ANNEX

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# Ageing policies – access to services in different Member States

## Annex VI - Country study on The Netherlands

Policy Department for Economic, Scientific and Quality of Life Policies
Directorate-General for Internal Policies
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# Ageing policies – access to services in different Member States

## Annex VI - Country study on The Netherlands

**Abstract**

The study provides an overview of the most recent developments with regards to ageing policies and access to services by older people in the Netherlands. It focuses on six areas: active ageing, economic participation, social participation, health care, long-term care, and supportive environments. The study includes examples of best practices regarding access to services and assesses the impact of COVID-19 pandemic on the well-being of older people.

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# LIST OF ABBREVIATIONS

| | |
|---|---|
| **ANBO** | The General Dutch Union for the Elderly<br>(Algemene Nederlandse Bond voor Ouderen) |
| **CBS** | Statistics Netherlands<br>(Centraal Bureau voor de Statistiek) |
| **ESF** | European Social Fund |
| **EU** | European Union |
| **KBO-PCOB** | Catholic Association of the Elderly - Protestant Christian Elderly Union<br>(Katholieke Bond van Ouderen - Protestants Christelijke Ouderenbond) |
| **OECD** | Organisation for Economic Co-operation and Development |
| **PBL** | Netherlands Environment Assessment Agency<br>(Planbureau voor de Leefomgeving) |
| **RIVM** | National Institute for Public Health and the Environment<br>(Rijksinstituut voor Volksgezondheid en Milieu) |

# EXECUTIVE SUMMARY

In the Netherlands, throughout all recent policy initiatives, one can identify a focus on independence and self-reliance. Key developments in different aspects of ageing policies are:

- **Economic participation**: Early retirement used to be highly common in the Netherlands. To stimulate people to work until a later age, the retirement age has been increased and access to early retirement schemes has been curtailed. Labour participation of older workers has since increased steadily. Most Dutch workers however would still prefer an early retirement.
- **Social participation**: Policy initiatives focus on loneliness among the elderly and include yearly visits to all above the age of 75 to inform about needs and group activities. COVID-19 negatively affected social participation, but did lead to some innovative solutions, such as increased use of video calling with relatives and concerts performed in front of care homes.
- **Health and well-being**: The Netherlands conducts various experimental programmes aimed at introducing innovation in the care of people with dementia. Other initiatives focus on improving cooperation between health-care providers, such as data-sharing and multidisciplinary teams, and supporting preventative care, involving GPs referring patients to dietary and fitness programs. COVID-19 led to a substantial scaling down of regular care, but also made possible an increase in digital care, increased data-sharing and a critical analysis of which care is truly necessary.
- **Long-term care**: The Netherlands emphasises homecare over residential care and expects informal care-givers to partially replace formal care. This approach is more cost-efficient, but faces several challenges: not all elderly are self-reliant, care services lack a pro-active approach and the increasing complexity of health issues among the elderly would benefit from more and better-trained formal care-workers. COVID-19 led to an increased pressure on informal care-givers, for example due to the halting of day-care services for the elderly. The use of e-health at home, such a sensors measuring movement, is shown to reduce the burden on informal care-takers.
- **Supportive environments**: The Netherlands monitors and supports the availability of suitable housing to age in through research and funding small-scale housing initiatives. Those unable to use public transport can make use of shared taxi-services and rent adjusted bikes or scooters at a low fee from municipalities. For older people with financial difficulties, the Dutch government offers housing and health care benefits.

Recommendations based on the Dutch context to the EU-level include:

- **Economic participation**: The Dutch experience showed that it is important to acknowledge that people's preferences vary and that despite the government wanting people to work for longer, many have reasons not to want this. Thus, the EU-level actions should focus on finding ways to make working more appealing at a later age.
- **Social participation**: The EU-level policymaking should use a pro-active stance to prevent loneliness, i.e. approach older people to clarify their needs, given that many are hesitant to ask for help. It is also important to acknowledge the benefits of and stimulate cultural participation of older groups through museum visits and performances among others.
- **Health care**: The EU-level action can benefit from the use of the Dutch knowledge of innovative solutions of care to people with dementia to help implement similar tools in other

Member States. It is also important to promote the sharing of insights on digital approaches to care gained during the COVID-19 pandemic.

