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sienha
Strategic Innovative Educational Network
for Healthy Ageing

The Netherlands

Country Profile on Healthy Ageing 2021

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Country profiles series

SIENHA is a European research project carried out by different universities whose aim is to support healthy ageing among European countries through the competence development of social and healthcare professionals.

Country Profiles provide an overview of the SIENHA project based on each partner country's situation regarding healthy ageing including demographics and epidemiology, health status, health system and population needs. These profiles aim to provide context and highlight specific needs of each partner with the subsequent purpose of translating these results into future competences

Content

The data and information in these Country Profiles are based, mainly, on European official statistics provided to Eurostat and the OECD, and Global Health Data Exchange to ensure data comparability. This information has been complemented by the National Statistics Institutes of each country.

1. Demographic and socioeconomic context

The population in the Netherlands increased during 2020 and stood at 17,408,000 inhabitants as of January 1, 2021.

The distribution of the population by age group and sex can be seen in Figure 1 and 2.

Within the Netherlands, crude birth rate (total per 1,000 inhabitants) was 9.7 and fertility rate in 2019 was 1.57 live births per woman.

The Dutch have an ageing population

Life expectancy at birth was 80.6 years (male) and 83.7 years (female) in 2019. Up from an average of 78.2 years in 2000 and above the EU average, although women are below the EU average.

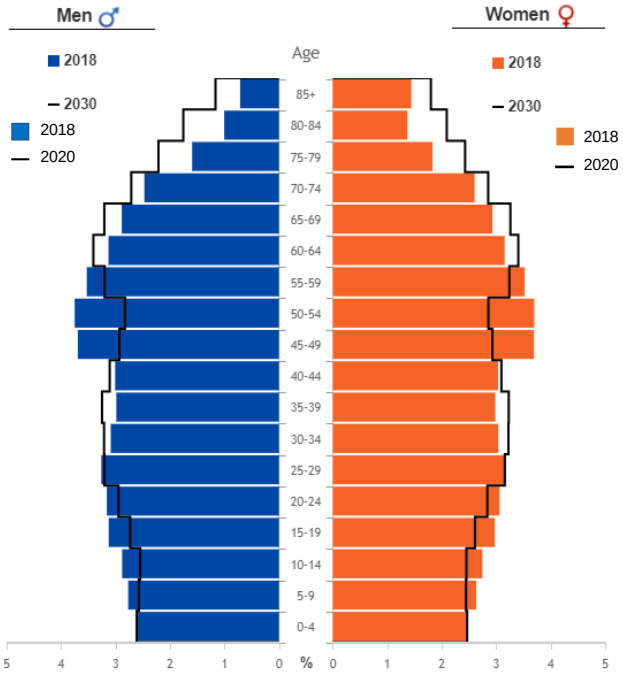

Figure 1. Population pyramid in The Netherlands in 2018 and its projection for 2030

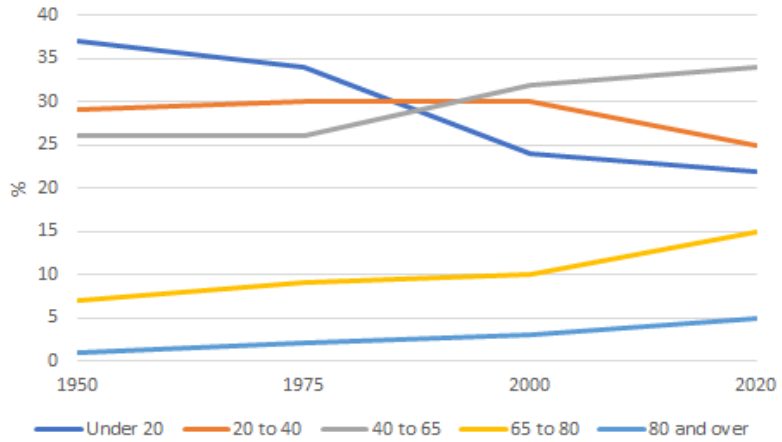

Figure 2. Population in The Netherlands since 1950, divided by age

Adjusted gross household disposable income (2017)	28.800€
Unemployment rate of persons aged 15-74 in de labour force (2019)	3,4 %
Degree of urbanization (2019)	91,88%

