Inside Europe

Care of the elderly in the Netherlands

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This is the second of a series of articles describing the ways some other countries look after their elderly populations—and how they plan to cope with the growing numbers of old people in all Western countries. The first article, on Denmark, appeared in the BMJ of 8 October 1983, p 1053.

The Netherlands, separated from Britain by less than 100 miles of North Sea, has a culture very similar to our own. It shares the same high population density as south east England, with just over 14 million people living in an area of 13 500 square miles (35 000 sq km). The Dutch are prosperous, they have made good use of their windfall of natural gas from the North Sea, and their stock of houses, hospitals, schools, and industrial plant has largely been rebuilt since the second world war.

Now, however, they have to face the prospect of the gas running out at a time of economic stagnation. On my most recent visit to Amsterdam the streets were littered with uncollected rubbish—evidence of a long drawn out strike; no post had been delivered for several weeks—again due to a strike; and the Dutch have substantial problems with drug addiction, disaffected youth, and ethnic minorities—all too familiar to the British visitor.

Yet there are no bleak vistas of unreconstructed urban decay, and the visits I made to sheltered flats and nursing homes showed that the Dutch, like the Danes, used the economic prosperity of the 1960s and early 1970s to give the elderly a share of the rising living standards. In the words of one of the foundations that provide accommodation for the elderly, "The care of elderly people is no longer a task for their children. Our society has grown too complicated for this duty. It is therefore society as a whole that has assumed responsibility."

Health care system

In theory the Dutch have left all medical and social care of individuals to the private sector, with tariffs and charges for services being negotiated between the organisations providing services on the one hand and the health insurance funds on the other. In practice the state has intervened progressively more year by year to control both the quality of the care provided and its quantity. Furthermore, since everyone in Holland is covered by some form of health insurance there are no financial barriers to medical care—and virtually no private sector as understood in Britain.

Health services in the Netherlands are, then, financed mostly through health insurance, with some costs met directly by the government. Individuals with an income above a minimum level are required to take out private insurance for themselves

and their families, while those with lower incomes are compulsorily insured through a public sick fund insurance scheme, with a premium set at a fixed proportion of personal income. Both employees and employers contribute to these funds. An additional insurance scheme for chronic or expensive illnesses is funded entirely by contributions from employers.

The hospitals and nursing homes in the Netherlands are private institutions—but they are not profit making. These institutions are run by non-profit-making foundations or boards whose directors and managers are expected to balance income (from the fees charged to patients at tariffs negotiated with the sick funds) against expenditure on salaries, supplies, maintenance, and capital investment costs.

As in other countries, however, costs and expenditure have risen sharply in the past five years or so, and in an attempt to slow these rising costs the Dutch government has introduced new controls: in particular, from 1983 onwards hospitals and nursing homes are being expected to work within fixed annual budgets.

Care of the elderly

Of the 14 million people in the Netherlands, 1.6 million (11.3%) are over the age of 65; the proportions in the different age bands are shown in table I. Most of these people live in

TABLE I—Elderly people in the Netherlands by age

Age	Population × 1000	Percentage
65-69	534	33.8
70-74	436	27.6
75-79	310	19.6
80-84	185	11.7
≥ 85	115	7.3

TABLE II—Where the elderly live in the Netherlands (per cent)

At home	72
Modified/sheltered housing/old people's homes	24
Nursing homes	3
Hospitals	1

their own homes (table II), but one quarter of the over 65s live either in purpose built homes for the aged or in houses or flats that have been structurally modified to provide some degree of "sheltering." Around 3% live in nursing homes, but these are very different from the British concept, providing a service far closer to that given in British NHS geriatric hospitals. The nursing homes I visited had full time medical staff and their own physiotherapy departments, laboratories, and so on. They

could not, however, be classed as hospitals: none had an x ray department, for example. Virtually all the old people who were admitted to nursing homes stayed there until they died; the average stay in the psychogeriatric units is two to three years.

How, then, does the Dutch system cope when an old person living at home becomes incapable of living independently? As in Britain, the general practitioner has the task of making the preliminary assessment and calling in other health care professionals—home nurses, home helps, and so on—and social care services such as meals on wheels.

If these home services are not enough the old person may decide to move into an old people's home. There are 1650 such homes in the Netherlands, providing accommodation and meals for around 140 000 people. Like nursing homes and hospitals, these homes are run as businesses by non-profit-making organisations. Typically, they provide a single room for single persons and two roomed flats for married couples.

