



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

**Fourth Review and Appraisal**

Dutch Ministry of Health, Welfare and Sport  
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## Abbreviation list

AOW	Old Age Pensioning Act [Algemene Ouderdomswet]
CBS	Statistics Netherlands [Centraal Bureau voor Statistiek]
COVID-19	Coronavirus disease of 2019
GDP	Gross Domestic Product
IGJ	Health and Youth Care Inspectorate [Inspectie Gezondheidszorg en Jeugd]
MIPAA	Madrid International Plan of Action on Ageing
NZa	Dutch Health Care Authority [Nederlandse Zorgautoriteit]
OECD	Organization for Economic Co-operation and Development
PPE	Personal Protective Equipment
RIS	Regional Implementation Strategy
RIVM	National Institute for Public Health and the Environment [Rijksinstituut voor Volksgezondheid en Milieu]
SCP	The Netherlands Institute for Social Research [Sociaal en Cultureel Planbureau]
SDGs	Sustainable Development Goals
UNECE	United Nations Economic Commission for Europe
WHO	World Health Organization
Wlz	Long Term Care Act [Wet langdurige zorg]
Wmo	Social Support Act [Wet maatschappelijke ondersteuning]
ZIN	National Health Care Institute [Zorginstituut Nederland]
ZonMw	The Netherlands Organization for Health Research and Development [Nederlandse organisatie voor gezondheidsonderzoek en zorginnovatie]
Zvw	Health Insurance Act [Zorgverzekeringswet]

## Part I

### Executive summary

This report presents the fourth review and appraisal of the Regional Implementation Strategy (RIS) of the Madrid International Plan of Action on Ageing (MIPAA) for the Netherlands. It reflects on the developments of the past five years to address the three main goals of the 2017 Lisbon Ministerial Declaration: i) Recognizing the potential of older persons; ii) Encouraging longer working life and ability to work; iii) Ensuring ageing with dignity. In addition, this review and appraisal describes the main achievements in the implementation of MIPAA/RIS over the past 20 years in a nutshell. The report also includes a brief overview of the lessons learnt from managing the consequences and impacts of the COVID-19 pandemic for older people.

An independent academic institute (IQ healthcare) carried out this research. The method used for this review and appraisal includes desk research and a qualitative approach. Desk research consists of collecting and selecting information from documents issued by the government as well as grey and peer-reviewed literature. The qualitative approach entails 27 semi-structured interviews with various stakeholders. These stakeholders are selected by means of purposeful sampling. The stakeholders represent different institutions (e.g. ministerial departments, local government, academia, and organizations representing the interests of older persons), offering a wide range of perspectives. We also gave the stakeholders the opportunity to provide feedback on the concept version of this report.

The main finding of this report is that the Netherlands has made significant progress in improving the lives of older persons through different programs and structural reforms. To meet the first goal (i.e. recognizing the potential of older persons), the Netherlands has made a shift towards 'ageing in place' and by promoting healthy ageing. Healthy ageing is anchored in various programs and agreements that advance lifestyle interventions and prevention. The most significant achievement to meet the second goal (i.e. encouraging longer working life and ability to work) is pension reform. The reform improves the sustainability of pensions and enhances intergenerational solidarity. With respect to the third goal (i.e. ensuring ageing with dignity), various programs have been initiated and implemented to address this goal, including large investments and significant programs to improve the quality of long-term care.

Even though welfare standards are high, the Netherlands should strengthen its efforts to improve the lives of older persons. We have made several recommendations on which the Netherlands can focus in the future (see page 39). We highlight four of these recommendations in this executive summary. First, the Netherlands should enhance their efforts to ensure that there is sufficient supply of suitable housing and care for older persons. Housing and staff shortages already cause disruptions and will likely become an even greater challenge in future. Second, a substantial disparity exists between social groups with respect to healthy ageing. People from a low socioeconomic class have a significantly lower life expectancy than those from a high socioeconomic class. Substantial future efforts are required to address this vertical inequity. Third, due to developments such as digitalization, older persons may feel increasingly excluded from society. Investments are needed to guarantee the inclusion of older persons in society. Fourth, regional variation remains with respect to the supply of care and support, and requires attention.

On the whole, an integrated approach is needed to strengthen efforts to improve the lives of older persons in the Netherlands. This calls for collaboration between different ministries; between national and local governments; and between government and relevant stakeholders (e.g. NGOs and interest groups).

## General information

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n/a

## National ageing situation

### Demographic indicators and their projections

As in many other OECD countries, the population in the Netherlands is ageing[1]. The relative share of persons aged 65 to 80 years has increased in the Netherlands from approximately 10% to 15% since 2000 (Figure 1). Combined with a slight increase in the relative number of persons aged over 80 years, demographic trends show substantial growth of the ageing population. The population pyramids in Figure 2 (in 2020) and Figure 3 (projection for 2030) indicate that the trend of ageing will not take a turn in the upcoming decade. In fact, a large share of the Dutch population is currently between 50 and 60 years old, contributing to a further increase of the elderly share in the population in the next ten years. The share of persons over 70 is highest in rural areas, whereas younger age groups concentrate in urban areas (Figure 4).

The characteristics of older people have also changed over the years. In 2014, about 38% of people aged 70 and over live alone, and 23% have no children[2]. Older persons who live alone are more likely to require support and care[3]. In addition, the share of older persons with a migrant background will increase. In 2020, the share of people aged 65 and over with a migrant background accounts for 14%. This will increase to 25% in 2050[4].

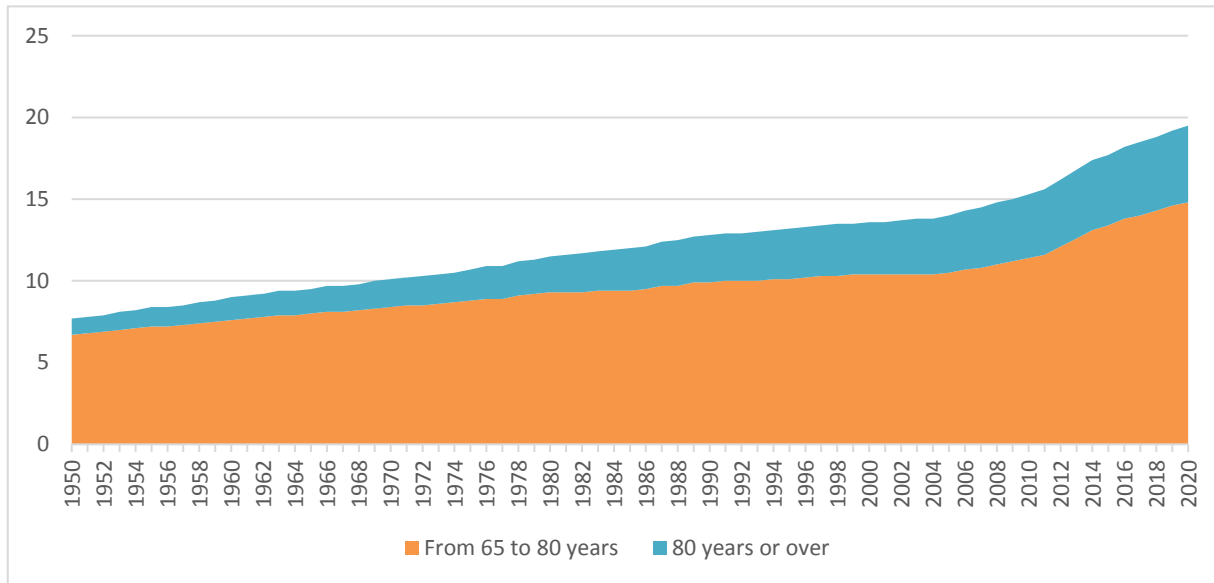
The average life expectancy has more or less stabilized for both males and females in the past five years (Figure 5). Life expectancy numbers for 2020 are outliers, which are likely caused by the COVID-19 pandemic and its detrimental effects on the older segment of the population[5]. The life expectancy in perceived good health, from 65 years onwards has fluctuated for females over the past five years, returning to the level of approximately 13 years in 2020 (Figure 6). Life expectancy in perceived good health for males has seen a steady rise in recent years, closing the gap with females (Figure 6). Life expectancy in perceived good health show opposite trends to actual life expectancy over 2020.

However, various factors are associated to life expectancy. One factor is socioeconomic status. Persons with a low socioeconomic status have a lower life expectancy compared to persons with a high socioeconomic status (Figure 7). This life expectancy gap between high and low socioeconomic status has increased in 2011-2014 compared to 2004-2007 with respectively 7.5 compared to 6.9 (Figure 7). Recent figures on the difference between low, middle and high educated persons exhibit similar trends[6]. The reasons behind this trend is numerous and complex, but people with a low socioeconomic status tend to have more unhealthy lifestyles. Which brings us to another important component behind life expectancy. A healthy diet and exercise are essential for a healthy lifestyle, and in turn relate to extending life expectancy (also in perceived good health). However, obesity remains a challenge in the Netherlands. Figure 8 shows that both sex and age relate to being overweight (BMI  $\geq$  25). Men are more often overweight than women and older persons are more often overweight compared to the younger age groups.

Figure 9 shows absolute numbers of death for each week in each year (2016-2020). The second quarter of 2020 demonstrates high mortality rates compared to previous years as a result of the COVID-19 pandemic. Most COVID-19 related deaths are suffered in age groups over 60. Males are more vulnerable to COVID-19 than females, demonstrated by higher COVID-19 related deaths in males (Figure 10).

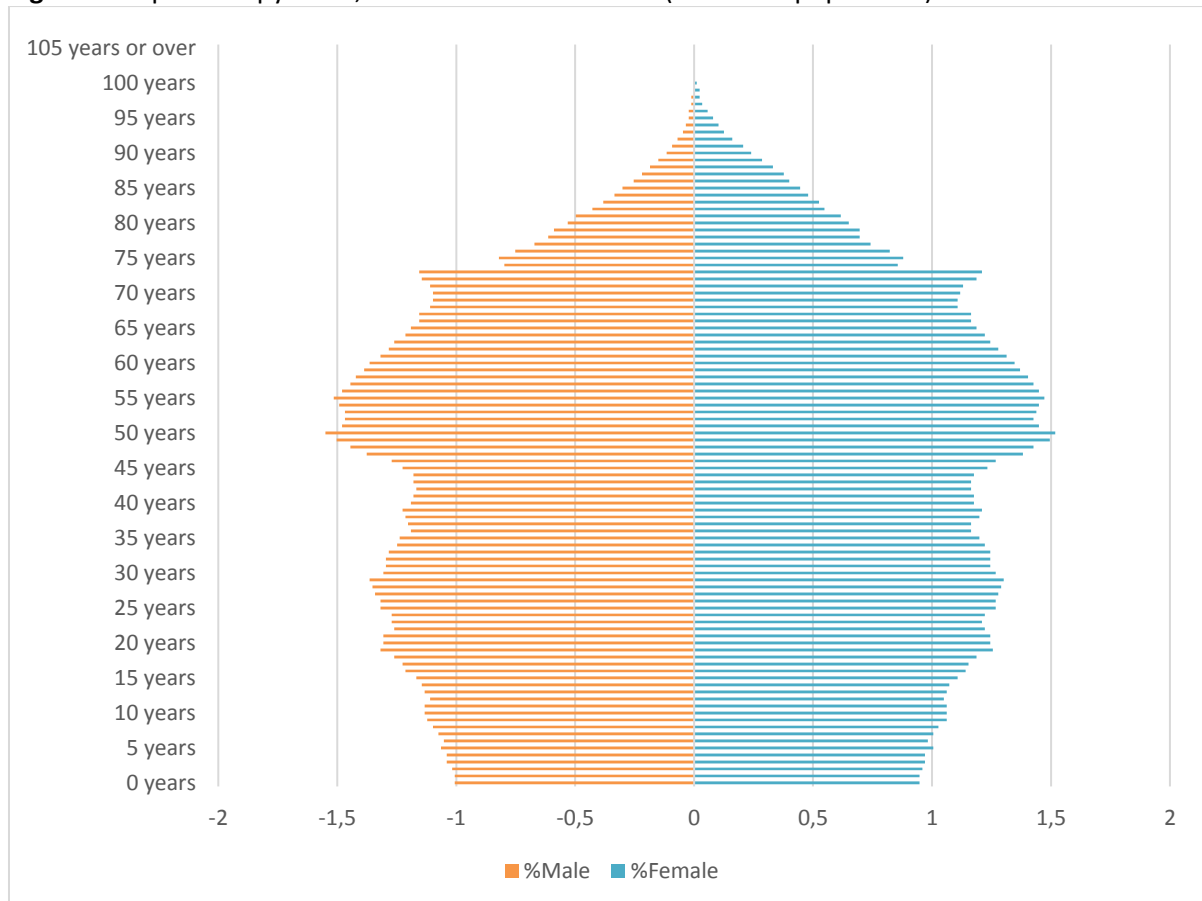
## Annex: Demographic indicators

**Figure 1.** Trend on ageing over 65 years and over 80 years (% of total population)



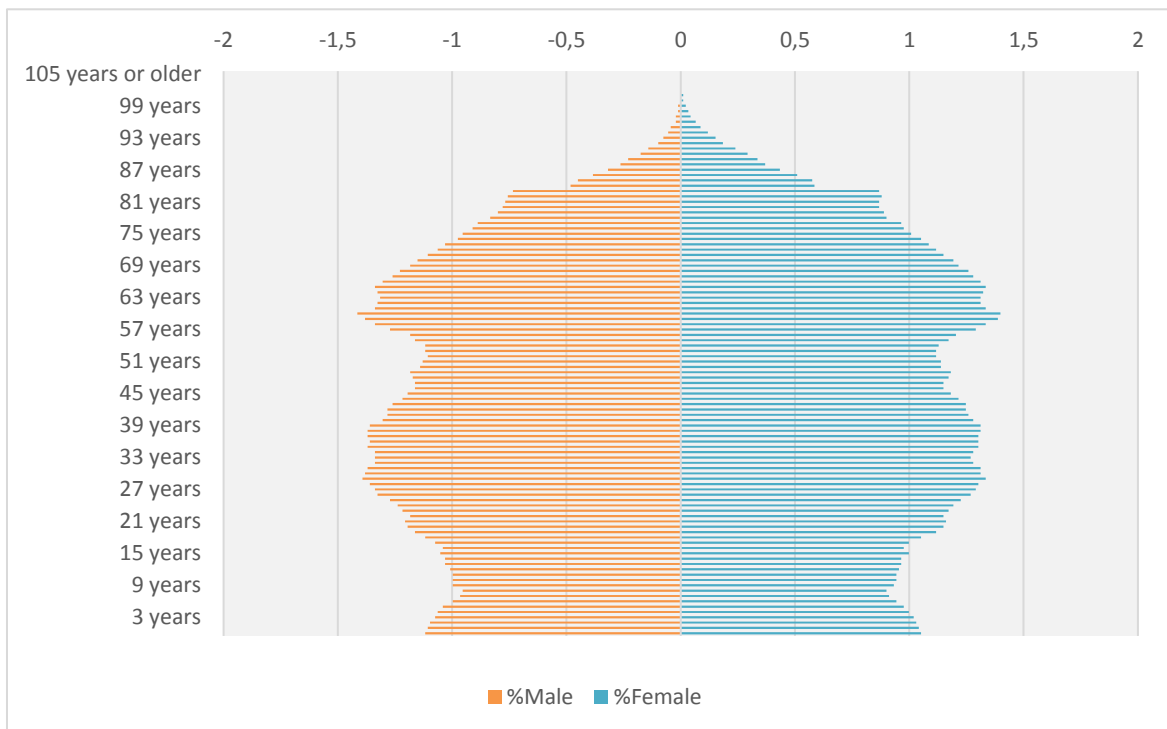
**Source:** Statistics Netherlands (CBS)[7]