Table 1. Socioeconomic characteristics

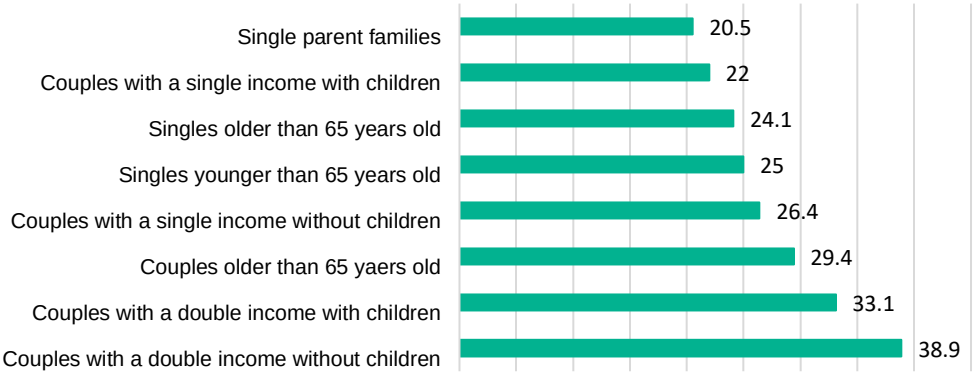

Figure 3. Average annual real disposable income of households in The Netherlands in 2017, by household type (in 1,000 euros)

Education distribution across men and women in the Netherlands

Proportion of population from 25 to 64 years divided up into three classes of educational attainment (low, middle, and high education) in 2019 in the Netherlands. Attainment profiles are based on highest completed specified level of education. 20.6% of men and 21.9% of women have not completed primary education, whereas 41.5% of men and 39.7% of women have upper secondary, post-secondary non-tertiary and tertiary education. 36% of men and 36.7% of women have tertiary education.

21,3%
Less than primary, primary and lower education
(levels 0-2)

40,6%
Upper secondary, post-secondary non-tertiary
(levels 3-4)

36,4%
Tertiary education
(level 5-8)

Figure 4. Percentage of population who have completed the respective levels of education 2020

2. Health status

Self-rated health by age and sex

The Dutch tend to rate their general health fairly high, with only 5% perceiving their health as poor or very poor (the fourth lowest proportion in the EU). However, this differs according to socioeconomic factors such as income, with only 2% of those in the highest income quintile describing their health as poor, compared to 10% in the lowest income quintile country.

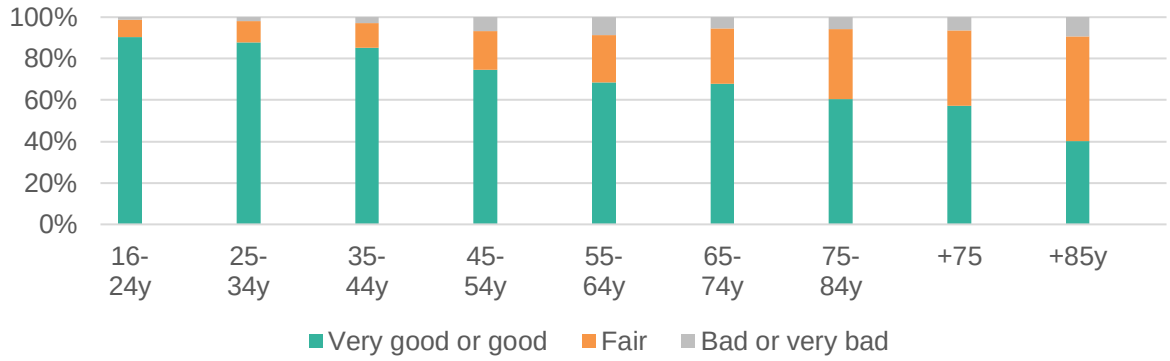

Figure 5. Self-rated health by age and sex

Main causes of death by age and sex

Increases in life expectancy are mainly the result of a consistent reduction of premature deaths from cardiovascular diseases (CVD), resulting in one of the lowest overall rates in Europe. Indeed, for men, cancer has now become the main cause of death in the Netherlands while, for women, cancer and CVD as a cause of death are about the same level (see figure 6).

