Care Work and Nursing at Hospitals and Health Centres in The Netherlands

Content

Introduction

Dear Student

◆ *Welcome to Holland, welcome to the Netherlands!*

We are very pleased to see that the choice of your practical study placement has been Holland! We really hope your time here will be beyond the expectations you may have at the moment you start.

The handbook you are about to read, is a result of the co-operation between Institutes for Vocational Education in six different countries: Finland, Estonia, Germany, Scotland, Sweden and the Netherlands.

It is written to help you understand the Dutch dynamic way of life, for students who want a practical study placement in a general hospital in Holland. It emphasizes what it is like to study and/or work in the system of Healthcare in Holland. The system is, like in other countries, constantly subjected to change at a national and therefore a local level.
"Caring for people in a healthy society" - under this motto the Ministry of Health, Welfare and Sport develops policy in the fields of health care, social care and sports.

Whilst every effort has been made to reflect up to date information at the time of writing this handbook you may be introduced to new initiatives whilst undertaking your practical study placement with us in Holland. Staff in your placement area will be happy to guide you to any new relevant information.

We advice you to read this manual before you start your practical study placement in a general hospital or another health care institute.
When you read "he", "his" or "him" in this manual, please also read "she", "hers" of "her".

We hope you will enjoy your time with us and trust that this handbook will assist you in your learning experience!

1. A Typical Day of a (Practical) Nurse Working at a General Hospital

Nursing in a General Hospital in Holland

At a general hospital, a nurse works in shifts. There are early shifts (from 7.00 a.m.), day shifts (from 9.00 a.m.), late shifts (from approximately 14.30 p.m.) and nightshifts (from approximately 22.30 p.m.). An early shift starts at 7.00 a.m. and ends at 15.00 p.m.

Every shift starts with a briefing. Nurses starting their shifts are informed by the nurses ending their shifts about the patients within their care. Also the nursing report, concerning the past shift, is read carefully. As a nurse you are responsible for independently carrying out the nursing process.

The National Professional Code for Health-care is one of the principles on which the nursing practice is based. This code was developed, inspired by the Declaration of the Universal Rights of Man.

In addition to this, the Professional Profile of Nurses looks upon: Observation and recognition of changes in health and wellbeing, nursing and care, support, (preventative) information and counselling. According to this Profile, personal contact with the patients should be considered as the most important part of the nursing process. The individual patient should be the centre of this process.

There are two different levels in professional nursing:

- MBO (secondary vocational education) and
- HBO (higher vocational education).

Tasks are assigned, based upon professional competences, not upon functional interdependences. On both levels, nurses are supposed tot carry out the primary nursing process.

In addition, a nurse on HBO-level should be able to:

- Carry out consultations;
- Occupy a role model position;
- Fulfil a management position in terms of content of care;
- Establish conditions for improving the primary nursing process.
- This implicates individual and cooperative activities to achieve quality assurance and professional development.

To make a nursing diagnosis, in Holland we use a diagnostic system called "**Gordon's Health Patterns**" (see chapter 2 and next). These patterns put flesh on the nursing process. According to Gordon, there are eleven health patterns. To classify the health problems and thus the demand of care, we referred to **the International Classification of Impairments, Disabilities and Handicaps (ICIDH)**.

In some general hospitals one or more patients are allocated to one particular nurse.

After the briefing, the nurse starts attending to the patients, e.g. daily personal hygiene, taking care of wounds, checking bodily functions, making the bed, and administers medicine. These are examples of activities that are carried out in direct contact with the patient.

There are a lot of elderly patients in most hospitals, because the Dutch population is aging and less babies are born. In 2015, seventeen percent of the Dutch population will be over 65 years old. Therefore the demand of care is increasing, in quantity as well as in complexity.

The demand of "custom made care" has also increased, due to individualization and assertiveness of the care-recipients.

With the introduction of the so called "'PGB" (personally administered budget: a personal budget for the chronically ill and the disabled), care-recipients were given the opportunity to choose between several care-suppliers. Care-recipients can weigh the pros and cons of the offered quality and the costs. Hospitals, on the other hand, are urged to work in an economically efficient way, which can implicate less quality in the care for the care-recipient. The PGB enables him to buy the sort of care that meets his individual requirements.

Professional nursing is carried out in the field of individual healthcare. Qualified nurses are registered if they fulfil the conditions of article 3 of the Law on Professions in Individual Healthcare (BIG).

Anne's day at Amphia general hospital in Breda:

To give you an impression of an average working day for a nurse, we will follow her from 7.00 a.m. This nurse, Anne, 22 years of age is working on an orthopaedic ward in a general hospital, called the Amphia Hospital in the city of Breda.

The Amphia Hospital is a periphery hospital, which means that patients are coming in from the city of Breda as well as from the larger region. The hospital has three sites, two of which are located in Breda, the third one in Oosterhout (about ten kilometres from Breda).

This hospital contains 1368 patients' beds. About 5.000 people are working here, including volunteers. The 241 medical specialists are covering almost every possible medical specialisation.

Medical specialisations can be trained inside this hospital, but also various paramedical professions, e.g. nurses, surgery-assistants, radiological laboratory-assistants.
The organisation of the orthopaedic ward is clustered but it has patients bed on two different locations. Thirteen orthopaedic surgeons are working here. Operations take place every day of the week. The registrar is responsible for the patients on his ward and he sees them every day. The orthopaedist sees his patients at least once a week, so he can re-adjust the medical treatment.

The orthopaedic ward is participating in a ***joint-care*** project. This means, e.g., that a patient who needs a new hip, will be informed about the operation and the recovery (by looking at a video) together with his "coach" (usually a member of the family or a close friend). The coach commits himself to be seriously involved with the recovery plan.
After the operation, the patient is hospitalised for about six days, and his coach is supposed to be at the hospital between 8.00 a.m. and 18.00 p.m. to help him with a speedy recovery.
The final revalidation takes place at home, still with the support of his coach.

At 7.00 a.m. Anne's day shift starts with brief information from the nurse ending the night shift. The ward contains two separate units. Anne reads the nursing report concerning the patients within her care.

After that, she starts handing out towels to the patients who can wash themselves. If necessary, she administers oral and intravenous medicine.
The first patient to have an operation this morning is taken to the operating theatre, to get a new hip.
Another patient, who had a pelvic operation two days ago, needs help to get washed. This patient has a temporary catheter, an epidural analgesic catheter, a drip and a redo drain. The patient still has no bowl movements and she has had nothing per os. Anne takes care of the wound which is kept sterile.
The third patient had a pelvic operation five days ago, and is able to wash himself from his waist up. Anne has to wash the lower part of his body. This patient still has a drip, a temporary catheter (he will have this for the next two weeks) and two redo drains.

Meanwhile the orthopaedic surgeon has seen his patients, together with the registrar, afterwards they report on their finding to their secretary.
On the planning list of the operation theatre, the next patient of today will have his knee operated. Anne administers him the medicine he needs before the operation.

At 9.00 a.m. there is a short break, Anne takes a cup of coffee and there is a consultation with the nurses from the other unit. Both units are running on schedule.
After this break, patients are helped getting their clothes on. Wounds are looked after, stitches are taken out, if necessary, urine samples are taken for cultivation.
Patients are mobilised (helped out of bed) and taken over by physiotherapists to help them exercise.
Beds are made, night tables are cleaned, supplies are replenished etc.
At 10.45 a.m. there is another short break and a consultation.

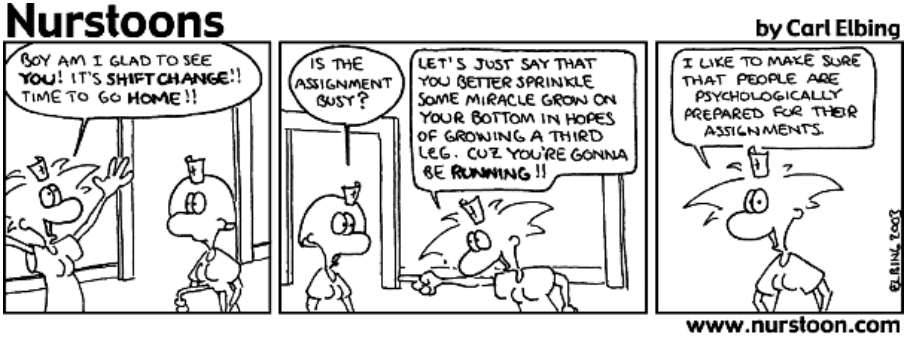
11:00 a.m. A patient, scheduled for a new hip tomorrow, has arrived. He and his wife (his coach) are accompanied to his room and nursing anamnesis takes place. Information about operation, post operative aspects, recovery and rehabilitation is exchanged. Preparation or pre operative aspects, amongst others shaving of the hip area and upper leg, is also part of this process.