Entry to these homes depends on assessment of the old person by a committee made up of social workers, psychologists, doctors, and the management of the home. A full report is prepared by the general practitioner, and the old person will then be visited and assessed in his own home by a social worker. Once admission is agreed the old person is put on to the waiting list—and in most parts of the Netherlands will now need to wait for about a year before a place becomes vacant.

Admission to a nursing home is by a very similar procedure: referral by the general practitioner leads to home visits by a social worker (not a physician), and the final decision is taken by a multidisciplinary committee. There are 320 nursing homes in the Netherlands, providing 48 000 beds. Half of the homes are for patients with physical disorders, one quarter for psychogeriatric patients, and one quarter for both categories of patients. At present the waiting time for a patient with a physical disability is around four weeks; for psychogeriatric patients it is about nine months.

Very few old people in the Netherlands end their days as long stay patients in a hospital. There are only five hospital geriatric units in the whole country, and the system depends on the assumption that patients who need long term care can be transferred to a nursing home with very little delay. Until a year or so ago the delay was rarely as long as four weeks. Now it is lengthening.

Typical homes

I visited a combined old people's home and nursing home in a district of Amsterdam close to the docks. The flats for the old people formed a rectangular 10 storey block, with the nursing home forming a low extension on one side. The flats provided accommodation for 610 people and the nursing home for another 130.

Each floor of the 10 storey tower had sets of single and double units, each with its own WC and washing facilities. Meals were taken in a communal dining room at one end of the floor. There was a big communal sitting room for social activities on the ground floor, together with an occupational therapy department and some shops. Residents could also come and go freely to the shops, bars, and other facilities in the neighbourhood.

The block was 13 years old and, the domestic superintendent explained, had had virtually no money spent on its internal maintenance and refurbishment in that time. Certainly the furnishings and the fabric looked rather worn, but everything was clean and nothing seemed to be broken.

The nursing home was divided into two sectors—somatic and psychiatric—and 90% of the patients had come from the flats in the old persons' home. Again the overall impression was one of rather austere efficiency, with adequate facilities but not many home comforts or luxuries. Most of the patients slept in four bedded units, with a few double units. Almost all patients are got out of bed every day; the home has its own physiotherapy and occupational therapy departments.

Psychogeriatric nursing home in Eindhoven.

I also visited a group of nursing homes in Eindhoven, not far from the Belgian border. The home for patients with physical disorders included a big department for the rehabilitation of patients after strokes, amputations, and so on. The psychiatric home was divided into five units for patients of different grades of disability. In Eindhoven the financial problems were less evident and both types of nursing home were well maintained and gave an impression of optimistic and dedicated staff working in a cheerful environment.

Quality control

In addition to monitoring the negotiations between hospitals and nursing homes and the insurance funds the Netherlands government also sets standards by specifying the numbers of doctors, nurses, and ancillary workers to be employed in units of different sizes. A team of inspectors makes periodic visits to all nursing homes, and if standards are not being met the management will, if necessary, be changed. Senior managers to whom I talked said they had no difficulty in getting staff, but there was a shortage of good candidates for nursing vacancies in the middle management range.

Overview and future prospects

Thus the Netherlands shares with its Scandinavian neighbours a system of care for the elderly sick which applies uniformly to the whole population, though its financial arrangements are very different. Apart from the very rich (who, as Scott Fitzgerald correctly observed, are different from the rest of us), everyone in a Dutch community will go to the same hospital or nursing home when they have a stroke or become demented. This in itself ensures that there is social pressure for the maintenance of good minimum standards.

Residential homes are a different matter. The old people's homes built in the postwar years are mostly homes for pensioners from social classes III, IV, and V. The middle classes can survive longer in their own homes or in relatively large numbers of service flats, which provide meals and a whole range of domestic services—at a price.

How, then, are the Dutch planning to meet the challenge of the rising numbers of elderly in their population in the coming decade? Between 1980 and 1990 the numbers of men and women aged over 65 will rise from 1.6 million to 1.8 million. Unfortunately the growth in numbers of old people is coinciding with a prolonged period of economic stagnation. Concerned by the rising costs of expenditure on health and social welfare, the Netherlands government is looking for economies. It plans to reduce the numbers of places in residential homes for the elderly from 140 000 to 120 000 in the next five years; and new building is to cease. In theory domiciliary support services are

to be expanded to help keep more old people in their own houses, but the Dutch to whom I spoke did not believe that enough money would be found for the expansion needed. As in Britain and Denmark, the government has mounted a public relations campaign to convince the population that old people are best cared for in their own homes with the support of their neighbours and family, with help from volunteers and from home nursing and home help services. Certainly there has been some increase in the numbers of home nurses, but other support services (such as helps) have been frozen or actually declined a little.