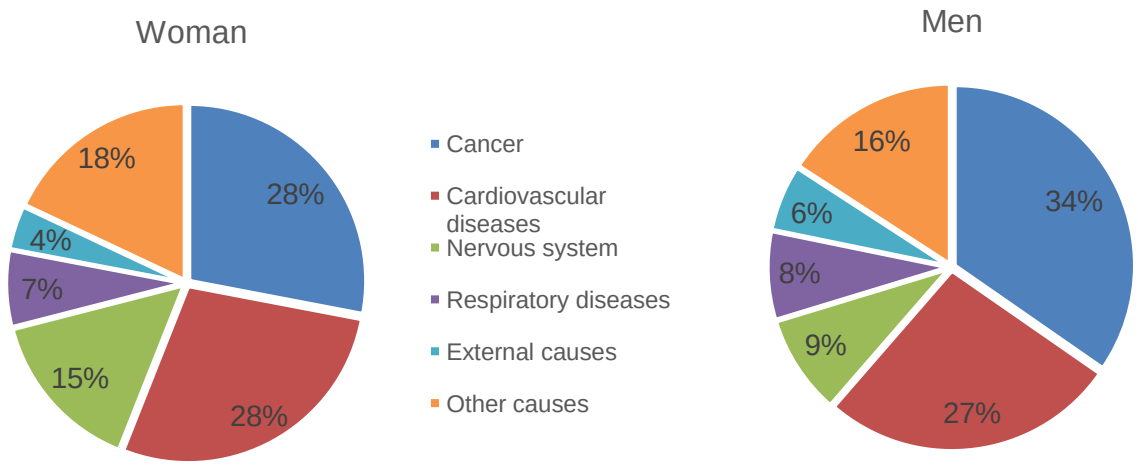

Figure 6. Causes of death — standardised death age, 2017

Still, there were over 5 000 deaths from these conditions in 2013 in people under 75 years of age. For both men and women combined, Alzheimer's and other dementias have become the second cause of deaths, after other heart diseases and before lung cancer (see figure 7).

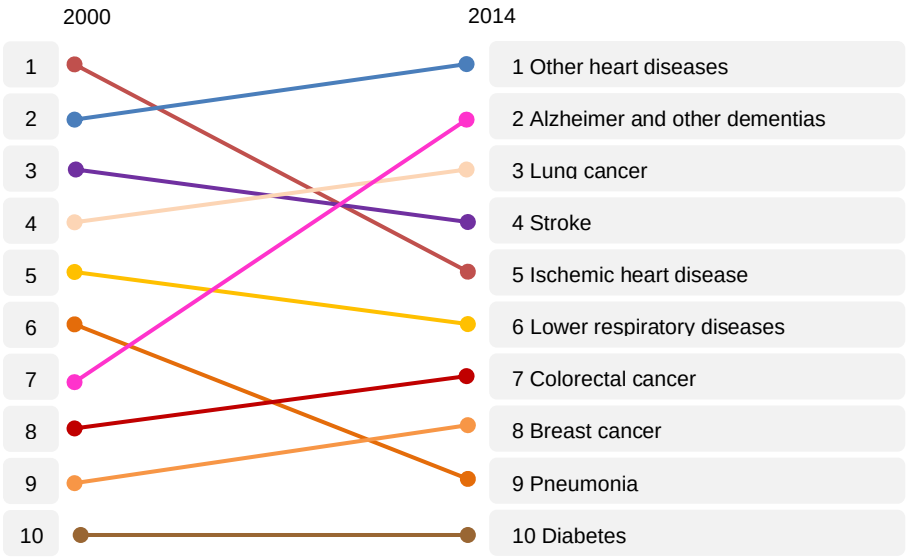

Figure 7. Ranking and evolution of the main causes of death between 2000 and 2014.

Main causes of burden of disease

Based on self-reported data from the European Health Interview Survey (EHIS), one in six people in the Netherlands live with hypertension, one in twelve with chronic depression and one in eighteen with asthma. People with the lowest level of education are nearly three times as likely to live with diabetes and 35% more likely to live with asthma as those with the highest level of education.

