



**Report on the Regional Implementation Strategy (RIS) of the  
Madrid International Plan of Action on Ageing (MIPAA) in  
The Netherlands**

*Third Review and Appraisal*

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## Abbreviations list

AOW	General Elderly Act (Algemene Ouderdomswet)
AWBZ	General Exceptional Medical Expenses Act (Algemene Wet Bijzondere Ziektekosten)
CBS	National Statistics Bureau (Centraal Bureau voor Statistiek)
CIZ	Care Assessment Centre (Centrum indicatiestelling zorg)
GDP	Gross Domestic Product
HOVO	Higher Education For Elderly (Hoger Onderwijs Voor Ouderen)
IGZ	The Health Care Inspectorate (Inspectie voor de Gezondheidszorg)
LE	Life Expectancy
LTC	Long Term Care
MIPAA	Madrid International Plan of Action on Ageing
MIPAA/RIS	Regional Implementation Strategy (RIS) for MIPAA for the UNECE region
OECD	Organisation for Economic Co-operation and Development
SCP	The Netherlands Institute for Social Research (Sociaal en Cultureel Planbureau)
SES	Social Economic Status
UNECE	United Nations Economic Commission for Europe
UWV	Dutch Social Security Agency
VNG	International Cooperation Agency of the Association of Netherlands Municipalities (Vereniging van Nederlandse Gemeenten)
VUT	Early retirement scheme (Vervroegde uittreding)
Wkkgz	Quality, complains and disputes in healthcare Act (Wet kwaliteit, klachten en geschillen zorg)
Wlz	Long Term Care Act (Wet langdurige zorg)
Wmo	Social Support Act (Wet Maatschappelijke ondersteuning)
Zvw	Health Insurance Act (Zorgverzekeringswet)

## Introduction

In 2002, national governments from all over the globe came together at the Second World Assembly on Ageing in Madrid, to resolve and adopt a global Plan of Action (i.e. The Madrid International Plan of Action on Ageing MIPAA) “to respond to the opportunities and challenges of population ageing in the twenty-first century and to promote the development of a society of all ages” (Political Declaration MIPAA United Nations 2002, Art. 1). As a follow-up to the MIPAA, a regional conference in 2002 with the UNECE member states in Berlin was held, to establish a Regional Implementation Strategy (RIS) for the UNECE region to carry out the commitments made in the MIPAA. One of the promises made in the RIS is to provide every five years an update on the current state of implementation of MIPAA/RIS. In 2007, the first reviews were published, and in 2012 the second cycle was finalized. This report is the 3<sup>rd</sup> MIPAA/RIS review for the Netherlands. The 3<sup>rd</sup> review report provides information on policies, strategies, legislation and special programmes on the implementation of the four main goals of the 2012 Vienna Ministerial Declaration, following the RIS commitments and the measures recommended by the Declaration.

The report contains two parts. Part I describes the national ageing situation with demographic, economic and social indicators; the social, economic and political situation; and the methodology for producing the report. Part II describes the National actions and progress in implementation of the main goals of the MIPAA/RIS Plan of Action. Hence, the aim of this report is not to provide an exhaustive overview of the policies or policy programs directed at older persons in the Netherlands.

For additional background information you are referred to the following key documents available on the ‘ageing’ section UNECE Population Unit’s website, [www.unece.org/population/ageing](http://www.unece.org/population/ageing):

- [Regional Implementation Strategy](#) (RIS) of the Madrid International Plan of Action on Ageing
- [Berlin Ministerial Declaration](#) – A Society for All Ages in the UNECE Region
- [Vienna Ministerial Declaration](#) – Ensuring a Society for All Ages: Promoting Quality of Life and Active Ageing

# Part I

## Executive summary

This report describes the achievements in the Netherlands addressing the four main goals of the 2012 Vienna Ministerial Declaration within the Regional Implementation Strategy (RIS) of the Madrid International Plan of Action on Ageing (MIPAA). This 3rd review report provides information on policies, strategies, legislation and special programs on the implementation of RIS/MIPAA in the past five years.

Encouraging longer working life (goal 1) was achieved by limiting options for early retirement and increase of the retirement age (AOW-age) to 67 years in 2021. Participation of older persons and social inclusion (goal 2) were addressed by supporting and protecting independency and participation of older persons in society via several national programs: The Longer Living Independently Program, the Elderly in Safe Hands Action Plan, and the Action Plan Against Loneliness. The main achievement in promoting dignity, health and independence (goal 3) was the reform of the long term care system carried out by the Dutch government during recent years. Other policy programs are aimed to facilitate and support this major reform. Intergenerational solidarity (goal 4) is integrated in describing the achievements for the goals 1 to 3.

This 3rd RIS/MIPAA review report shows that most of the recommendations in the previous RIS/MIPAA report have been addressed over the last 5 years. These achievements contributed to the quality of life of older persons in their social context, whereby human dignity and tailored measures - addressing individual needs - were main building blocks of these policy developments. All these policy developments as a whole built upon the fundamentals of solidarity.

## General information

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4. *Name, reference, and date of adoption or status of preparation of national strategy, action plan or similar policy document on ageing (please attach relevant documents in the annex):* N.A.



## 1.1 National ageing situation

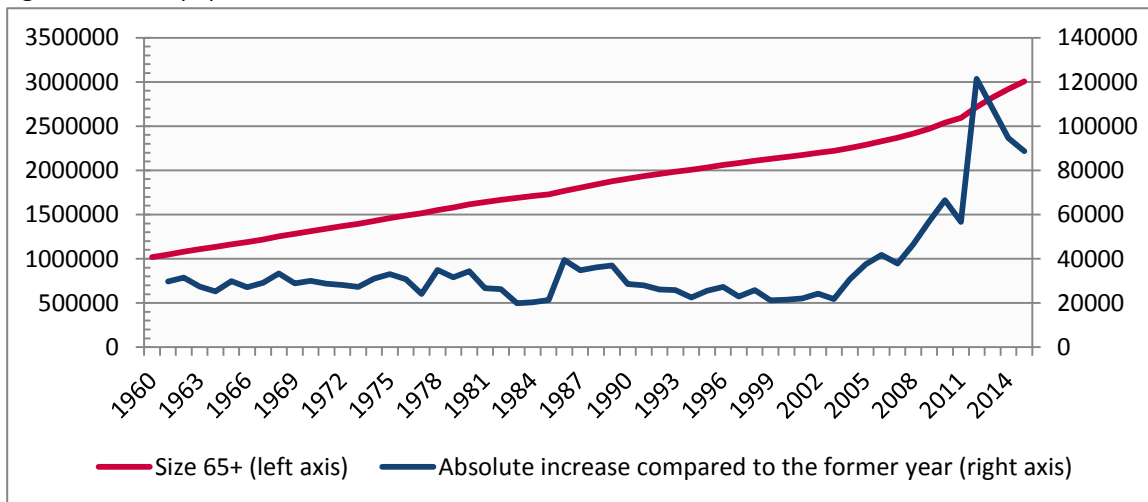
### 1.1.1 Demographic indicators

The Netherlands experienced a gradual increase in the total size of people of the age 65 and over. Figure 1 presents the absolute annual increase compared to the former year, showing a rise in the absolute increase of people in the age category 65 and over from 2003 onward, with a significant peak from 2012 to 2014. This increase represents the baby boom generation, whereby around 2.4 million babies were born just after World War Two (1946-1955) and the peak signifies the baby boom generation entering the age of 65. This generation is also noticeable in Figure 2 and Figure 3, where in 2005 the baby boom generation was in the age group 50-54 and 55-59. Figure 2 shows a noticeable smaller share of people aged 0-25, which indicates a slowdown in the growth of the population. In Figure 3, a contracting population pyramid and ageing population unfolds in 2015. Notable, both population pyramids show a higher share of women in the older age categories. In 1981, a 60 year old man had a life expectancy of another 18 years, for women this was 23 years at the age of 60, a difference of 5 years. In 2014, the gender life expectancy gap shrank to less than 3 years (Figure 4). The CBS (National Statistics Bureau) warns for the slowdown in the upward trend of life expectancy by women, due to an increasing unhealthy lifestyle, while men seem to have decreased their amount of smoking over the years (Centraal Bureau voor de Statistiek (CBS), 2016<sup>a</sup>).

Reaching older age is also connected to an increase in the burden of chronic diseases. This is represented in Figure 5, where the years in perceived good health are shown. The takeaways of this graph are that there is an increasing trend over the years that people perceive themselves to be in good health, that the gender gap for good health is much smaller compared to the gap in life expectancy, and that the number of remaining years in good health is much lower than the life expectancy (Figure 4). The years in perceived good health at the age of 60 fluctuates around 13 to 14 years. To put all of this in perspective, the number of people aged 65 and over has increased, but those aged 65 now differ from those aged 65 in 1950. Someone aged 71 now has the same remaining life expectancy (15 years) as someone aged 65 in 1950. The share of people expected to live another 15 years only slightly increased (Figure 6) (van der Gaag & de Beer, 2014). Hence, the Dutch society is getting older but as soon as one takes the number of years expected to live into the equation, the society appears to be less ageing. Figure 7 shows the percentage being inactive -in the age group 75 and over- is related to the higher number of people dealing with complications hampering to be active. Smoking and drinking behaviour figures show that among the age group 55-64 around 25% smoke, for drinking behaviour this is less. The decreasing share of people who smoke and drink per age category, indicates that the mortality among this group is likely to be higher. Note that these figures do not take into account the complete life course perspective, while smoking and drinking at young age could have significant long-term health consequences. The high percentage of older people who classify as being overweight is a point of concern in the Netherlands. Although not shown in Figure 7, along with overweight, malnutrition of older persons is also considered as a serious risk. Of older persons in nursing- and residential care homes, 19% are estimated to cope with undernutrition, and for home-care the estimates are between 10 to 35% (Halfens, et al., 2015) (Schilp, et al., 2012).