- **Long-term care**: The Netherlands has shown a change from formal and residential care to informal and at-home care. While challenges remain, this model can be used for other Member States to study given the shortage of care workers.
- **Supportive environments**: At the EU-level, guidelines could be made to increase the suitability of the housing stock for the older populations as well as minimum requirements for transport services to the elderly and funding options to secure these services in Member States in need.

# 1. INTRODUCTION

This country report provides insights into the Netherlands' national ageing policies and statistics as regards economic and social participation, health and well-being, long-term care and supportive environments, giving particular attention to the impact of COVID-19. The aim is to identify good practices and gather suggestions for action at the EU level. The study is mainly built on government reports and documents, such as reports by the National Board on Health and the National Institute for Public Health and the Environment (Rijksinstituut voor Volksgezondheid en Milieu – RIVM) as well as data provided by Statistics Netherlands (Centraal Bureau voor de Statistiek – CBS) and the Netherlands Institute for Social Research. Another important source consists of policy programmes drafted by the Ministry of Health, Wellbeing and Sport.

In addition to desk research, three interviews were held with Dutch stakeholders, representing the two biggest associations for senior citizens, ANBO (Atie Schipaanboord, Head of Public Affairs) and KBO-PCOB (Marielle van Oort, Head of Advocacy) as well as Vilans (Henk Nies, Director of Strategy and Development), the national Centre of Expertise for long-term care in the Netherlands. Since the Netherlands has not yet submitted its plan for the Recovery and Resilience Facility, this aspect cannot be addressed in the report. Other use of EU funding in the Netherlands for ageing policies appears limited to the European Social Fund (ESF) (2014-2020) and ESF+ (2021-2027) in relation to improving the sustainability and quality of employment of older people, therefore, the coverage of the use of EU funding in the Netherlands ageing policies in this report is limited.

# 2. ACTIVE AGEING IN NATIONAL POLICY

## 2.1. Changing approach to ageing

The Dutch central government describes the aim of its ageing policies as "*creating a society in which older people feel seen and valued, a society in which they receive good care and loving attention and in which they can keep participating*"[1]. Throughout all of the recent policy initiatives, one can identify a focus on independence and self-reliance. A report of a government committee on older people living at home, titled "Old and independent in 2030" (Committee on the future of care for elderly living at home, 2020) highlights that the way people in the Netherlands think about ageing is changing. There is a growing attention for ageing as a long-lasting process that is part of life and that offers opportunities and possibilities as well as adjustments. Most of older people are now seen as capable of themselves deciding what they need and how they want to live. The committee also mentions that the way of thinking about health is changing, with health formerly seen mostly as an absence of illness making way for the concept of positive health: the ability of people to adjust and to independently decide how to deal with the social, physical, and emotional challenges of life. This change towards a focus on the abilities and strengths of older people instead of illness is welcomed by the three interviewees contacted for this report. As highlighted in the interviews, ageing policies in the Netherlands are still too heavily linked with health care and rising health care costs, reported by the Ministry of Healthcare, Welfare and Sport overseeing the topic. Interviewees would prefer to see an increased focus on prevention and preparation for ageing, for example with people planning where to live and how long or in what capacity to keep on working at an earlier stage in life. This could facilitate active ageing for more people without the involvement of the health care sector.

Current elderly care in the Netherlands is focused primarily on investing in older people's own ability to take responsibility for the way they live, rather than the government taking over this responsibility. A central goal in Dutch ageing policies is to stimulate everyone, including those with increasing physical and cognitive limitations, to participate in society as actively as possible and to organise support among their family and friends as opposed to receiving formal care and to live independently at home for as long as possible. This goal is strongly tied to the need to guarantee elderly care at acceptable costs and acknowledging the decreasing availability of care workers and informal caretakers (Netherlands Environment Assessment Agency [Planbureau voor de Leefomgeving – PBL], 2020). This process is combined with a decreasing focus on medicalising the care for the elderly (Committee on the future of care for elderly living at home, 2020).

## 2.2. Effects of COVID-19

The interviewees mentioned that the pandemic did reduce the independence and assertiveness of older people and reduced their abilities to partake in social activities. Based on government documents however, the pandemic is not seen as having had a negative effect on the ability to realise an environment in which older people can be more independent. The government committee on ageing emphasised that the pandemic did not change their view on ageing.

[1] Government of the Netherlands. *The value of ageing (De waarde van ouder worden)*. Available at: https://www.rijksoverheid.nl/onderwerpen/ouderenzorg/waardig-ouder-worden.