11:30 a.m. Colleagues, meanwhile, are distributing medication and also standard physiological checks are executed. If necessary, catheter reservoirs are emptied. Patients, who still produce limited quantity of urine, are advised and stimulated to drink extra, if possible. The patient of the knee surgery was picked up at recovery by two staff nurses. He is attended to after his return according to instructions of the colleagues of recovery and the surgeon.

12:15 p.m. Half of the team, including Anne, leaves for a lunch at the restaurant. The other colleagues stay behind to assist the patients enjoying their meals.

13:30 p.m. Visiting hour. Anne is available for the next of kin of the patients in her care to answer the questions they may have.

14:00 p.m. A patient, scheduled for a knee operation tomorrow, has arrived. Anamnesis takes place and his nursing



file is updated. Anne shaves the leg and the anaesthetist is called to see the patient. He arrives, checks the health status and talks to the patient about the options of anaesthesia.

15:00 p.m. Late shift has arrived and reads the files. Afterwards, details of patient care of the day are emphasized, exchanged and explicated. Anne evaluates the day in general, too.

15:30 p.m. End of shift, Anne changes clothes and leaves for home and a game of tennis with her boy friend.

1.1. Case Study 1 – Neurological Speciality Unit / CVA

◆ Mrs. Visser is a 66 year's old married woman, she has no children. She recently moved to a flat for elderly people with special accommodations. She is of Dutch nationality and is a practising Roman Catholic. Her favourite pastime hobbies are knitting, playing cards and bingo.

Mrs. Visser was taken to the hospital in an ambulance, accompanied by her husband, because she got ill while they were shopping.
When she arrived at the hospital, she was approachable; she talked hardly audible but coherently.
There was a visible loss of functions on her left side.

History of past illness:
Mrs. Visser consulted the neurologist in 1996, when she had a stroke (cerebral vascular accident) from which she fully recovered.

History of present illness:
Mrs. Visser has been consulting an internist because she suffers from diabetes type 2. She has a sugar free diet and takes oral diabetics.

When she came to the hospital, the neurologist performed a neurological examination. He could not execute a lumbar punction because Mrs. Visser was too agitated. A CT-scan was made instead. Her blood pressure was 180/ 110 mm/ Hg. Her temperature 37.6 C. Her pulse 88 per minute. Weight : 75 kilograms. Height 1,50 meter.

Medical diagnosis:
Repeating CVA with hemi paresis on the left side and motion aphasia.

Medical treatment:
- Every three hours the patient's blood pressure, pulse, pupil reaction and consciousness will be checked.
- Liquid, sugar free diet.
- Confinement to bed.
- EEG and a CAT scan of the brain.
- in due course: Physiotherapy and speech therapy.
- Medication: once a day 300 milligrams acetylsalicylate, twice a day 150 milligrams Persantin (diprydamole) and once a day 50 milligrams Tenor in (atonally).

Nursing case history:
Mrs. Visser used to do the housekeeping on her own. Because this was getting difficult, she applied for home care.
She tried her very best to keep to her diet. She is a bit hard of hearing and uses a hearing aid.

Specifications during hospitalisation:
During the first days, Mrs. Visser suffers from urine incontinency and she is very much ashamed about this. After a medical consult, she receives a temporary catheter. Her husband is very supportive; he visits her as often as he can.
Mrs. Visser is gradually getting better. The speech therapist helps her to communicate again, using a notebook. The physiotherapist helps her to walk again, using a walking frame.
Ten weeks after the CVA, Mrs. Visser is discharged from the hospital. A nurse that is specialised in transmural care has organised the after care at home.

1.2. Case Study 2 – Orthopaedic Speciality Unit / fractura colli femori

◆ Mrs. Pieters is an 84 years old widow, who lives in a sheltered accommodation, attached to a home for the elderly, in a village called Halsteren. She has three children. Her husband died of intestinal cancer eight years ago. Mrs. Pieters is a practising Roman Catholic. Her daughter lives in the same neighbourhood and comes to visit her on a regular basis.

On one of her daily visits, her daughter finds her lying on the bathroom floor. She has slipped while taking a shower and is writhing in pain. Her daughter has calls the GP, who arrives immediately and diagnoses a broken hip. He calls an ambulance to take Mrs. Pieters to the hospital.

History of present illness:
Mrs. Pieters has diabetes, type 2, and because her pancreas produces not enough insulin, she takes Gibenclamide (Glyburide), once a day 5 milligram and once a day 10 milligram.

The anamnesis does not bring out any peculiarities. Height: 1, 60 meter. Weight: 55 kilograms. Blood pressure: 140/85, pulse regular, 84 per minute. Temperature is 37 C.

Medical diagnosis:
The orthopaedic surgeon diagnoses a broken hip and decides to do a total hip operation (a complete hip prosthesis).

Medical treatment:
Traction of two kilograms is applied to the left leg (the one that is broken) and Mrs. Pieters is confined to bed.
The orthopaedic surgeon consults a cardiologist, a pulmonary specialist, and an internist, who all agree to the operation.
The internist wants to keep informed about the blood sugar level.
ECG and the pulmonary functions are satisfying. Haemoglobin 7.3 and hematocrites 0.36. Blood type A positive.
Two units of packed cells (a preparation of red blood cells separated from the blood plasma) are prepared.

Mrs. Pieters is prepared for a total hip operation (a complete hip prosthesis). She will be operated late in the afternoon.
Premedication: 7.5 milligram Dormicum (a benzodiazepine) and 10 milligram Normison (also a benzodiazepine) before she goes to sleep.
She is given spinal anaesthesia and after that an epidural catheter for post operative analgesic (three times a day 7.5 milligram morphine during maximum 48 eight hours).
During the operation she is administered 2000 milligram Zinacef (cefuroxime), and she receives a drip that gives off 2000 millimetre glucose salt per 24 hours.

Nursing plan:
After the operation her blood sugar level and the blood clotting are tested. Because it takes too much time for the bleeding to stop, she is administered Sintrom (an anticoagulant).
During the operation, Mrs. Pieters received two redo drains in the wound. After the operation, a nurse will frequently check the drains, pulse, blood pressure, loss of blood, and urine production.
Mrs. Pieters is confined to bed, lying on her back or semi sitting up, her legs spread out. The bed is set in a Trendelenburg position (the head of the bed is lower than its foot). She is given a treatment to prevent decubitis on the coccyx and heels.
Because the haemoglobin has declined, she gets a prescription of 200 milligram Ferro granulate per day.

After the operation, Mrs. Pieters has been somewhat agitated and confused. She refuses to eat or drink anything. Her family is invited for a consultation on her recovery and further revalidation.

Two days after the operation the physiotherapist starts the revalidation program. Mrs. Pieters is taught how to get out of bed and how to use her crutches

Because she still seems to be confused and refuses to eat, a dietician is called in for advice.
If the revalidation program is going well, Mrs. Pieters will be discharged on the fifth day after the operation.
A nurse who is specialised in transmural care, contacts a home care organisation. When Mrs. Pieters comes home, she will need home care.

To trigger your curiosity we challenge you to study these cases. Why, where and how would you interfere as a nurse? Then study Gordon's Patterns (chapter 2 and next) and find the similarities between your and Gordon's approach.

2. Nursing and Caring in the Netherlands

Health care sector and branches

A person, qualified in Secondary Vocational Education Nursing (in Dutch: *MBO-verpleegkundige*) can be employed in most branches of the Nursing and Care sector.
He* is qualified to work in the following branches: general hospitals, psychiatric hospitals, specialised medical centres, nursing homes, convalescent homes or homes for the mentally handicapped.
The proficiency of nurses, qualified in Secondary Vocational Education, is officially protected by a law (the BIG act). Standards for professionals in individual health care are established in this law. A nurse can subscribe to the BIG-register if he meets the educational and training requirements. These requirements are defined in the student's qualification file.

Contexts

A person, qualified in Secondary Vocational Education Nursing, can be employed in general hospitals, psychiatric hospitals, nursing homes etc., but also at the care- recipient 's home or in a combination all these possible settings.
He is qualified to administer medical care to several **categories of care-recipients**** in every age bracket, e.g.: people with a chronic somatic disease, geriatric patients, care-recipients with insufficient ability to self care, somatically or psychosocially, physically handicapped, mentally handicapped, juvenile care-recipients, care-recipients with a psychiatric disorder, pregnant women, women in childbed, new mothers and their babies, and care-recipients at home.

He works in different settings in health care, on the crossing point of (medical) care, housing conditions and welfare. He focuses on administering medical care to the individual care-recipient and his direct family and friends, and on groups of care-recipients (e.g. in a small scale home for mentally handicapped). He independently carries out the nursing process, in medium to highly complicated care situations, in short

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*In Holland there is no unanimity about the use of professions that can apply to a man as well as to a woman. In this text we could have written "he/her", "his/her" and "he/she", every time this occurred. We decided not to do so, because it would not have improved the readability. From our point of view, the nurses and other care workers in this text can be women as well as men.