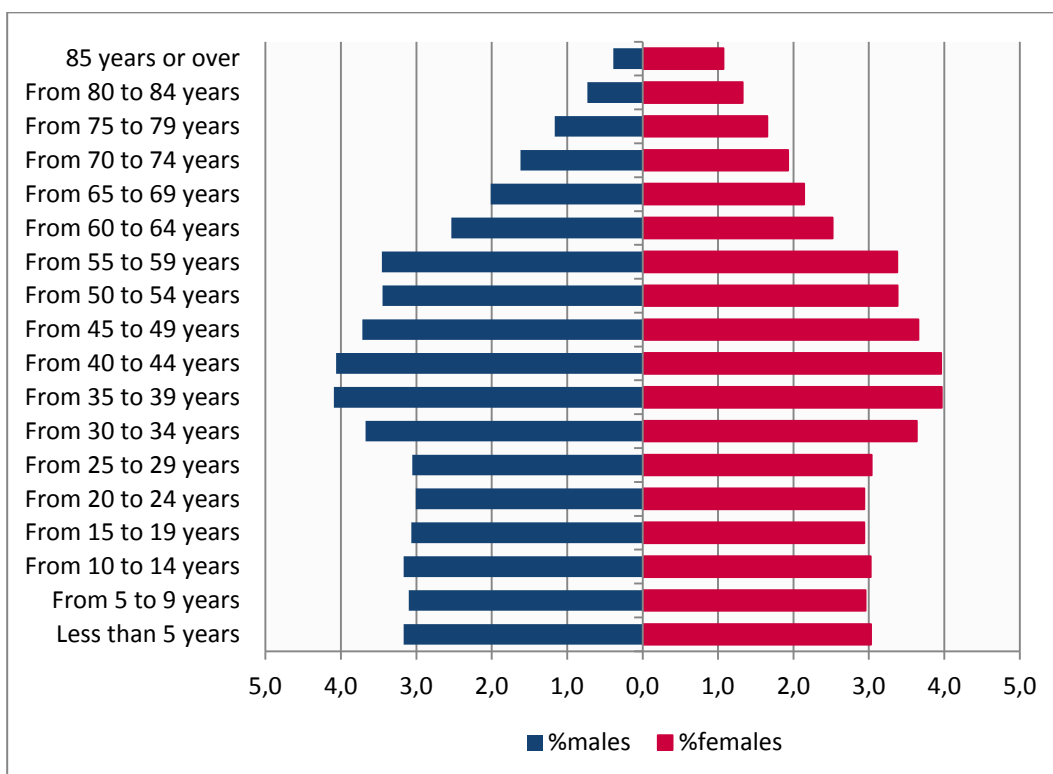
Annex: Demographic indicators

Figure 1. Size of population 65+ and absolute increase 65+



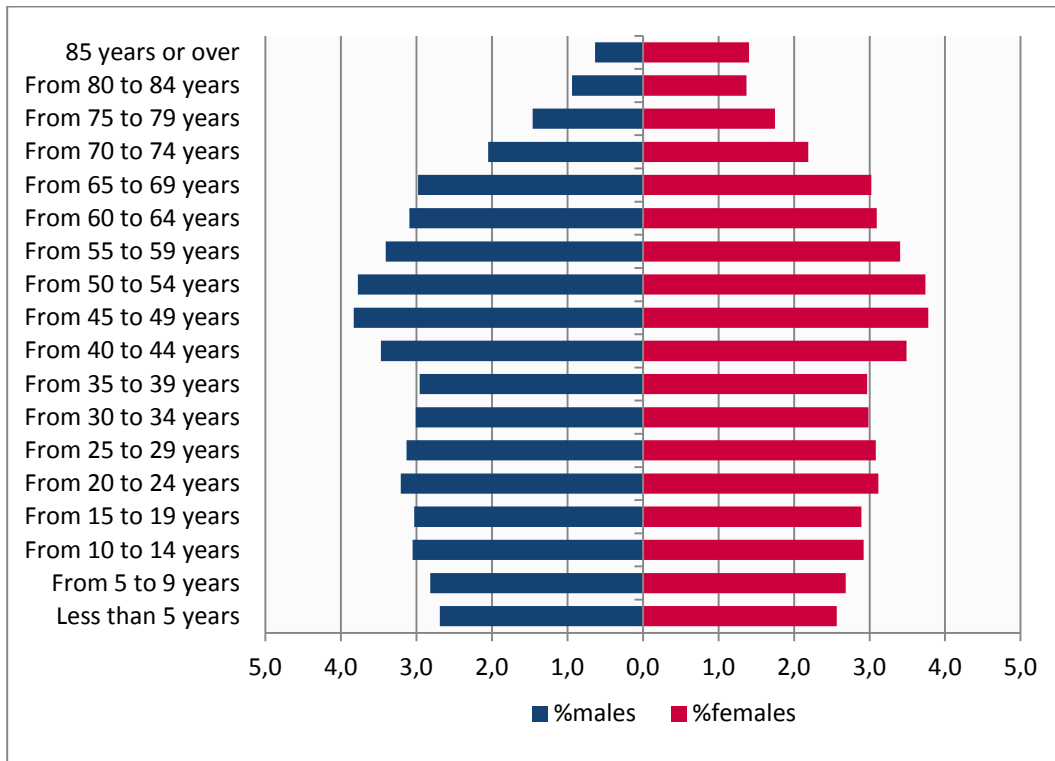
Source: CBS, last update 26-11-2015, Bevolking; kerncijfers

Figure 2. Population pyramid, The Netherlands in 2005



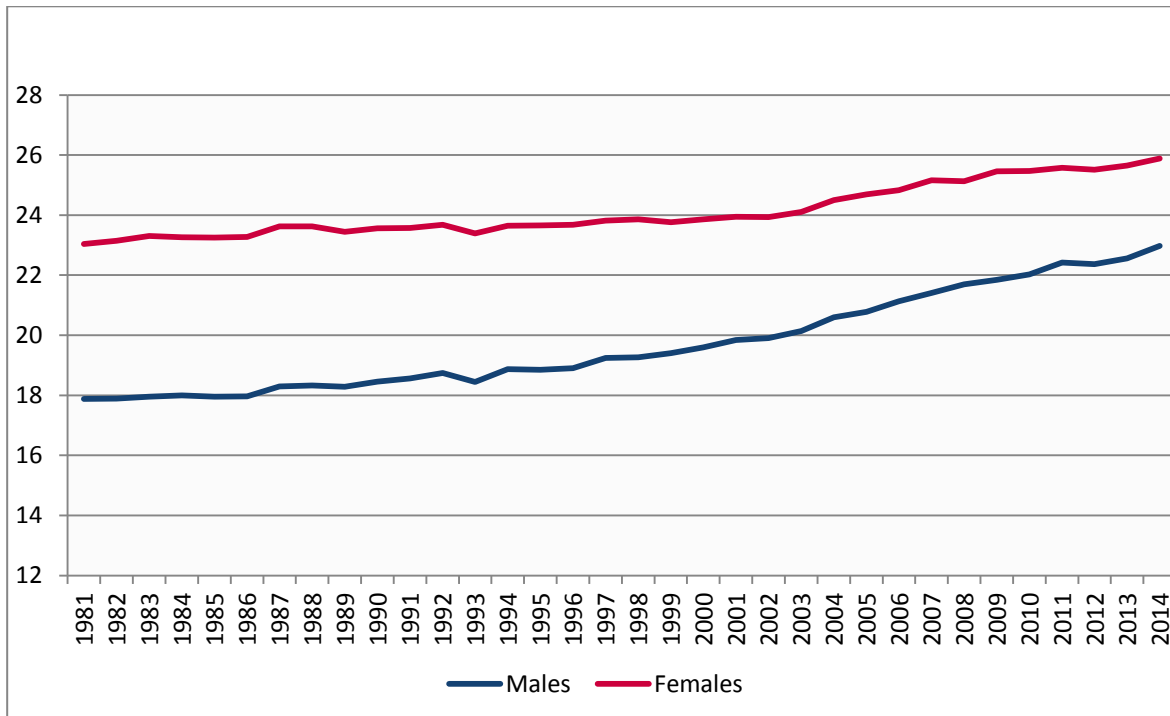
Source: Eurostat 2016, last update 22.04.2016, demo\_pjangroup

**Figure 3.** Population pyramid, The Netherlands in 2015



Source: Eurostat 2016, last update 22.04.2016, demo\_pjangroup

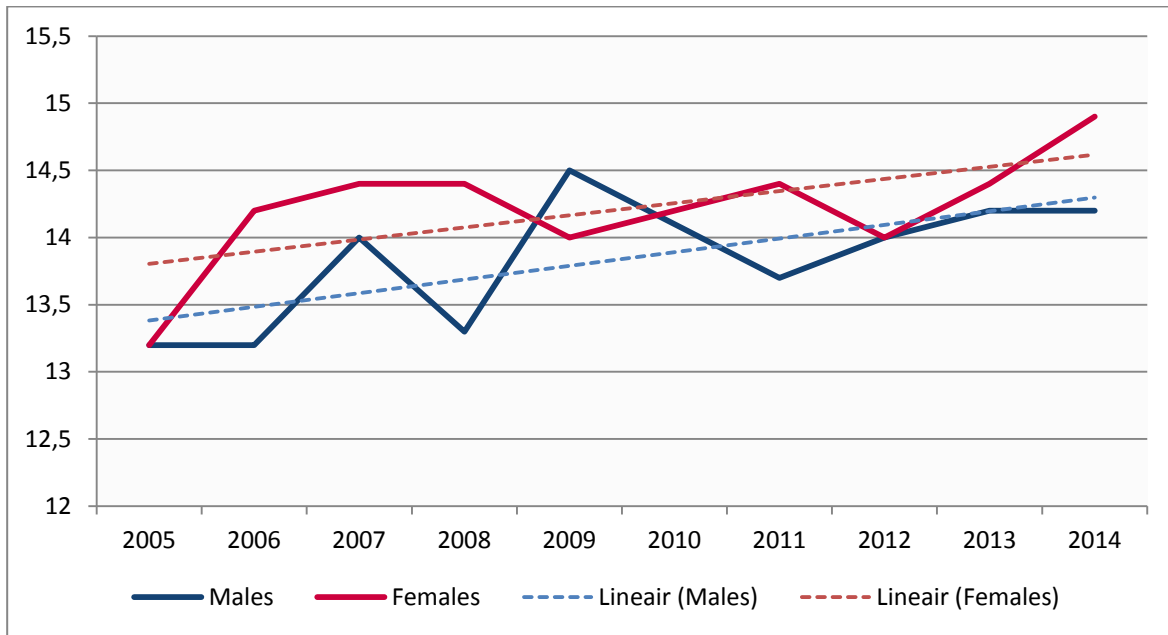
**Figure 4.** Life expectancy from 60 years old: 1981 - 2014



Source: CBS, last update 18-01-2016, Gezonde levensverwachting; vanaf 1981

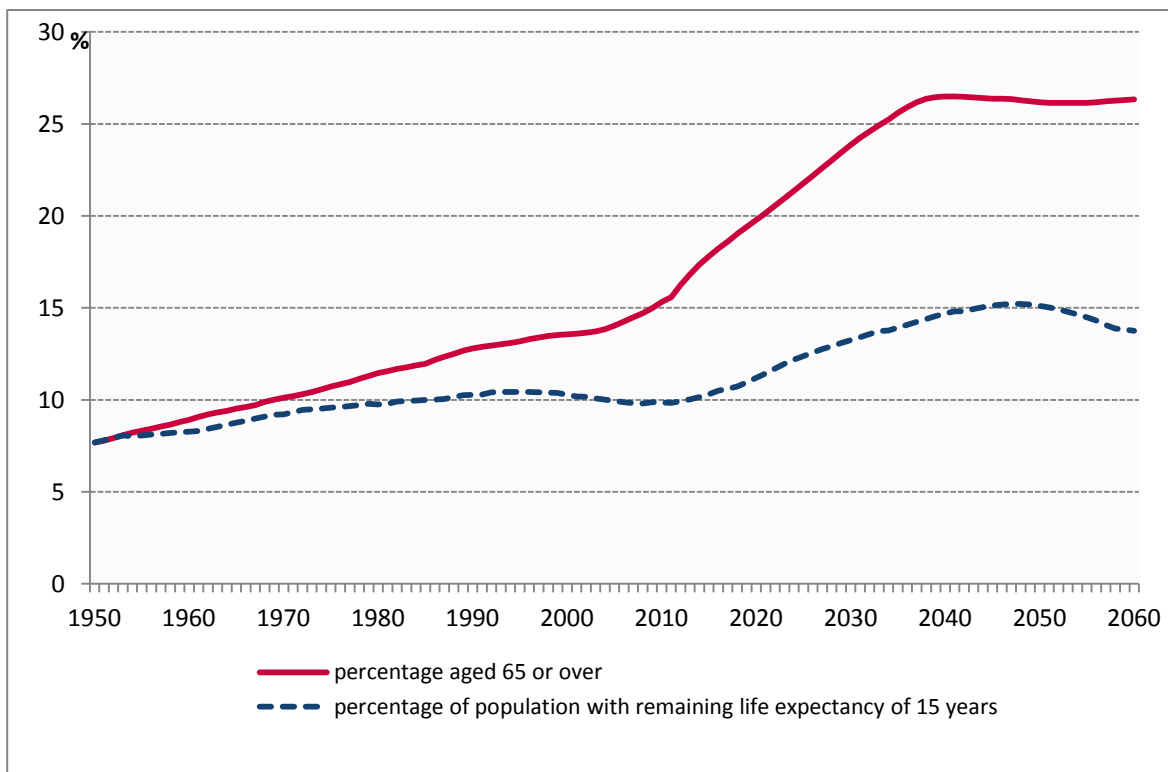


**Figure 5.** Life expectancy in perceived good health from 60 years old



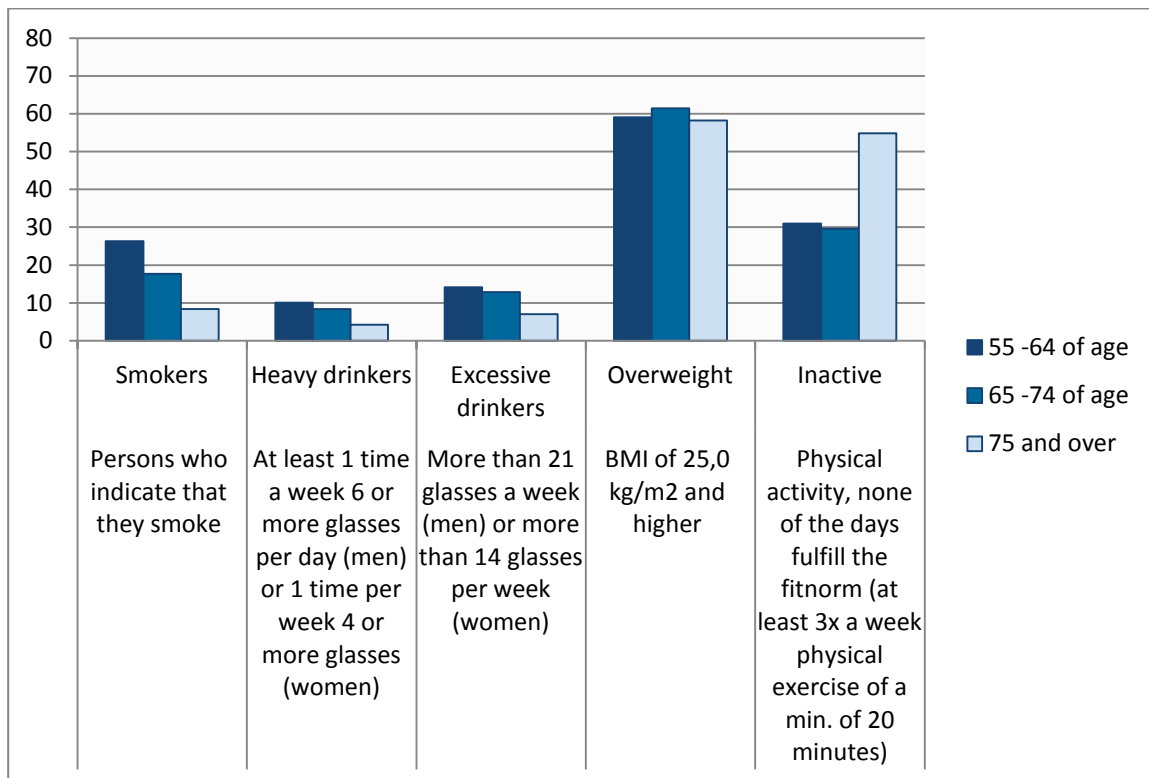
**Source:** CBS, 18-01-2016, Gezonde levensverwachting; vanaf 1981