**Figure 2.** Population pyramid, the Netherlands in 2020 (% of total population)



**Source:** Statistics Netherlands (CBS)[8]

**Figure 3.** Population pyramid projection for 2030 (% of total population)



**Source:** Statistics Netherlands (CBS)[8]

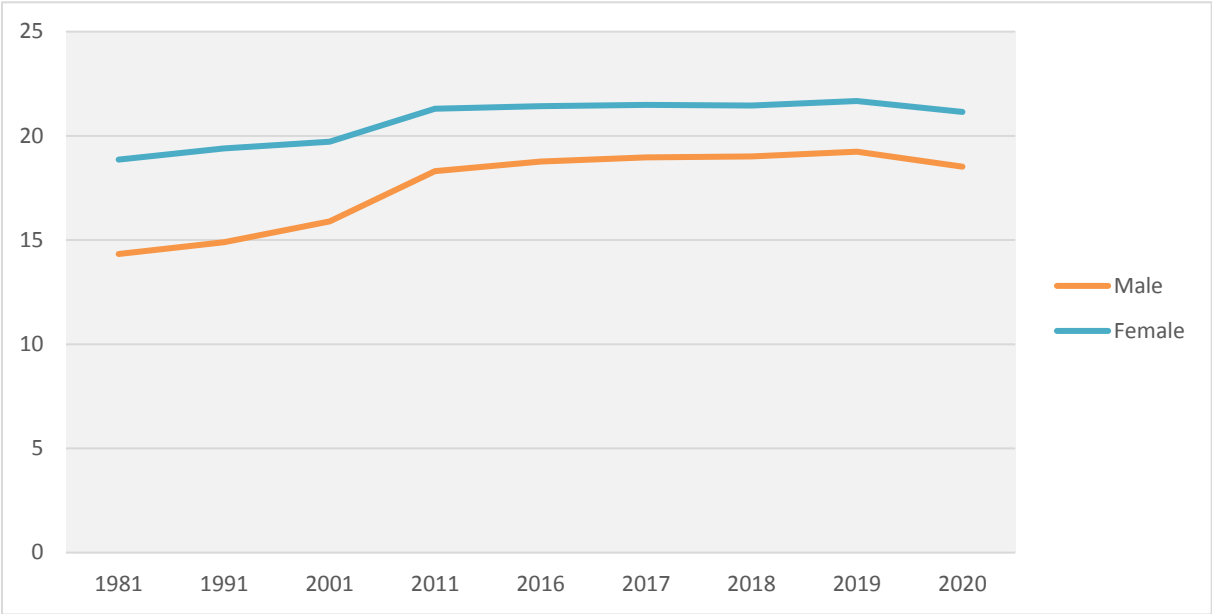
**Figure 4.** Regional variation in share of persons over 70 years



**Source:** Statistics Netherlands[9]

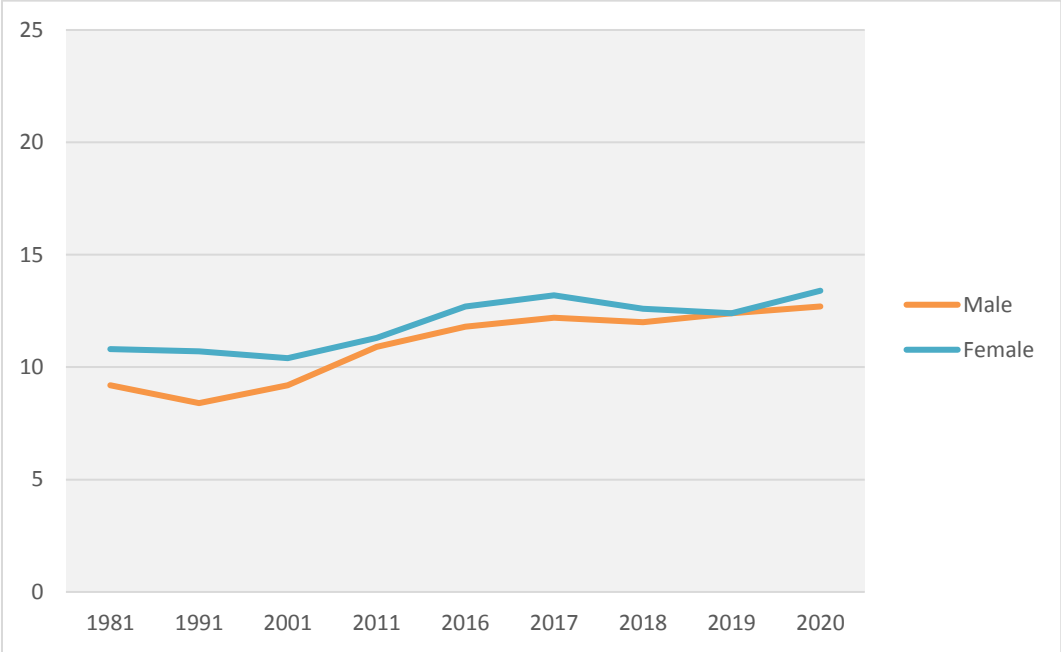


**Figure 5.** Life expectancy from 65 years old (in years)



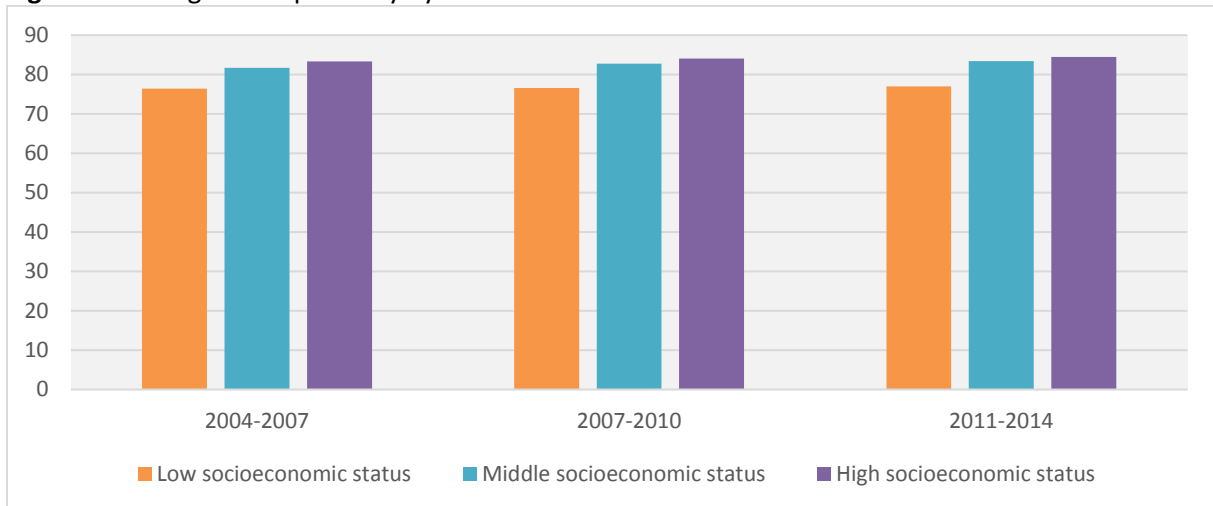
**Source:** Statistics Netherlands (CBS)[10]

**Figure 6.** Life expectancy in perceived good health from 65 years old (in years)



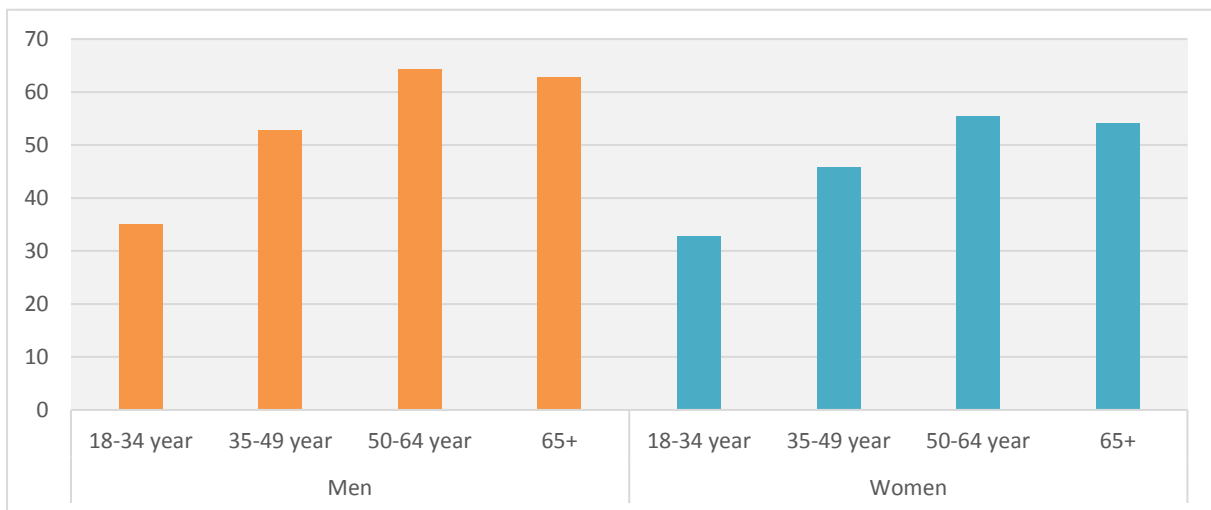
**Source:** Statistics Netherlands (CBS)[10]

**Figure 7. Average life expectancy by socioeconomic status**



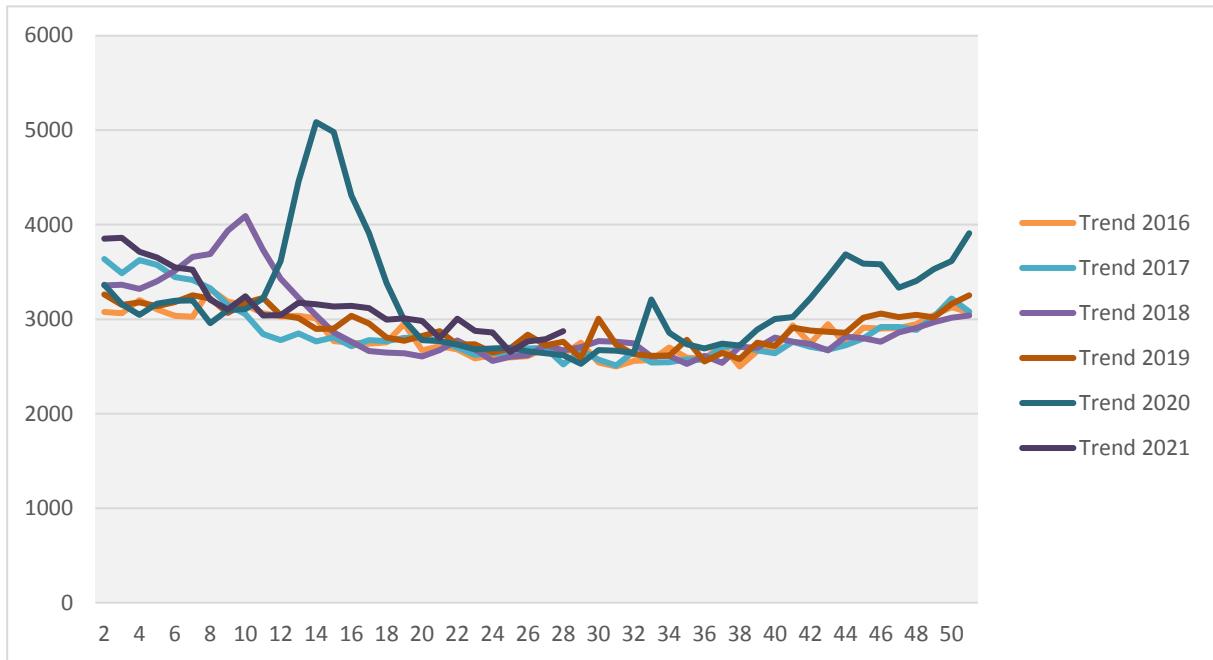
Source: RIVM 2018[11]

