care.
- o Assisting with delivery.
- o Supporting a new mother, her partner and any children.

PARTIAL QUALIFICATION 312: DIFFERENTIATING SHORT-TERM CARE 3-vz

- o Differentiation comprises:
 - care after hospital discharge;
 - care after accidents;
 - care for rehabilitating residents/clients
 - care for terminal residents/clients
- o Emphasis more on broadening experience and knowledge.
- o When planning and providing care, special attention is to be paid to:
 - the short-term relationship;
 - the transfer;
 - after-care;
 - the residents or clients
 - developments in short-term care.

PARTIAL QUALIFICATION 313: DIFFERENTIATING MATERNITY CARE 3-vz

- o Differentiation comprises intensification of care during delivery and the lying-in period, both in normal and in atypical cases. Emphasis more on broadening experience and knowledge.
- o When planning and providing care, special attention is to be paid to:
 - disturbed development from birth;
 - positive and negative influences on development;
 - atypical course of events during delivery and lying-in period;
 - nursing children with a paediatric illness;
 - ethical questions and dilemmas;
 - the short-term relationship;
 - developments in maternity care.

PARTIAL QUALIFICATION 314: DIFFERENTIATING CARE FOR THE ELDERLY 3-vz

- o Differentiation comprises intensification of care 'of the elderly. Emphasis more on broadening experience and knowledge.
- o When planning and providing care, special attention is to be paid to:
 - the processes of ageing;
 - support in finding a new lifestyle and coping with limitations;
 - life in the light of ageing;
 - well-being of the elderly residents/clients;
 - the long-term care providing relationship;

- palliative care;
- ethical questions and dilemmas;
- developments in the care of the elderly.

PARTIAL QUALIFICATION 315; DIFFERENTIATING IN THE CARE OF THE CHRONICALLY ILL 3-vz

- o Differentiation comprises intensification of care of the chronically ill. Emphasis more on broadening experience and knowledge.
- o When planning and providing care, special attention is to be paid to:
 - support in finding a new lifestyle and coping with limitations;
 - life in the light of chronic illness;
 - the long-term care-providing relationship;
 - palliative care;
 - ethical questions and dilemmas;
 - giving instructions;
 - providing information about social and legal regulations;
 - providing information about techniques and ways of treatment;
 - continuity of care;
 - the residents/clients own network;
 - promoting expertise that the residents/clients and family and friends have;
 - developments in the care of the chronically ill.

10. References

- 1) Fact sheets: Senior Citizens in the Netherlands ,1999, <http://www.nizw.nl/nizwic/Infodesk/factsheets/senior.htm>
- 2) A few articles found under: Facts and Figures about elderly persons in the Netherlands:
<http://www.kenniscentrum-ouderen.nl>
- 3) Who Cares? An overview of the Dutch Systems of Health Care and Welfare, Hans van Ewijk, Tessa Kelder, 1999 Netherlands Institute of Care and Welfare (NIZW), all rights reserved, NIZW International Centre,
http://www.nizw.nl/nizwic/_Werkdocus/Publications/who%20cares.htm
- 4) Information about Dutch Social Security: <http://www.2ZW.nl>, linking to "Informatie sociale zekerheid, linking to "Internationaal", next to "English summary"
- 5) Mutual Information System on Social Protection in the EU Member States and the EEA (MISSOC):
http://europe.eu.int/comm/employment_social/missoc2000/missoc_info_en.htm
- 6) <http://www.minvws.nl>
Ministry of Health, Welfare and Sports
- 7) <http://www.minocw.nl>
Ministry of Education, Culture and Science
- 8) <http://www.nizw.nl>
Netherlands Institute for Care and Welfare
- 9) <http://www.ovdb.nl>
National Board of Secondary Vocational Education of Welfare, Health and Sports

Appendix 1 Example BIO Protocol

Number 1:

This is an example of a BIO protocol form. Only the main items are mentioned here, sub-items are not mentioned because otherwise this example would be too long.

BIO protocol form for examination of a client's situation, as used by a RIO

Name of client	Date of birth
Name of assessment advisor	Date of examination
Nationality: Dutch, other nationality: What language is spoken: Religion:	
CAK	
Housing and environment:	
1 present housing 2 size of the housing 3 special remarks on the housing	4 problems concerning housing 5 problems concerning environment
Umbrella care (Care given by children and neighbours):	
Name, telephone, address, relation to client, kind of contact, what kind of help is given, frequency and total of the time that help is given per week	
Available lifting and transfer aid materials:	
Actual clinical picture:	
Actual disorders:	
Medication:	
Prognosis:	
Limitations and impediments:	
A. Physical functions: excretion, functioning of heart and lungs, disorder in nutrition, skin and sensibility disorders	
B. Self care	
C. Basic motor skills: change of posture, maintaining of posture	
D. Mobility	
E. Household skills	
F. Functioning of the senses	
G. Psychological and cognitive functioning: awareness, attention, thinking, perception, insight in one own illness, memory, behaviour, moods, basic cognitive skills	
H. Communication: formulating and sending of messages, receiving and understanding of messages	
I. Interpersonal relations	
J. Work experience/ Education/ Pastime	
K. Specific risks	
Participation problems and goals:	
Filter for products:	
Legal examination:	
Products as advised:	
Home care (extra-mural care)	
Semi-mural care	
Residential home / nursing home (intra-mural care)	
Notes of the assessment advisor:	

Appendix 2 Glossary

- ✓ Umbrella care Dutch: Mantelzorg
Care given by children, relatives, neighbours and volunteers
- ✓ Nursing home Dutch: Verpleeghuis
The traditional nursing home and nowadays restructured from 4- 6 person's room to one or two-person rooms
- ✓ Residential homes Dutch: Verzorgingshuizen
Small private (most) one room-apartments, with shower and kitchenette.
- ✓ Home care and home help service Dutch: Thuiszorg
All care, nursing, supervision and monitoring of people who require assistance at home.
- ✓ Sheltered housing Dutch: Aanleunwoning
Heterogeneous category of newer and older flats and "hofjes", most of them built and managed by not-for-profit housing corporations.
- ✓ BIO protocol Dutch: BIO protocol
A form, which can be filled out for an independent, objective and integrative manner of assessing for living, care, and well being.
- ✓ Nursing workers Dutch: Verpleegkundige
Are responsible for independent planning of nursing activities. They organise and supervise individual beneficiaries.
- ✓ Care workers Dutch: Verzorgenden
Offer help in those places and at those moments when the beneficiary's personal living environment requires additional help
- ✓ Assistant Workers Dutch: Helpende
The care helper provides domestic care and everyday tasks

Other concepts are explained in the Handbook.

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All materials of the project are downloadable for free from partners websites:

www.caritas-mg.net/frame9.htm

www.haus-berg.com

www.davinci.nl

www.whitehallcollege.com

www.hesote.edu.hel.fi/english

www.linkoping.se/birgitta

www.linkoping.se/ljungstedtska

www.dundeecoll.ac.uk/work_placements_abroad