**Figure 6.** Two indicators of population ageing: percentage of population aged 65 or over and percentage of population with remaining life expectancy of 15 years



**Source:** van der Gaag en de Beer 2014. Relying on data from the Netherlands Statistics and calculations NIDI

**Figure 7.** Lifestyle and health status in 2015, percentages over the total age group



**Source:** CBS, last update 05-04-2016, Leefstijl en (preventief) gezondheidsonderzoek; persoonskenmerken

## 1.1.2 Key quantitative social and economic indicators

The Dutch population gets older, and enjoys more years in good health from the age of 60 and over. This trend is also mirrored in the average age that people start to retire, primarily due to an institutional change to increase the effective retirement age (see Section II). Figure 8 illustrates a significant higher share of people entering their retirement at the age of 65 or over in 2015 (59.1%) compared to 2000 (13.5%). This makes the share of people who enter their retirement younger than 60 and between 60 and 65 much smaller. In 2015, 4.8% of the employees who retire are younger than 60, while in 2000 this was almost 25.9%. Figure 9 also illustrates the same movement, the increase in the average pension age, climbing from just below 61 in 2006 to an average of 64 years in 2015. Since 2000, the total number of persons entering their pension kept increasing, with a significant peak in 2006. The reason for this peak was primarily due to the number of people who decided to retire just before the introduction to phase-out early retirement schemes (more on this in Section II p.17).

This transfer toward extending working lives is also shown on the employment side, whereby the share of people between 55 and 65 in employment is growing and in parallel the share of people inactive on the labour market is decreasing (Figure 10). Also the percentage of people aged 55 to 65 in unemployment is increasing. Unemployed men aged 55 to 65 accounted for 3,7% -over the total active and non-active workforce aged 55 to 65- in 2012 and grew to 6,5% in 2015. Among women aged 55 to 65, unemployment rose from 2,6% in 2012 to 4,3% in 2015. This significant increase is partly caused by the replacement of people who would have been defined as inactive before working lives were extended. Another notable trend, that deserves attention here, is the geographical representation of the older population, since this is not equally distributed over the country. There are areas where the population is shrinking, and these regions are mostly located in the more rural areas since the younger population move towards the more urban areas (the West) for study and/or working purposes. Consequently, these areas are dealing with declining business activity, resulting in fewer facilities in these regions, and thus less economic and social activity in the region. These areas are mostly marked with an increasing old age dependency ratio. This is shown in Figure 11, whereby the dark areas represent the high share of old people within a region and this overlaps with the areas that also experience a shrinking population.

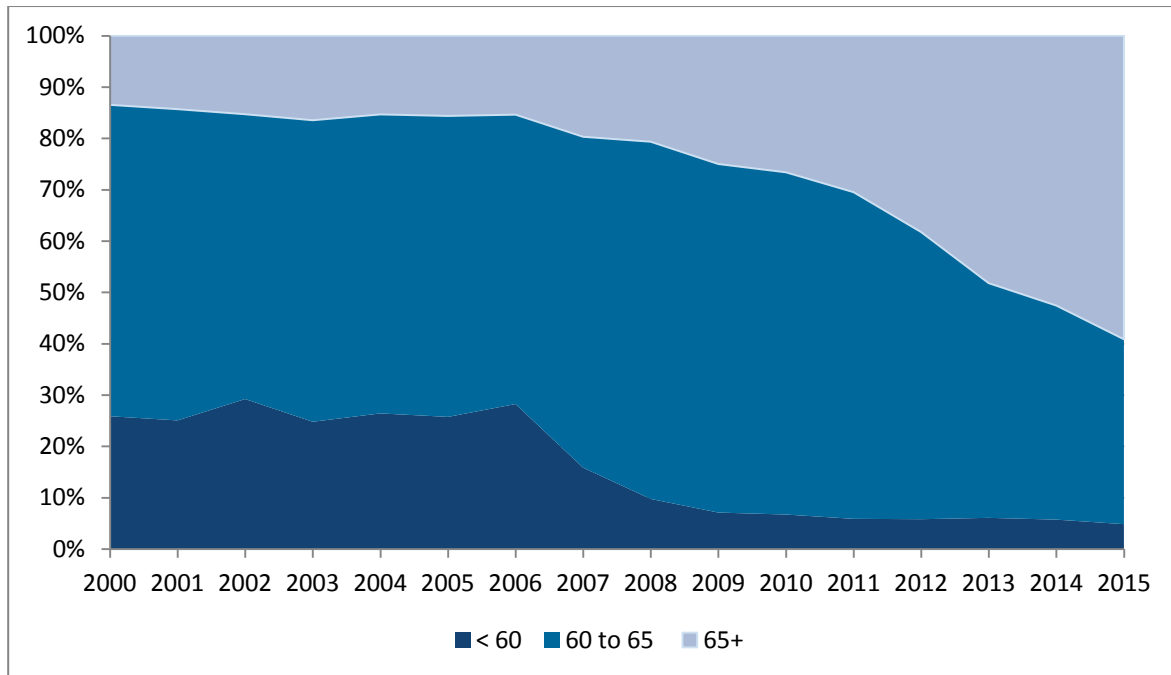
The comprehensive pension scheme in the Netherlands safeguards the economic status after retirement. In 2014, the people ageing 65 and over, who are not active on the labour market, received an average standardized disposable income of €23 600.<sup>1</sup> This is an increase of 4.9% compared to 2010. While the ones who are still active on the labour market receive an average of €37 800 per year in 2014, representing an increase of 3.0% compared to 2010 (CBS, Gemiddeld inkomen; personen in particuliere huishoudens naar kenmerken 2015). A recent study showed that the median replacement rate at retirement is 86% of the net income per household, this percentage includes multiple factors related to income (Knoef, Been, Caminada, Goudswaard, & Rhuggenaath, 2016). One of the themes in MIPAA is to eradicate poverty in old age (United Nations 2002: 12, b). The Netherlands is performing better in this regard compared to the EU average; there is a smaller gender difference and the average percentage of older persons that are at risk at poverty is much lower than the EU average (Figure 12).

In the Annex, complementary indicators are included - provided by the UN working group – for labour market, participation in society, independent, healthy and secure living, capacity, and enabling environment for active ageing.

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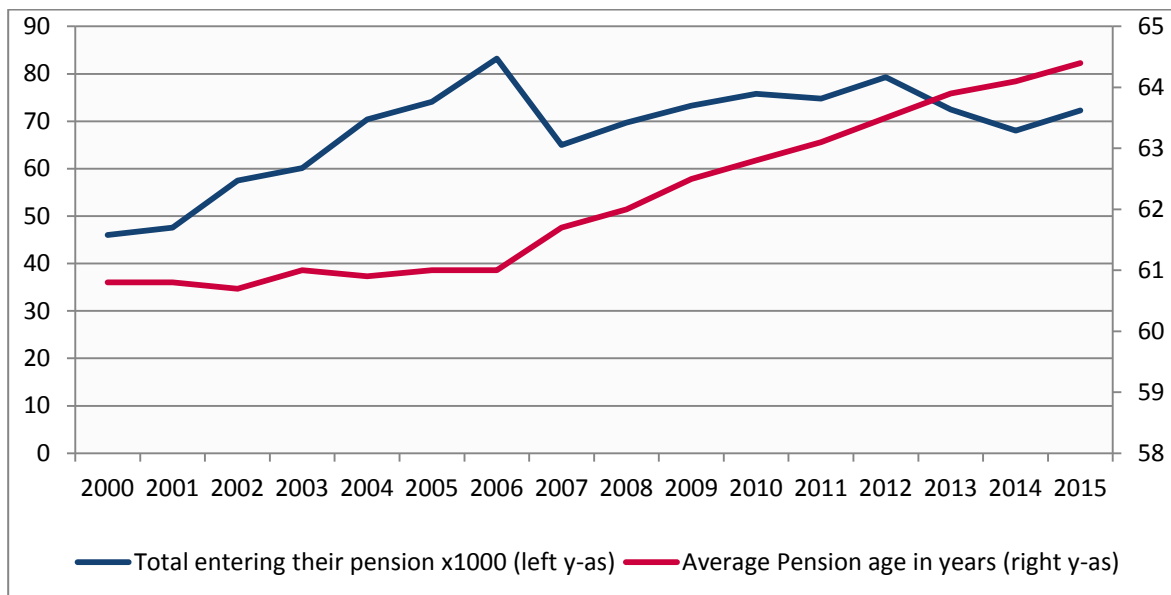
<sup>1</sup> Income represents standardized disposable income, controlled for the size and composition of the household

**Figure 8.** Retirement age of employees over the years



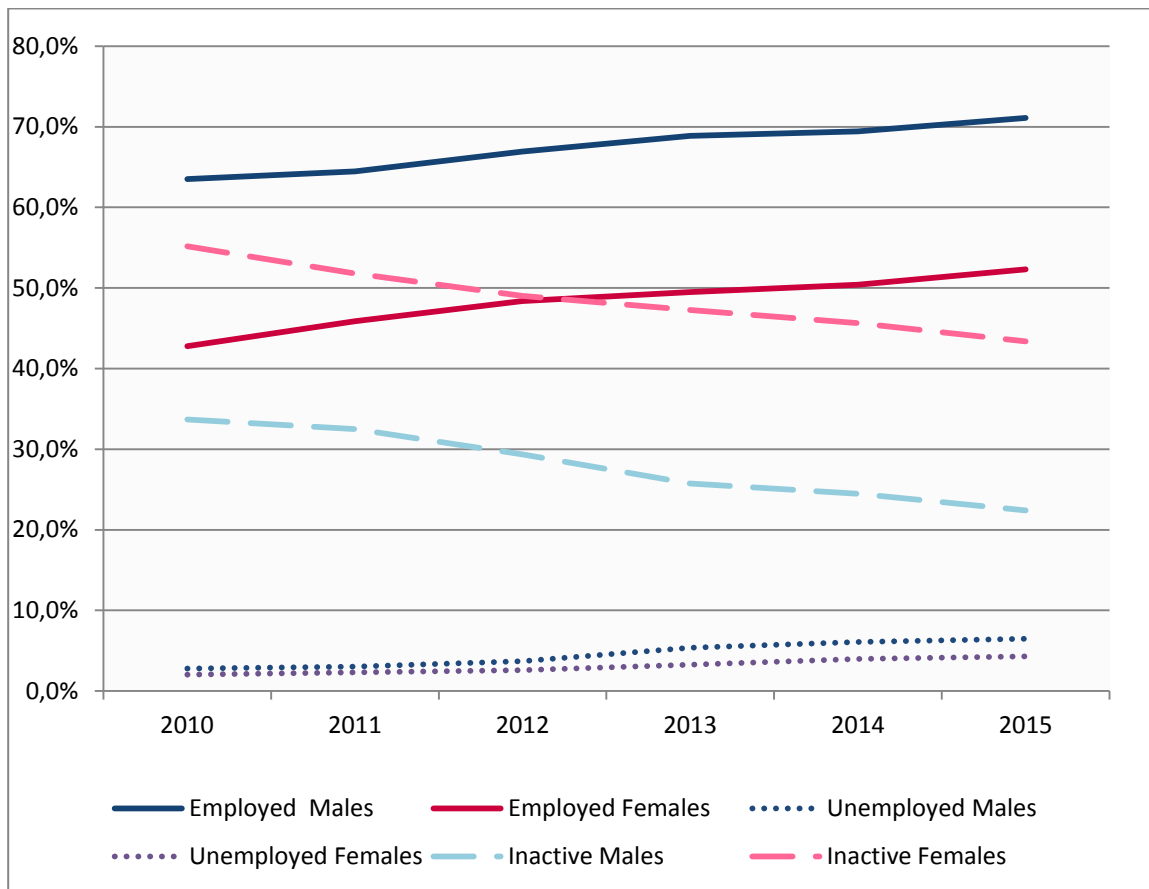
Source: CBS, 01-03-2016, Van arbeid naar pensioen; personen 55 jaar of ouder