** When we have used the term "care-recipients", you can also read patients, clients or handicapped.

term as well as in long term care. In home care (and in small scale homes), he usually carries out his work within the privacy of the care-recipient.
He works in a team (e.g. in a hospital or a mental health institution) as well as on his own (e.g. on home care). In most settings he will have to cooperate with the management, his colleagues, care workers, care assistants and care helpers, and professionals from other disciplines like doctors, physiotherapists, midwives and social workers.

The nature of nursing and health care

A person, qualified in **Secondary Vocational Education Nursing**, focuses on administering (medical) care to the individual care-recipient and his direct family and friends. In his work, the personal relation between care-recipient and care-provider is of crucial importance.

- **He draws a nursing plan*****, based on the nursing diagnosis.
- He is responsible for the nursing process, supports the care-recipient with basic personal care and medical care.
- He supports (groups of) care-recipients with emotional and social problems and respects their autonomy.
- He contributes to the concept and combination of different procedures. He participates in medical research and uses the results of this research in actual practice.
- He promotes the health and wellbeing of society, carrying out preventative activities like preventing diseases and health problems (primary prevention) or giving advice and counselling on how to deal with diseases and disabilities (tertiary prevention).
- He coordinates care and carries out tasks within the organisation.

The nursing and care, administered by a person, qualified in **Secondary Vocational Education Nursing**, can diverge from day to day, depending on the care-recipient and the complexity of his needs. Working hours also depend on the needs of the care-recipient, which means twenty four hours a day, seven days a week.

- His daily activities include administering practical care to the care-recipient, as well as working together with colleagues in a professional setting.
- He carries out his work professionally, according to the policy and directions of the institution.
- He supports trainees, trains new colleagues, and gives instructions to care-helpers and care-workers.
- By reflecting on his own acting and by developing his own expertise, he contributes to the quality and proficiency of nursing.

*** When we have used the word “nursing plan”, you can also read treatment plan, supporting plan etc.

Professional attitude

A person, qualified in Secondary Vocational Education Nursing, acts in the interest of the care-recipient, is empathic to the needs of the care-recipient, is respectful to the care-recipient and is communicative.

- He has an eye for the abilities and disabilities of the care-recipient and respects and stimulates his autonomy.
- He carries out his work with a professional attitude, based on **the professional code******, his own moral standards and the policy and directions of the institution he works for.
- He carries out his work independently, deals with occurring problems and creates solutions for the care-recipient's complex health problems and social problems.
- He shows initiative and is pro-active.
- He works efficiently, method-based, hygienically, ergonomically and has an eye for safety, for financial costs and for the environment.

He has a "helicopter view" while he is carrying out his work.
He knows his own limitations and those of other people.
He carries out his work, using his professional expertise and skill.

Difficult choices, finding the right balance

A person, qualified in Secondary Vocational Education Nursing, will have to make choices to find the right balance. The right balance between being personally involved with the care-recipient and keeping professional distance. He has to find the right balance between complying with the care-recipient's wishes (and those of the '*mantelzorger*') and the professional care he can offer. The care-recipient's wishes can differ from the employer's vision and instructions or from the nursing plan. (For instance, the care-recipient might be more interested in an informal conversation with the nurse, where he has planned to give instructions on hypodermic injection.)

In his daily work he has to decide if he should report changes in the care-recipient's health situation to his superior, or just wait and see how this situation is developing.
He has to choose between making the care-recipient do things himself as much as possible, or partly or totally taking over tasks and responsibility from the care-recipient.

He has to find a balance between:

- the individual needs of the care-recipient versus the interest of the group;
- the care-recipient's ideas on treatment and care and those of his family versus his own professional view;
- the care-recipient's wishes and needs versus the employer's (financial) possibilities, restrictions and points of view;

**** The Professional Ethic Code of (Practical) Nurses.

- involving volunteers, family and close friends (mantelzorgers) versus calling in more professional care;
- high quality nursing standards versus meeting the employer's efficiency requirements.

2.1. The Professional Ethic Code of (Practical) Nurses

1. Standards of a professional exert. As a (practical) nurse

- I am personally responsible for the way I provide care
- I am aware of the necessity to keep my competences, needed to provide professional care, at a high standard
- I only act within the lines of my competences
- I attend to and support students at work placement when they develop their nursing skills and general competences
- I support and initiate activities that contribute to reach higher standards of professional quality
- I contribute to measures of safety in caring and nursing
- I demonstrate responsibility in the way of handling the means at my disposal
- I meet the demands of the profession in the way I dress and use jewellery

2. Standards in communication with a client. As a (practical) nurse

- My starting-point is, that every client has a right to receive professional care
- I put the interests of my client in the centre
- I provide care to the best of my abilities in the areas of values and principles, culture and religious identity of my client
- I start, maintain and end a professional relationship with my client (or representative)
- I acknowledge and respect the role of my client and his or hers next of kin as partners in care and provide them with necessary information
- I will ask my client's (or representative's) permission before starting a process of care
- I will report all information (confidential or not confidential) in a responsible and professional way
- I know the rights of my client when reporting
- I respect and protect the privacy of my client
- I have the right to refuse to co-operate in certain professional actions at a basis of scruples or sincere moral conflicts

3. Standards in communication with other professionals. As a (practical) nurse

- I co-operate in a functional and professional way with various disciplines to present my client the best possible care

- I respect the competences, experience and contribution of the professionals of these disciplines
- I overview and watch over the care that my client receives and it's quality
- I protect my client if care, provided by others, is unethical, incompetent, dangerous or professionally unacceptable in any other way
- I will support other professionals or colleagues, willing to conduct according to the professional code, but being hindered doing so
- I contribute to the development, implementation and evaluation of the policy of the institute or organisation I am working

4. Standards towards society. As a (practical) nurse

- I contribute, within my professional field of care, to progress of healthcare in general
- I co-operate in scientific research that focuses on the improvement of health care and the individual care of clients
- I support activities that will lead to a higher standard of practising my occupation or profession
- I will also attend somebody without hesitation, if he or she is in need of professional care
- I contribute to the protection of the environment
- I contribute to a justified, responsible and balanced distribution of collective means
- I do not co-operate or contribute to activities, discrediting the independence, reliability and credibility of myself and / or my fellow professionals

2.2. Model of Nursing

◆ **Gordon's functional health patterns** is a method or model, devised by **Marjory Gordon** to be used by nurses in the nursing process to provide a more comprehensive **nursing assessment** of the patient.

Nursing assessment is the gathering of information about a patient's physiological, psychological, sociological and spiritual status.

Stages of the nursing process
Assessment is the first stage of the nursing process in which the (practical) nurse should carry out a complete and holistic nursing assessment of every patient's needs, regardless of the reason for the encounter. Usually, an assessment framework, based on a nursing model is used.

The purpose of this stage is to identify the patient's nursing problems. These problems are expressed as either actual or potential. For example, a patient who has been rendered immobile by a road traffic accident may be assessed as having the "potential for impaired skin integrity related to immobility".

The other components of a nursing assessment are:
Nursing history
Psychological and social examination
Physical examination
Documentation of the assessment
On that basis, the other stages are:
***Diagnosis** (of human response needs, that nursing can assist with)*
***Planning** (of patient's care)*
Implementation (of care)
***Evaluation** (of the success of the implemented care)*

Gordon's Patterns Self-Test

Check your understanding of the differences between Gordon's 11 functional patterns, and how a nursing diagnosis might express a dysfunction in one or more patterns.

1. Health perception and management
2. Nutrition and metabolism
3. Elimination
4. Activity and exercise
5. Sleep and rest.
6. Cognition and perception
7. Self-perception and self-concept
8. Roles and relationships
9. Sexuality and reproduction
10. Coping and stress management
11. Values and beliefs

Identify the specific functional pattern(s) that would be at-risk or dysfunctional for the following nursing diagnoses to be made:

a. social isolation related to lack of transportation
b. chronic low self-esteem related to obesity
c. knowledge deficit [signs of hypoglycaemia]
d. spiritual distress related to inability to practice religious rituals
e. diversional activity deficit related to long-term confinement to home
f. sleep pattern disturbance related to sensory overload
g. ineffective family coping: disabling related to recurrent marital discord
h. role performance disturbance related to effects of chronic pain
i. potential for violence directed at others related to effects of hallucinations.

Ask yourself the following questions.

A. Identify the patterns showing high functioning. Under a title, for example "FUNCTIONAL AREA", list these patterns.

B. Identify the patterns where functioning is currently a problem or could become a problem. Under a title, for example "RISK AREAS", list these patterns.