Rather, the pandemic sped up developments that were already in the making and highlighted topics related to the need for a holistic view on wellbeing and health, such as:

- More critically evaluating which care is essential and identifying ways to de-medicalise care.
- Increasing the use of telemedicine, making older people less dependent on transportation to and from care facilities.
- Acknowledging the need for social contact and the existence of loneliness among elderly.
- Focusing on the impact of a healthy lifestyle on the risks of contracting diseases.

# 3. ASSESSMENT OF ACCESS TO SERVICES FOR OLDER PEOPLE

## 3.1. Economic participation

In the Netherlands, the concept that people need to work until a later age, both to guarantee the affordability of pensions and to address the needs of the labour market, is widely accepted (Regioplan, 2020). To achieve this goal, the Dutch government has focused on three lines of action of the past decades: increasing the retirement age, restricting the access to early retirement schemes and supporting the employability of workers above the age of 55.

### 3.1.1. Policies to increase working until a later age in the Netherlands

A 2018 report by the Organisation for Economic Co-operation and Development (OECD), "Key policies to promote longer working lives in the Netherlands" (OECD, 2018), offers an overview of policies implemented in the Netherlands covering the period 2007 to 2017. In 2012, the government started a major pension reform, the final agreement of which was reached in 2019. The Netherlands uses a pension system consisting of three pillars, of which the first pillar is the statutory pension, offering a flat-rate benefit gained on the basis of having lived in the Netherlands. The second pillar offers earnings-related benefits paid out on top of the statutory pension and the third pillar are optional private savings. As part of pension reforms, the statutory pension age will be increased gradually from 65 – albeit more slowly than initially planned – and will reach 67 by 2025. From 2026, the pension age will be tied to life expectancy. Statistics Netherlands estimates that the pension age following this form of calculation will reach 69 years and three months in 2040 (Health Council of the Netherlands, 2018). The retirement age of occupational pensions is increased from 67 to 68 years and will also be linked to life expectancy. Combining pensions, both statutory and occupational, is made possible, but only after the retirement age.

Early retirement was a highly common practice for older workers in the Netherlands, due to the existence of tax-funded early retirement programmes introduced in the eighties, which were meant as a way for older workers to make space for younger workers suffering from youth unemployment (Schippers, 2019). These schemes had a major effect on both the cultural stance and people's personal attitudes towards early retirement, with leaving the labour force around the age of 60 being common, desired and socially accepted. In 2005 the tax-exceptions for early retirement schemes were removed, leading to a change in people's retirement behaviour and attitudes. People have also been discouraged from using alternative pathways to early retirement, namely the use of unemployment benefits, disability benefits and social aid. Benefits targeting older workers have been abolished, while universal schemes have been made less generous over the years (OECD, 2018).

In terms of supporting the employability of older workers, meaning encouraging employers to retain and hire older workers, the government has (Regioplan, 2020):

- launched campaigns to raise public awareness about age discrimination using role-models;
- handed out financial incentives to employers hiring people over 50;
- introduced coaching for older people in finding new employment; and
- offered career advice to older people to refocus their skills.

### 3.1.2. Position of older workers on the Dutch labour market

It appears that the government measures to increase working lives have been effective. The labour participation of older workers in the Netherlands is increasing steadily since 2005 and the average retirement age has increased. In 2020, the average pension age was 65 years and 6 months, up from 61 years in the early 2000s. A major increase was seen in 2007, since then the average retirement age has been rising steadily [2]. While this is in line with government policy, it deviates from the preferences of people. Despite reforms, most people of working age indicate that they would like to retire at 61, a figure that has been stable since 2010 (Netherlands Institute for Social Research, 2020). The participation rate of older workers has also increased substantially. In 2020, 58 % of people between 60 and 65 years old work, compared to 33 % in 2010. For the age group between 65 and 70 years, in 2020, 17 % were employed (Employee Insurance Agency, 2020).