**Figure 9.** Number of employees starting their pension and average age



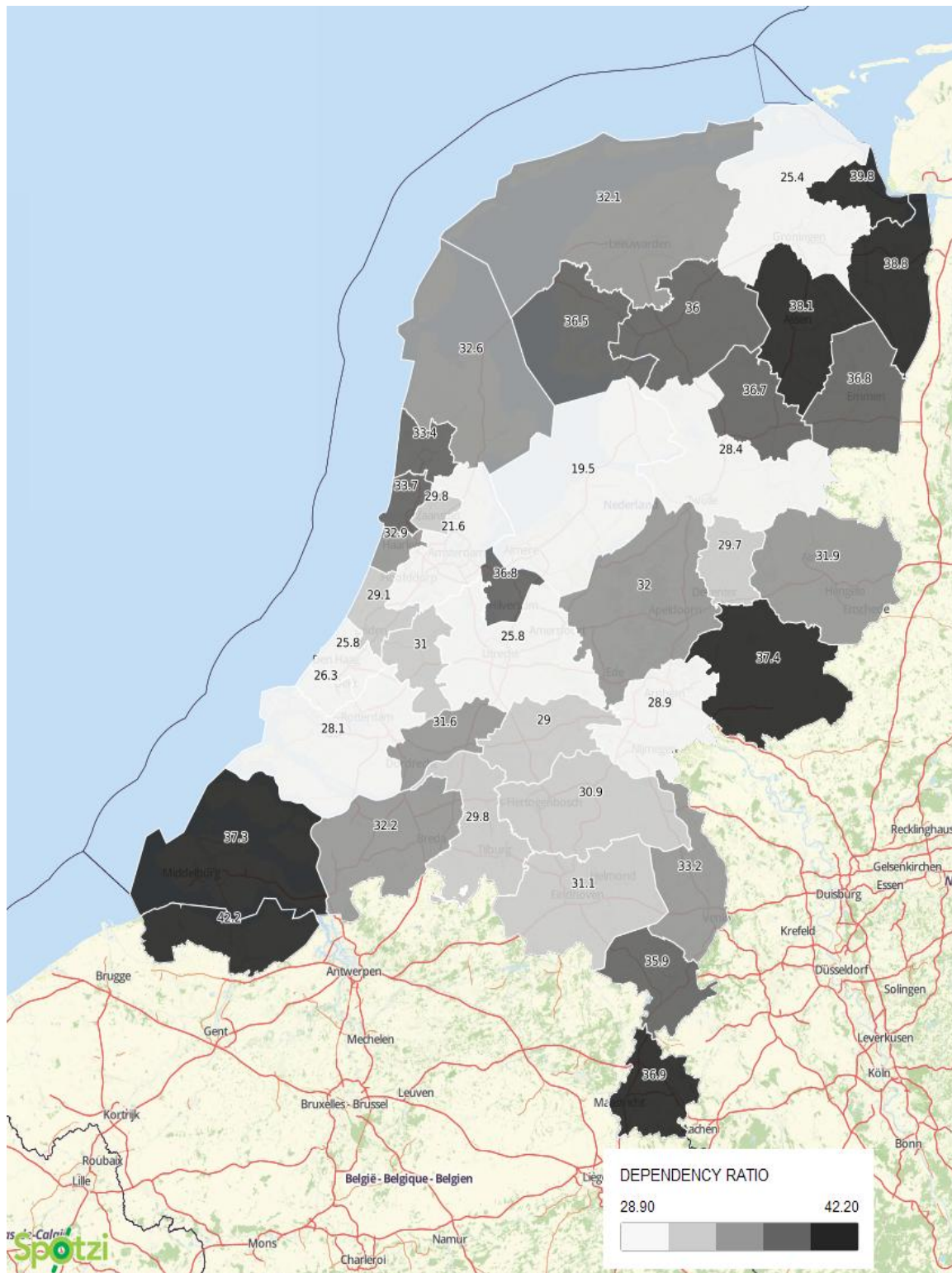
Source: CBS, last update 01-03-2016, Van arbeid naar pensioen; personen 55 jaar of ouder

**Figure 10.** Employment participation for 55-65 years (excludes people in institutions)



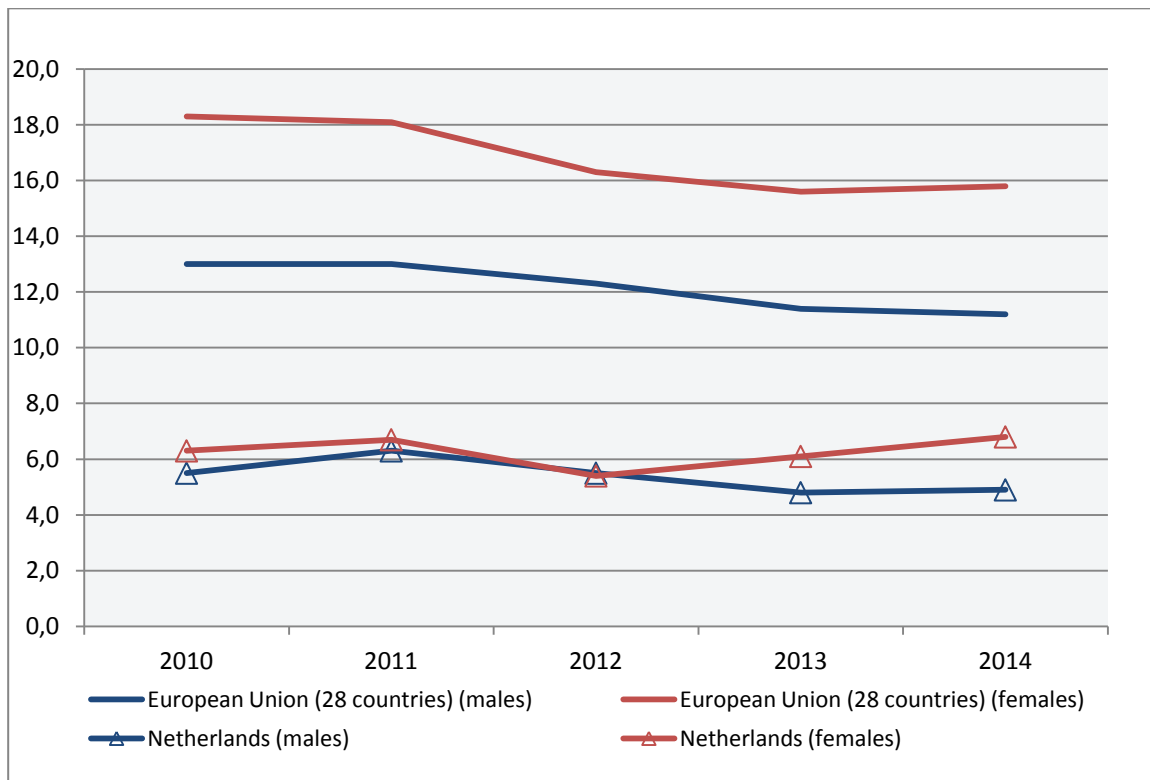
Source: CBS, 17-05-2016, Arbeidsdeelname, kerncijfers

**Figure 11.** Dependency percentages, number of 65 years or older over the productive age group 20 to 64 years old by COROP Region in 2015



Source: CBS, last update 26-11-2015, Regionale kerncijfers Nederland

**Figure 12.** At risk of poverty rate (65 or over) percentage over total population



Source: Eurostat, last update 29-06-2016, ilc\_pnp1

### 1.1.3 Description of social, economic and political situation

On the 21<sup>st</sup> of March in 2016, a milestone was reached in the Netherlands by counting 17 million inhabitants (Centraal Bureau voor de Statistiek, 2016<sup>b</sup>). The Netherlands is already known for its very high population density, with 501 people per sq. km of land area in 2014 (World Bank, 2016), scoring as one of the most densely populated countries within Europe. A temporary economic recovery in 2010 after the financial crisis was interrupted by a decline in real GDP in 2012 and 2013. But in 2014 and 2015 the trend was reversed again and signified a period of growth, experiencing a small growth of 1% GDP in 2014, and a growth of 1.9% in GDP in 2015 (European Commission, 2016). The Netherlands has a health expenditure -as a share of GDP- of 10,8% in 2015, this accounts for the 7<sup>th</sup> highest health expenditure among the OECD countries (OECD, 2016), while the Netherlands was holding the second place in 2013 (OECD, 2015).

Since a long time the Netherlands has provided an old age pension system that builds upon collectivism and solidarity. This pension system is based upon three pillars. The first pillar is the AOW (General Elderly Act), which is a flat-rate state pension related to minimum wages for those who passed the legally set AOW eligibility age (65 in 2012). Several factors determine the amount of AOW an individual receives; this is related to the household composition and the number of years a person lived and/or worked in the Netherlands in the 50 years before the AOW eligibility age. The AOW premium is collected via social premiums and taxation. The second pillar consists of occupational pensions; these are agreed upon between the industry or firm social partners. The third pillar represents voluntary individual pension products. Third pillar pension savings are fiscally facilitated only if first and second pillar savings are insufficient to achieve the general ambition level of 75% replacement rate at retirement.

According to the UNECE Active Ageing Index, the Netherlands is performing relatively good regarding active and healthy ageing, compared to the other 28 European Union Countries (United Nations Economic Commission For Europe & European Commission, 2014). In the overall ranking of 28 EU Member States the Netherlands is number 3, after Sweden and Denmark. Whereas for the domains 'employment, social participation' the Netherlands ranks the 6<sup>th</sup> place, and for 'Independent Living plus 'Capacity for active ageing', the Netherlands is ranked 3<sup>rd</sup> and 4<sup>th</sup> respectively.

## 1.2 Method

For this report, the findings are based upon academic and grey literature<sup>2</sup>, statistical material and interdepartmental consultation with multiple ministerial departments (i.e. Ministry of Health, Welfare and Sport; Ministry of the Interior and Kingdom Relations, Ministry of Economic Affairs, Ministry of Infrastructure and the Environment, Ministry of Education, Culture and Science and Ministry of Social Affairs and Employment). The process to compose this report was divided in three different phases. In the first phase existing literature was explored related to policies for older persons in the Netherlands. This includes an examination of the academic and grey literature, and especially exploring policy documents issued by the Dutch government. In addition, the methodology of demographic, social and economic indicators and the possibilities to represent and obtain relevant indicators were examined.

In the second phase, relevant developments in policies were identified for older people and related demographic and socio-economic indicators. The analysis was especially focused on the past five years, emphasizing developments since the previous report published in 2012. Those were then outlined in a draft report. Based upon this documentation, several consultations took place with the various ministerial departments, to discuss the (potentially) relevant indicators and policy developments. These meetings were held during the months June, July and September of 2016. Their suggestions were thereafter incorporated in the draft report. Simultaneously, dialogues with statistical experts took place to optimize the demographic and socio-economic indicators. The next step was to provide a platform for other stakeholders, i.e. representatives of several organisations for older persons in the Netherlands, to discuss the different themes included in the report. Throughout the process, desk research was carried out and close cooperation and dialogue with the National Focal Point was maintained.

Through the various consultation moments with the departments and the stakeholders, the policies, regulations and programs mentioned in this report were selected. All the relevant ministerial departments had the opportunity to provide input.

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<sup>2</sup> Grey literature means information that originate from research that is published by non-academic organisations (e.g. government reports) or are unpublished (e.g. working paper)



## Part II

### 2.1 National actions and progress in implementation of MIPAA/RIS

#### Introduction

Part II describes the relevant and prominent policy developments that promote and facilitate active and healthy ageing. These policy developments are categorized by the four goals, based upon the Vienna declaration in 2012.