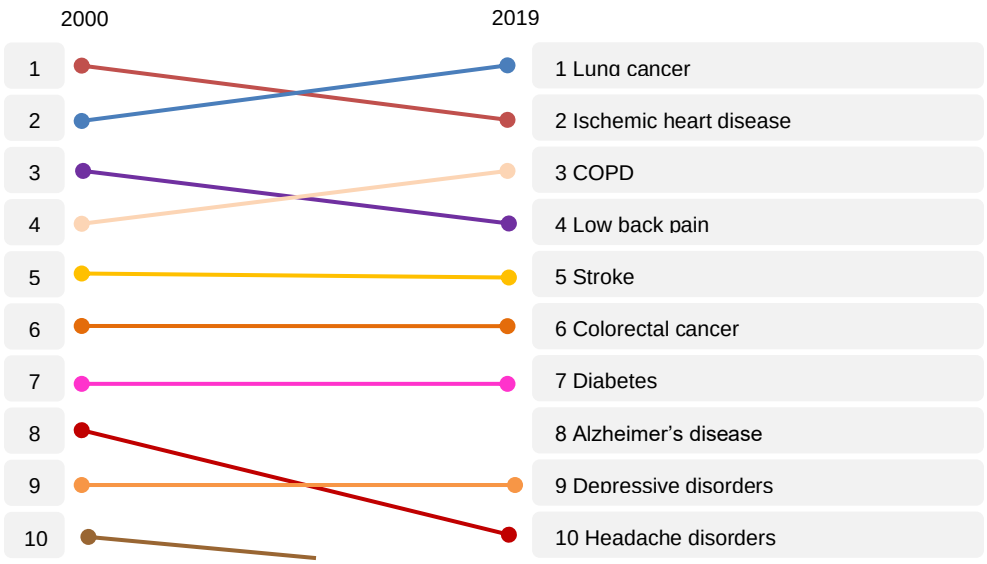

Figure 8. Ranking and evolution of the main diseases between 2000 and 2019.

Situation of main risk factors: physical activity, sedentary lifestyle, tobacco, alcohol, dietary habits, hypertension, and any other relevant to the country.

The good health status of the Dutch population is linked to a range of determinants. Data from IHME suggests that more than a quarter (26%) of the overall burden of disease in the Netherlands in 2015 (measured in terms of DALYs) is linked to behavioural risk factors – including smoking, poor diet, low physical activity, and alcohol use. Of risky behaviours in the Netherlands, smoking and dietary factors contribute the most to poor health, the latter by impacting on overweight and obesity (See figure 9).