Administrators of nursing homes can produce objective evidence of a recent decline in the quality of care provided for the elderly. Projections based on demographic change have shown that 5000 additional beds will be needed by the end of the decade. No one now believes that these new nursing homes will be built. Waiting lists are lengthening substantially: in Eindhoven (population 200 000) the number waiting for admission to psychogeriatric beds has doubled (from 90 to 180) in the past 12 months. Patients in hospital beds (who make up

about 25% of all admissions to long term psychogeriatric care) are now having to wait for between six and 12 months for transfer to a nursing home—only two years ago the average delay was only one month.

Those doctors, nurses, and administrators to whom I talked saw the future as depressing. Until very recently the system had functioned efficiently and compassionately, with few old people having to wait more than a few weeks between assessment and admission to a nursing home. Now the administrators have been told to cut their budgets by 3% in the coming year; new building has come to a virtual end; and—remarkably quickly—free movement of the elderly from their own houses to residential units or nursing homes has slowed down and in some cases stopped. The presence of demented old persons in units meant for the physically disabled is lowering the quality of life for the non-demented—a problem all too familiar in Britain but new to the Netherlands. Resignedly, however, the health professionals accept that the economy is in a poor state, and they believe that the care of the elderly will have to worsen substantially further before there is any real public protest.

The State of the Prisons

The physical health of prisoners

RICHARD SMITH

The uninitiated might imagine that dreadful diseases are to be found in our thoroughly unpleasant prisons and that prison doctors are specialists in dealing with these conditions. It was true at the end of the eighteenth century that prisons had their own disease—gaol fever, a form of typhus—but now the diseases to be found in prisons are the same as those in the community, only some are much commoner behind prison walls. The special skills required of a prison doctor are less to do with knowledge of disease and much more to do with being able to practise medicine within difficult conditions.

Conditions of prisoners on entering prison

Any doctor who has ever worked in the casualty department of a large hospital in an inner city would recognise the chaos that prevails in the prisons that take prisoners directly from the street. At Brixton, for instance, which is London's main remand prison for men, about 200 new prisoners come in each day, and many of them are in a desperate state. Many have spent some time in police cells, but few have been "sorted out." The mad, the bad, the sad, the homeless, the filthy, the infested, the drunk, the high, the dangerous, the grief stricken, and the suicidal pour into Brixton every day and have to be quickly sorted out into those needing close medical attention, those who need to be watched, and those who will be safe in the main body of the prison.

All of them are searched, bathed, and examined, usually by part time doctors who are also local general practitioners but sometimes by full time prison doctors, but the examination is necessarily brief. This is triage, as in a wartime casualty station, and any diabetic or epileptic or prisoner with a heart problem, no matter how stable his condition, is likely to end up in the hospital for a while at least, and anybody showing the least sign of mental instability will be sent to the euphemistically named "psychiatric wing."

I know of no detailed study of the medical state of prisoners entering British prisons, but a study was done on 1420 prisoners entering the New York City correctional facilities over two weeks in June 1975.¹ Thirteen hundred of the prisoners were men, and 120 women; three quarters were under 30; and 57% were black, 24% Hispanic, and 17% white. Forty one per cent of the prisoners gave a history of illicit drug use, and a previous study reported in the same paper had found that urine samples from 36% of 485 adult male prisoners taken on admission contained either opiates, methadone, barbiturates, or amphetamines. In addition 18% of the men and 14% of the women had a history of alcohol abuse.

More than a quarter of the prisoners reported an illness at the time of admission, and 60% received at least one diagnosis. Four per cent gave a history of epilepsy, 8% of asthma, and 8% of hepatitis. On examination new trauma was seen in 10% of the men and 17% of the women. An abnormality of the mouth and teeth was noticed in 18%, and a detailed examination of the 257 with dental findings showed that two fifths had missing teeth and a third multiple caries. Seven per cent had eye abnormalities, and 46% skin abnormalities—mostly scarring secondary to drug use, tattoos, non-specific dermatitis, and fungal infections. When it came to making an examination of the prisoners' mental state, 13% of the total and 10% of the women were judged to be