**Figure 8. Share of persons being overweight (BMI  $\geq 25$ ) (2020)**



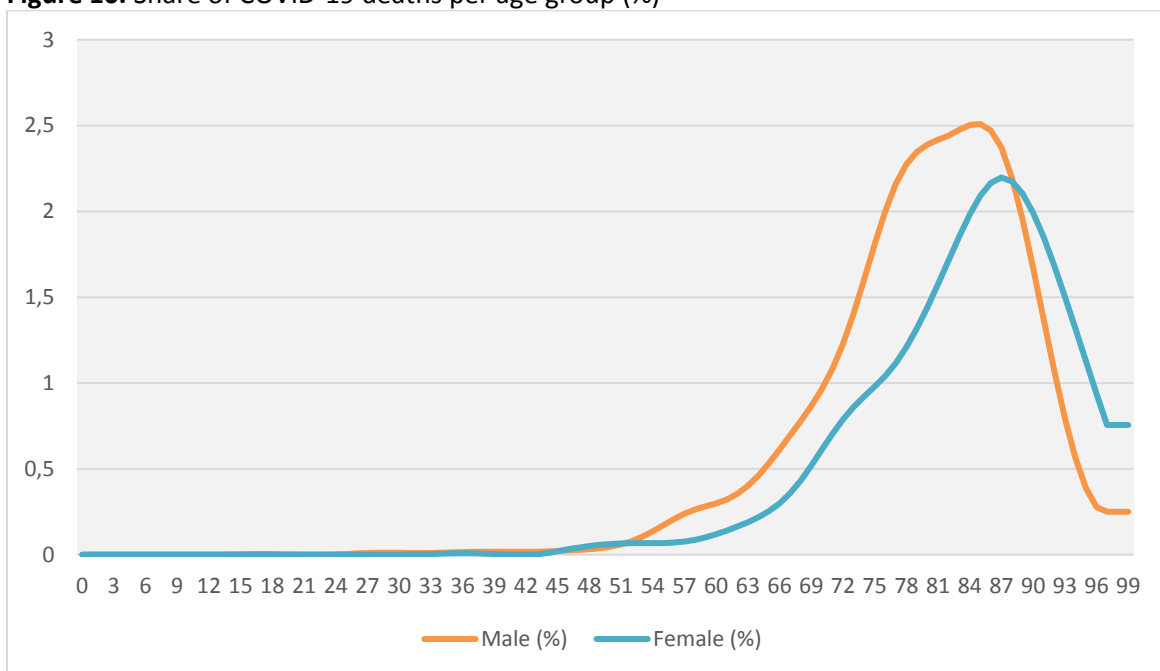
Source: [www.volksgezondheidenzorg.info](http://www.volksgezondheidenzorg.info) 2021 [12]

**Figure 9.** Number of deaths per year (absolute numbers per week)



**Source:** Statistics Netherlands (CBS)[13]

**Figure 10.** Share of COVID-19 deaths per age group (%)



**Source:** Statistics Netherlands (CBS), September 2020[5]

## Key quantitative social and economic indicators

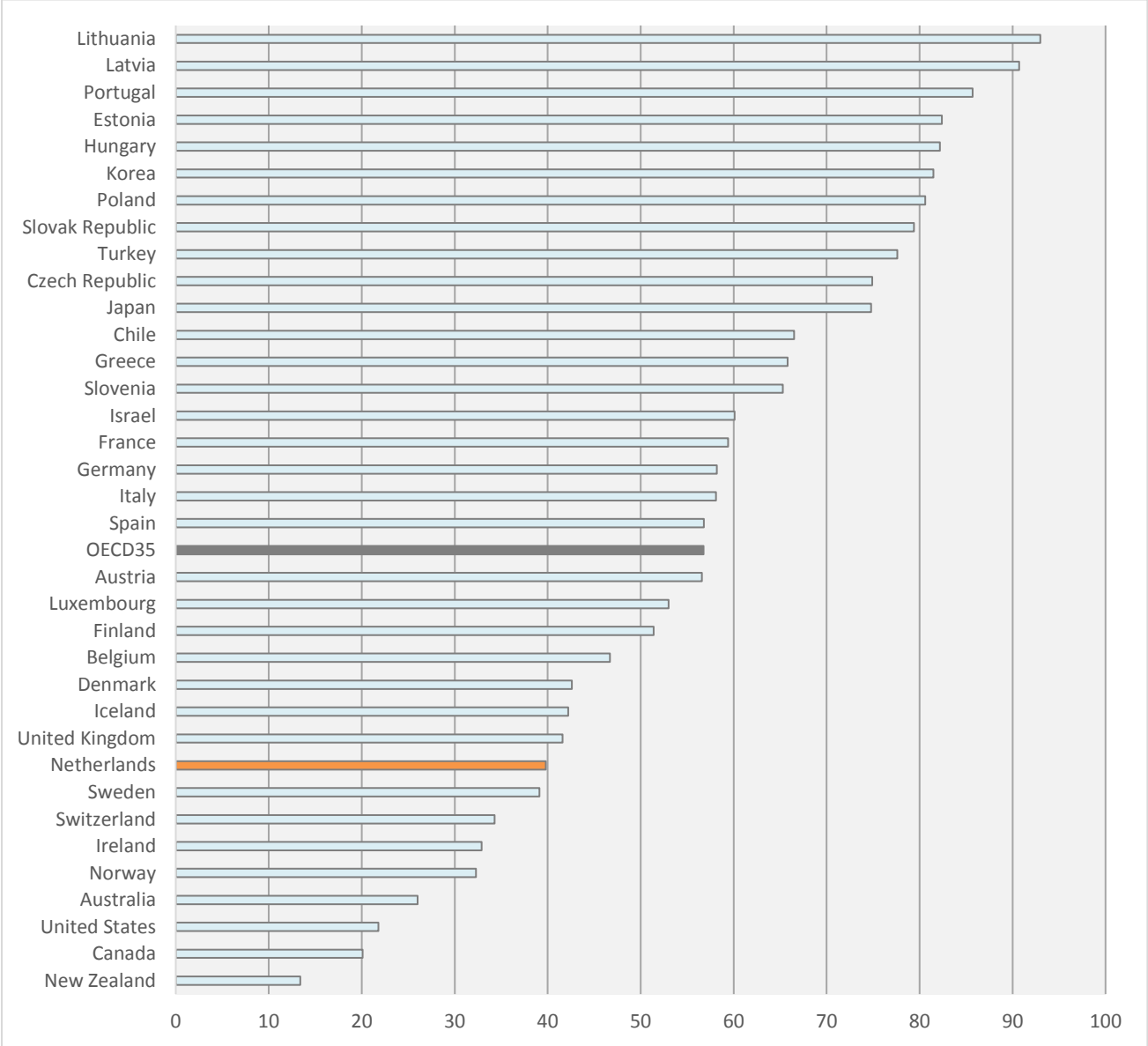
Compared to other OECD countries, the Netherlands scores well on different measures that relates to the well-being of Dutch citizens[14]. Life satisfaction among those 65 years and over in the Netherlands does not differ much from other age groups[15]. Also life satisfaction of older persons in the Netherlands is higher compared to the European average[15]. In addition, the share of persons aged over 65 years who rate their own health as fair, bad or very bad is low compared to other OECD countries (Figure 11).

Along with an ageing population, the average working life in the Netherlands increased over the years (Figure 12). The average age of retirement was 64.2 years in 2015 and 65.6 years in 2020. A large share of retirees was 66 years old in 2018-2020, which is illustrated in Figure 13. These trends are paired with improved labor participation in the age group 55–65 years old (Figure 14). The gross labor participation rate shows people that are either employed or unemployed (i.e. persons without paid work but are looking for work), whereas the net labor participation rate only indicates how many people are in paid work. The net rate excludes unemployed people, and is therefore lower than gross rates. Figure 14 also shows that the gap between male and female labor participation in the age group 55–65 years old has decreased in the past five years. Both groups have increased their labor participation, but female participation rates have also risen compared to male rates.

Although life expectancy, average retirement age and labor participation rates are increasing, a larger share of persons over 65 years was at risk of poverty in 2020 than in 2015 (Figure 15). These persons are “at risk of poverty after social transfers, severely materially deprived or living in households with very low work intensity”[16]. Social transfers include social support structures such as old-age pensions, unemployment benefits and family-related benefits[17]. As far as our knowledge goes, the determinants behind this rise remain uncertain. One possible factor is the increase in the share of older persons with a migrant background as migrants face higher risks of poverty[18]. Another potential factor that relates to poverty among older persons is home ownership. Older persons who do not own a house face financial difficulties more often than homeowners[19, 20].

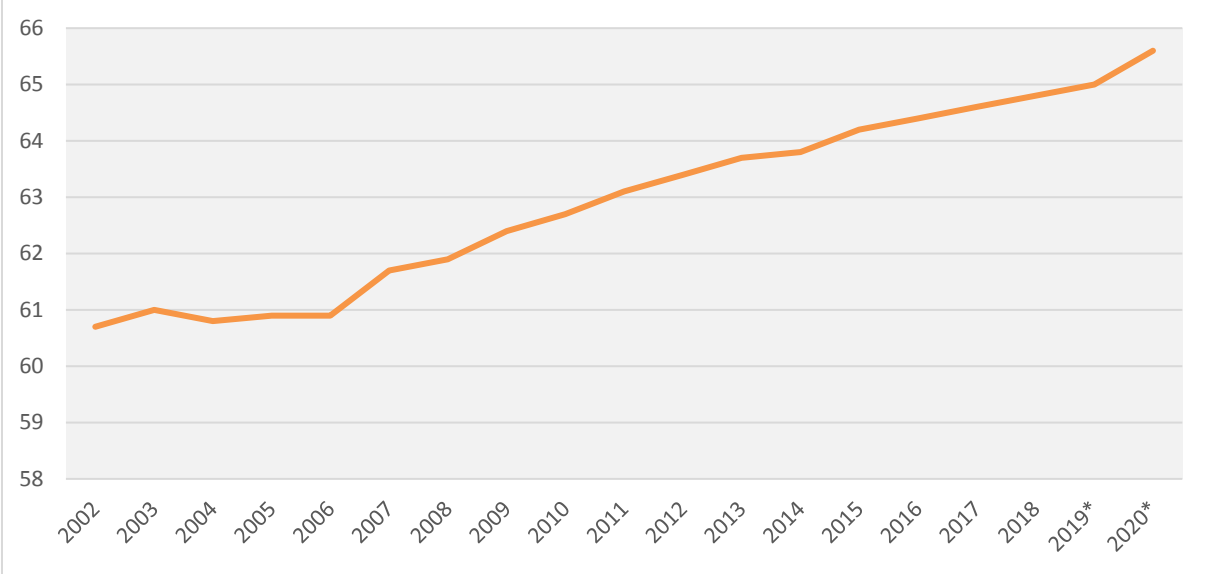
**Annex: Social and economic indicators**

**Figure 11.** Country comparison of the share of adults aged 65 years and over rating their own health as fair, bad, or very bad (2017 or nearest year)



Source: OECD 2019[21]

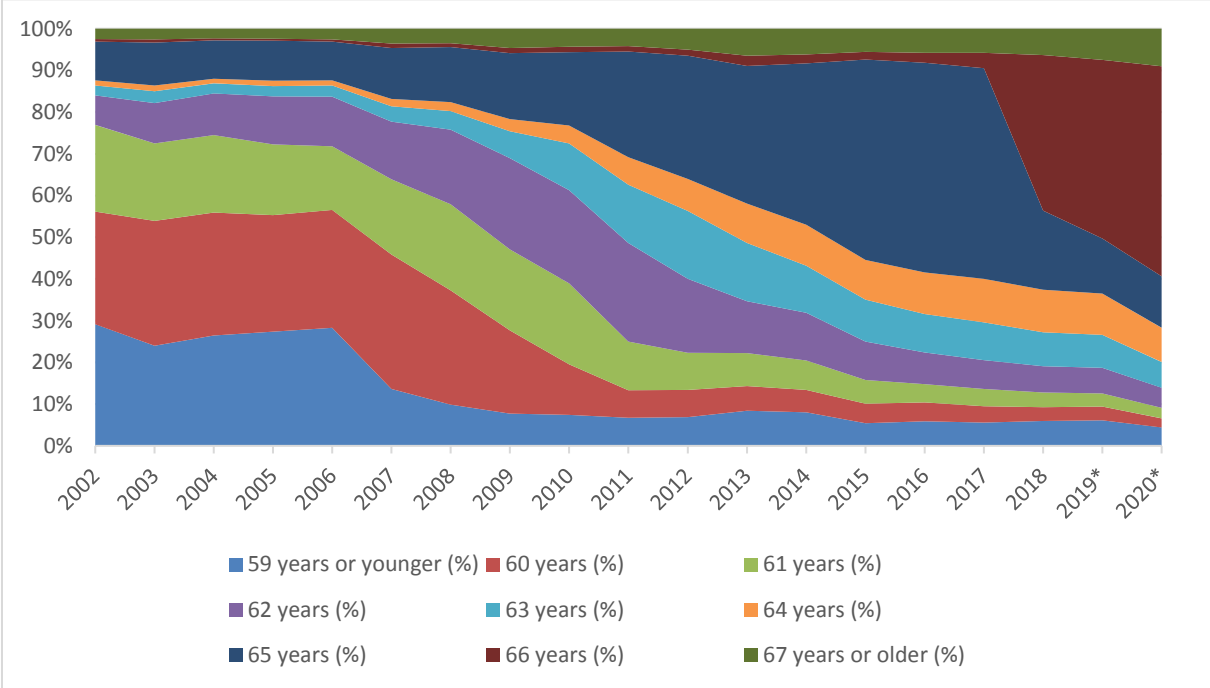
**Figure 12.** Average retirement age (in years)



\*Preliminary statistics

Source: Statistics Netherlands (CBS)[22]