Research on the position of older people on the labour market in the Netherlands focuses mostly on the age group 55-65, rather than on those over 65. This may be due to the fact that recent policy measures aiming to make people work longer are not aimed at those working past the retirement age, but rather at the group of people between the age of 60 and 65 in the Netherlands who could previously benefit from early retirement schemes. A report by the Dutch Board on Health (Health Council of the Netherlands, 2018) defined "working longer" for the purpose of their report not as working past the retirement age, but as working past the age of 55 and up to 65. This report identified a difference in the labour participation of those between 55 and 65 between higher- and lower educated individuals. The labour market participation of lower educated people aged 55-65 increased from 34 % in 2006 to 50 % in 2016, while for the highly educated these numbers equalled 58 % in 2006 and 78 % in 2016. More recently however, it was shown that lower educated workers who were not forced to stop earlier due to health reasons on average actually work longer than highly educated workers as well as having longer working lives in total because they start working at an earlier age.

In addition, older men are more economically active than older women. When people get older, they more often work in part-time jobs as opposed to full-time jobs and are more often self-employed, because employers are hesitant to hire them on fixed contracts. While older workers are not more often unemployed than younger workers, the risks of long-term unemployment is higher. Of those unemployed long-term, 8 out of 10 are older than 50 (Regioplan, 2020).

### 3.1.3. Impact of COVID-19

Research on the impact of COVID-19 on the labour market position of older people is still scarce. However, there are indications that pre-existing vulnerabilities of older people are intensified by the pandemic (Netherlands Institute for Social Research, 2020). Because the elderly are more at-risk of severe illness due to COVID-19, employers may be fearful to hire older people. Age-discrimination and a high risk of long-term unemployment may be more severe in a labour market made less favourable by the pandemic, and COVID-19 may have increased age-discrimination.

## 3.2. Social participation

### 3.2.1. Social participation and loneliness among the elderly

In the Netherlands, social participation of the elderly is treated by the government mainly from a health perspective, with a focus on the health consequences of loneliness among the elderly (Ministry of

[2] Statistics Netherlands (CBS). *More workers went on retirement in 2020 (Meer medewerkers met pensioen gegaan in 2020)*. 13 April 2021. Available at: https://www.cbs.nl/nl-nl/nieuws/2021/15/meer-werknemers-met-pensioen-gegaan-in-2020.

Health, Welfare and Sport, 2018). Loneliness among the elderly is associated in the Dutch policy debate with physical, mental and financial risks as well as the risk of a premature death. The government highlights that loneliness becomes more prevalent with age. Of those 75 years and older, 54 % reports feelings of loneliness and 11 % feels very lonely. A recent government programme against loneliness among the elderly, named United against Loneliness, lists various reasons why older people are more at risk for loneliness. With age, people experience more loss – losing partners, friends, family, mobility and health. Other societal factors also play a role (Council of Public Health and Society, 2017). Dutch families are likely to be smaller, with the average number of children down from 3.2 in 1975 to 1.7 today. Older people are also more likely than before to live at a greater physical distance from their children after the children move out of the house. The fact that more and more services are provided online can also increase loneliness, as older people experience difficulties in adjusting to the digital skills required and miss the physical contact of previous exchanges (as mentioned in the interviews). Statistics Netherlands also measures the percentage of people that are socially marginalised, meaning they hardly participate socially, reporting few or no social contacts, not being a member of organisations and not participating in voluntary work[3]. This percentage goes up with age, being 8.3 % for those aged 55-65, 11.1 % for those 65 to 75 and 12.1 % for those 75 years and older. In the Netherlands, about half of people aged between 15 and 75 are involved in voluntary activities, for example in a sports, political, or church organisation, at least one time a week. This number goes down to 34.9 % for those 75 and older (Statistics Netherlands, 2018).

Within the government programme United against Loneliness, actions to reduce loneliness among older people include:

- awareness raising campaigns;
- yearly visit to each person above 75: since the government assumes it can be difficult for people to take action when they are lonely, all municipalities are encouraged to organise home visits to their population aged 75 and above, so that local government staff can explain to them what kind of support and activities are available to them if they feel the need;
- collecting indications of loneliness: the government supports municipalities in collecting indications that some of their older residents may be suffering from loneliness, by bringing together reports from medical professionals, volunteers, nurses and other people interacting with the elderly;
- funding telephone lines available to older people, so that they can speak to a volunteer or social worker 24 hours a day if they are in need; and
- supporting "wellbeing by referral", an initiative in which general practitioners refer patients that report feeling lonely to local activities.

Other efforts to reduce loneliness are mainly executed on a local level, for example (Movisie, 2016):

- organising courses to support older people in finding activities that provide a sense of enjoyment and fulfilment;
- group activities meant to increase social support; and
- offering courses in making friends online.