1. Pattern of Health Perception and Health Management

- How does the person describe her/ his current health?
- What does the person do to improve or maintain her/ his health?
- What does the person know about links between lifestyle choices and health?
- How big a problem is financing health care for this person?
- Can this person report the names of current medications s/he is taking and their purpose?

- If this person has allergies, what does s/he do to prevent problems?
- What does this person know about medical problems in the family?
- Have there been any important illnesses or injuries in this person's life?

2. Nutritional - Metabolic Pattern

- Is the person well nourished?
- How do the person's food choices compare with recommended food intake?
- Does the person have any disease that affects nutritional- metabolic function?

3. Pattern of Elimination

- Are the person's excretory functions within the normal range?
- Does the person have any disease of the digestive system, urinary system or skin?

4. Pattern of Activity and Exercise

- How does the person describe her/ his weekly pattern of activity and leisure, exercise and recreation?
- Does the person have any disease that affects her/ his cardio-respiratory system or muscle-skeletal system?

5. Pattern of Sleep and Rest

- Describe this person's sleep-wake cycle.
- Does this person appear physically rested and relaxed?

6. Cognitive - Perceptual Pattern

- Does the person have any sensory deficits? Are these corrected?
- Can this person express her/ himself clearly and logically?
- How educated is this person?
- Does the person have any disease that affects mental or sensory functions?
- If this person has pain, describe it and its causes.

7. Pattern of Self Perception and Self Concept

- Is there anything unusual about this person's appearance?
- Does this person seem comfortable with her/ his appearance?
- Describe this person's feeling state?

8. Role - Relationship Pattern

- How does this person describe her/ his various roles in life?
- Has, or does this person now have positive role models for these roles?
- Which relationships are most important to this person at present?
- Is this person currently going through any big changes in role or relationship? Which ones?

9. Sexuality - Reproductive Pattern

- Is this person satisfied with her/ his situation related to sexuality?
- How have the person's plans and experience matched regarding having children?
- Does this person have any disease/ dysfunction of the reproductive system?

10. Pattern of Coping and Stress Tolerance

- How does this person usually cope with problems?
- Do these actions help or make things worse?
- Has this person had any treatment for emotional distress?

11. Pattern of Values and Beliefs

- What principals did this person learn as a child that is still important to her/ him?
- Does this person identify with any cultural, ethnic, religious, regional, or other groups?
- What support systems does this person currently have?

3. The Education of a (Practical) Nurse

Secondary Vocational Education Nursing and Care

Content of the general part of the training for practical nurse.

Essentials:
A nurse supports the care-recipient in a professional way. He has a positive influence on the abilities of the care-recipient, where actual or potential reactions to health problems or health related problems are concerned, as well as on the treatment or therapy, in order to maintain or re-establish the load- and-capacity- balance.

Specific areas within the nursing range:
The nursing practice can be divided into the following areas:
- Care Practice (A)
- Organisation of Care Practice (B)
- Professional Development (C)

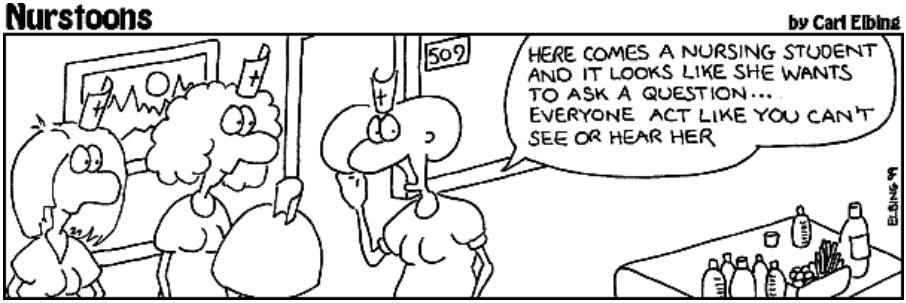
Core tasks:
Core tasks within the A-area Care Practice:
- Supporting the care-recipient with basic care
- Counselling and supporting the care-recipient with psychosocial problems
- Supporting the care-recipient and his family to stay in charge of his own life (self management).

Preventative tasks of a nurse: consultation, advice and instruction:
Tasks within the B-area, Organisation of Care Practice:
- Organising and planning care
- Contribute to the organisation and control of the care-unit

Tasks within the C-area, Professional Development:
- Contribute to the quality assurance of care
- Contribute to professional development

Core assignments:

Core assignments within the A-area, Care Practice:
Finding the right balance:
- Between involvement and professional distance



- Between professional and personal attitude
- Between optimal health and quality of life of the care-recipient
- Between demand leading care and personal interpretation of the needs of the care-recipient
- Between rigidity and flexibility towards the changing needs of the care-recipient
- Between giving responsibility and taking over responsibility
- Between individual interests and group-interests

Core assignments within the B-area, Organisation of Care Practice:
Finding the right balance:
- Between performing every task yourself and delegating
- Between the individual interests of the care-recipient and his family, and the policy and possibilities of the organisation

Core assignments within the C-area, Professional Development:
Finding the right balance:
- Between the care-recipients values and those of his family (self management) , and you own, professional values
- Between taking care of the client needs and your own personal development

A qualified nurse has acquired the following competences:

1. Supporting care-recipients adequately in daily life, if they are unable to do so as a result of health problems, treatments or therapy, giving the care-recipient the possibility to recover or to maintain.
2. Support care-recipients and their family with psychosocial problems, in order to help the care-recipient cope with his situation.
3. Working methodically; this means that his tasks are carried out in an effective and accountable way.
4. Carrying out his work efficiently, being aware of the financial costs, and thus optimising the results of his efforts.
5. Empathizing with the care-recipient and his family, anticipating and supporting the needs of the care-recipient
6. Recognizing the needs of the care-recipient and his health problems, making these needs the leading principle in his work, according to his own professional insights.
7. Promoting the care-recipients autonomy, on a way that he can make his own decisions and stay in charge of his own life as much as possible.
8. Recognizing abilities and disabilities, the health situation and the health risks of the care-recipient, or groups of care-recipients, in order to anticipate and, if necessary, call in the assistance of other disciplines.
9. Analysing the health situation of the care-recipient, in order to make clear what the care-recipient needs.
10. Handling complex situations, to make the right decisions without any delay, in order to guarantee consistency and continuity.

11. Anticipating in order preventing health problems.
12. Providing the care-recipient and his family with consultations, advice an instructions concerning his health situation, in order to optimize his situation.
13. Creating the circumstances to help the care-recipient with his convalescence.
14. Carrying out his work accurately and just, in order to provide the care-recipient with the care he is entitled to.
15. Carrying out his work, including reserved procedures, in a professional way, preventing medical complications and supporting the care-recipients therapeutic treatments.
16. Cooperating with colleagues, professionals from other disciplines, volunteers and the care-recipients family, in order to contribute to the best possible result.
17. Evaluating his own expertise and professionalism and evaluating his work in relation to the work and expertise of others, in order to improve his own contribution to the best possible result.
18. Supporting new colleagues and trainees, in order to help them developing their own professionalism.
19. Presenting innovative procedures, in order to help solving occurring problems in the organisation.
20. Dealing with limitations and tensions to make sure that they do not prevent working according to quality standards.
21. Communicating adequately with others.
22. Passing information and give advice in a comprehensible way.
23. Using his expertise in every possible way, in order to contribute to the health situation and the wellbeing of the care-recipient and of society.
24. Solving problems by innovative procedures in order to develop quality.
25. Taking care of his own position in the organisation and to have a positive influence on his own working conditions in order to find his work satisfactory.
26. Develop his own expertise and skills, after analysing and evaluating his work.
27. Being open minded about new professional developments, and integrating new procedures into care practice. At the same time he should be realistic, according to evidence based practice in order to contribute to the development of the medical care profession.
28. Being aware of how his work is appreciated by the care-recipient. He should be able to reflect on his own actions, emotions and personal and professional values and their effect on others, and if necessary, adjust his attitude in order to promote his own personal and professional development.

4. Health Care in the Netherlands in a Nutshell

4. 1. The Organisation of Self Care, Primary Care, Second Line Care and Specialised Care

◆ In Dutch these different lines of Health Care, are called: *nuldelijns (no line), eerstelijns (1st line), tweedelijns (2nd line) and derdelijns (3rd line) zorg*.
Self care belongs to nuldelijns zorg and so does the preventative work of care workers at Public Health Centres or Infant Welfare Centres.