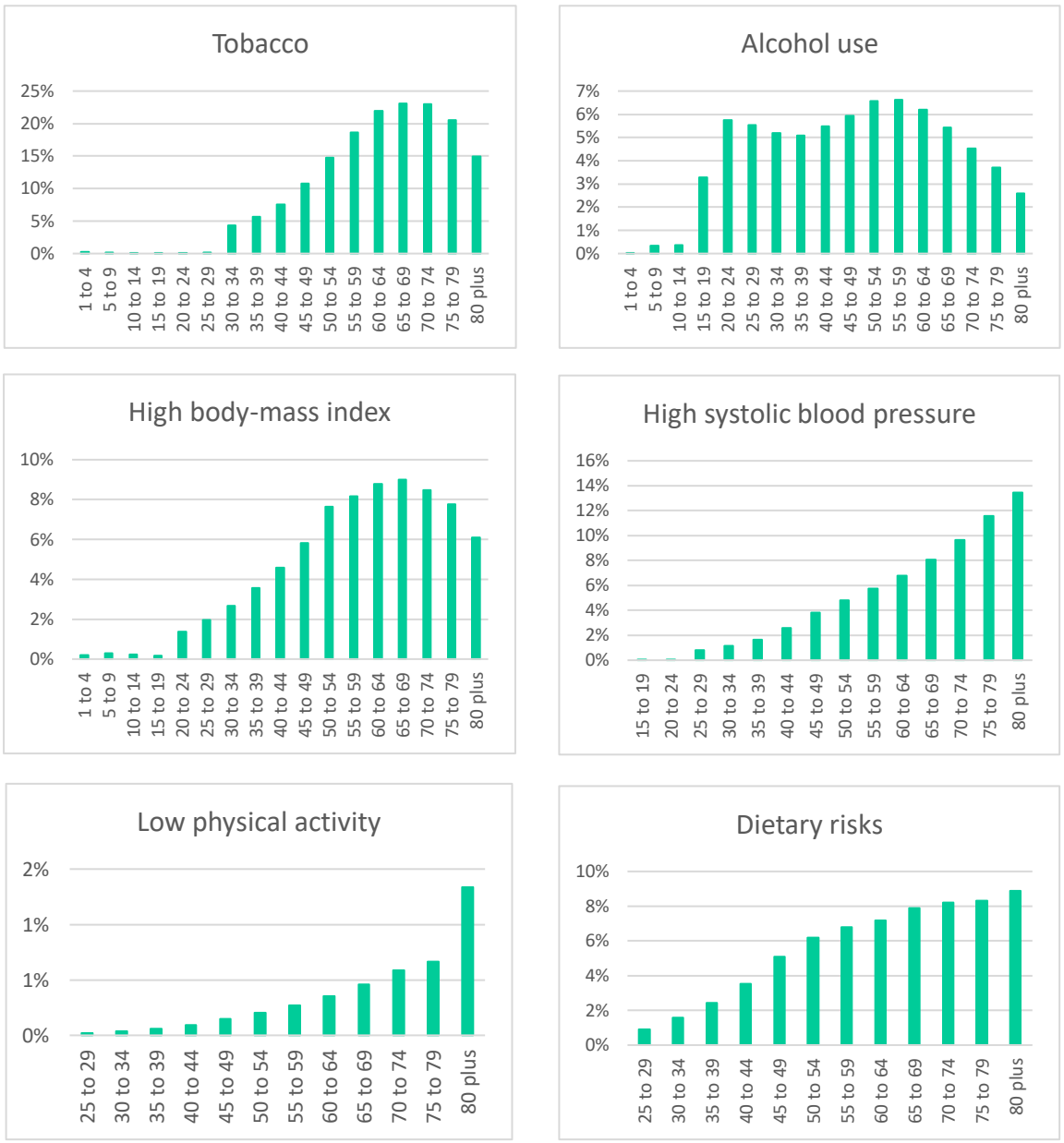

Figure 9. Risk factors divided by age

Data on living conditions and social protection: population on social wages

The Participation Act (*Participatiewet*) guarantees a minimum income for everyone who is living legally in the Netherlands and who has insufficient means to maintain themselves.

People have the right to social assistance benefit if they:

- are living legitimately in the Netherlands
- are at least 18 years old;
- a single person, single parent or family have an income that is lower than social assistance norm;
- cannot claim any other benefit;
- have assets that do not exceed a certain sum;
- are not in jail or a detention centre.

Assets may not exceed a certain maximum for married couples, couples living together or single parents, and a different maximum for single people. Assets include not only savings, but also assets such as for example a car. If someone owns a home, then its value will also be taken into account when assessing your assets.

If someone receives a social assistance benefit, he/she must do everything possible to find work. Single parents with a child up to 5 years old do may request dispensation from the obligation to look for work. The parent is, however, obliged to attend training courses.

3. Health system

A comprehensive reform in 2006 established a single private insurance market under regulated competition. Before 2006, the Dutch health system was based on social insurance combined with a private insurance scheme covering the better-off. All residents are now mandated to purchase insurance policies, which cover a defined benefit package. Insurers must accept all applicants and are expected to contract providers based on quality and price.

The government acts as supervisor of the health insurance, purchasing and provision markets aided by watchdog agencies such as the Authority for Consumers and Markets (fair competition), Health Care Authority (supervision and price regulation) and the Health Care Institute (care quality standards and insurance package advice). Both insurers and providers have been consolidating, in part to strengthen their market positions, and four insurers, each carrying various brands, now cover almost 90% of the market.

Health spending in the Netherlands is high: EUR 3 954 per head in 2015. This is 10.7% of GDP and the fourth highest in the EU (which averages 9.9%). It is also increasing (up from 9.4% in 2005) but broad sectoral agreements in 2012 have flattened the cost curve. High overall spending is mainly due to comparatively large long-term care expenditure. Over 80% of health spending is publicly funded, although the share of out-of-pocket spending has increased and become a topic for public debate.