[3] Statistics Netherlands (CBS). *1 in 10 older people show limited social participation and limited trust (1 op 10 ouderen weinig participatie en laag vertrouwen)*. 13 March 2018. Available at: https://www.cbs.nl/nl-nl/nieuws/2018/11/1-op-10-ouderen-weinig-participatie-en-laag-vertrouwen.

### 3.2.2. Impact of COVID-19

The increased vulnerability of the elderly regarding COVID-19, the social distancing measures and the visitors ban in nursing homes that was introduced in 2020 in the Netherlands all negatively affected social participation and increased loneliness among the elderly (Netherlands Institute for Social Research, 2020). This did not however affect all older people equally. As was mentioned in one of the interviews, particularly older people with dementia or intellectual limitations appeared to benefit from reduced visitors and day-time activities and more one-to-one contact. Up to the start of the pandemic, one could see an increase in the participation of older people in arts and cultural activities (Van Campen, 2020), but this development was halted by the pandemic. Before the pandemic, about a third of people above eighty regularly visited cultural events, up from 20 % in 1995. The decreased possibilities for physical contact or physical attendance to cultural events did lead to a range of innovative solutions, among which:

- People visited the elderly on their doorstop, not entering the home.
- On social media channels, people volunteered to do shopping for older people who were afraid to visit shops – these efforts were sometimes facilitated by municipalities or local shops.
- Social workers in certain municipalities organised coffee-meetings for older people via phone, bringing together 6 people at a time.
- Nursing homes organised concerts and theatre performances that could be followed by residents through the windows.
- Nursing homes helped older people to video call with loved ones and encouraged them to record video diaries.

## 3.3. Health and well-being

### 3.3.1. The Dutch health insurance system

The Dutch health insurance system in its current form is based upon the Health Care Act introduced in 2006 and consists of a combination of public and private elements (Ministry of Public Health, Welfare, and Sport, 2016). The central government has put down a number of requirements for individuals and health care providers, among which:

- Individuals are obligated to purchase basic health insurance (at a cost of around EUR 1,200 a year);
- Health insurers are obliged to accepts all private individuals, regardless of their health condition;
- Premiums for health insurance are the same for all individuals, regardless of health condition, age or background;
- Health insurers have a duty of care, meaning they must guarantee that healthcare included in the basic insurance package is available for all policyholders; and
- The central government is responsible for setting the contents and size (in other words, which services are provided) of the basic health insurance package.

The basic package involves a large range of services, including medical care provided by general practitioners, medical specialists, hospitalisation, medications, medical aids, ambulance support, mental health services and dental care up to the age of 18. Older people, as counts for all private

individuals, carry some individual costs. First, they must pay the cost of the basic health insurance of around EUR 1,200 a year. With the aim of increasing cost-awareness, individuals also pay an amount of close to EUR 400 in policy excess a year if they use healthcare. For some types of care, individuals are required to cover a co-payment on top of the policy excess. To assure affordability of health care among lower-income residents, the Netherlands offers a means-tested health care insurance allowance that covers a large portion of the premium and policy excess. While the central governments sets the rules for which care should be provided under the basic package, insurers are responsible – through negotiations with health care providers- to decide where and how such care will be provided.

### 3.3.2. Complex care needs among the older population

Older people often suffer from multimorbidity, dealing with several (chronic) health issues simultaneously, meaning older people often need a more complicated form of care to be provided. The majority of this care is provided while living at home, with only the most vulnerable elderly being admitted to care homes. An indication of the frail condition of older people being admitted to care homes is that the average stay of residents in care homes went down from 12 months to 9 months over the course of the past years, meaning that people pass away more quickly after being admitted. Among Dutch older people above the age of 75 in the Netherlands, only 7 % do not suffer from a chronic illness and 80 % suffer from more than one chronic condition. They also deal with problems such as falling down, eye-sight problems, hearing defects, incontinence, loneliness and polypharmacy, meaning the use of several medications by one individual (National Institute for Public Health and the Environment, 2018). Projections made by the National Institute for Health and the Environment show that due to the ageing population, multimorbidity will increase. In 2040, the main illnesses in society as a whole and among older people in particular will be dementia, strokes and arthrosis.