Goal 1	Goal2	Goal3	Goal4
Longer working life is encouraged and ability to work is maintained	Participation, non-discrimination and social inclusion of older persons are promoted	Dignity, health and independency in older age are promoted and safeguarded	Intergenerational solidarity is maintained and enhanced

The topics for goal 1, 2 and 3 (i.e. policies and programs) will be discussed separately, while some of the topics might have some overlap. The order in which the topics are discussed, represents a certain order of importance; especially the policy developments mentioned first are considered to be the most important and essential ones. This also applies to the summary tables at the end of every section. After consultations with various ministerial departments, the 4<sup>th</sup> goal 'Intergenerational solidarity is maintained and enhanced' will not be mentioned separately in this review, due to the fact that this goal was deemed inherent to the other goals, and serves as one of the cornerstones of the Dutch system as a whole. Therefore it is not a goal in itself but perceived as a means. We therefore integrated relevant aspects in the other three goals.

Every section covers several secondary policy developments included in a text box. These developments are not paramount for this rapport, nevertheless illustrative for the themes and worth mentioning.

### 2.2 Longer working life is encouraged and ability to work is maintained (Goal 1)

#### Revision of flat-rate state pension

In the area of working life, much has changed during the last five years. This was already indicated in section I, showing that people have extended their working lives gradually over the years. The first part of reforms to extend working lives aimed to moderate the options for early retirement, which consist of early retirement (VUT), pre-pension and life course schemes. "Previously, the Netherlands had extensive early retirement schemes (referred to as a VUT), one of the main reasons for a low effective exit age from the labour market" (OECD, 2014, p. 61). By now, most VUT schemes are phased-out, after the introduction of legislation in 2006 to adjust the early pension schemes (wet VUT, Prepensioen and Levensloop VPL).

One of the recent developments to address the transition to extending working lives, is the reform of the *Old Age Pensioning Act* (AOW age), which means the age whereby someone is entitled to receive a flat-rate state pension. The introduction of the flat-rate state pension in 1957 set the retirement age to

the age of 65 and the retirement age was fixed until 2013. Mainly due to demographic changes and economic circumstances, the (financial) sustainability of the retirement scheme was put into jeopardy. Hence reform was needed, and as of 2013, the AOW age is gradually increasing to 66 years in 2018; and to 67 in 2021 (see Table 1). After 2021, if the life expectancy increases, the retirement age will increase accordingly.

Year	Increase in months	Statutory retirement age	Applies to people born:
2013	1	65+ 1 month	After 31 December 1947 and before 1 December 1948
2014	1	65 + 2 months	After 30 November 1948 and before 1 November 1949
2015	1	65 + 3 months	After 31 October 1949 and before 1 October 1950
2016	3	65 + 6 months	After 30 September 1950 and before 1 July 1951
2017	3	65 + 9 months	After 30 June 1951 and before 1 April 1952
2018	3	66	After 31 March 1952 and before 1 January 1953
2019	4	66 + 4 months	After 31 December 1952 and before 1 September 1953
2020	4	66 + 8 months	After 31 Augustus 1953 and before 1 May 1954
2021	4	67	After 30 April 1954 and before January 1955

Source: Rijksoverheid : <https://www.rijksoverheid.nl/actueel/nieuws/2015/06/02/aow-leeftijd-versneld-omhoog>

### Facilitate extending working lives

Anticipating on the trend to extend working lives, the Dutch government became active in encouraging and facilitating workplaces for older employees. In 2010, the government and the social partners set up an agenda for 2020 regarding the previously mentioned pension adjustments (Stichting van de arbeid, 2011). The social partners acknowledged their responsibility to assist in this reform whereby the various labour market sectors, committed with their sector plans to facilitate the objectives of this agenda. Various labour market sectors announced that they would try to facilitate employees to extend their working lives. Especially improving the employment of vulnerable employees will be stimulated with programs promoting sustainable employability. In sum, through the cooperation of the social partners, various sectors and the government, the labour market is better equipped to anticipate upon future challenges, and one of those challenges is to improve the position of older persons in the labour market (De Minister van Sociale Zaken en Werkgelegenheid. L.F. Asscher. De Staatssecretaris van Sociale Zaken en Werkgelegenheid. J. Klijnsma, 2013).

The increase in AOW age, and the need for more flexibility and adoption towards individual needs and desires to increase the working lives of Dutch citizens, was bounded by the legislative framework that was outdated, and previous legislation made it quite difficult to extend working life after the AOW age. As a reaction, the *legislation to facilitate working after AOW-age* became effective on the 1<sup>st</sup> of January in 2016 to simplify the transition from working after retirement age, by enabling older employees to continue working, as well as enabling employers to hire employees older than the AOW-age. Among the implemented measures is a re-adjustment of previous legislation, which initially dictated that employers should continue paying their employees for two years if they become chronically ill. This risk of becoming chronically ill is perceived to be higher among older persons, which became a serious disincentive to hire older persons. To reduce this disincentive, the maximum duration was reduced to 13 weeks. Furthermore, the legislation reduced the obligation of employers for the reintegration of their employees of AOW age.

The working force among the age group 50 to 65 has grown over the years. Section I demonstrated that the share of people age 50 and over in employment grew, but also the share of unemployment grew among the older age groups. The *Actionplan 55 and over* (Actieplan 55plus) became effective on the 1<sup>st</sup> of July in 2013 to halt the latter trend. This plan addresses (structural) unemployment among persons aged 55 and over, and 67 million Euros was allocated by the government to this program. In 2014, the

scope of the program was expanded and also included people who are 50 years and over (De Minister van Sociale Zaken en Werkgelegenheid. L.F. Asscher, 2014). The reason for expanding the scope was that the obstacles and challenges faced by people 55 years and over or 50 years proved to be similar. The government added additional funding to make it possible to support this expansion, adding up to 100 million Euros for the duration of the program. The Dutch Social Security Agency (UWV) is responsible for executing this program together with other social partners. They help older people to get a job through a variety of means such as:

- Providing networking events and organizing free workshops tailored towards the demands and needs of older persons;
- Issuing awareness programs, whereby the discrimination towards people over 50 is highlighted, emphasizing the financial benefits for employees to hire older persons. For more information consult [www.openvoor50plus.nl](http://www.openvoor50plus.nl) (only in Dutch);
- Use of education vouchers and placement fees, for which a subsidy was installed in October 2013. This made it possible for jobseekers to apply for a maximum of €750 education voucher, under the condition that there is a possibility to be employed. Hence, a statement by the employer needs to be included ('kansberoep');
- Facilitating the possibility to do a test run at a workplace for a maximum duration of two months, with the benefit to retain the entitlements of the social benefits. One of the conditions for such a test run is that there should be a prospect for employment for at least half a year.

A new program *Perspective for 50plus* (Perspectief voor vijftigplussers) is announced for 2017/2018. This plan continues some of the measures introduced in the Actionplan 50Plus, but in a different form; it continues measures introduced in the "beleidsagenda 2020" of social partners; and contains new measures. Important part of the approach is a campaign to break down certain preconceptions of employers. To support this campaign the Dutch government appointed an ambassador for the unemployed persons of 50 years and older. Also a mid-career advice will be introduced, public employment services (PES) will be expanded for employers and HRM staff to facilitate allocation of older unemployed, compensation for sickness benefits will be expanded, and free workshops for older persons will be continued. Some 68 million Euros have been allocated by the government for this program.

There are multiple financial incentives for employers to hire employees of 55 years and over. One of these incentives is to compensate for the sickness benefits -usually paid by the employer- in case the employee gets sick (under the condition that the employee was employed after July 8, 2009) (Compensatieregeling oudere werknemer). Another financial benefit for employers to hire a person unemployed and 56 years or over is to apply for a discount in the tax premiums (Mobiliteitsbonus). This discount is capped at € 7.000 per year, for a maximum duration of three years.

### **Lifelong learning**

To pursue the goal of lifelong learning, the Netherlands facilitates the *learning throughout the life course program* (Leven lang leren), also to support the trend of extending working lives. Herein, an increase in the stipend (levenlanglerenkrediet) for students over 30 years, will become effective in 2017. Moreover, there is a specific institution in place for older adults to receive education called the HOVO, which means Higher Education for Elderly (Hoger Onderwijs voor Ouderen). This school tailors its courses to the older age groups.

## Main policy developments Goal 1:

### Longer working life is encouraged and ability to work is maintained

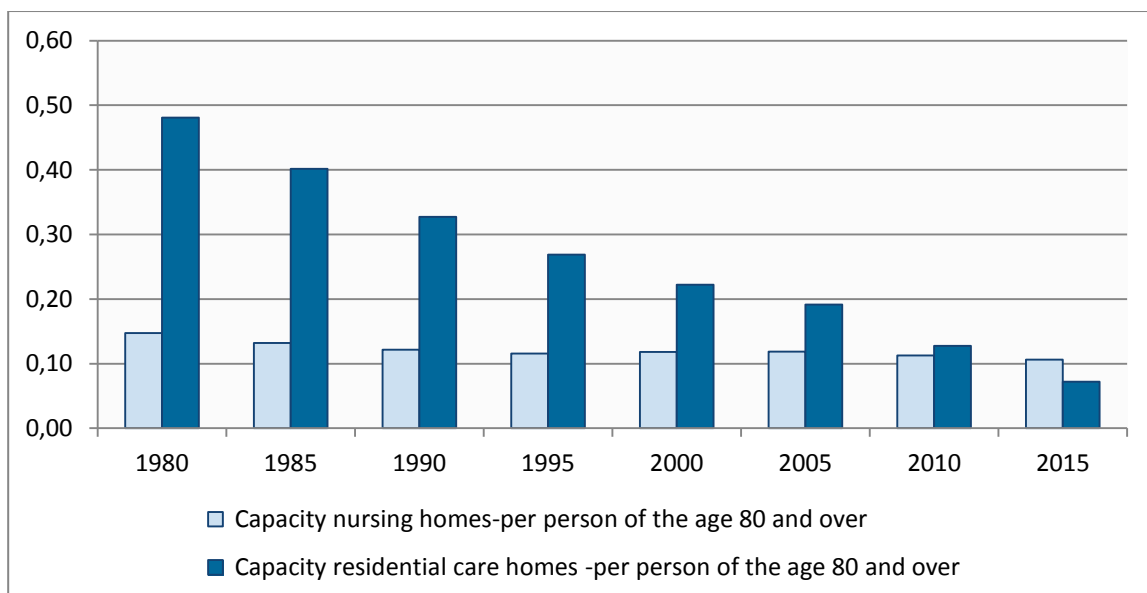
The main achievement in this area is the extension of the working lives of people. The options for early retirement have been limited, followed by increasing the retirement age (AOW-age) to 67 years in 2021. In 2021 the AOW-age will be connected to the life expectancy. To assist this movement, legislation to facilitate working after AOW-age was introduced. In order to insure a smooth transition and inclusion of older persons in the workplace; the *Actionplan 55 plus* (later 50 plus) was introduced to reduce unemployment.

## 2.3 Participation, non-discrimination and social inclusion of older persons are promoted (Goal 2)

### De-institutionalization

The Netherlands was known to be a highly institutionalized country with many older persons living in institutional settings. This highly institutionalized provision of care for the older population could be considered as a serious obstacle to the participation and social inclusion of older persons in society. Since the 80s, the number of older persons that live independently grew. As a consequence, in the same period the number of residential care homes decreased, whereas the number of places within nursing homes increased slightly. The capacity per person of the age 80 and over remained relatively stable over the years (due to the increase of persons of the age 80 and over) (Figure 13). This movement can be understood as a social movement towards a willingness to live independently and moving away from the institutionalization of older people.

Figure 13. LTC provision and social development towards independent living



Source: CBS (URL: <https://www.hetzorgverhaal.nl/langer-thuis-wonenverzorgingshuis-en-verpleeghuisplaatsen>)

Also the Dutch government gradually moved towards promoting and facilitating longer living at home (more on this topic in the 3<sup>rd</sup> goal 'Dignity, health and independence in older age are promoted and safeguarded'). *The Longer living independently* (Transitie agenda langer zelfstandig wonen) is a policy program, introduced on the 4<sup>th</sup> of June in 2014, facilitating this development. The aim was to enhance regional collaboration in stimulating independent living by sharing innovations, collectively identifying barriers, and preventing mismatches (De Minister voor Women en Rijksdienst. S.A. Blok. De Staatssecretaris van Volksgezondheid, Welzijn en Sport. M.J. van Rijn, 2014). This policy program aspires to assist the municipalities at national level. The program facilitates cooperation by organizing regional meetings, which include not only municipalities but also health care providers and other relevant partners. During these meetings, among other things, the developments regarding restructuring former health care institutions are discussed. Also, the government set up an expert team to foster information gathering and exchange (Aanjaagteam Langer Zelfstandig Wonen). Lastly, experimental programs were initiated, named 'Longer at Home' (Langer thuis), executed by Platform31 and the Kenniscentrum Wonen en Zorg (KCWZ); this program aims to stimulate the use of technology to accommodate more people to live at home.