If self care does not help, you look for professional help
If you are ill, you usually try to get better yourself (self care). You might take an aspirin or another medicine that is available without a prescription. If that does not help, or you are still worried about your health, you could go to the GP (general practitioner or family doctor, in Dutch: *huisarts*).
If you need kinetic help, you can go to a physiotherapist. If you are pregnant, you go to a midwife and if you have a toothache, you go to the dentist.
If you need help to get out of bed, to get clothed or to put medical drops in your eyes, you can ask help from the Home Care organisation.
If you have a prescription for medicine, you can go to the apothecary.
All these people are working in primary healthcare (in Dutch: *eerstelijns zorg*).
Primary care is administered by professionals who are generalists, e.g.: general practitioners (GP's), dentists, midwifes, paramedics, practical nurses and care workers in Home Care. They offer health care at home or in the neighbourhood.

Primary care does not include hospitalisation (it is extra-mural care). You don't need a referral to go to the GP, the dentist, the midwife or the physiotherapist. You do need a referral to go to other paramedics.
To get Home Care (when you have a chronic disease o are handicapped), you need an indication on medical grounds.
Second line care (in Dutch: *tweedelijns zorg*) is administered by professionals who are specialised (e.g. a gynaecologist or a cardiologist in a general hospital).
Specialised care (in Dutch: *derdelijns zorg*) is administered at the University Hospitals.

Besides professional care, there is also informal care
People often try to solve their health problems themselves: self care. And even if a doctor gives you professional

care, you might still need practical assistance and emotional support from family and friends. In Dutch this is called *mantelzorg*.
It comes naturally, when you are emotionally involved with your friends and family. But sometimes it is from sheer necessity: if professional care is not sufficient or does not meet the specific needs of the care receiver. Taking care of a good friend or a member of your family, can be very fulfilling, but also very demanding. To make this easier on the person that gives the *mantelzorg*, every now and then the patient can be admitted to a clinic for a few days (respite care).
In Dutch healthcare, volunteers are very important.
For most diseases, there is a specific organization of patients. They can give information and promote the patient's interest.

Regular health care and complementary or alternative treatments
An important part of the Dutch people, appeal to complementary or alternative treatments, usually in addition to regular health care.
Some of these complementary or alternative treatments are given by care workers who also studied regular health care (e.g. physiotherapists, GP's, practical nurses).
Nowadays, most medical insurances cover the expenses of alternative or complementary treatments.

From primary to second line and specialized health care
If a health problem can not be solved by a generalist working in primary health care, the patient gets a doctor's referral to have second line health care: in a general hospital or the policlinic of a general hospital.
This second line health care is more specialized and patients can be hospitalized.
Second line medical care is usually administered in general hospitals with several medical specialists, but also in specialized or private clinics.
Besides general hospitals, there are also categorical hospitals, specialized in specific diseases, e.g. rheumatism, cancer, drugs- or alcohol addiction, eating disorder, epilepsy. Rehabilitation centres are also part of second line care.
In some medical centres, like university hospitals, you will find the top of clinical care (specialized care). These are also centres of scientific medical research.

Cure and care
Cure and care are English terms that are also used in Dutch health care.
Health care that focuses on medical research and treatment is called cure. Hospitals and most of the primary health care belong to this "cure sector".
Health care that focuses on long term nursing, and health care to prevent complications and loss of functions, is called care.
Care is administered by primary care workers, but when situations become more complicated, patients are often

admitted to institutions of second line care: nursing homes for somatic and psycho geriatric care, psychiatric hospitals, homes for mentally disabled, and hospices that provide palliative care for terminal patients.

***Ketenzorg* (literally: care in a chain)**
Sometimes patients change from primary care to second line care, or the other way around. If a patient is discharged from hospital (second line), he still might need home care (primary care). If institutions for primary and second line care regionally cooperate, this is called *ketenzorg*.

Stepped care (another English term, used in Holland) in organisations for mental health care (*GGZ's*).
People with psychological problems generally are treated by their family doctor, a psychologist or a social worker. If things are getting more complicated, they are referred to second line mental health care.
The organisations for mental health care offer different sorts of ambulatory care as well as hospitalization. Most *GGZ's* are the result of merges between smaller psychiatric hospitals and organisations for ambulatory mental health care.
Just like in somatic health care, the idea is: short term therapy if possible and intensive/ long term treatment if necessary. In the field of the *GGZ's* this approach is called *stepped care*.
Although they are part of mental health care, there are special centres for people with a drug and alcohol dependence.

Health care for the mentally handicapped
Health care for the mentally handicapped starts very early. People, who have a mentally handicapped child at home, need help and advice during and after this diagnosis. They need professional support in pedagogical and educational matters. Later, their children might need help with more practical problems like housing, work etc.
Nowadays, the mentally handicapped are encouraged to participate in society. Small scale accommodations within a neighbourhood, instead of large scale institutes, make this possible.

Preventative care
Preventative care includes disease prevention, public health improvement and public health protection. Disease prevention includes all activities to prevent people from getting diseases, or activities at the very beginning of illness, before there are any symptoms.
Disease prevention is applied in primary, as well as in second line health care, to individual patients. There is also prevention directed to certain groups, or the entire population, e.g.: flu immunisation, child vaccination, mammography or cervical screening, counselling, education on Sexually Transferred Diseases, support of volunteer care workers (*mantelzorgers*) to prevent a burn out.
These forms of preventative care are carried out by public health

care: health care that is offered without an individual demand for help. It is also called: collective preventative care.

Public health improvement includes activities to promote a healthy way of life. Sometimes these activities are organised for specific areas, districts or neighbourhoods with a high-risk population. Disease prevention and public health improvement are carried out by the *GGD's* (the area health authority) according to the law on public health. Public health protection means: taking adequate measures to protect people against harmful influences. This includes occupational health and safety regulations in transport, traffic and food industry.

Health care in bigger cities
Big cities have to deal with more complex health problems. A large part of the population belongs to the lower class that has a small income and little education. As a result, they have more and often more serious health problems. Moreover, big cities attract people living on the edge of society, like the homeless, like drug addicts or people without a residence permit. In most big cities you will find a small group of people with psychiatric or mental problems, who tried to make it on their own but did not succeed. These people often grow very lonely and isolated and most of them refuse to be helped.

Occupational health and safety regulations
According to the *Arbowet* (Occupational Health and Safety Act) employers are obliged to protect their employees against harmful influences on their jobs. When an employee is disabled, the employer has to do his very best to find him an alternative job. Big companies have their own *Arbodienst* (health and safety executives). Smaller companies use extern health and safety executives, with company doctors, nurses, paramedics and employment support workers. They also offer the employees preventative care and activities for health improvement.

4.2. The Development of Health Care and Health Care Policy

We may live longer but during these extra years we usually need more care.
Improvements in technology and care resulted in a higher standard of living. We live longer, but the last years of our lives we have to deal with diseases and disabilities. Since the second part of last century, we realise that the demand on professional care grows more and more.

Professional health care increased and so did the costs of health care.
During he second part of the last century, population and economy were

booming. Professional care was living up to the demand. Because people were getting older, the demand on professional care grew more and more. Technology made more things possible. There were more professional care workers, more health institutions, more hospital beds etc. These developments were not the same all over the country, and in some regions things were better organised than in others.

In the sixties and seventies of the last century, the costs of health care gradually became unmanageable. It took the Dutch Health Department until 2000 to get the costs under control again. They tried to make the organisation of health care more transparent. They reduced the expenses by setting limits to the freedom of establishment of medical professionals and by setting a maximum to the amount of hospital beds etc.
In the eighties of the last century, every health institution was given a limited budget every year. The money was spent more adequately. But when Holland got into economic decline a few years later, other problems occurred, like extremely long waiting lists.

From a rigid organisation to more custom-made care
Things did not improve for the individual patient who had to find his way through a rigid organisation. Waiting lists were getting longer; there was little cooperation between specialists, etc. Patients wanted a more custom-made care, and the government supported this demand.

The government introduces "demand leading" organisation of health care
According to the new political line, the demand of potential patients must be the leading principle for the organisation of health care. Marketing processes and competition are a few of the new instruments. Care providers offer a more flexible range of care, e.g. some hospitals offer day care or specialist care at home.

New tendencies: policlinic care, day care and home *care*
Less hospitalisation and more home care, also helps to cut on the expenses of health care.
In mental health care we see the same tendency, partly out of economic motivations, partly as a result of new methods and views upon the position of people with a psychiatric disease.
One of these new principles is that psychiatric patients should participate in society as much as possible, that they should be able to live in a neighbourhood instead of in an institute. Instead of long term stays, patients are offered day time care, policlinic care etc.
Semi-mural arrangements are made for patients that need some more protection: small scale, custom- made solutions for psychiatric patients, mentally retarded and people suffering from dementia.

New jobs and job descriptions in health care

Health care becomes more flexible, but also more complex and the pressure of work increases. Part of the work of a GP, is now taken over by a nurse or other paramedics. New functions are created, like nurse practitioners, physician assistant with their own responsibilities. The so called "*alfahulp*" (home help) carries out domestic work that used to be part of the task of the care assistant.