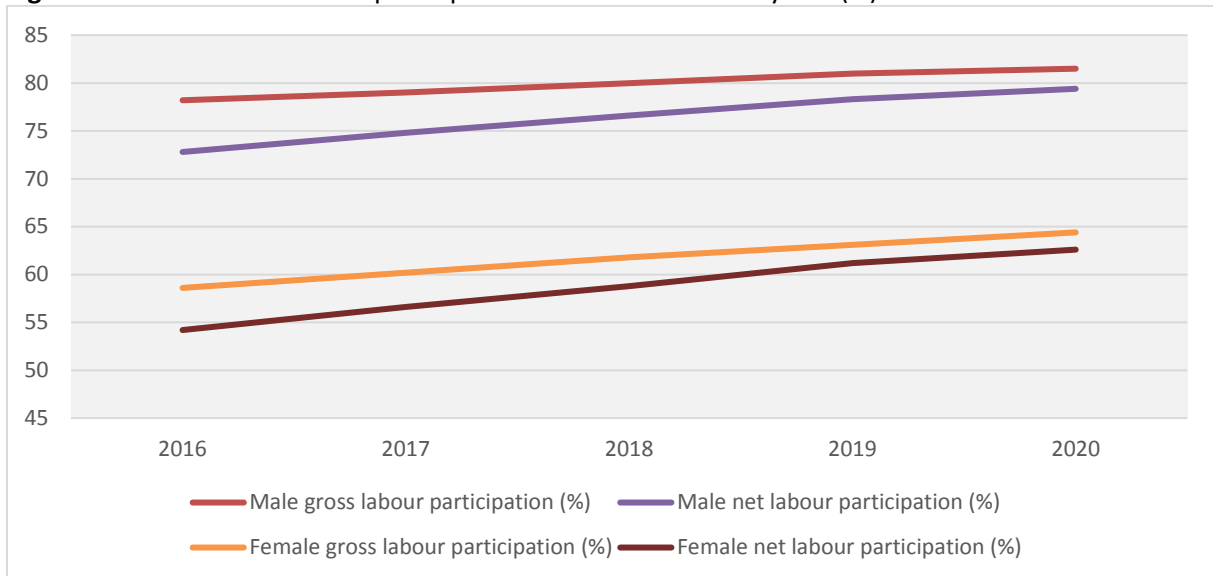
**Figure 13.** Relative number of pensioners per age group (%)



\*Preliminary statistics

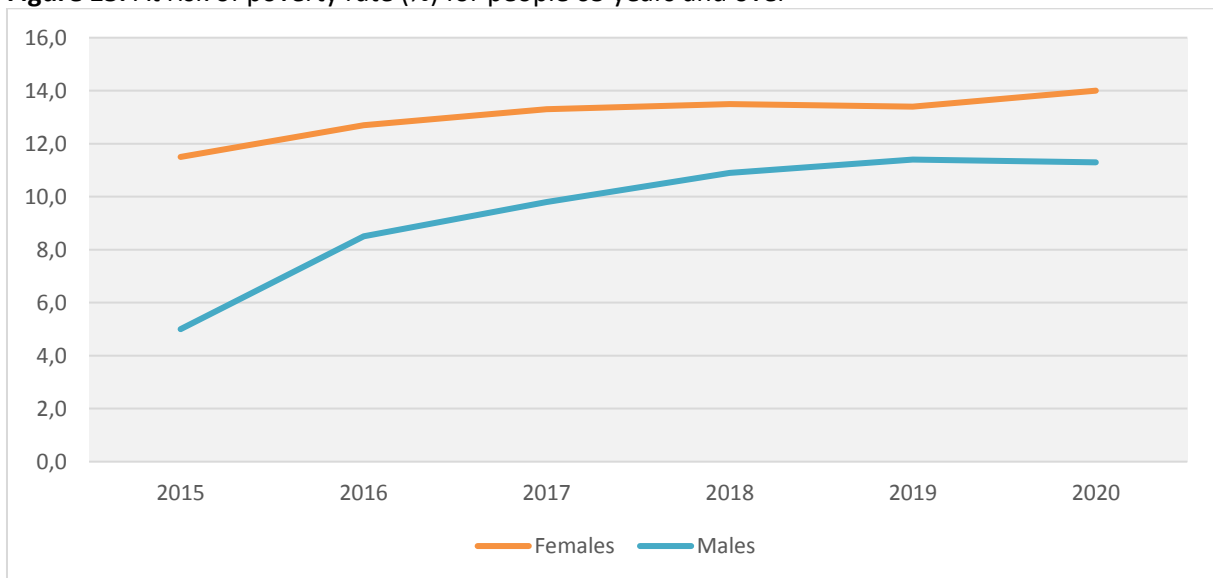
Source: Statistics Netherlands (CBS)[22]

**Figure 14.** Gross and net labor participation between 55 and 65 years (%)



**Source:** Statistics Netherlands (CBS)[23]

**Figure 15.** At risk of poverty rate (%) for people 65 years and over



**Source:** Eurostat[24]

## Description of social, economic and political situation

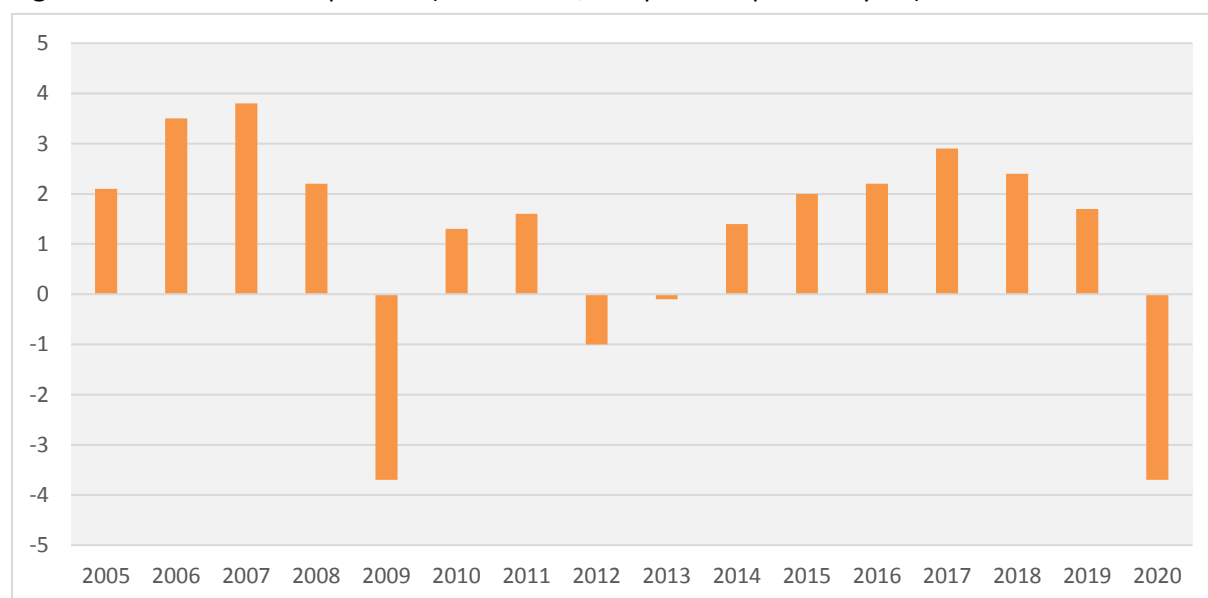
The third Review and Appraisal of MIPAA/RIS reported reaching the milestone of 17 million inhabitants in the Netherlands[25]. As of August 2021, the number of inhabitants has surpassed 17.5 million. The population density is relatively high compared to most other countries, with 517 inhabitants per square kilometer as of January 2020[26]. As a result, the Netherlands is the most densely populated nation in the European Union, after Malta.

The Dutch economy was characterized by annual growth in the period 2014-2019 (Figure 16). Due to the COVID-19 pandemic and its subsequent measures, the Gross Domestic Product (GDP) in the Netherlands dropped significantly in 2020. Recent figures do show recovery signs, as investments are increasing, but household consumption is still below the levels of before the COVID-19 pandemic[27].

The total amount of health care expenses in relation to the GDP have steadily risen since 2000. However, growth of these expenses has decelerated in the last 10 years as compared to the period 2000-2010[28]. The Netherlands rank 7<sup>th</sup> in the OECD in terms of health expenditure in relation to GDP, as of 2019 (Figure 17).

The Netherlands has the highest long-term care expenses of all OECD countries, allocating more than 3.5% of GDP on long-term care services in 2018[29] (see Figure 18). The majority of these expenses are in nursing homes (approximately 80%), and remaining expenses are allocated to hospitals, home care, social providers and households[29]. (Please note that the definition of long-term care expenses differs across OECD countries. It is therefore difficult to compare these costs across borders. A recent study finds that the long-term costs discrepancy between the Netherlands and Denmark is much smaller than the OECD statistics suggest[30], because Denmark does not include all its social care expenses in its OECD statistics.)

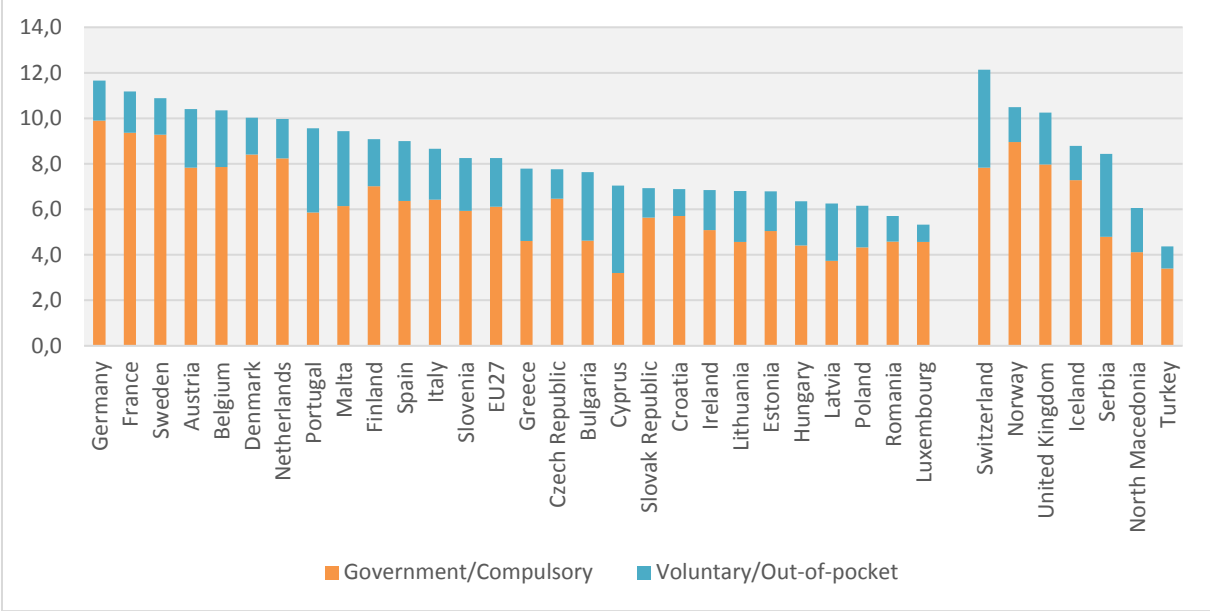
**Figure 16.** Gross domestic product (%-mutation; compared to previous year)



**Source:** Statistics Netherlands[27]

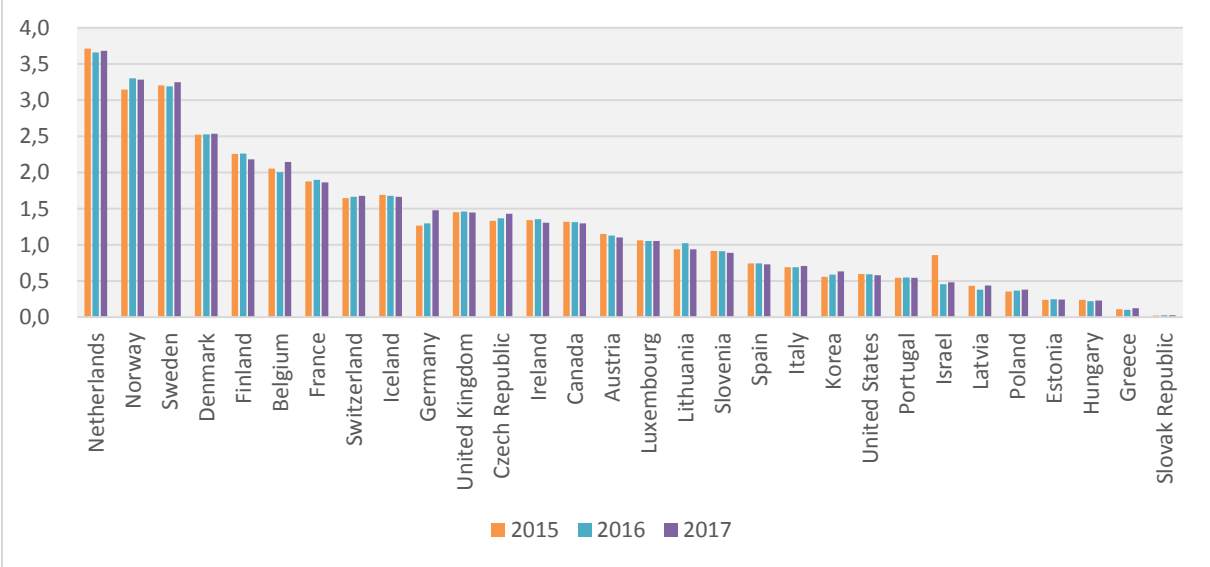


**Figure 17.** Health expenditure in relation to GDP, in percentages (2019)



**Source:** OECD[31]

**Figure 18.** Long-term care expenditure by government and compulsory insurance schemes in relation to GDP, in percentages (2017 or nearest year)



**Source:** OECD [21]

**Social and economic policies in relation to the COVID-19 pandemic**

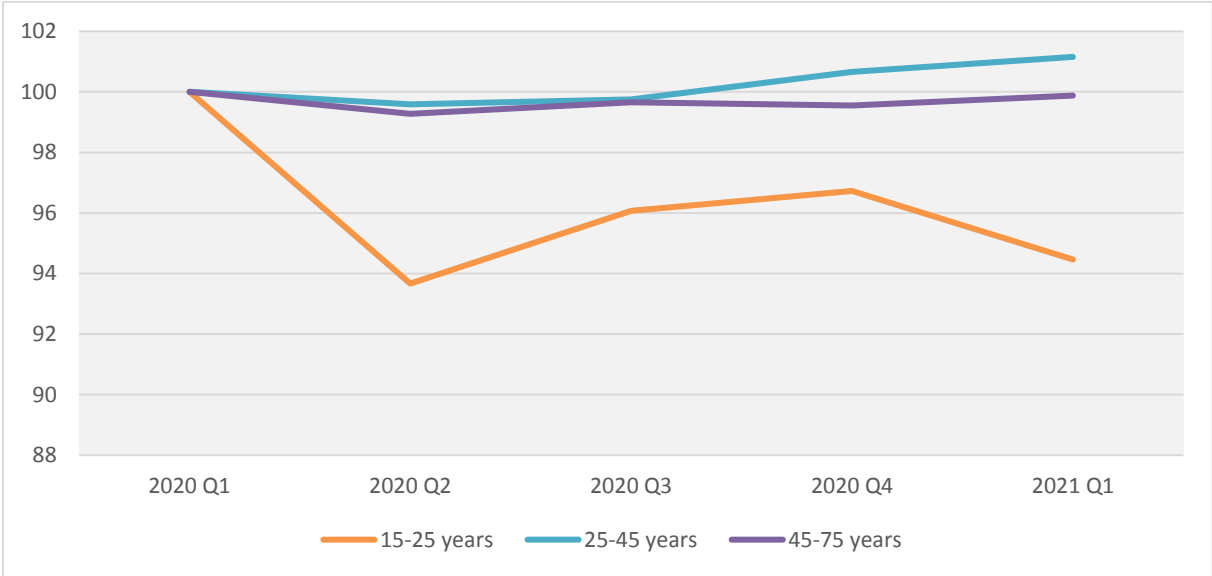
The first case of COVID-19 was identified at the end of February 2020 in the Netherlands. Shortly after, government measures were taken to prevent the spread of the virus[32]. The government instituted an ‘intelligent lockdown’, meaning that not all outdoors activities were banned and persons without any COVID-19 symptoms or within their household were still allowed to leave their house. Those

suffering from symptoms were required to take a COVID-19 test and go into quarantine. Older persons were particularly affected by the visitor ban for nursing homes, which was instituted on March 20<sup>th</sup> in 2020[32]. (This report includes a longer description of the impact of the COVID-19 pandemic on page 36.)