Governmental or scientific stated needs based on demographics and epidemiology

The National policy document on health presents five spearheads on health: overweight and obesity, diabetes, depression, smoking and (excessive) alcohol consumption. Next, the government places great emphasis on exercise and physical activity.

The government's vision in regards to public health considers three main themes:

1) confidence in health protection:
   - · a healthy start: family and school
   - · living in a healthy neighbourhood
   - · work is healthy and healthy working can be improved

2) care and sport in the neighbourhood:
   - · healthcare providers active in prevention
   - · screening, health checks and prevention of specific conditions

3) personal lifestyle decisions:
   - · basic protection at required standard
   - · availability of healthy food
   - · food and product safety
   - · a healthy environment

Development of strategies and policy actions to support healthy ageing across the lifespan (i.e.: equipment, social actions, governance, changes in the training of professionals…).

Prevention for the elderly is part of the care chain, not only connected to cure and care, but also with living and well-being. The preventive measures and interventions are in the field of both healthcare and social sector. It mainly concerns local activities on the basis of the Wet Publieke Gezondheid (WPG) and the Wet Maatschappelijk Ondersteuning (WMO). But also some interventions for individual elderly people based on the AWBZ and Zvw that are financed, fall within the broad definition of prevention.

Many organizations are involved in development and carry out prevention. There are many different organizations in the Netherlands involved in prevention aimed at the elderly. It includes national as well as regional and local organizations.

They focus on: - physical, psychological and social functioning;
- disease-oriented prevention aimed at health promotion;
- depression prevention
- preventive offer for people younger than 65 years

These programs focus on themes such as: influenza, breast cancer, physical activity, psychological disorders, loneliness, dementia, healthy or successful aging, self-reliance or fall prevention.

Most organizations do not specifically target the elderly. National organisations, such as Vilans, Elderly Unions and various thematic institutes, are concerned with the agenda, development and organization of prevention for the elderly. The regional and local organizations are responsible for its implementation. Many professionals from the care and welfare sector, (voluntary) employees of ecclesiastical and private organizations, such as the Salvation Army and Red Cross, and volunteers from organizations such as Humanitas and Zonnebloem, preventive activities. In addition, the elderly themselves are an important provider of preventive activities
for the elderly population. They accomplish this as volunteers in senior citizens' unions or in collaboration with welfare organizations as a voluntary elderly advisor.

Data regarding the application of the Global Strategy and Action Plan on Ageing and Health, GSAP (WHO, 2016), which focuses on five strategic objectives:

In recent years, the Dutch cabinet, together with responsible parties, has already focused on this change with the central goal: the right care in the right place. This has led to many new initiatives regarding the prevention, relocation and replacement of care. However, more is needed to make our healthcare more secure and full-proof. Both, the urgency (“the why”) and the direction (“the what”) of the much needed change in healthcare is becoming increasingly clear. That is why it is now important to determine together 'how' we will take the change further and what is needed locally, regionally and nationally.

Without measures, we will fail to achieve the three public goals in our care - quality, accessibility and affordability. This requires adjustments by all parties involved (government, providers, buyers and citizens). In recent years, efforts have been made to achieve this necessary transformation through numerous processes. We strive for the well-being of people which is central as health care is integral, starting with the neighbourhood and focussing further away only if it is better as quality and/or efficiency are crucial. We strive for person-oriented care that is in line with what people need to be able to organize their lives in the best possible way with an illness or condition.

The measures focus on 3 main themes:

• Prevention & Health. A move is needed from the current focus on disease and care towards promoting health and well-being. It should be less about 'the patient' and more about 'people' and how he or she wants to give meaning to his or her life. This calls for better embedding in our health care of prevention, lifestyle and self-management and a stronger investment in the social base and efforts to tackle social problems at an early stage.

• Organization & Direction. To ensure that the care offers better and reflects what people really need. While increasing the efficiency of care, more far-reaching agreements are needed about the prevention, relocation and replacement of care. This requires an intensification of cooperation between all parties involved, across the boundaries of traditional domains and in the region. It is also important to improve coordination between different types of care. The complexity of the way we organise care should not lead to people not getting the help they need.