Evidence based practice as a leading principle

At this moment about 35 % of medical practice is evidence based practice. The medical sector (care and cure as well as preventative care) is called to account for their results. Procedures, based on scientific research or on 'best practice' are being developed to support this.

Another leading principle nowadays, is the idea of 'stepped care': short term therapy if possible and intensive/ long term treatment if necessary.

Transmural Care: crossing institutional borders

Since demand is a leading principle in care, custom-made care sometimes crosses borders between the institutions. Specialist care can be carried out in hospital while the patient stays at home (e.g. electronic cardiac control or electronic foetal control, epidural analgesic)

Sometimes a GP and a specialist, or a GP and a physiotherapist have joint consultation hours.

These are all examples of transmural care (an interface between primary and secondary line care) in somatic care, but it also exists in mental health care.

The same care-team and the same care worker attend to the patient, during hospitalization as well as in policlinic care or day care.

The care worker that treats a mentally disabled child at an institution also supports the parents of this child at home.

The position of the patient becomes more and more important. If health care really wants a change towards demand leading care, the needs of the patient should be the starting point.

The regional cooperation between primary and second line care (*ketenzorg*) is also reorganised. In every region agreements are made between health care institutions on what sort of care should be available and who should provide it.

Quality first?

In 1985 several reorganisations had improved the efficiency in health care. Expenses were under control now. Quality was the new leading principle, quality that was visible and measurable. Professional health organisations developed methods to control quality. Health authorities also required quality standards from the institutions.

There is a law (*BIG*) that sees upon professionals in individual Health Care, laws (*WGBO and BOPZ*) that see upon patient's rights, a law (*Kwaliteitswet*

Zorginstellingen)f that sets the quality standards of health institutions and a law for clients and patients participation.
Quality standards are controlled by the National Health Authority, called the *IGZ*.

Every region should supply a coordinated health care, according to the needs of patients
Professionals and organisations in health care should take a serious interest in the needs of patients, not only as far as their own organisation is concerned. They should try to supply custom-made care, as promoted by the authorities. This is sometimes complicated by the fact that health care regions are not always clear, or regions for somatic health care are not the same as those for mental health care.

Finance of the health care system

There a three laws for the finance of health care:
1. *Zorgverzekeringswet* (the law on health insurance) which compensates most expenses for short term hospitalisation, medicine, GP, dentist, physiologist etc.
2. *AWBZ* (a collective insurance which compensates most expenses of long term hospitalisation, if referred by the CIZ (centre for medical indication)). This CIZ gives medical indications of the amount of care and the specific care (nursing, personal care etc.) that a patient needs. Usually the care is supplied by an institution, but people can also "buy their own health care" with a so called PGB (a personal budget for buying individual health care).
3. *WMO* (a law for financing social participation of the elderly, for people who are disabled, or people who have a chronic disease.) It compensates the expenses of special transport, housing adjustments for disabled an elderly people, hearing aids etc.

Marketing processes to promote demand leading health care
By changing the conditions for being accepted as a professional health care institution, the authorities can stimulate competition.
By initiating financial incentives, the authorities can promote a healthier way of life.
Marketing processes can also be used by health insurance companies.
These are all different ways to make health care workers listen to the needs of their (potential) clients and to make health care more custom-made. And that is exactly what the health authorities are aiming for.

Competition between health insurance companies
Health insurance companies can promote efficient health care, if they only make financial deals with those care providers that offer professional care for a fair price.

Competition between health insurance companies is possible if their clients can choose between different services, e.g. a solution for the waiting lists at hospitals.

Competition between health care providers

Health care providers can compete with quality, with prices but also with a large range of services. To be able to do so, there have been a lot merges between health care institutions. There are less hospitals and homes, though there are more hospital locations belonging to one big hospital.

Home care organisations have also merged with nursing homes and homes for the elderly, to enlarge their market.

Competition can turn out positive.

The Dutch Health Authority promotes this competition and prevents big cartels and monopoly in health care.

Health care: a free market? What should be the role of the government?

We are dealing with a withdrawing government.

This market consists of three parties: the care providers (institutions and professionals), the health insurance companies and the care – recipients.

A withdrawing government wants people to feel responsible for their own health. This tendency is to be found all over Europe nowadays.

A withdrawing government also leaves the instructions to the professionals; they can play it by their own rules, set up their own systems of quality control.

Health insurance companies can decide for themselves what medical costs will be covered by their policy, although they have a legal obligation to cover basic costs and to accept every client for this basic insurance.

This is how the government provides a framework for the organisation of health care, making sure that the necessary basic health care is accessible for everyone.

To stay in control, there is the Dutch Health Authority.

In some circumstances they can even close down a hospital or a ward, if it does not live up to minimal quality standards.

Another governmental task is the promotion of Public Health and collective preventative care, carried out by the *GGD's* (local health services) and infant welfare centres.

5. The National Characteristics

5.1. The Legislation

The BIG Act
In the Netherlands, the provision of healthcare services by individual practitioners is regulated by the Wet op de beroepen in de individuele gezondheidszorg (Individual Healthcare Professions Act), generally known by its Dutch acronym, 'BIG'. The purpose of this legislation is to safeguard and promote the quality of care services. It also protects patients against inexpert or negligent treatment by a healthcare provider.

European directives
Within Europe, reciprocal agreements have been made with regard to the recognition and accreditation of professional diplomas. These agreements are established by various European Directives which have been incorporated into the relevant Dutch legislation.

Disciplinary rules
A healthcare provider is obliged to work with due care and to provide services of good quality. This applies not only to the treatment itself, but to the personal interaction with patients and their families.

The professions listed in Article 3 of the BIG Act (see column on right) are subject to disciplinary rules. Any patient who considers that a practitioner has not fulfilled his professional obligations may submit a complaint to the relevant authority.

The Individual Healthcare Professions Act (BIG Act) regulates two specific groups of healthcare professions. These groups are known by the numbers of the articles in which they are listed in the act: 'Article 3 professions' and 'Article 34 professions'.

Article 3 professions
The requirements for education, training and the specific areas of expertise for Article 3 professions are established by various government directives. The professional title is legally protected, whereby anyone wishing to use such a title must first be registered in the BIG-register. These professions are subject to disciplinary rules and Codes of Conduct.

Article 34 professions
The education, training and the specific areas of expertise for Article 34 professions are also established by law. However, there is no official register. Anyone who is able to meet the stated requirements is able to use the (protected) professional title.

'Reserved procedures'
In principle, every practitioner is authorized to carry out every form of medical treatment. However, there are

a number of exceptions, known as the 'reserved procedures'. These are medical interventions which present a greater risk to patient safety if not expertly performed. Accordingly, only the care providers specifically listed in the BIG Act may perform such interventions. Doctors are authorized to perform all the reserved procedures, while dentists and midwives are authorized to perform those which form part of their normal professional activities, such as the administration of injections. However, in all cases the practitioner must be fully competent and able to perform the intervention with due care.

Disciplinary rules and proceedings

A care provider must work with due diligence and must provide care of good quality. This applies not only to actual treatment and medical interventions, but also to the personal interaction with patients and their families.

The patient's right to complain

If a patient is not satisfied with the manner in which a care provider has acted, he or she should first lodge a complaint with that care provider or his employer (e.g. the hospital). All healthcare organizations have set procedures for dealing with grievances and complaints. This is a simple way in which to make your dissatisfaction known. The complaints procedures themselves are not regulated by the BIG Act. However, the Act does provide various possibilities for action to be taken against care providers who do not meet the required professional standards.

Article 3 professions	Article 34 professions
Clinical psychologist Dentist Doctor Midwife Nurse Pharmacist Physiotherapist Psychotherapist	Pharmacist's assistant Dietician Ergonomics therapist Skin therapist Clinical physicist Speech therapist Oral hygienist Cesar therapist Mensendieck method therapist Optometrist Orthopodist Podiatrist Radiodiagnostics laboratory technician Radiotherapeutics laboratory technician Dental technician ('denturist') Nurse in individual healthcare ('private nurse')

The Health Care Inspectorate
The Health Care Inspectorate (IGZ) can bring a BIG-registered care provider before the Council for Medical Supervision, and can request the council to impose a disciplinary measure. In the most serious cases, for example where the Inspectorate considers that the care provider should not be allowed to practise due to "inadequate physical or mental constitution or addiction", he or she will be struck off the register.

If the Inspectorate considers that a practitioner is not providing 'responsible' care, it has the authority to order changes. In the most extreme case, the Inspectorate can close down the care provider's practice.