In response to this program, the expert team received the mandate to collect information from the various regions and partners, to identify the barriers to successfully execute the transition to longer living at home. They identified three main tasks: (1) Awareness among people to prepare themselves to live longer at home (Communicatie over langer zelfstandig wonen); (2) To make longer living at home financially feasible for older persons. As a result, a loan scheme to realize these adjustments was designed (blijverslening); and (3) The construction and development of new affordable innovative living arrangements are endorsed, to facilitate independent living over the life course (Minister voor Women en Rijksdienst en Staatssecretaris van Volksgezondheid, Welzijn en Sport , 2016).

### **Vulnerability**

The older population is vulnerable to discrimination, social exclusion and abuse. Research that was conducted in 2012, highlighted that around 0.5% of older people became victim of domestic abuse in the last five years, which means around 15 000 victims. Note that this survey did not include financial exploitation or neglect; therefore it is likely that the numbers are an underrepresentation of the actual number. About 40 to 50% of the professional and volunteers reported that they experienced some sort of elderly abuse throughout their career (note that the professionals and volunteers could report about the same case). Most often it was related to physical violence, followed by financial exploitation (Plaisier & de Klerk 2015). In March 2011, an action plan was implemented to dismantle elderly abuse: *'The Elderly in Safe Hands' Action Plan* (Actieplan Ouderen in veilige handen). The elements that were included in this action plan were: prevention, information campaign, 'Declaration of Good Conduct', toolkit for volunteer organizations, training and education, elderly abuse reporting centers, victim support, and prosecution of offenders.

Due to successful results and the increasing recognition of the necessity to eliminate abuse among older persons, the program will be continued until 2017. For instance, the number of reports regarding elderly abuse in 2010 was 855, and in 2014 this increased towards 2,432. This does not necessarily mean that more older persons became victim of abuse; it is more likely that more people recognized the problem as such and were less reluctant, or experienced fewer obstacles, to report this malpractice (Sociaal en Cultureel Planbureau , 2014).

The continued program of 2015-2017 includes a public campaign to raise awareness of elderly abuse (i.e. physical, financial and emotional) and prevention of abuse by informal care givers. The overall objectives are that the municipalities will design specific policies to tackle elderly abuse, together with various partners (i.e. health care organizations, volunteers, health care purchasing organizations 'zorgkantoren', Public Prosecution Service 'openbaar ministerie OM', and the police). This subject

became a crucial element on the agenda of the partners and the municipalities (De Staatssecretaris van Volksgezondheid, Welzijn en Sport. M.J. van Rijn, 2015<sup>a</sup>).

The research project to map the frailty of older persons (Ouderen van nu en straks: zijn er verschillen in kwetsbaarheid) was established, to get a good grip on the determinants of the frailty among older persons. A study was conducted by the National Institute for Public Health and the Environment (RIVM) to map these determinants (van Oostrom, et al., 2011). In a related project, a factsheet was developed that describes starting-points to improve initiatives on early detection of frailty in older persons, directed to various stakeholders, e.g. policymakers and healthcare institutions (De Bruin, et al., 2016).

Apart from abuse, social isolation and loneliness are also a noticeable risks among older people. 'Coalitie Erbij' is an organization that was established in 2008, with the mission to scale down the prevalence of social isolation and loneliness at all ages. In 2014 they received support from the government. The Ministry of Health, Welfare and Sport reinforced the objective with the action plan '*Reinforced action plan against loneliness*' (Versterking aanpak eenzaamheid) (De Staatssecretaris van Volksgezondheid, Welzijn en Sport. M.J. van Rijn, 2014). The plan, to reduce loneliness and social isolation at all ages, is carried out in cooperation with 'Coalitie Erbij' and the national Cooperation Agency of the Association of Netherlands Municipalities (VNG) (van de Maat & van Xanten, 2013). With this action plan, three action points were introduced. First, to foster cooperation with municipalities, care institutions, health insurance organizations and volunteer organizations, with the aim to provide an integrated approach to reduce loneliness. Second, to collect and share knowledge by conducting research and identifying knowledge gaps to prevent, and reduce loneliness, plus social isolation. Furthermore, with knowledge dissemination, the aim is to put loneliness on the agenda among various care institutions and provide tools on how to reduce loneliness to municipalities. The third and last point of action was to carry out an overall campaign to raise awareness on this issue (Campagne 'Samen tegen eenzaamheid'). This program runs from 2014 to 2016 and €900.000 was allocated for the complete program.

*The Covenant Elderly and Culture* (Convenant Ouderen en Cultuur) aspires to provide a platform for older persons to participate in society, by engaging them in cultural activities. This platform tries to build bridges between various partners (i.e. elderly organizations and cultural organizations). This covenant is supported by the Ministry of Health, Welfare and Sport and the Ministry of Education, Culture and Science, and they agreed upon the necessity that cultural participation contributes to the health, wellbeing and personal development of older persons. The positive aspects of ageing should be highlighted and the right to participate in the cultural life is facilitated. Cultural participation is a form of social participation which is part of the foundation to an active civil membership. The action program entails an array of activities by cultural institutions tailored towards older persons. This program runs from 2013-2017.

## Rights

The rights of older persons is a pertinent theme in all the elderly policies. With the help of the *Netherlands Institute for Human Rights* (College voor de Rechten van de Mens), the rights of older persons are enhanced and highlighted. The Netherlands Institute for Human Rights has placed the rights of older persons in care institutions high on the agenda, in order to protect and advocate for the rights of older persons in the Netherlands. In their research they reconciled the care for older persons in the framework of human rights. Based upon the results of this study they handed over their report to the Commission of Health, Welfare and Sport of the Dutch parliament, highlighting the commitments and responsibility of the government to reassure that the human rights of older persons are fully respected (Dooijeweert, 2016). In this report, they advocated for active involvement by the government to

promote the rights of older persons in nursing homes (College voor de Rechten van de Mens, 2016). Their general assessment was that the rights of older persons are upheld. However, they raised concerns about the daily activity of older persons. The Ministry of Health, Welfare and Sport responded upon this in their 2<sup>nd</sup> report of *the Dignity and Pride* (Waardigheid en Trots) report, by stating that they will allocate more resources to the daily activities of older persons in nursing homes (De Staatssecretaris van Volksgezondheid, Welzijn en Sport. M.J. van Rijn, 2016<sup>a</sup>).

The Netherlands is perceived as one of the most progressive countries to protect and promote the rights of the LGBT community. Nonetheless, older persons still face challenges and problems to enjoy this right. Therefore the Dutch government facilitates various projects aimed at the more than 300.000 LGBT people of 50+ years of age, through the support of the 'Gay-Straight Alliance LGBT Elderly' (Homo en Hetero Ouderen-alliantie 2012 – 2014; project van 'Consortium Roze 50+ Nederland'). LGBT people run a higher risk of social isolation and therefore loneliness compared to their heterosexual peers, especially at older age. Although the 50+ generation has paved the way for the improvement of social acceptance of LGBTs in the Netherlands, they still need to empower themselves. It is also notable that many elderly citizens hide their sexual orientation or gender identity.

The focus of the policies lies on visibility, advocacy and empowerment of these 50+ citizens. For seniors, the visibility is stimulated by special events such as the "out & proud" boat at the Amsterdam Canal Parade and the presence during the national 50+ fair. Also awareness-raising activities are taking place at regional and local levels for the well-being of this policy target group, which are done by 'pink ambassadors' from the community. A tolerance scan ('Pink Passkey') has been developed to assess care facilities on their LGBT friendliness. The results will assist facilities in optimizing their LGBT policy. The Ministries of Health, Welfare and Sport, and Education, Culture and Science support the activities in this area.

Another right which received much attention recently, was the right of persons with disabilities. The older people become more likely of suffering from one or more disabilities. Therefore, the ratification of *The Convention on the Rights of Persons with Disabilities UN CRPD* (Ratificatie VN-verdrag betreffende de rechten van personen met een handicap) should improve the well-being and conditions of older persons with disabilities. This ratification means that their rights will be enhanced, protected and maintained. With this ratification several laws will be adjusted. One of the important adjustments is to increase the scope of the law on equal treatment in relation to disabilities and chronic diseases (Wet gelijke behandeling van handicap of chronische ziekte).

## Regional

As indicated in Section I, several regions in the Netherlands are coping with a population decline (depopulation areas) and consequently have a relatively overrepresentation of persons of older age due to the fact that mostly the younger persons move away. A policy was designed to address this concern, called the *Actionplan against Regional Population decline* (Actieplan Bevolkingsdaling. Samenwerkingsafspraken voor een structurele aanpak in de krimp -en anticipeerregio's ) (Ministerie van Binnenlandse Zaken en Koninkrijksrelaties, 2016). This action plan undertakes measures to overcome the consequences of a population decline in those regions that already experience a decline or are anticipating that they will do so. Important to note is that this program does not strive towards reversing the trend and to try to keep the younger population in those declining areas. It is mostly about steering the movement and facilitating those regions to cope with this shift. Furthermore, the responsibility lies with the regional and local institutions such as the provinces, municipalities, so this

plan is a decentralized action plan. The national government has a facilitating role, for instance with legislation or other implications that falls under the mandate and responsibility of the national bodies.

**Main policy developments with Goal 2:  
Participation, non-discrimination and social inclusion of older persons are promoted**

The main developments were to support and protect the independency and participation of older persons in society. The *Longer Living Independently Program* aims to enhance regional collaboration in stimulating and facilitating independent living. The *Elderly in Safe Hands Action Plan* was continued to dismantle elderly abuse. Moreover, the reinforced *Action Plan Against Loneliness* limits the chance of experiencing loneliness among older persons.

## **2.4 Dignity, health and independence in older age are promoted and safeguarded (Goal 3)**

### **Reform of Long Term Care**

One of the most prominent policy changes that occurred in recent years was the reform of the LTC system, with the objective to promote and support independent living. Before this reform the AWBZ (Exceptional Medical Expenses Act) was in place since 1968. This scheme used to include all expenditures ranging from personal-and nursing care, accommodation and guidance. The spending of this scheme grew substantially over time, hence to ensure financial sustainability in long-term care (LTC) as well as to better align the LTC provision to the needs and desires of clients, the LTC scheme in the Netherlands changed significantly. As of 2015, the AWBZ was fully replaced by the Wmo, Zvw, Wlz and the Youth act.

The introduction of the Long-term Care Act (Wet Langdurige Zorg: Wlz) in 2015 covers the persons in the most vulnerable categories, i.e. those requiring permanent supervision or 24-hour care nearby, providing a broadly defined set of services including residential care. These clients are identified by the Care Assessment Centre (Centrum indicatiestelling zorg: CIZ), which is a public independent governmental body that makes the decision if a client needs Wlz-care ('indicatiebesluit'). The regional care offices ('zorgkantoren') are in charge to purchase care with nursing homes and other long term care institutions. These regional care offices operate independently and bear no financial risk on purchasing care. The LTC tariffs are regulated by the Dutch Health care Authority (NZa). This act is financed based upon solidarity through a compulsory health insurance policy in combination with co-payments.

*The Social Support Act* (Wet maatschappelijke ondersteuning: Wmo) first introduced in 2007, partly replaced the AWBZ. The Wmo is designed for the persons that need assistance but are not defined as severe cases. The focus of the Wmo lies on social participation. The Wmo covers assistance programs (e.g. transport services, meal services, funding to adjust houses, household cleaning), community programs (e.g. daily activities) and the provision for household services was decentralized to the municipalities, given them the discretionary power to make an assessment of need per client. Whereby during the assessment also the position of the informal care givers have to be taken into account.

The Wmo underscores the individual and social responsibility, decentralized to the municipalities, tailor-made services assessment executed by the municipalities based on the need assessment procedure ('keuken-tafelgesprek'), means-testing is prohibited. The Wmo is funded by taxes and co-payments. Co-



payments are income and wealth dependent. To provide care under the new Wmo 2015, the municipalities receive state budgets, and additionally they have the option to fund the Wmo 2015 through cost-sharing schemes depending on -among other things- the annual income and size of the household, to safeguard that these services are accessible to everyone.