The government introduced several economic policies to support individuals, households and organizations suffering financially from lockdown measures[33]. The most important measure of these so-called ‘support- and recovery packages’ is NOW [Noodmaatregel Overbrugging voor Werkgelegenheid]. This package consists of funds for entrepreneurs suffering at least 20% up to a maximum of 80% of revenue loss. Up to 85% of personnel costs are covered by this government measure[34]. The NOW package has been extended for the fourth time, until September 30, 2021[34].

Government lockdown and support measures seem to affect younger persons (15-25 years) negatively in their employment rates, while persons in the age categories 25-45 and 45-75 are mostly unaffected (Figure 18). The lockdown measures resulted in a reduction of temporary and part-time jobs (typically filled by younger people) and support measures created a safety net for those in tenure jobs (typically older persons).

**Figure 18.** Employment rates per age category since 2020 (Quarter 1 of 2020 is base period =100)



**Source:** Statistics Netherlands[35]; inspired by “Jong tijdens corona: minder werk, meer bijstand, geen stage en achteraan in de vaccinatierij” Mathijs Bouwman, Het Financieele Dagblad, 25 juni 2021

## Method

Several data sources were used to review and appraise the advancements in the Regional Implementation Strategy (RIS) of MIPAA in the Netherlands. First, several publicly available statistical data sources were used to chart key demographic, economic, social and political developments. Most data were available through Statistics Netherlands [Centraal Bureau voor de Statistiek]. Data by Eurostat and OECD were also used to supplement national data.

Second, academic and grey literature (e.g. government reports, working papers, policy briefs) were used to identify policy developments for people aged 65 and over in the past five years. We searched academic literature for evaluations using empirical evidence on policy reforms for older persons in since 2002.

Third, dialogue sessions were organized with representatives of ministerial departments, NGOs, social partners, academic organizations and civil society (see Table 1 for an overview). These dialogue sessions were held online due to COVID-19 restrictions. The sessions were semi-structured and followed three steps. First, a short introduction on MIPAA/RIS was given by the authors, explaining the three main goals adopted in the 2017 Lisbon Ministerial Declaration. Second, stakeholders were then asked to reflect upon these goals from their point of view, using the last five years as time frame. Finally, stakeholders were asked to reflect on the impact of COVID-19 and the lessons learnt for managing the consequences and impacts for older people in emergency situations.

A draft report was written after collecting data from these three sources. Subsequently, participating stakeholders were approached to provide feedback on the draft report. This led to several corrections and additions to the draft report. Close cooperation with the National Focal Point was maintained throughout the process of the review and appraisal.

Older persons are traditionally defined by the United Nations and researchers as persons aged 60 and over or 65 years and over[36]. However, a more nuanced perspective on ageing may be required to account for international and regional differences in mortality risks, health status and socioeconomic characteristics[36]. Therefore, in this report we refrain from defining 'older persons' by a certain age, because the definition is likely to be topic- and context-dependent. The report adopts the definition of older persons used in the relevant policies, reports or measures.

## Annex

**Table 1.** Overview of respondents per stakeholder and type

<b>Stakeholder</b>	<b>Type</b>	<b>Number of respondents</b>
Ministry of Health, Welfare and Sport	National government	4
Ministry of Social Affairs and Employment	National government	1
Ministry of Infrastructure and Water Management	National government	1
Ministry of Economic Affairs and Climate Policy	National government	2
Ministry of Education, Culture and Science	National government	1
Municipality of Amsterdam	Local government	1
Zorginstituut Nederland (ZiN) [National Health Care Institute]	Governmental organization	1
Rijksinstituut voor Volksgezondheid en Milieu (RIVM) [National Institute for Public Health and the Environment]	Governmental organization	1
Sociaal en Cultureel Planbureau [Social and Cultural Planning Office]	Governmental organization	3
Vilans (Long-term care expert center)	NGO	2
Member of Raad van Ouderen (RVO) [The elderly council]	Representative organization for older persons	1
Koepel Gepensioneerden	Representative organization for older persons	1
Algemene Nederlandse Bond voor Ouderen (ANBO)	Representative organization for older persons	1
KBO-PCOB Katholieke Bond van Ouderen en Protestants Christelijke Ouderenbond	Representative organization for older persons	1
Actiz (Branch association long term care providers)	Social partner/ NGO	1
Leyden Academy on Vitality and Ageing	NGO/ academic organization	1
Pharos (expert center for inequalities in health care)	NGO	1
Alzheimer Nederland (Alzheimer's Netherlands)	NGO	2

## **Part II: 20 Years of MIPAA/RIS**

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

At the fourth Ministerial Conference on Ageing in Lisbon in 2017, the representatives of the member States of the United Nations Economic Commission for Europe (UNECE) restated their commitments to fulfil the Regional Implementation Strategy (RIS) of MIPAA. At the Lisbon Ministerial Declaration [37], three main policy goals for 2022 were set:

- (1) Recognizing the potential of older persons;
- (2) Encouraging longer working life and ability to work;
- (3) Ensuring ageing with dignity.

Part II of this report discusses the progress towards these policy goals. Relevant and important policy developments are described for each goal. The most prominent developments are described first within each goal. Additional and supporting information is provided in textboxes throughout the report.

### **Recognizing the potential of older persons**

Several developments took place in the Netherlands over the past five years to improve and optimize the potential of older persons. This development can roughly be categorized into three categories: 1) the long-term care reform and ‘ageing in place’; 2) facilitating healthy ageing and age-friendly environments and housing; and 3) positive image of older persons.

#### The long-term care reform and ‘ageing in place’

The long-term care system in the Netherlands was drastically reformed in 2015 (as described in the previous MIPAA/RIS review and appraisal[25, 38]). This reform supported a change towards financial sustainability, more decentralization, and deinstitutionalization[38]. Financial sustainability was one of the main drivers of the long-term care reform. Before the reform, long-term care costs were increasing steadily and policymakers aimed to curb the trend. During the reform, significant cuts were made to the long-term care budget. This raised serious concerns about the quality of care in nursing homes and, in response, long-term care funding picked up again just two years after the reform[39].

The reform consisted of several elements. In the Social Support Act [Wmo], social care was decentralized and became the municipalities’ responsibility – more so than before the reform. This meant that municipalities were mandated to manage more social care tasks and, subsequently, a higher budget. However, the cumulative total long-term and social care budget was smaller, due to expectations of efficiency gains from decentralization. The Long-term Care Act [Wet langdurige zorg] regulated and organized long-term care for clients with severe care needs at home or within a residential care setting. Regional care offices remained responsible for purchasing long-term care within their region. These offices are run by a single health insurer, typically the regional market leader. Deinstitutionalization of the long-term care reform was part of a normative reorientation towards reducing medicalization and towards more individual and social responsibility[38]. As a result, policies aim to facilitate ageing in a home-setting instead of an institutional setting (‘ageing in place’). This transition required however some fine-tuning along the way. Three policy developments that have smoothed the transition are outlined below.

First, the ‘alliance for elderly care’ [Pact voor de Ouderenzorg] was formed in March 2018 to address three main points of action: combating loneliness, supporting ‘ageing in place’, and improving quality of nursing home care[40]. Through this alliance, various programs were launched, which are mentioned in this report as well (e.g. United against Loneliness’ [Eén tegen Eenzaamheid]). The alliance

was signed by 35 stakeholders (i.e. branch organizations, municipalities, health care providers, elderly representative organizations, and private companies) in the field.

Second, the policy program to facilitate ‘ageing in place’ and maintaining autonomy for older persons was initiated in 2018 [Programma langer thuis]. The government allocated €340 million in 2018 until the end of 2021 to achieve three aims: (1) providing better support and care at home; (2) supporting informal caregivers and volunteers; (3) facilitating more age-friendly living environments for older persons[41].

Third, funds were also allocated to relieve the burden of informal caregivers and volunteers. A respite care incentive [Aanjager respijtzorg] was introduced to encourage the uptake of respite care among informal caregivers. In addition, a pilot started in ten municipalities which facilitated older persons who receive informal care at home to stay at a nursing home temporarily (a kind of respite care). The government supported this pilot with €1 million[42].

### Facilitating healthy ageing and age-friendly environments and housing

Prevention has gained public interest in the past five years. The National Prevention Agreement [Nationaal preventieakkoord] was introduced in 2018, supported by a large number of stakeholders in civil society and the private sector[43]. Its main targets are reducing smoking, obesity and alcohol use among the wider population. One prevention program, introduced as part of the National Prevention Agreement, encourages and supports municipalities to reduce the life expectancy gap between socioeconomic groups [GezondIn] (see Figure 7). (The Public Health Act [Wet publieke gezondheid], introduced in 2008, had already given municipalities the responsibility for protecting and promoting public health among older persons[44].)

Current and future generations are likely to benefit from the National Prevention Agreement, as improving lifestyles is likely to improve healthy ageing. An early evaluation (2019) of the effects of the National Prevention Agreement shows moderate positive results[45]. Other prevention programs are relevant for older persons as well, such as reducing the risk of falling and the vaccination program for the influenza virus, carried out by The National Institute for Public Health and the Environment [RIVM]. In addition, the aim of the RIVM is to establish early detection mechanisms for frailty in older persons[46].

#### **Box 1:**

##### **Municipality of Amsterdam: Vital & Healthy**

The municipality of Amsterdam launched the policy program ‘Vital & Healthy’ [Vitaal & Gezond] for the period of 2020-2024. The municipality of Amsterdam began to collaborate with one large health care insurer, various health care providers and client organizations to reinforce policies across medical and social care domains. The aim of the program is to achieve equal opportunities to live in good health. While the program may benefit all inhabitants of Amsterdam, specific focus goes out to elderly care, mental health, youth care and chronic care[47].

The housing market in the Netherlands has faced shortages over the past five years. The nationwide deficit of appropriate housing is estimated at 300,000 homes in 2021[48]. The financial crisis in 2008 caused the construction of houses to stagnate, despite the continued growth of the population. Recently, environmental restrictions have resulted in fewer permits for construction[49]. Older persons are also affected by these trends as fewer elderly-friendly living facilities are available for the growing share of persons aged over 65. A recent advisory report from an inter-ministerial workgroup stresses the need to address housing challenges for vulnerable groups such as older persons by means of an integrated approach[50].

Age-friendly living environments were stimulated by several policy measures. A policy was released in 2019, which aimed to incentivize the development of new facilities for housing and care for older persons[51]. The policy focused on financing initiatives of citizens or social entrepreneurs. This consisted of three arrangements:

- Subsidy for initiating a new housing and care arrangement;
- The government is the guarantor for 2/3 of the loans up to a maximum of €200,000 in the development phase;
- The government is guarantor for 15% of the loan of establishment costs, which allows entrepreneurs to finance the project at a faster rate[52].

This financial stimulation program targets the development of small-scale and clustered housing arrangements for people with low and middle income. Furthermore, municipalities are supported in developing a vision for housing – fitting their local context. A taskforce was initiated in 2020 to further aid this process [Taskforce Wonen en Zorg]. Several stakeholders are involved in this taskforce: the Ministry of Health, Welfare and Sport; the Ministry of Interior and Kingdom Relations; the Association of Dutch Municipalities (VNG); Aedes and Actiz (umbrella organizations for housing corporations and long-term care organizations, respectively)[53]. Their aim is to facilitate municipalities in addressing the housing deficits for elderly. In 2021, the Association of Health Insurers (ZN) joined this taskforce. On April 8 2021, these organizations agreed to build an additional 25,000 nursing home units and an additional 60,000 housing facilities in the next five years, and also to increase the number of adapted housing units for older persons [Bestuurlijke afspraken Wonen en Zorg][54].

**Box 2:**

**Bicycle mobility program elderly [Programma Doortrappen]**

Cycling has a positive effect on healthy ageing, social inclusiveness and autonomy for older persons. However, 75% of cycling accident casualties are among people aged 65 years and over[55]. The program for bicycle mobility, initiated by the Ministry of Infrastructure and Water Management in 2018, aims to stimulate older persons to keep cycling safely. Municipalities are free to join the program that is designed with stakeholders in the region. Approximately 150 municipalities have joined the program. The national government has invested €100 million in improving safety of bicycle lanes and bicycle parking for the overall population.