Disciplinary Councils
The Netherlands has five regional Disciplinary Councils for the healthcare professions and one central council. Complaints to the regional councils can be submitted by the Health Care Inspectorate or by a member of the public. If complainants do not agree with the findings of a regional council, they may appeal to the central council.

The sanctions available to the disciplinary councils are:
a. a warning;
b. an official reprimand;
c. a fine of up to € 4.500,-;
d. suspension of registration for a maximum period of one year;
e. partial withdrawal of authorization to practise the profession stated in the register;
f. withdrawal of registration: the practitioner is 'struck off'.

Only sanctions d, e and f will be noted in the BIG-register itself.

Judiciary (Criminal Court)
A court of law can also pass a verdict whereby a sanction is imposed on a care provider, which may entail partial withdrawal or being 'struck off'.

5.2. Health Care Statistics and Press Releases

Statistics

Web magazine CBS Statistics Netherlands *Gerard Verweij and Agnes de Bruin*
01 April 2008 15:00

Fewer stroke and prostate cancer patients die within one year after their first hospitalisation

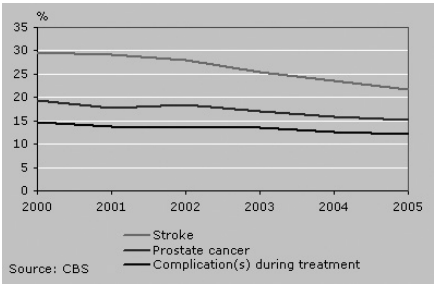
Between 2000 and 2005, mortality among stroke and prostate cancer patients within one year after their first hospital admission dropped by more than 25 and 21 percent respectively. The mortality rate for various other life-threatening diseases also dropped. Cancer has the highest ***mortality rate within one year after first hospital admission***.

One-year mortality for stroke patients reduced by one quarter

In 2005, 22 percent of stroke patients died within one year after they had first been hospitalised. One of the reasons for the reduction of the stroke mortality rate by a quarter since 2000 was intensification of after-care by providing more ***stroke services***. Treatment is also better fine-tuned to the individual patient as a result of a more accurate diagnosis.

One-year mortality for prostate cancer patients dropped to 15 percent in 2005. The reduction is possibly related to an increase in the use of PSA tests, which allow early detection and treatment of prostate cancer.

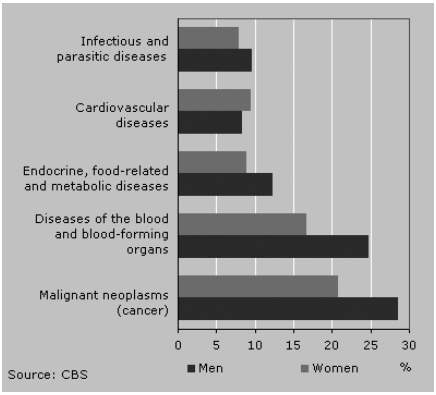
One-year mortality



Mortality rate also down after hospital admission due to medical complications

Mortality following hospitalisation related to medical complications also declined considerably. This is either due to improved care or less serious complications. The one-year mortality rate related to congenital diseases, diverticular disease (intestinal disorder), cardiovascular diseases and chronic kidney diseases decreased substantially too.

Diagnosis groups with highest one-year mortality rate, 2005

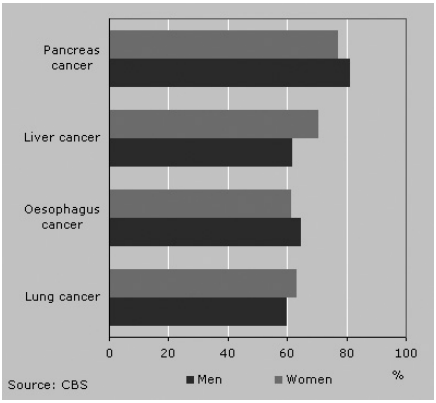


Highest one-year mortality rate for cancer patients

Malignant neoplasms (cancer) scored the highest ***corrected one-year mortality*** in 2005. Nearly 25 percent of cancer patients who were admitted to hospital for the first time, die within the span of one year. The rate for blood diseases is 20 percent, for metabolic diseases 10 percent and for cardiovascular and infectious diseases 9 percent.

With 80 percent, pancreas cancer has the highest one-year mortality score among both genders, before liver cancer, oesophageal cancer and lung cancer.

Types of cancer with highest one-year mortality rate, 2005



Press Releases

Press release CBS 16 May 2007 15:00

Care spending up by 4.4 percent

According to figures from Statistics Netherlands, spending on health care and welfare in the Netherlands amounted to 65.7 billion euro in 2006. This is 4.4 percent more than in 2005. The increase in spending on care has grown by between 4 and 5 percent for three years now. In the period 1998-2003 it rose by an average 9 percent per year. Wage costs for workers in care institutions rose in 2006, fees in the free professions also rose. Physiotherapists, in particular charged substantially higher prices. In addition a new financing system for general

practitioners also resulted in higher costs.

Spending on hospitals up slightly
Hospitals and specialist practices (specialist medical care) constituted by far the largest cost item within the care sector. Spending on care in these institutions rose by 1.7 percent last year. However, this is not the actual development of spending on care. Real expenditure on hospitals was about 6 percent higher than in 2005. The discrepancy is connected with the introduction of a system of diagnosis-treatment combinations in 2005. This system resulted in a considerable over-financing of hospital care in 2005, which was taken into account in the calculation of care expenditure for 2006. The over-financing affected hospital spending upwards in 2005, while it tempered hospital spending in 2006.

Strong increase in spending on GPs and physiotherapists
Spending on GP practices rose by nearly 17 percent in 2006. This was mainly the result of a new financing system (a combination of registration and consultation fees) connected with the introduction of the basic health insurance system. For each insured patient, more services (so-called consultation units) were declared than had been estimated beforehand. Spending on physiotherapy practices also rose substantially, by 14 percent. According to insurers and physiotherapists, this was the result of a price increases to bring the fees to a level in line with the market.

Medicines increasingly expensive
Spending on medicines rose by 4.5 percent in 2006. In 2005 the increase was 4.4 percent. Not only the number of prescriptions rose in 2006, but cheaper medicines are increasingly being replaced by better quality, but more costly, alternatives.

Welfare spending rose by nearly 5 percent
Nearly 5 percent more was spent on welfare in 2006. This increase is evenly distributed cross the various providers of welfare. Spending on care for the elderly, care for the disabled, child care and other providers rose by 4 to 5 percent.

Fewer people with excess insurance policies
The new health insurance system introduced in 2006 has resulted in considerable changes in how care is financed. Everybody in the Netherlands now has compulsory – private - basic medical insurance, and optional extra insurance coverage. Considerably fewer people have excess policies, where they have to pay for part of the costs themselves. This has resulted in lower costs being paid by patients themselves.

Press release CBS 18 March 2008 15:00

More people adopt healthier lifestyle

In recent years, the Dutch have adopted a more healthy lifestyle. The percentage of smokers and heavy drinkers has marginally declined. An increasing number of people in the Netherlands exercise enough and the number of moderately overweight adults is no longer increasing, but there is still an upward trend in obese people, according to the latest figures released by Statistics Netherlands.

Fewer smokers

Last year, 31 percent of Dutch men in the age category 12 years and older smoked, as against 25 percent of women. The downward trend which could be observed in the male population prior to 2004 appears to gain ground again, but the percentage of smoking women remained stable over the past three years. The amount of heavy smokers has dwindled among both genders in recent years. Another positive aspect is that a large proportion of young people have never smoked: in the 12–24 age bracket, people who never touched a cigarette in their lives grew from 58 to 66 percent between 2001 and 2007.

Slightly downward trend among heavy drinkers

The proportion of heavy drinkers aged 12 years or older fell from nearly 14 percent in 2001 to nearly 11 percent in 2007. With 18 percent, excessive drinking among men is more than four times as high as among women (4 percent). One in five are teetotallers.

More Dutch do enough exercise

The percentage of people from the age of 12 complying with the Dutch Standard for Healthy Exercise had increased marginally last year relative to 2006. Since 2001, the proportion of people who do enough exercise has gradually grown from 52 to 56 percent. This applies to both men and women.

Moderate overweight no longer increasing

Nearly 35 percent of Dutch adults were moderately overweight in 2007. Until 2002, the number of moderate overweight people increased annually, but it has remained stable in recent years. In 2007, more than 40 percent of men and nearly 30 percent of women were moderately overweight.
Over a longer period, the amount of Dutch adults with excessive overweight has continued to grow. In 2007, more than 11 percent of adults had to cope with obesity, more than twice as many as twenty years ago. Obesity is more frequent among women (12 percent) than among men (10 percent).