The role the health care insurers also expanded, under the Health Insurance Act (Zorgverzekeringswet: Zvw), to cover a part of the long term care related to direct health or ADL (activities of daily living) limitations. Activities provided by the Zvw are home-and community nursing ('wijkverpleegkundige') and personal care (95% of personal care is reimbursed through the Zvw and 5% through the Wmo). The Zvw is financed based upon solidarity through a compulsory health insurance policy. There are no co-payments for these LTC activities in the Zvw.

Besides care in-kind, people who fall under the Wlz, Zvw or the Wmo, can opt for a personal budget ('persoonsgebonden budget: pgb'). The people with a personal budget can arrange their own care or support that fit their needs and desires with cash benefits. The decision on the access to pgb rests with the regional care offices for the Wlz, with the municipalities for the Wmo and the insurers for the Zvw.

### Informal care

More (vulnerable) older persons live independently. The trend towards deinstitutionalization and increasing reliance on informal care demanded for a growing awareness to be responsive to this matter. Therefore, in 2013 the parliament highlighted the necessity to put informal care on the political agenda, asking for more financial resources to support the informal care givers. These resources should support for example: innovations by healthcare providers that improves the cooperation between health care professionals and informal care givers; municipalities that would like to bring the informal care support to a higher level; and innovative projects that foster the combination of working and providing informal care. As a result, the program *'Yes to Informal Care'* (In voor Mantelzorg) facilitates and fosters better collaboration between informal care givers and health care providers. It should encourage the transition from 'caring for' older persons towards 'working together' with them and their close social environment, in providing supporting and arranging appropriate care. Between 2014 and 2015, 80 health care institutions participated in this program, ranging from home-care, elderly care and rehabilitation institutions. The organizations that participated received training materials. One of the concrete results of this program is a workbook that was brought together containing information to assist health care professionals to improve the cooperation with informal care givers (Scholten & Peters, 2015).

### Quality in long-term care institutions

Aside from informal care, also institutional care has received particular attention. One program was triggered by a report by the Dutch Health Care Inspectorate (IGZ) on nursing homes, highlighting concerns in relation to the quality of care (Inspectie voor de Gezondheidszorg, 2014). As a response, a program was launched by the Ministry of Health, Welfare and Sport in cooperation with various other public institutions (De Staatssecretaris van Volksgezondheid, Welzijn en Sport. M.J. van Rijn, 2015<sup>b</sup>) called: *'Dignity and Pride. Loving Care for our elderly'* (Waardigheid en Trots. Liefdevolle zorg voor onze ouderen). This program strives towards two main goals. The first goal is to eliminate the risks of poor quality standards that the Health Care Inspectorate identified in their rapport (Inspectie voor de Gezondheidszorg, 2014). The second goal is to prioritize the relationship between the client, their social support and healthcare professionals (Ministerie van Volksgezondheid, Welzijn en Sport, 2015). In order to boost the quality of nursing homes, the implementation of this policy is based upon five elements: (1) Optimal cooperation between client, informal care and caregiver; (2) Ensuring that basic principles are in order (e.g. safety); (3) Enhancing the discretionary space for professionals; (4) Good leadership among the management of health care institutions; (5) Transparency of care. One of the concrete examples that came with this policy is to focus on providing integrative dental and oral care in nursing homes.

Furthermore, when the program was launched, concrete recommendations for the establishment of a Taskforce were included. This Taskforce consists of various institutions (e.g. Health Care Inspectorate, Ministry of Health, Welfare and Sport and representatives of healthcare enterprises 'Actiz'), which received the mandate to monitor the progress of the program.

In 2016, a second report communicated several results from the Dignity and Pride program, including: (1) the program started with 150 LTC providers who profile themselves as best practices, naming themselves a 'Dignity and Pride' organisation; (2) increased supervision of the Health Care Inspectorate on the providers with higher risk profiles and reinforcing good quality standards with coercion; (3) structural implementation of 200 million euro's, providing extra resources for the education of nursing care. In addition, the report concluded that more research is needed, focusing on the relationship between quality and health care professionals (i.e. nurses and other employees working in the LTC). This research objective was outsourced to third parties.

Another policy program, aiming to improve the quality of long term care, is the so-called Care reform agenda: *Living in dignity with care* (Waardig leven met zorg). This program induces a paradigm shift that the primary concern should not be providing *care* but a broader perspective should be maintained towards the *well-being* of the persons who rely on LTC. Three goals were set:

- Give people with severe limitations substantially more (financial) control to choose their support and care at their home or in other living arrangements,
- Encourage more innovative health care providers in LTC,
- Stimulate technological innovations in LTC.

In order to achieve these goals the following conditions have to be met and addressed:

1. Ensure better alignment between the provision of LTC institutions and the wishes of people. This should cultivate the demand for LTC services in-kind (and decrease the number of people making use of personal budgets).
2. The people in need of LTC and their social support should receive more control over their own care.
3. More diversity and customization of care is needed so that LTC facilities (in kind care) match better with how people want to live (De Staatssecretaris van Volksgezondheid, Welzijn en Sport. M.J. van Rijn, 2016<sup>b</sup>).

With pilot projects throughout the Netherlands, *pilot programs in team based elderly care* ('Proeftuinen Ouderenzorg'), the optimal mix of staff and skills to provide and improve LTC within a team that supports the client, was evaluated. The project included various partners working together, such as patient organizations, educational institutions, health care institutions, and research institutes. The care team may consist of nurses, nursing specialists, doctors, psychologists, informal care givers and various other care givers. The aim of this project was not only to identify the right balance of professionals in a care team, but also how to make this team function as effective as possible. This pilot has been finalized, and after a thorough evaluation of this project, the overall conclusion is that there is no one-size-fits-all solution, and that per client the mix of staff and skills need to be reassessed. Nonetheless, among the various recommendations, the researchers highlighted that a team with various experts and skills perform better (NIVEL, 2015). This project is part of the covenant *Investing in Long Term Care 2011-2015* (Investerings Langdurige Zorg 2011-2015), whereby the government allocates extra resources to professional caregivers in LTC, for improving the quality of care in intramural care.

### Improving quality of care (beyond formal- and informal care)

The institutional context should provide a suitable framework to provide good quality of care. Nonetheless, one-on-one care deserves just as much attention as the framework it operates in. Therefore three policies programs that do not strictly fall under formal- and informal care provision, are mentioned in this section as examples for improving the quality of care.

*The National Program of Elderly Care* (Nationaal Programma Ouderenzorg, NPO) started in 2008 and aims towards further improvement, development and innovation of care for older persons. The core component of the program is that projects are established in close cooperation with the older population. This means that older persons play an important part in the development, assessment, execution and evaluation of the projects initiated by the NPO. Older persons are now represented in the policy process, in expert groups. This program was continued from 2014 through 2016.

Other development in quality enhancement is related to dementia. Dementia is a brain disease that prevails on later ages, and makes people very dependent on others, not only because they lose their cognitive abilities but also lose mobility and frequently suffer from depression and pain. The majority of the people with dementia still live at home and receive a combination of formal and informal care. It is very likely that the number of people with dementia will grow exponentially over the years, since the absolute number of older people will grow (baby boom after the World War II) and the life expectancy grows. This will impose serious challenges for the society as a whole. To recognize and overcome this challenge the *Deltaplan for Dementia* was introduced in 2013, an eight year action plan in which government, scientists, industry and charities work together in a public-private partnership. Goal of this action plan is threefold:

- to improve the care and support for people with dementia and their families;
- to establish a dementia friendly society; and
- to enable research to improve diagnostics and care for today's patients and to prevent dementia and, ultimately, find a cure for tomorrow's patient ([www.deltaplاندementie.nl](http://www.deltaplاندementie.nl)) .

In 2013 a research programme, *Memorabel*, started with a government funding of € 32,5 million (2013 – 2016). During the course of the programme private funding of around € 8,5 million was added to the programme budget. In September 2016 the government announced to invest another €30 million to the second phase of *Memorabel* (2017 - 2020). On the 9th of May 2016 at the international conference on 'Living well with(out) dementia' a campaign was launched that is going to raise awareness around dementia, and aims to make the Dutch society more dementia friendly. Also, this action plan introduced a new website with a free training on how to deal with people dealing with dementia in daily practices (<https://www.samendementievriendelijk.nl/>). A nationwide program to improve dementia care is under development and is expected to start early 2017.

For people suffering from serious chronic diseases, it is of outmost importance to provide the best possible and suitable care to improve the quality of life of the persons in their last stages of life and their close social environment. In 2014, a program with a budget of 51 million euro's to assure and improve palliative care was initiated, labelled *the National program palliative care* (Nationaal Programma Palliatieve Zorg: NPPZ). The program is aimed at improving education and research on this topic and to translate knowledge into practice. Furthermore, subsidies are allocated to volunteers to support their work within this area.

Beyond long term care, the curative sector also adopted programs tailored towards the older population. One of those programs is the label for hospitals to be referred to as a 'senior friendly hospital'. The hospitals with this label excel in providing care that fit the needs and wishes of older persons. Hospitals who would like to acquire this label, go through a thorough assessment process, to be able to call itself a 'senior friendly hospital'. The aim of this program is to incentivize hospitals to become more senior friendly.

## Life course perspective

Establishing a healthy and active ageing society requires a life-course approach (World Health Organisation, 2015). Hence, the National Prevention Program: Everything is health (Nationaal Programma Preventie Alles is gezondheid) was launched in 2014 and runs until 2016. This program aspires to reduce the number of people that will suffer from chronic diseases, and to close the health disparities that exists, for example for people with lower socio-economic status (SES), lower education, and poor living conditions. It will do so by focusing on three areas. The first area has as theme 'healthcare close by', aiming to improve -in an integrative way- the health of people and to prevent chronic diseases, by focusing on education, promoting health in the neighbourhood, and occupational health. The second area is to give prevention a vital place in the healthcare system as whole, among other things, by improving the cooperation with health care partners. One of the examples is that consultations with health care insurers are organized to inspire them to focus on prevention. The third area is to maintain the good level of health and avoid major threats. This includes maintaining and enhancing vaccination programs, and ensuring healthy and safe food provision (Rijksoverheid, 2013). This prevention scheme targets all age groups, from programs in schools towards programs that address malnutrition among older persons (i.e. Alliantie Voeding Gelderse Vallei). Furthermore, this program seeks partners from various sectors who wish to cooperate in getting prevention high on the agenda. In 2015 a total of 1,265 partners pledged to actively contribute to a healthier society. Around 900 organizations actively cooperated under this scheme, think of partners like schools, workplaces, communities. The number of subsidy applications was 3,157 for a maximum of 10 000 Euros in 2015.

## Innovation

Innovation in health care may encompass various components, like improving service delivery methods, products, technologies etc. New ways of thinking and intentions for societal challenge can add value to the system (e.g. the health care system) by improving efficiency, effectiveness, quality, sustainability, and safety. In other words, innovation is a crucial element to ensure progress.

E-health is a well-known innovation in the health care sector. The Netherlands is putting great emphasis on trying to increase the leverage and usage of e-health, since it sees great potential in this innovation. On the 8<sup>th</sup> and the 10<sup>th</sup> of June in 2016 the Dutch Ministry of Health, Welfare and Sport co-organized the international eHealth Week 2016, hosting around 2000 e-health experts travelling from 28 EU member states to discuss and share knowledge in this field.

Besides this event, The Netherlands also put serious efforts to set *e-health goals* to increase the implementation of e-health within LTC for 2019 (De Minister van Volksgezondheid, Welzijn en Sport. E.I. Schippers , 2014). The goals that are particularly relevant for the older population are:

- For the chronicle ill and vulnerable elderly people, 75% will be able to independently monitor themselves and a (professional) caregiver can track these patients
- Everyone should have access to receive care with the use of video calling

These objectives set out in the e-health goals are instrumental by nature. The main objective is to contribute to the needs and wishes of older persons, in order to bolster independent living among older persons.

Another movement worth noting here is the cooperation of regions to represent *active and healthy ageing cities or regions*. Various regions are affiliated to the European Innovation Partnership on Active and Healthy Ageing (EIP-AHA), for instance Health Valley in Nijmegen and a cooperation of Smarter Living in 2020 in Brabant (Brabant is a province in the Netherlands). Another good example of an initiative of a regional network is the Healthy Ageing Network Northern Netherlands (HANNN). This platform brings together knowledge institutions, companies from different industries (i.e. life science, biotech, pharmacy, ICT, nutrition industry sector and local authorities) to enhance and improve the active and healthy ageing environment.