• Innovation & Job satisfaction. Innovation is essential to meet the challenges facing us to cope with. For example, innovation through e-health can help make care more personal and closer to home or at home. Innovation in the way of working is also necessary to give professionals more space and to promote their job satisfaction, so that working in care becomes more attractive. In order to enable care providers to tailor-make, more attention is needed for appropriate care, outcome-oriented care and electronic data exchange.

Educational needs that derive from the epidemiological situation regarding healthy ageing and how these needs have been incorporated into educational programs at different levels.

The report of the Dutch Health Care Institute, published in 2016, provides generic guidelines for learning and training in order to meet the demand for care in the Netherlands in the year 2030. This also applies to healthy ageing as part of a large set of developments.

These are:

Professional competence is the basis. It is aimed at promoting and, if necessary, restoring

health with a focus on the functioning, resilience and self-management of citizens. The starting point is a biopsychosocial model. This links care and welfare, among other things.

Cooperative capacity only develops if from the start of the training by putting the practice in education and teaching into practice. This is done by focusing on practical situations right from the start of the training and by solving them jointly and interprofessionally.

The learning ability of professionals is essential. Permanent learning in teams, organization and networks contributes to a better connection with the changing help and care demands. This applies in particular to living, learning and working with technology that is developing very fast. Personal development and the permanent sharing of knowledge can only take place in an environment that stimulates and facilitates learning with and from each other in the workplace and in networks.

The central concepts of functioning, resilience and self-management include biopsychosocial models such as the health model in the International Classification of Functioning, Disability and health (ICF) and the pillars of the positive health model.

To map the functioning and resilience (including the ability to age healthily) of the citizens, a positive model of health is used, which has 6 pillars.

1. Body functions a. Medical facts b. Medical observations c. Perceived health d. Physical functioning e. Complaints and pain f. Energy	2. Mental well-being a. Cognitive functioning b. Emotional state c. Self-esteem and respect d. Feeling of control (manageability) e. Self-management and self-direction f. Resilience g. Understanding your situation (comprehensibility)	3. Meaning a. Meaningfulness b. Pursuing goals and ideals c. Future perspective d. Acceptance
4. Quality of life a. Well-being b. Experience happiness c. Perceived health d. Feel comfortable in your own skin e. Lust for life f. Balance	5. Social and social functioning a. Social and communication skills b. Social contacts c. Meaningful relationships d. To be accepted e. Social involvement f. Meaningful work	6. Daily functioning a. Basic general daily life activities b. Instrumental daily life activities c. Health skills

The above mentioned aspects are cornerstones of all care and welfare courses in the Netherlands.

According to latest advice report of 'Sector Plan Higher Health Education 2020-2025' of the Association of Universities of Applied Sciences in the Netherlands, students should not only acquire professional competence in a specific field, but also acquire the competencies to optimally use that professional competence for comprehensive solutions for citizens that they develop together with professionals from other disciplines.

The starting points are that professional competence remains the cornerstone. It is and remains a pride of a specific professional identity. This professional identity is and will remain substantial in the relevant curriculum. To support citizens in directing and self-management in order to, for example, be able to grow old healthily, this requires not only great professional competence in their own field, but also skills to come up with integrated solutions for people with complex care needs, which concern several areas of life.

It is important to connect the healthcare and welfare sector in education. For interprofessional training, the courses must have a common conceptual framework. Currently, higher health education is provided by the Canadian Medical Education Directions (CanMEDs). The role of care or social worker is central to professional practice. The other roles are linked and transcendent. Roles as a collaborator, communicator, organizer and (practical) researcher are just as important and enable interprofessional collaboration. The use of a common organization and roles and competencies benefits a consistent anchoring of interprofessional learning in curricula. The International Classification of Functioning, Disability and Health (ICF) model is an classification that is suitable for both care and welfare training.

Another premise is that interprofessional learning should start early in the curriculum. The joint development of interprofessional learning pathways is a requirement for this. To achieve this, a connection with practice and environment (society) with real issues is necessary.