Positive image of older persons

Several achievements have been made to improve the representation and positive image of older persons. An advisory body of elderly to the Ministry of Health, Welfare and Sport was established in 2018, to ensure involvement of older persons and their representatives[56]. The so-called council of elderly [Raad van Ouderen] offers advice to the Ministry and raises attention for new policy themes (agenda-setting). An advisory report was published by the Council of Public Health and Society – an independent advisory body to the government and parliament – on the image of older persons within society[57]. They noted an important precondition for optimizing the potential of older persons: the generational awareness of the added value of older persons for society. A manifest was published and endorsed by several political parties, elderly organizations and an elderly broadcasting organization in 2017, which aimed to improve the image and appreciation of older persons [Waardig ouder worden; WOW][58]. The Ministry of Health, Welfare and Sport and the council of elderly launched a campaign to further raise this awareness at the end of 2020 called ‘The value of ageing’[59].

## Participation in other campaigns

The Global Campaign to Combat Ageism is led by the World Health Organization (WHO). Ageism is defined as ‘how we think (stereotypes), feel (prejudice) and act (discrimination) towards others or ourselves based on age’[60]. While the Netherlands does not take part in the Global Campaign, several policy measures are in place to combat ageism, which are described below. The Netherlands does participate in the Open-ended Working Group on Ageing (OEWG-A).

Discrimination in general is prohibited by law (Article 1 of the constitution), and an act to ensure equal treatment at the workplace across age groups was passed in 2004[61]. Furthermore, employers are financially incentivized to hire older (over 56 years) and those disabled since 2018. While a policy program was active prior to 2018 and offered a discount on social premiums for older employees, the new arrangement allows more employers to make use of the compensation[62]. Finally, The Netherlands Institute for Human Rights [College voor de Rechten van de Mens] actively protects and promotes human rights since 2012[63].

## Potential of older persons in the last 20 years

Three main developments characterize the shift towards recognizing the potential of older persons in the last two decades. The first shift is an increase of older persons living autonomously at home (‘ageing in place’). The Dutch government has both facilitated and stimulated this shift [Program Langer Thuis]. An evaluation by the RIVM in 2020 found that of among persons over 75 living at home, 75% consider themselves in control of their life, 63% indicate they receive adequate support and care, and 74% consider themselves competent in arranging support and care[64]. The second trend is a shift towards healthy ageing, lifestyle interventions and prevention. The National Prevention Agreement [Nationaal Preventieakkoord] embodies this development. The notion of positive health is illustrative of this broader approach to health (see box 3 for a short description). Policymakers and researchers have increased their efforts to focus on and improve positive health[65]. The third trend is the recognition that pensioners remain a key workforce for society. For example, they contribute as volunteers or as informal care workers.

Future actions require a persistent focus on prevention, as lifestyle diseases such as obesity are becoming more prevalent. Whereas approximately one third of the population was overweight in the Netherlands in the 1980s, this number has risen to approximately half of the Dutch population[66]. The National Prevention Agreement aims to reduce overweight, heavy drinking and smoking by 2040. The National Institute for Public Health and the Environment [RIVM] has contributed to research on prevention and closely monitors the progress of policy efforts that address prevention. Their efforts, as well as other academic institutions, play an important role in addressing future challenges in prevention. For example, alcohol consumption among older persons remains a challenge and deserves future attention[67]. Furthermore, housing deficits remain an important challenge for older persons in the upcoming years. An increased share of older persons who remain in their home-setting (‘ageing in place’) require appropriate housing, such as housing with street-level entrance and proximity to facilities[68]. The current housing crisis may make those efforts more challenging. The last topic that will require attention is to continue efforts that make environments age-friendly. This requires collaboration between different governments (national and local), ministries and sectors.

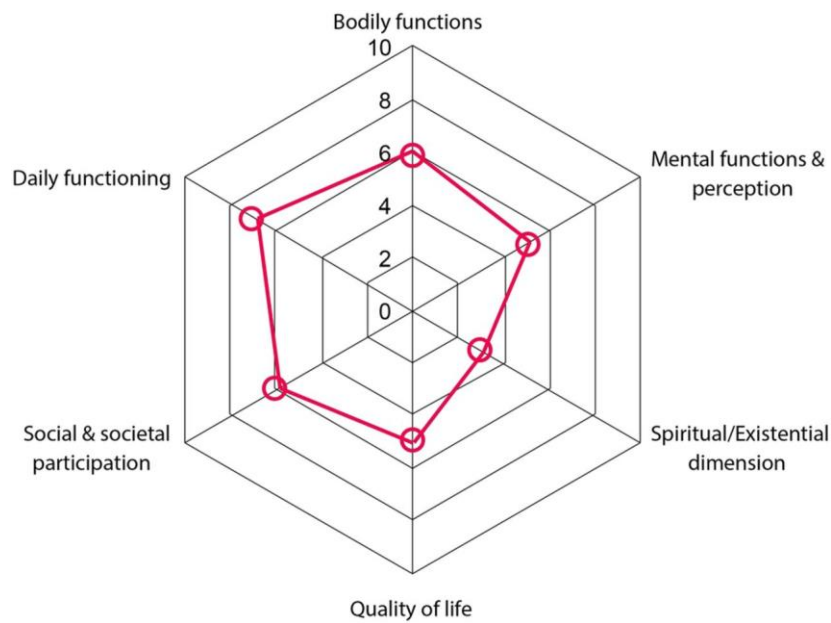
### **Box 3.** The concept of ‘positive health’

The WHO defined health as ‘A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’ in 1948[69]. Recent developments have led to broader considerations of the concept of health, in which disease may coexist with health. In the Netherlands, the concept of ‘positive health’ was introduced by Machteld Huber[70]. This concept encompasses six dimensions of health: (1) bodily functions; (2) mental functions and perception; (3)



spiritual/ existential dimension; (4) quality of life; (5) social and societal participation; (6) daily functioning (Figure 19). The approach of 'positive health' allows for a more dynamic approach to health, in which personal dimensions can influence the perception of health. This concept is particularly relevant for older persons, as they often suffer from one or multiple diseases, while they may still consider themselves healthy. Policy developments in the last 20 years have incorporated these dimensions and taken personal circumstances into consideration.

**Figure 19.** Six dimensions of 'positive' health (fictional estimation)



**Source:** Huber et al., 2016[70]

## Encouraging longer working life and ability to work

As the description of the quantitative social and economic indicators in the rapport already highlighted, the trend towards a longer working life has persisted in the Netherlands over the last five years. Various policy reforms and programs have been implemented to support and regulate this development. These can be categorized into three domains: 1) pension reforms; 2) lifelong learning/development; and 3) encourages labor participation and hiring.

### Pension reforms (2020)

The average retirement age has risen over the past five years in the Netherlands, as illustrated in Part I. Early retirement schemes were phased-out after the introduction of new pension legislation in 2006. At the same time, the age at which a person is entitled to their flat-rate state pension has increased gradually. The so-called 'Old Age Pensioning Act' [Algemene Ouderdomswet; AOW] was set to increase in retirement age according to rising life expectancy – one year increase in life expectancy results in one year increase of retirement age. However, the pension agreement [Pensioenakkoord] has proposed several reforms, which are described below.

As of January 2020, the retirement age for the flat-rate state pension has been adjusted for the period up to 2025 (Table 2). The pension agreement has proposed that the retirement age after 2025 is set to rise eight months for each additional year increase in life expectancy[71].

**Table 2.** Reform to flat-rate state pension effective January 2020

Year	Previous retirement age	New retirement age
2020	66 years and 8 months	66 years and 4 months
2021	67 years	66 years and 4 months
2022	67 years and 3 months	66 years and 7 months
2023	67 years and 3 months	66 years and 10 months
2024	67 years and 3 months	67 years

**Source:** Rijksoverheid[72]

Another proposal in the pension agreement is a temporary subsidy arrangement for sustainable employability and early retirement. Sector organizations are able to apply for subsidies to increase employee longevity. Early retirement schemes have become financially unattractive as a result of an early retirement levy [Regeling Vervroegde Uittreding; RVU-heffing]. Until 2025, employers are exempted from paying the levy up to a ceiling of €1847 monthly gross income[73]. This exemption offers opportunities for early retirement in burdensome professions. Besides the waiver to pay taxes on the flat-rate pension, a program [Maatwerkregeling Duurzame Inzetbaarheid en Eerder Uittreden (MDIEU)] was initiated which subsidizes sustainable employability and supports employers to offer their employees an early retirement for those who desire to do so[74, 75].

Furthermore, structural investments have been proposed for sustainable employability and lifelong development. A policy program is developed in cooperation with the labor foundation [Stichting van Arbeid][71]. The aim of this program is to provide structural (financial) support to the development of policy for the labor force in achieving sustainable employability and lifelong learning. The policy transcends individual sectors and targets all employees, employers and entrepreneurs in the Netherlands.

### Lifelong learning/ development

The Ministry of Social Affairs and Employment and the Ministry of Education, Culture and Science support lifelong learning [Leven Lang Ontwikkelen]. Four types of subsidy are available for educational

purposes for those who are ineligible for traditional student financing schemes[76]. First, a lifelong learning credit is available for persons up to 57 years. Second, another credit is available for all persons between 18 years and the retirement age [Nederland leert door]. Third, the STAP-budget [Stimulerend Arbeidsmarktpositie] is available for improvement of the personal labor market position, effective from March 2022. This budget (up to €1000) is a replacement for the previous tax deductible for costs related to education. Fourth, the SLIM arrangement [Stimuleringsregeling leren en ontwikkelen in mkb-ondernemingen] was introduced, which targets small- and medium-sized enterprises. Several ministries are involved in the SLIM arrangement. Lifelong learning is often not embedded within these organizations.

Illiteracy or low literacy remains a concern in the Netherlands – about 2.5 million citizens (between 16 – 65 years old) experience serious difficulties with reading, writing and/or mathematics[77]. The share of older persons that belong to this group is significantly higher compared to other age groups[78]. The government initiated a program in 2015 [Tel mee met Taal] to reduce the number of people who experience serious difficulties with respect to writing, reading and math skills[79]. This program has been extended to 2024[80]. This program subsidizes social activities and employers to prevent or reduce illiteracy or low literacy. On top of the €60 million that the government spends on adult education every year, this program [Tel mee met Taal] spends €25 million annually[80].

### Encouraging labor participation and hiring of older persons

The Ministry of Social Affairs and Employment launched an action plan in 2016 for labor market opportunities for persons aged 50 and over[81]. The program ran until 2020 and its main goals were: 1) Equalizing labor participation rates for persons aged 50 and over to those under 50; 2) Increasing the opportunities and use of educational programs for persons aged 50 and over; 3) Reducing the odds of long-term unemployment for persons 50 and over.

The population is ageing, which means that the share of older persons will increase over the total (working) population. However, this can also provide opportunities. The older population could also be considered a ‘silver economy’[82]. The green paper on ageing by the European Commission also indicated that a longer working life may alleviate the pressure on the labor force[83]. In order to address possible employment discrimination, the foundation ‘open hiring’ was initiated in 2016 to promote hiring of employees irrespective of ethnicity, age or disability. The foundation closely cooperates with the Dutch Social Security Agency (UWV), Ministry of Social Affairs and Employment, and municipalities to develop this initiative through pilots. The concept was brought to the Netherlands in collaboration with Greystone, a company that has successfully introduced the idea of open hiring in the United States[84]. An evaluation in 2020 of the pilot companies showed promising results[85].

Furthermore, an agreement to address staff shortages in the long-term care sector was signed by several branch organizations and the Ministry of Health, Welfare and Sport in 2017[86]. The Ministry of Health, Welfare and Sport allocated €72 million for training and education of new health care professionals.

If regular unemployment social benefits are terminated, persons aged 60 years and over who are unable to find employment may apply for social security, [Wet inkomensvoorzieningen oudere werklozen; IOW]. This measure was set to expire in January 2020, but is extended until January 2024.

### **Gender pay and pension gap**

The Netherlands has the largest part-time employment rate of all OECD countries[87]. Relatively few women work full-time jobs (26% of the labor force in 2020[88]). Among other factors, parental-leave

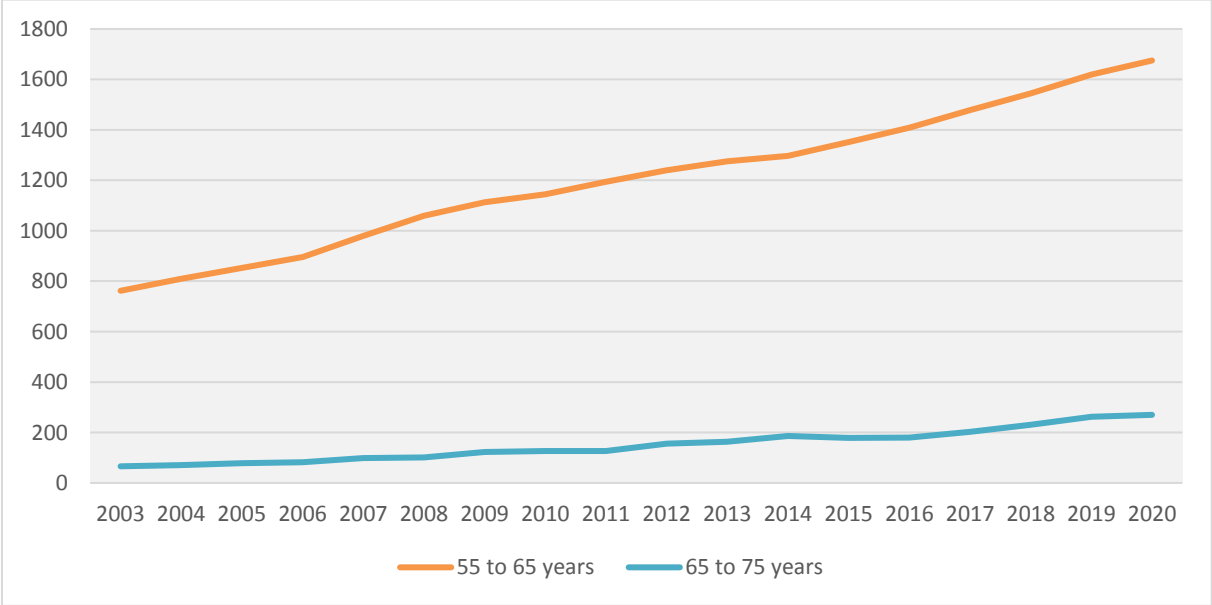
policies may influence gender inequality in both formal as informal work[89]. Until 2019, paternity leave was limited to two working days in the Netherlands. The share of paid and unpaid work between men and women can be equalized by reducing the parental-leave gap between mothers and fathers[90]. Recent legislation extended paternity leave up to one working week, with the option of an additional five weeks at 70% of salary (provided in social security). Additional parental leave legislation was introduced as of July 2020 [Wet invoering extra geboorteverlof; WIEG][91]. Although this measure does not affect the position of older persons immediately, this new legislation may contribute to reducing gender inequality in (formal and informal) work, which could benefit the financial position of women at older age in the long run.