An example of international cooperation is the so-called AAL Program. Since 2008, the Netherlands have invested in the Ambient Assisted Living Program (from 2014 on called the Active & Assisted Living Program), a joint program of 20 EU member states and Canada (since 2016). This program fosters the development and market entry of ICT based solutions with the aim to facilitate older persons to live longer at home and as independently as possible. It is an investment with two goals, one is to improve the quality of life of older persons and support their self-management, and the second is to simultaneously, improve the effectiveness and efficiency of professional care.

### Main policy developments Goal 3:

#### **Dignity, health and independence in older age are promoted and safeguarded;**

The reform of the long term care system is one of the most profound reforms carried out by the Dutch government during the past few years. Other policy programs mentioned in this section are aimed to facilitate and support this major reform. Especially the *Dignity and Pride: Loving care for our Elderly Program* plays a substantial role to promote and improve the quality of nursing homes. As well as the *Living in Dignity with Care*, which stimulates the well-being of persons relying on long-term care.

The leading program on dementia, the *Deltaplan for Dementia*, provides an innovative approach to cultivate research, healthcare improvement and a dementia friendly society.

Lastly, the *National Prevention Program Everything is Health* is an important development to note, because it has a life course perspective and aspires to close existing health disparities and promote active and healthy ageing.

## 2.5 Conclusions and priorities for the future

The Netherlands has made noticeable progress in achieving the outlined objectives within the Regional Implementation Strategy (RIS) of the Madrid International Plan of Action on Ageing (MIPAA) over the last five years. In sum, the main achievements were that the pension age increased, the long term care system was reformed and the participation of older persons to society has improved. These achievements contributed to the quality of life of older persons in their social context, whereby human dignity and tailored measures - addressing the needs of individuals - were main building blocks of these policy developments. All these policy developments as a whole built upon the fundamentals of solidarity.

This 3<sup>rd</sup> RIS/MIPAA review report shows that most of the recommendations in the previous RIS/MIPAA report have been addressed over the last 5 years. In the previous review, it was highlighted that the state old-age pension (AOW) should be on a firm financial footing. The review indicated that the state pension age would raise and advocated a robust and future-proof pension scheme. In addition, the report campaigned for more trained carers, more patient rights, more and better quality standards, a stronger Healthcare Inspectorate (IGZ), lower overheads, less regulation, more community care, smaller

care institutions, and more measures to prevent elderly abuse. This 3<sup>rd</sup> review report shows that most of these aspects have been addressed either with legislative changes or policy programs.

The shared objective of the Dutch policies on ageing is to achieve better alignment with societal developments. The policies support the movement from relying on institutions towards a more personal approach, enhancing independency (e.g. fostering independent living), and taking into account the (social) context of older persons in need of support and/or care. In short, this entails the paradigm shift that underlies the LCT reform. One of the elements is a better balance between formal and informal care, with also. To achieve this goal is also important to pay special attention to the position of informal care givers. Policy programs were installed to support the Long Term Care reform, with the objective to guide this reform (e.g. Yes to Informal Care), or to promote the quality of care (e.g. Dignity and Pride Program). The reform to renew the pension scheme follows the same line of thought, whereby labor market changes (i.e. more labour market dynamics and flexibility), has led to reforming and matching the pension scheme to the underlying social and labour market shifts.

The Netherlands has made significant progress to strengthen active and healthy ageing; nonetheless there is still room for improvement. To enhance the participation of older persons (and limit loneliness), it is essential to add the human dimension to the equation. Henceforth an integrated approach is needed to align (components of) the different policies. For example, policies at improving the availability of public transport in rural areas should be aligned with the needs for older people seeking healthcare at remote hospitals. Another example is that activities aimed at stimulating an active and health life style, should be tailored to older people in deprived areas. It is important that the participation of older persons is promoted through an integrated approach, with solutions that are tailored to the needs of individuals and hereby encompass a human dimension.

Through the consultations and discussions with the different ministerial departments, six themes were identified, whereby the Netherlands could further improve policy to strengthen active and healthy ageing:

- Further develop and execute the Care-Reform-Agenda ('Living in dignity with care') (De Staatssecretaris van Volksgezondheid, Welzijn en Sport. M.J. van Rijn, 2016<sup>b</sup>). This agenda describes the options towards a more client-centered way of implementing care within the Long Term Care act. This means that the system should adapt to the increasing choice that clients have as a result of the LTC reform. Other topics in this agenda are related to:
  - Improvement of client support
  - Reduction of administrative procedures relating to access to long term care
  - Simplifying the way care providers are paid
  - Stimulating technological innovation
- Address further challenges of implementing the pension scheme in relation to financial and societal sustainability of the system (De Staatssecretaris van Sociale Zaken en Werkgelegenheid. J. Klijnsma, 2016). The pension system should offer a solution to the currently insufficient pension savings for independent entrepreneurs and persons working prolonged under temporary contracts. Furthermore, the pension scheme should fit the specific needs and preferences of people more than now. Altogether, this is connected to and builds upon the Act Amending the Financial Assessment Framework ('Wet aanpassing financieel toetsingskader pensioenfondsen') implemented on the 1<sup>st</sup> of January 2015.
- Intergenerational solidarity deserves -especially in regards to the pension scheme- special attention in the upcoming years.
- Strengthen the resilience of older persons in the workplace, through investing in education and mobility within the labour market.
- Address regional and local differences in an integrative and tailored approach, aligned to clients, care providers, regional bodies and the national government.

- Establish an integrated approach to stimulate active and healthy ageing throughout the life course within the extended National Prevention Program ('Alles is Gezondheid').

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<sup>3</sup> All the names are on alphabetical order based on the first letter of the surname

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## Annex

INDICATOR	SUGGESTED VARIABLE	Year 1 (2005 or close)			Year 2 (2010 or close)			Year 3 (2015 or close)			DATA SOURCE	VARIABLE AND METADATA
		TOTAL	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL	MALE	FEMALE		
<b>1. Labour market (older people's contribution through paid activities)</b>												
1.1. Employment rate for the age group 55–59	Same as indicator	61,7	74,9	48,3	70,1	81,2	59,0	71,8	80,3	63,4	Eurostat	
1.2. Employment rate for the age group 60–64	Same as indicator	24,9	32,3	17,5	37,3	47,7	26,7	50,5	60,9	40,2	Eurostat	
1.3. Employment rate for the age group 65–69	Same as indicator	9,2	13,3	5,2	12,0	16,5	7,7	13,1	18,3	7,9	Eurostat	
1.4. Employment rate for the age group 70–74	Same as indicator	4,4	7,7	1,6	6,2	9,6	3,1	6,3	10,4	2,4	Eurostat	
<b>2. Participation in society (older people's contribution through unpaid activities)</b>												
2.1. Voluntary work by older adults (aged 55+)	Percentage of older population (aged 55+) providing unpaid voluntary work through the organizations (at least once a week)	–	–	–	25,3	23,4	27,2	20,7	21,8	19,3	EQLS	For the year 2010, data for 2007 are used; for 2015, data for 2011/12 are used
2.2. Care to children, grandchildren by older population (aged 55+)	Percentage of older population (aged 55+) who provide care to their children and grandchildren (at least once a week)	–	–	–	18,1	21,3	14,9	30,8	32,6	29,4	EQLS	For the year 2010, data for 2007 are used; for 2015, data for 2011/12 are used

2.3. Care to older adults by older population (aged 55+)	Percentage of older population (aged 55+) providing personal care to elderly or disabled relatives (at least once a week)	–	–	–	15,7	11,7	19,3	14,1	14,0	14,1	EQLS	For the year 2010, data for 2007 are used; for 2015, data for 2011/12 are used
2.4. Political participation of older population (aged 55+)	Percentage of older population (aged 55+) taking part in the activities or meetings of a trade union, political party or political action group, or signing petitions, including email and online petitions	–	–	–	31,1	37,3	25,5	26,8	28,3	25,5	EQLS	For the year 2010, data for 2007 are used; for 2015, data for 2011/12 are used
<b>3. Independent, healthy and secure living</b>												
3.1. Physical exercise for older adults (aged 55+)	Percentage of people aged 55 years and older undertaking physical exercise or sport almost every day	–	–	–	–	–	–	23,4	22,6	24,1	EQLS	For the year 2015, data for 2011/12 are used
3.2. Access to health and dental care (for those aged 55+)	Percentage of people aged 55 years and older who report <b>no unmet need</b> for medical and dental examination or treatment during the last 12 months preceding the survey	97,7	97,5	97,8	97,6	97,7	97,5	97,7	98,3	97,2	SILC	For the year 2005, data for 2008 are used; for the year 2015, data for 2012 are used
3.3. Independent living arrangements (for those aged 75+)	Percentage of people aged 75 years and older who live in a single household alone or in a couple household	97,9	97,8	98,1	97,4	97,3	97,5	97,5	97,7	97,4	SILC	For the year 2005, data for 2008 are used; for the year 2015, data for 2012 are used

3.4. Relative median income (for those <b>aged 65+</b> )	Ratio of the median equivalised disposable income of people aged 65 and above to the median equivalised disposable income of those aged below 65	88,1	88,5	88,1	87,1	89,0	86,5	89,2	90,8	88,3	Eurostat, SILC	
3.5. No poverty risk (for those <b>aged 65+</b> )	100 – Percentage of people aged 65 years and older who are at risk of poverty (using the 50 per cent of median income threshold)	97,7	98,0	97,6	97,9	98,5	97,4	97,6	97,9	97,4	Eurostat, SILC	
3.6. No severe material deprivation (for those <b>aged 65+</b> )	100 – Percentage of people aged 65 years and older who are severely materially deprived (having an enforced inability to afford at least 4 out of the 9 selected items <sup>1</sup> )	98,8	98,5	98,9	99,7	99,8	99,6	99,5	99,2	99,7	Eurostat, SILC	
3.7. Physical safety (for those aged 55+)	Percentage of people aged 55 years and older who are feeling very safe or safe to walk after dark in their local area	77,6	88,6	66,4	80,9	88,9	72,0	83,2	92,4	72,5	ESS	For the year 2005, data for 2006 are used; for the year 2015 data for 2014 are used
3.8. Lifelong learning (for those aged 55–74)	Percentage of people aged 55 to 74 who stated that they received education or training in the four weeks preceding the survey	5,8	5,0	6,6	7,0	6,5	7,6	8,6	8,1	9,0	Eurostat	
<b>4. Capacity and enabling environment for active ageing</b>												
4.1. Life expectancy at age 55	Same as indicator	26,8	24,7	28,8	28,0	26,0	29,7	28,7	27,1	30,1	Eurostat	For the year 2015, data from 2014 are used

4.2. Healthy life expectancy at age 55	Same as indicator	17,0	16,7	17,3	15,3	15,3	15,2	16,1	16,9	15,3	Eurostat <sup>2</sup>	For the year 2015, data from 2014 are used
4.3. Mental well-being (for those aged 55+)	An index that measures self-reported feelings of positive happy moods and spirits	–	–	–	86,0	92,6	79,1	73,7	77,4	70,7	EQLS	For the year 2010, data for 2007 are used; for 2015, data for 2011/12 are used
4.4. Use of ICT by older adults (aged 55–74)	Share of people aged 55 to 74 using the Internet at least once a week	44,0	56,0	33,0	70,0	77,0	63,0	83,0	85,0	82,0	Eurostat	
4.5. Social connectedness of older people (aged 55+)	Share of people aged 55 or more that meet socially with friends, relatives or colleagues at least once a week	67,8	61,4	74,3	68,8	65,7	72,2	65,5	62,1	69,5	ESS	For the year 2005, data for 2006 are used; for the year 2015 data for 2014 are used
4.6. Educational attainment of older people (aged 55+)	Percentage of older persons aged 55 to 74 with upper secondary or tertiary educational attainment	54,6	65,8	43,7	55,7	65,5	46,1	60,0	68,1	52,0	Eurostat	

<sup>1</sup> to pay their rent, mortgage or utility bills; 2) to keep their home adequately warm; 3) to face unexpected expenses; 4) to eat meat or proteins regularly; 5) to go on holiday; 6) a television set; 7) a washing machine; 8) a car; 9) a telephone

<sup>2</sup> life tables and a question on Self-perceived long-standing limitations in usual activities due to health problem by sex, age and labour status [hlth\_silc\_06]