In addition to interprofessional learning, additional competencies such as knowledge and skills in the field of technology and ICT and learning, inquisitive and entrepreneurial attitude are competences that all courses must pay attention to in the curriculum.

All of the above forms a vision and a basis for curricula of training courses in the care and welfare domain, in order to be able to tackle issues surrounding healthy ageing.

In the Netherlands, all study programs try to incorporate advice from the above reports into curricula. There are also quite a few examples in the Netherlands where and how healthy assessment takes place in curricula. For example, education is integrated in many study programs, both professionally and inter-professionally. An example of a program in the field of healthy weight is for example from Hanze Hogeschool Groningen, the Netherlands. Education is multidisciplinary and focused on innovation. It is interwoven in study components and projects in the major, the minors and the specializations. All courses in the Care & Welfare sector are strictly prohibited with the theme Healthy Ageing. Healthy Ageing education is strongly linked to practice-oriented research in the knowledge centers, with the research centers and with the innovation workshops. This university of applied sciences also has a specific master in Healthy Ageing (Healthy Ageing Professional).

This same type of master also exists at Fontys Hogeschool Eindhoven Netherlands. The bachelor's degree programs deal with the professional components in the curriculum that are necessary to guide people with healthy ageing. These are specific professional skills. Furthermore, all courses follow the advice of 'Zorg Instituut Nederland' and 'HGZO' to give shape to interprofessional training. For example, Utrecht University of Applied Sciences recently started projects in 'healthy and well in the neighborhood', 'healthy and well in the clinic',' interprofessional preventive health checks'. All these projects work with issues from practice (mono-disciplinary, multidisciplinary and inter-professional). The students, teachers, professionals and researchers then work together to solve these issues. For example, in the project healthy and well in the neighborhood, a situation was created in which 1 teacher from the care domain and 1 teacher from a welfare domain teacher work on location with a local partner and guide students on location to solve social issues. Healthy ageing throughout life is part of this. This concept has already fully been successfully implemented at Arnhem and Nijmegen University of Applied Sciences.

There are also various initiatives in the field. Examples are Healthy Ageing in the UMCG (Healthy Aging in the UMCG), Healthy Ageing Network in Northern Netherlands (Europe ›Healthy Ageing Network www.hannn.eu , Healthy Ageing Campus (Healthy Ageing Campus› Campus Groningen), Vitality Oriented Innovations for the Lifecourse of the Ageing Society (VOILA) consortium (VOILA - Dutch Association for Ageing Research (www.dusra.nl); Vitality and Ageing master of science (Vitality and Ageing (MSc) - Leiden University (universiteitleiden.nl))

4. Key findings and population needs

The increased life expectancy and the low fecundity rate in the Netherlands is having an important impact on the ageing index. This has two important effects in the Health System. First, it increases health care needs and second, it decreases its funding due to the decrease of the working force. The main challenge in the future years will be how to deal with this situation whereas finding other ways to increase the budget or improve the system's efficacy.

Increases in life expectancy are mainly the result of a consistent reduction of premature deaths from cardiovascular diseases, resulting in one of the lowest overall rates in Europe. Indeed, for men, cancer has now become the main cause of death in the Netherlands while, for women, cancer and cardiovascular disease as a cause of death are about the same level.

Data shows that the overall burden of disease in the Netherlands is linked to behavioural risk factors – including smoking, poor diet, low physical activity and alcohol use. Of risky behaviours in the Netherlands, smoking and dietary factors contribute the most to poor health, the latter by impacting on overweight and obesity.

The Dutch health system is a single private insurance market under regulated competition. All residents are now mandated to purchase insurance policies, which cover a defined benefit package. Insurers must accept all applicants and are expected to contract providers based on quality and price. The government acts as supervisor of the health insurance, purchasing and provision markets.

Health expenditure in the Netherlands is increasing (up from 9.4% in 2005), but broad sectorial agreements in 2012 have flattened the cost curve. High overall spending is mainly due to comparatively large long-term care expenditure.

The National policy document on health presents five spearheads on health: overweight and obesity, diabetes, depression, smoking and (excessive) alcohol consumption. Next, the government places great emphasis on exercise and physical activity.

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