The previous administration (2017-2021) has introduced several policy measures to improve the labor participation in women, such as financial compensation for day-care and education for women with low socioeconomic status, single mothers and migrant women[92]. Finally, the national government aimed to achieve a larger share of women in high-level functions. The Netherlands Institute for Social Research (SCP) demonstrated that more women have found their way to the top in the period 2018-2020[93].

**The last 20 years of employment of older workers**

Increasing labor participation of older persons has been the most significant development in the Netherlands with respect to reaching the second goal of the Lisbon Ministerial Declaration (see Figure 20). This trend has two components: 1) the share of persons aged 65 and over in relation to the total population has increased; 2) within this group, the number of persons in paid work has increased over the years[94]. Only about 9,000 persons aged over 75 were in paid work in 2003, opposed to 30,000 persons in 2020, indicating a longer (working) life.

**Figure 20.** Labor participation in age groups 55-65 and 65-75 (x1000)



**Source:** Statistics Netherlands[23]

Extending working life was stimulated through a gradual increase of the eligibility age for the Old Age Pensioning Act [Algemene Ouderdomswet; AOW] since 2013[95]. This act has been an important pillar for social security for older persons in the Netherlands since 1957. This pension is a flat-rate state pension which is available for all persons over 66 years and four months as of 2021 (See Table 2).

Future actions are required to protect older persons with a low socioeconomic status. The indexation of pensions to adjust for inflation has been limited in the last five years, except for the basic flat rate pension scheme [AOW] which is adjusted for inflation. Although inflation rates have been low during the pandemic, they are expected to rise as more restrictions are lifted[96]. This resulted in lower purchasing power for pensioners since 2008. In 2017, pensioners experienced a 0.3% year-on-year decrease in their purchasing power, whereas the total population gained purchasing power (0.5%)[97]. Finally, an extension of the working life is not feasible for those working in heavy-duty jobs. Temporary measures were taken to financially support pensions in these jobs, but structural actions are still to be determined.

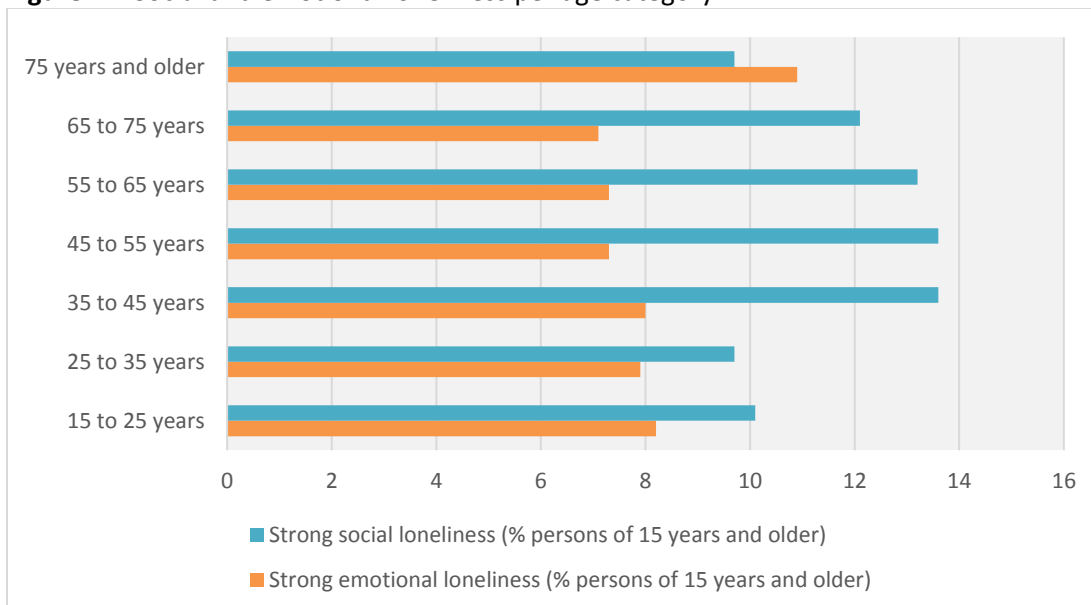
## Ensuring ageing with dignity

The Dutch government has continued their efforts to ensure ageing with dignity. Several policy programs have been continued or extended in this regard, and various new policy programs have been introduced to address ageing with dignity. The following themes stand out: 1) Loneliness; 2) Quality of care in nursing homes and beyond; 3) Networks for frail elderly; 4) Dementia; 5) End-of-life care; 6) Digital inclusion.

### Loneliness

The 'Alliance for Elderly Care' has identified loneliness among older persons as an emerging challenge. Modern society has become increasingly individualistic – signified by smaller households, longer geographical distance between parents and their children[40]. Loneliness is negatively associated with physical and mental wellbeing: it is a strong predictor for premature death, depression, dementia and heart failure[98]. Emotional loneliness stems from the absence of close relationships, and social loneliness refers to the absence of having a group of contacts[99, 100]. Figure 21 demonstrates that emotional loneliness is most prevalent among persons aged 75 or over, whereas social loneliness is more common in age groups above 35. The national program 'United against Loneliness' [Eén tegen Eenzaamheid] was launched by the Ministry of Health, Welfare and Sport in March 2018, and its aim is twofold: (1) signaling loneliness and facilitating dialogue on the topic; (2) addressing loneliness in a structural and sustainable fashion[101]. A total of 212 municipalities had joined the program as of December 2020. These municipalities are inhabited by approximately one million persons aged over 75, equal to 71% of all persons aged over 75[102]. The national program supports the formation of local coalitions of organizations to combat loneliness.

**Figure 21.** Social and emotional loneliness per age category



**Source:** Statistics Netherlands[99]

### Quality of care in nursing homes and beyond

Improving the quality of care in the nursing home sector is been placed high on the political agenda since the long-term care reform. Concerns were raised that quality of care in some nursing homes was too low[39] – possibly due to the significant budget cuts during the long-term care reform. Several programs were introduced to address these concerns.

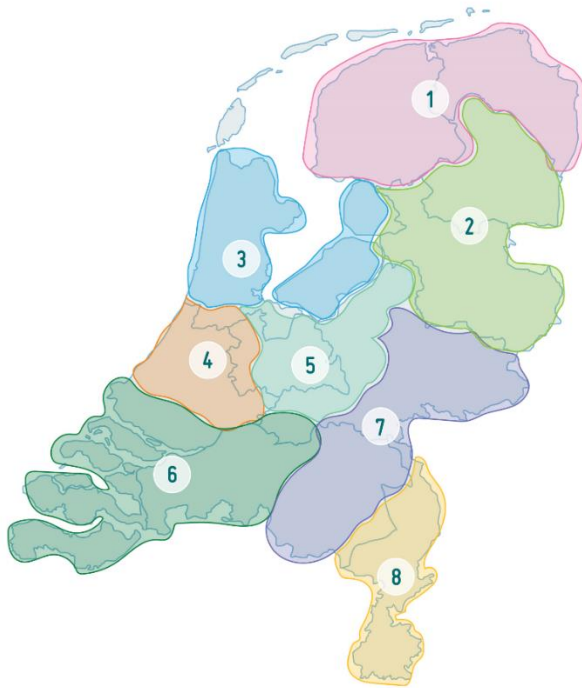
The significant budget cuts that were tied to the long-term care reform were overturned by allocating additional funding to the long-term care sector. The government expressed their commitment to increase additional funds gradually, up to €2.1 billion from 2021 to improve quality of care within the long-term care sector. One of the main goals of these investments was bolstering client-to-staff norms and reducing waiting lists[103]. These investments were granted to support the quality framework, developed by the National Health Care Institute (ZIN) in 2017, which prescribes quality standards for nursing homes[104]. The quality framework includes different components such as person-centeredness, competence and use of personnel, and the management of quality and safety[105]. The Health and Youth Care Inspectorate [Inspectie Gezondheidszorg en Jeugd] also uses this framework to monitor quality and safety within the long-term care sector[106].

Several projects were implemented to support and facilitate further quality improvements. The Ministry of Health, Welfare and Sport partnered up with various health care providers, the National Health Care Institute (ZIN), the Dutch Health Care Authority (NZA), and the Health and Youth Care Inspectorate (IGJ) for the policy program 'At Home in the Nursing Home, Dignity and Pride at every location' [Thuis in het Verpleeghuis, Waardigheid en Trots op elke locatie][106]. This policy program focused on (1) more time and personal attention for residents of nursing homes, (2) sufficient, motivated and competent caregivers, (3) learning, improving and innovating. The 'At home in the nursing home, dignity and pride at every location' program is nested in the wider program 'Dignity and Pride' [Waardigheid en Trots]. This program has been a large and successful program, with 418 nursing homes participating in this scheme to enhance their quality of care[107]. Furthermore, the national government, labor unions and representatives of long-term care providers have launched a program, the Labor Market Agenda 2030 [Arbeidsmarktagenda 2030], in 2017 to address imminent long-term care staff shortages[108]. This program invests in keeping current personnel and in making the nursing profession attractive for future generations.

### Networks for frail elderly

Regional networks in the Netherlands between stakeholders were established to improve the collaboration and exchange of knowledge with respect to care for older persons. The national program for elderly care [Nationaal Programma Ouderenzorg; NPO] ran from 2008 until 2016 with the aim of improving care and support for frail elderly[109]. In 2017, the program transitioned into [BeterOud], a consortium of stakeholders to continue this aim. The national program resulted in eight regional networks (Figure 22). These networks consist of general practitioners, pharmacists, physical therapists and other providers, focused on coordinating care for frail elderly. Furthermore, local networks aim to improve participation of older persons in society. Providers can apply for subsidies to initiate networks[110].

**Figure 22.** Regional networks for older persons in the Netherlands



**Source:** BeterOud[111]

1. Regional delegation for elderly Friesland/Groningen;
2. Regional delegation for elderly Drenthe/Overijssel;
3. Regional delegation for elderly Amsterdam region and foundation elderly network West-Friesland;
4. Regional elderly deliberation Zuid-Holland Noord;
5. Netwerk Utrecht Zorg Ouderen (NUZO);
6. Regional delegation for elderly GENERO;
7. Network 100;
8. Regional delegation for elderly Limburg

The government has put knowledge advancement in the long-term care sector high on the political agenda[112]. Significant investments have been made to build networks between long-term care providers and knowledge institutions. One prominent example is local networks [Academische werkplaatsen] which have received structural financial support from the government[113]. These networks often have partnerships with academic organizations, knowledge and educational institutions, and long-term care providers.

### Dementia

Approximately 280,000 persons in the Netherlands suffer from dementia, and projections show an increase up to 420,000 persons in 2030, and 520,000 in 2040[114]. The Ministry of Health, Welfare and Sport has sought to improve dementia care since 2004, with several national programs, the most recent being the Deltaplan Dementia (2013-2020) and the National Dementia Strategy (2021-2030)[114]. The Deltaplan Dementia set out three goals: preventing and curing dementia, creating a positive image of persons with dementia, and facilitating customized care. Three programs are worth mentioned that have been part of Deltaplan Dementia. First, a national research program [Memorabel] ran from 2013 until 2020 to support the first aim – to deploy research for preventing and curing dementia. Second, Deltaplan Dementia led to the publication, in 2020, of a revised guide to providing dementia care [Zorgstandaard Dementie 2020][115], with the aim of improving the quality of care for



people with dementia and those close to them. Third, a nationwide program was initiated in 2016 to provide information on, and to improve awareness of, how to interact with people with dementia in day-to-day situations [Samen Dementievriendelijk][116]. This initiative is run by the organization representing the interest of people with dementia [Alzheimer Nederland], and consists currently of a collaboration of 150 municipalities and 550 companies.

An evaluation of the Deltaplan Dementia (2013-2020) was published at the end of 2019, demonstrating that the policy program led to increased attention and awareness of dementia, and facilitated interdisciplinary cooperation among stakeholders. While scientific advancements were made in caring for persons with dementia, effective medical treatments were not found[117].

The National Dementia Strategy is characterized by crosslinks with other governmental policy programs, as its primary aims are: facilitating 'ageing in place'; combating loneliness; improving nursing home care and supporting informal caregivers. These policy programs reinforce the goals of the National Dementia Strategy and vice versa.

Another development to improve care for people with dementia is the increasing prevalence of dementia networks. About 60 regional networks have been established to foster collaboration between professionals and enhance knowledge sharing across domains[118]. Another example of a network initiative that has received research funding is DementiaNet. This initiative organizes local networks consisting of medical, long-term care and social care professionals to improve the coordination around a person with dementia[119].

### End-of-life care

The Netherlands may be considered progressive, compared to other European countries, in terms of end-of-life care[120]. The Dutch Euthanasia Act [Wet toetsing levensbeëindiging op verzoek van hulp bij zelfdoding; WtI] was passed in 2002, which allows for physician assistance in 'regulating the ending of life by a physician at the request of a patient who is suffering unbearably without hope of relief'[121]. However, recent years were characterized by debate on 'fulfilled life' [Voltooid leven], in which the prerequisite of medical suffering for euthanasia was questioned[122]. Research on this topic in 2020 showed that on estimate 0.18% of all persons over 55 years, approximately 10,000 people, wished to end their lives, without having unbearable medical suffering[123]. While this has not led to alterations in legislation, the government has initiated a campaign to improve awareness and provide information on possibilities in end-of-life care[124]. Furthermore, a subsidy for (informal) mental caregivers at home and in hospices was made available in 2019[125].