6. What is European Health Policy Like?

6.1. Background

◆ **European Union's recent general health policy lines** were set out in 2002 with the concept of a **Europe of Health** in 2002. Work was undertaken on addressing health threats, including the creation of a **European Centre for Disease Prevention and Control** (**ECDC**) (2004), developing cross-border co-operation between health systems and tackling health determinants. The Community's **health information system** provides a key mechanism underpinning the development of health policy. This development work has already resulted for example in European health insurance card.

Naturally work and efforts in promotion of health had taken place during previous years. One significant effort being programme of **Community health monitoring programme (1997-2002)**. The aim of the programme was to produce a health monitoring system to monitor the health status in the Community, facilitate the planning, monitoring and evaluation of Community programmes and to provide member states with information to make comparisons and to support their national policies.

Before existing Programme of Community Action in the Field of Public Health was drawn lot of previous work and programmes had been carried out. Development of health indicators (Programme of Community action on health monitoring) has resulted in European Community Health Indicators (ECHI). Other programmes have been e.g. pollution related diseases programme, the cancer programme, the drugs prevention programme and rare diseases programme. Previously carried out work has resulted in following programme.

Aim has been on prevention and finding joint indicators and monitoring systems to facilitate comparison of health status and determinants effecting it.

6.2. Present situation

Programme of Community action in the field of public health (2003-2008)

The Council and Parliament set in 2002 as overall aim "**to protect human health and improve public health**" and as **general objectives**:

A. to improve information and knowledge for the development of public health; that is to be reached by e.g. following measures:

- developing and operating a sustainable **health monitoring system to establish comparable**

quantitative and qualitative indicators at Community level … concerning health status, health policies and health determinants, including demography, geography and socioeconomic situations, personal and biological factors, health behaviours such as substance abuse, nutrition, physical activity, sexual behaviour, and living, working and environmental conditions, paying special attention to inequalities in health;

- developing an **information system for the early warning, detection and surveillance of health threats**, both on communicable diseases, including with regard to the danger of cross-border spread of diseases (including resistant pathogens), and on non-communicable diseases;
- improving the **system for the transfer and sharing of information and health data** including public access and by improving analysis of **health policy developments** and of other Community policies and activities.

B. to enhance the capability of responding rapidly and in a coordinated fashion to threats to health; that is to be reached by following types of measures:

- enhancing the capacity to **tackle communicable diseases** by supporting the further implementation of Decision No 2119/98/EC on the ***Community network* on the epidemiological surveillance and control of communicable diseases**;
- supporting the network's operation in relation to common investigations, training, continuous assessment, quality assurance
- developing strategies and mechanisms for preventing, exchanging information on and responding to non-communicable **disease threats, including gender-specific health threats and rare diseases**
- exchanging information concerning strategies in order to **counter health threats from physical, chemical or biological sources in emergency situations**
- exchanging information on **vaccination and immunisation strategies**;
- enhancing the **safety and quality of organs and substances of human origin, including blood, blood components and blood precursors**
- implementing vigilance networks for human products, such **as blood, blood components and blood precursors**;
- developing strategies for **reducing antibiotic resistance**.

C. to promote health and prevent disease through addressing health determinants **across all policies and activities**; that is to be reached by following types of measures:

- preparing and implementing strategies and measures, including those related to public awareness, on **life-style related health**

determinants, such as nutrition, physical activity, tobacco, alcohol, drugs and other substances and on mental health, including measures to take in all Community policies and age- and gender-specific strategies;
- analysing the situation and **developing strategies on social and economic health determinants**, in order to identify and **combat inequalities in health and to assess the impact of social and economic factors on health**;
- analysing the situation and developing strategies on **health determinants related to the environment**
- analysing the situation and exchange information **on genetic determinants and the use of genetic screening**;
- developing methods to evaluate quality and efficiency of health promotion strategies and measures;
- encouraging relevant training activities related to the above measures.

6.3. Future

Programme for Community Action in the Field of Health 2007-2013

The new Community Action in the field of Health sets three broad objectives. These objectives align future health action with the overall Community objectives of prosperity, solidarity and security. This will help to create synergies with other Community programmes and policies – which is inevitable as health issues and their origins derive from existing environment, society and economy. It is to form a continuum for predecessing programme 2003-3008. The objectives of new programme are to:

1. Improve citizens' health security
- to protect citizens against health threats including working to develop EU and Member State capacity to respond to threats
- to cover actions such as those in the field of patient safety, injuries and accidents, and community legislation on blood, tissues and cells and in relation to the International Health Regulation.

2. Promote health for prosperity and solidarity
- to foster healthy active ageing and to help bridge inequalities, with a particular emphasis on the newer Member States.
- to incorporate action to foster cooperation between health systems on cross-border issues such as patient mobility and health professionals.
- to cover action on health determinants such as nutrition, alcohol, tobacco and drug consumption as well as the quality of social and physical environments.

3. Generate and disseminate health knowledge

- to exchange knowledge and best practice in areas where the Community can provide genuine added-value in bringing together expertise from different countries, e.g. rare diseases and cross-border issues related to cooperation between health systems
- to cover key issues of common interest to all Member States such as mental health.
- to expand EU health monitoring and develop indicators and tools as well as ways of disseminating information to citizens in a user-friendly manner, such as the health portal.

Despite being reduced in scope compared to the original proposal, the modified Programme proposal is broad enough to be able to accommodate key health issues as well as those which may arise unexpectedly and need urgent attention.

Glossary

PGB – personally administered budget: a personal budget for the chronically ill and the disabled.

BIG – Individual Healthcare Professions Act, generally known by its Dutch acronym, 'BIG'. The purpose of this legislation is to safeguard and promote the quality of care services. It also protects patients against inexpert or negligent treatment by a healthcare provider.

ICIDH – 'International Classification of Impairments, Disabilities and Handicaps'.

Marjorie GORDON – proposed functional health patterns (1987) as a guide for establishing a comprehensive nursing data base. These 11 categories enable a systematic and standardized approach to data collection to help the nurse determine essential aspects of health and human function.

JOINT CARE - A patient who needs a new hip (or another joint), will be informed about the operation and the recovery (by looking at a video) together with his "coach" (usually a member of the family or a close friend). The coach commits himself to be seriously involved with the recovery plan.

MANTELZORGER – informal care - practical assistance and emotional support from family and friends.

PROFESSIONAL ETHIC CODE – deduction of the code of the International Council of Nursing – standards, of how to be a professional in Health Care.

CURE – Health care that focuses on medical research and treatment is called cure.

CARE – Health care that focuses on long term nursing, and health care to prevent complications and loss of functions, is called care.

INTRA-MURAL – primary line care.

EXTRA-MURAL – secondary line care.

SEMI-and TRANS-MURAL – interfaced (between intra- and extra) care.

GGD – Rural Health Services.

GGZ – The organisation for mental health care: it offers different sorts of ambulatory care as well as hospitalization.

GP – General Practitioner (physician).

CHAIN CARE – co-operation between institutions for primary and second line care (regionally).

STEPPED CARE – short term therapy if possible and intensive/ long term treatment if necessary.

ARBO – Occupational Health and Safety Act.

CIZ – Centre for Medical Indication: specification of the necessary care.

WGBO – Law, that sees upon patients rights in institutions

BOPZ – Like WGBO, but specifically for mental health care

AWBZ – Collective insurance which compensates most expenses of long term hospitalisation

WMO – Law for financing social participation of the elderly, for people who are disabled, or people who have a chronic disease

References

Nurstoon http://www.nurstoon.com/

BSL (Publisher) – book: http://home.bsl.nl/
Introductie in de gezondheidszorg (Health Care Introduction) ISBN 978 90 313 4812 1

Ministry of Health, Welfare And Sport http://www.minvws.nl/en/

RIBIZ (BIG register) http://www.ribiz.nl/en/

Calibris http://www.calibris.nl/
(qualification structure senior secondary vocational education)

VenV http://www.venvn.nl/
(professional organization of nurses in the Netherlands)

LEVV http://www.levv.nl/
(Netherlands Centre for Excellence in Nursing)

CBO http://www.cbo.nl/home_html
(Dutch Institute for Healthcare Improvement)

CBS (Statistics Netherlands) http://www.cbs.nl/en

Dutch Government Websites http://www.overheid.nl/english/

Amphia Hospital Breda http://www.amphia.nl/

Chapter 6. http://ec.europa.eu/health/ph_programme/programme_en.htm
Decision No 1786/2002/EC of the European Parliament and of the Council of 23 September 2002 adopting a programme of Community action in the field of public health (2003-2008)

Amended proposal for a DECISION OF THE EUROPEAN PARLIAMENT AND OF THE COUNCILestablishing a second Programme of Community action in the field of Health. Brussels, 24.5.2006/ COM(2006) 234 final/ 2004/0042 A (COD)

http://ec.europa.eu/health/ph_overview/pgm2007_2013_en.htm