### Digital inclusion

Society is increasingly reliant on digital technologies. Access and skills on technology may limit autonomy, self-determination and participation in society for older persons. Civil affairs, such as applying for identification documents, have become mostly digitalized. Most online government services require the use of online identification, called DigiD. Approximately four million persons experience problems in digital correspondence with the government[126]. To support older persons through these digitalization developments, various programs were initiated. First, public organizations partnered up with libraries in 2019 to open digital information points. In July 2021, 200 digital information points were opened and the aim is to open 400 digital information points by the end of 2022[127]. Second, platform was created to improve digital skills of health care providers and citizens because the uptake of e-health solutions, such as telemonitoring, increased in recent years. [Digivaardig in de zorg][128]. Third, and connected to the former, subsidies were made available to finance e-health technology which supports care for patients in a home-care setting[129]. This subsidy specifically targets older persons and those suffering from chronic illness or disability to support the

shift towards 'ageing in place'. Last, a public-private alliance was established to make digital equipment better accessible to citizens [Alliantie Digitaal Samenleven]. This alliance collects used computers from their partners, and allocates the refurbished computers to those in need of digital equipment. In addition, the alliance provides digital support where needed[130]. One of the main target groups for this initiative are older persons.

### **Ensuring ageing with dignity in the last 20 years**

The most important achievements during the last 20 years achieve the third goal of the Lisbon Ministerial Declaration are related to 'ageing in place' and the National Dementia Program.

Although the 2015 reforms were paired with budget cuts, significant efforts were targeted at improving quality in nursing home care. An evaluation of the policy program 'At home in the nursing home, dignity and pride in every location' [Thuis in het Verpleeghuis, waardigheid en trots op elke locatie] demonstrated several achievements[131]. The main achievements were an increase of 18,500 employees (9000 FTE) in the nursing homes in 2018 as compared to 2016. Furthermore, nursing homes and regional care offices have successfully enhanced their collaboration to address staff shortages on a regional level.

Supporting persons suffering from dementia has been a key focus area for national policy since 2004. The current National Dementia Strategy runs from 2021 until 2030. These programs have led to increased attention and awareness of this disease. From national programs, regional initiatives have grown that coordinate health care providers and social support treating patients with dementia.

The future holds three major challenges for older persons to age in dignity: (i) tackling imminent staff shortages as a result of an ageing population (increasing demand) and a shrinking workforce (decreasing supply) – possibly jeopardizing the quality of (long-term) care; (ii) ensuring sufficient places in long-term care facilities that fit the care needs and wishes of older persons; and (iii) finally, safeguarding the inclusion of older persons in society, in the face of societal developments such as digitalization. Building upon the final challenge, the complex web of institutions and laws in both the medical and long-term care sector introduces additional barriers for older persons to find appropriate care[132]. This may also widen the health gap between social groups because people with a low 'health literacy' experience higher barriers to access appropriate health and care services[133].

## Part III: Healthy and Active Ageing in a Sustainable World

### Contribution of ageing-related policies to the implementation of the 2030 Agenda and its Sustainable Development Goals

The Netherlands submitted a Voluntary National Report to the High-Level Political Forum in 2017[134]. In the Voluntary National Report to the High-Level Political Forum in 2017 elderly are specifically mentioned in this report[134]. For example, a reference is made that the social security system in the Netherlands offers support to groups in society, including elderly. In addition, Aid to the Most Deprived (FEAD) were allocated specifically to support older persons in the Netherlands. Furthermore, Dutch knowledge institutions focus on major research areas, such as ageing and Alzheimer’s disease [e.g., 135].

The Association of Dutch Municipalities also published a report which supports Dutch municipalities to integrate sustainable development goals (SDGs) across their policies[136]. Ageing issues are also explicitly mentioned in this report. For example, to address SDG 3 (Good Health and Well-Being – see Figure 23), municipalities should support older persons to live independently, tackle loneliness and provide meaningful daytime activities. Another example is their commitment to fulfil SDG 11 (Sustainable cities and communities) and to improve the accessibility of public spaces for older persons.

**Figure 23.** Sustainable Development Goals



**Source:** UN, 2020[137]

According to different reports, including one report from Statistics Netherlands [CBS][138], the Netherlands scores high compared to other OECD countries with respect to achieving the goals and targets of the SDGs[139-141]. The Netherlands scores particularly high on targets such as eradicating poverty (SDG 1); industry, innovation and infrastructure (SDG 9); peace and justice and strong institutions (SDG 16)[142].

Based on this MIPAA/RIS Fourth review report and the overall assessment on the current progress to achieve SDG of the Ministry of Foreign Affairs[142], there are three SDGs that require special attention. First, the Netherlands can improve on food security (SDG 2) – reducing unhealthy food. The number of older people who are overweight (BMI  $\geq 25$ ) remains high in the Netherlands – 62.7% among men and 55.4% among women (see also Figure 8)[143]. Second, the Netherlands can improve on (gender) equality (SDG 5 and 10). Life expectancy between women and men is still significantly different – women live longer than men because men have more often unhealthy lifestyles (e.g. alcohol and smoking) resulting in worse health outcomes (see above). In contrast, women are more at risk of poverty and face lower financial security in old age compared to men. Furthermore, there is room for improvement to reduce inequality between social groups. For example, life expectancy is lower for people with low socioeconomic status compared to people with high socioeconomic status[144].

## **Lessons learnt from managing the consequences and impacts for older people in emergency situations: the COVID-19 pandemic**

Both the deadly impact of the COVID-19 virus as well as the measures to curb the COVID-19 pandemic severely affected the lives of older people in the Netherlands. Excess mortality during the pandemic was significantly higher among older persons compared to younger cohorts – see Figure 9 and 10 in the section on demographic indicators and projections. More specifically, mortality among long-term care users was significantly higher. *“Nursing home residents are overrepresented in the mortality figures in the second wave: approximately 50% of the COVID-19-related deaths are nursing home residents”* [145, p. 6-7]. Also the fear of contracting the virus among the older population affected this group. This fear harmed their mental health[146]. In addition, because of the fear of contracting the virus, older persons suspended their medical care (around 3% in both the first and second wave did)[146, 147]. Measures to control the COVID-19 pandemic, such as a national nursing home visiting ban and a governmental advise to avoid contact with those vulnerable to the virus (e.g., persons aged 65 and over), were largely implemented to protect the older population from the (deadly) impact of the COVID-19 virus. However, these measures were not without harm. Social restrictions have limited the number of social contacts, especially face-to-face contact, for a large share of the older population. As a result, loneliness among older adults increased significantly during the COVID-19 pandemic[148, 149]. In addition, these measures lay bare an intergenerational tension between the older population and younger population. The younger population received some of the blame behind the surge in cases during the second wave (around August and September 2020). The younger population felt they had to restrict their freedom to protect the older population while they faced much lower health risk[148].

The pandemic has revealed both the strength and weaknesses of the formal and informal support and care system for older persons in the Netherlands. As for the strengths: First, the pandemic has shown that some bottom-up initiatives were quickly to respond to the pandemic, making system more resilient to external shocks. For example, the pandemic fostered cross-sectoral and cross-organizational collaboration between hospitals, nursing homes and other social organizations[150]. In addition, various social innovation programs were launched to reduce the risk that older persons may get socially isolated[145]. Existing networks, systems (e.g. strong primary care network) and programs, including programs mentioned earlier in this report such as Dignity and Pride, have played a significant role in providing information on the pandemic and in cushioning the impact of the virus[151, 152]. Second, the pandemic strengthened the social fabric and ties of society, especially during the first wave of the pandemic[153]. Numerous bottom-up social initiatives mushroomed to improve the lives of older persons during the pandemic. (e.g. neighbors collectively getting groceries for older persons)[154]. Third, the pandemic provided a window of opportunity for a dramatic expansion in the usage and accessibility of e-health. This can be beneficial for older persons who have difficulties traveling or to support ‘ageing in place’ more generally[155]. Fourth, although this was actually a serious weakness at the start of the pandemic, organizations that represent the older Dutch population were increasingly involved to participate in decision-making on COVID-19 related restrictions on governmental or local level. For example, representative organizations for older persons and long-term care organizations were included to partake in the decision-making about whether to perform triage on the ICU based on age when the ICU would hit a point of extreme shortages.

However, the pandemic also revealed several weaknesses in the Dutch support system for older persons. First, The Dutch long-term care system was severely affected by the impact of the crisis. When the pandemic first set foot in the Netherlands in February 2020, the long-term care sector was overshadowed by the crisis in the acute care sector. As a result, Personal Protective Equipment (PPE) was extremely scarce, resulting in high excess mortality among long-term care users at the beginning of the first wave. Second, pre-pandemic staff shortages in the long-term care system got worse during the pandemic due to care personnel catching COVID-19 or having COVID-19 related symptoms. These staff shortages increased the working pressure significantly within the long-term care sector. Third,

informal care was under pressure during the pandemic because various social care activities (e.g., home care provision and daytime activities) were suspended[156]. For other informal care givers, their informal care cut off to reduce the risk of transmission. The latter may have put older persons at higher risk of feeling socially isolated[156].

### **Activities in preparation and implementation of the WHO Decade of Healthy Ageing 2020 – 2030**

The activities in preparation for the WHO Decade of Healthy Ageing 2020-2030 are delayed due to the restrictions caused by the Covid-19 pandemic. The RIVM is setting up the WHO Collaborating Center on Lifecourse and Ageing. Within the scope of this WHO Collaborating Center, RIVM performed an analysis in the Doetinchem Cohort Study to show the course of cognitive decline in persons with and without overweight. Outcome of the analysis is that a healthy weight goes together with better cognitive functioning and less rapid cognitive decline. Furthermore, the government launched the policy 'Nederland vitaal en in beweging' in May 2021. This policy aims to establish a structural change in behavior, leading to an active lifestyle for people of all ages. This change will be reached in three stages: motivation, capacity (eliminate barriers to become more active) and opportunity (physical activity as part of the daily routine). This integrated policy by six ministries forms the base of connected action lines:

- Promotion, communication and awareness
- A physical environment tempting people to physical activity
- Schools and daycare provoking physical activity
- Sports and recreation setting people in motion
- Working environments facilitating and stimulating to be active
- Activity and sport as part of care

The government is expected to set up more activities in the near future.

## Conclusions and priorities for the future

In the past five years, the Netherlands has expanded its efforts to improve the lives of older persons and to address the objectives outlined in MIPAA/RIS. Four main developments illustrate those efforts. First, numerous investments and programs have been implemented to improve the quality of long-term care. Second, the Netherlands implemented a new pension scheme. This new scheme improves the sustainability of Dutch pensions and strengthens intergenerational solidarity. In addition, this new scheme further enhances the resilience of older persons in the workplace. Third, the Netherlands has made significant progress in improving healthy ageing. This manifests itself in the general shift among policymakers, health care providers, researchers and other relevant stakeholders towards 'Positive Health'. Programs such as the National Prevention Program cement this development. Fourth, the representation of older persons has been strengthened with, for example, the appointment of the elderly council [Raad van ouderen]. The COVID-19 pandemic also increased recognition in central and local government that older persons should be represented and involved decision-making.

The developments outlined in this report address most of the recommendations made in the third review and appraisal of MIPAA/RIS of the Netherlands[25]. The Netherlands can however further their efforts to improve the lives of older persons in seven ways.

First, providing appropriate housing for older persons is one of the major challenges in the Netherlands. This is already an issue but will become more significant in the near future. This housing challenge includes a wide range of factors. For example, the shortage of staff and limited capacity within the nursing home sector. In addition, people's demands have changed over time, particularly by becoming more varied with respect to the kind of care they desire in old age (e.g. small-scale home). Currently, these demands are not fully met within the current nursing homes sector[157].

Second (and connected to the previous point), governments should continue efforts to support the shift towards 'ageing in place'. Significant challenges remain to support informal care givers sufficiently and avoid overburdened informal care givers[158]. In addition, staff shortages remain a challenge within domiciliary care.

Third, significant differences between social groups (e.g. socioeconomic status, ethnic background) persist with respect to healthy ageing[159]. There is, for example, a disparity in life expectancy between social groups[144]. The complexity of the long-term and social care system may perpetuate the problem: people with low health literacy, often with a low socioeconomic and/or migrant background, face more difficulties in finding appropriate care and support within the complex web of laws and institutions[132, 133]. Further policy efforts could be made to close the health gap between social groups and to address vertical inequity.

Fourth, several respondents pointed out that there is room for improvement in how policies for older persons are established and implemented. The challenge is twofold. First, the policies for older persons are generally carried out in the form of 'programs'. Respondents raised concerns that this may result in a fragmented maze of programs to fulfil the MIPAA/RIS objectives. In addition, policy programs are generally not a sustainable solution for long-term issues since programs usually have an end date. Second, the majority of the policies outlined in this report are developed or initiated by the Ministry of Health, Welfare and Sport. (Respondents flagged the overrepresentation of the Ministry of Health, Welfare and Sport in the developing and overseeing the implementation of policies for older persons.) This may result in a restricted approach to improving the lives of older persons. Improvements might include a more integrated approach across different ministries.

Fifth, the Netherlands has potential to improve on actions against ageism and on preparing people for the third phase of life. A large share of efforts to tackle ageism have come from private/bottom-up initiatives (e.g. Alzheimer Nederland). In addition, governments could invest in encouraging Dutch citizens to prepare for old age.

Sixth, Dutch society has become more digitalized and the COVID-19 pandemic has accelerated this development. However, older persons are likely to face difficulties in keeping up with the pace of digitalization. This challenge requires continuous efforts to ensure that the society remains inclusive, especially for older persons with limited digital skills.

Seventh, regional and local variation require an integrated and tailored approach. Variation persists with respect to health care utilization, indications for long-term care, and waiting times for nursing home care[160]. The third review and appraisal of MIPAA/RIS made a similar recommendation, but even though efforts have been made since then to tackle regional variation, the disparity remains a concern.

To conclude, welfare standards are generally high in the Netherlands, and improving the lives of older persons has been high on the political agenda. To continue to improve on these high standards, the Dutch government should bolster its efforts to pursue the objectives of MIPAA/RIS, maintaining strong engagement with Dutch citizens and building citizens' support for future steps[161].



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