### 3.3.3. Initiatives to improve health care for older people

The Dutch government is implementing a variety of initiatives, aimed at dealing better with the increasing complexity of care needs of the elderly, the increasing prevalence of dementia and directed at providing better preventative care for older people. Examples of initiatives include:

- Experimental programs aimed at introducing innovation in the care of people with dementia, especially for those living at home (National Institute for Public Health and the Environment, 2017). Recent research shows that people with dementia can benefit from types of day-care activities currently provided in care farms (zorgboerderijen), namely taking care of animals, providing people with meaningful activities and having the possibility to spend time outdoors. Another form of day-time activities for people with dementia is creating activities in community gardens (National Institute for Public Health and the Environment, 2018), which are also shown to improve the social contacts of dementia patients as well as providing informal care takers with some respite from care duties.
- Better integral care in so-called "care networks", helping actors active in the care for older people – primarily those with dementia, arthrosis and Parkinson- to better cooperate and communicate. Examples are better registration of care provided to care-users and the sharing of these data among care-givers as well as shared-decision making processes such as working together in a multidisciplinary team or periodical meetings (National Institute for Public Health and the Environment, 2020).
- Programs aimed at preventative care. These include training general practitioners, home care workers and others involved in elderly care to conduct early signalling of health issues and to refer patients to life-style improving interventions, such as dietary and movement advice. The

central government assists municipalities and local health care providers by collecting and sharing good practices and offering financial assistance[4].

### 3.3.4. The use of telemedicine

The large number of older people living independently, especially those suffering from dementia, has led to an increased use in telemedicine, also known as domotics[5]. Examples of domotics that are frequently used in homecare in the Netherlands are medicine dispensers, video communication with care-givers and lifestyle monitoring devices using smart sensor technology. The latter is mostly used for people suffering from dementia and entails a network of sensors installed in the home of the person in question. Informal caretakers, which in the Netherlands are responsible for a substantial part of the care to older people, report being satisfied with the increased sense of security that this form of monitoring provides. The interviewees highlighted that despite the big gains in digitalisation during the pandemic, health care providers should not forget to take into account the demands this puts on older people. Within a short time frame, older people were suddenly expected to have consultations with doctors online or to order medicine online. There needs to be sufficient attention for the fact that many older people struggle with this shift and need more support and training, as well as to maintain the possibility to conduct these activities in-person.

### 3.3.5. Impact of COVID-19

COVID-19 has had a number of implications for health care for the elderly, both positive and negative (National Institute for Public Health and the Environment, 2021). During the first wave of the pandemic, regular health care was scaled down substantially, meaning many people, including older people, had their health treatments postponed. However, positive effects include:

- The pandemic led to a big increase in digital care. Financial mechanisms that used to discourage digital care, for example because physical visits were reimbursed at a different rate, were changed to maintain the availability of care;
- The scaling down of regular care offered a chance to analyse which care is truly necessary and which care can be postponed or provided in a different way, although is it still unclear whether such insights will hold in a post-pandemic situation; and
- The pandemic led to increased data-sharing and cooperation among health care providers.

## 3.4. Long-term care

### 3.4.1. Shift to self-reliance: the introduction of the "Long-term care Act"

The Netherlands emphasises homecare over residential care and expects informal care to serve as a replacement for care that was previously provided formally. Older people more frequently remain in their own house and the percentage of people aged 75 years and over living in care homes is decreasing. From 1995 to 2018 this share decreased from 16 % to 8 %, and it is expected to remain stable at 5 % for the foreseeable future. The percentage of older people above 90 in care homes is also estimated to drop further, from 32 % in 2015 to below 20 % in 2035 (Ministry of Health, Welfare and Sport, 2018). A major change in Dutch policy occurred in 2015, when the new "Long-term care Act" was

[4] National Institute for Public Health and the Environment (RIVM). *Healthy and active ageing (Gezond en vital ouder worden)*. Available at: https://www.loketgezondleven.nl/gezondheidsthema/gezond-en-vitaal-ouder-worden.

[5] Better care (Zorg voor beter). *Domotics for homecare (Domotica voor thuis: zorg op afstand)*. 06 February 2020. Available at: https://www.zorgvoorbeter.nl/veranderingen-langdurige-zorg/ehealth/domotica-zorg-op-afstand?_ga=2.61220143.222427183.1621839820-934365381.1621839820.

introduced. This piece of legislation emphasises older people being self-reliant, in charge of their own lives and is based on four assumptions (Doekhie et al., 2014):

- older people want to live independently for as long as possible;
- older people want and can pay more for support and care;
- informal care and volunteers can largely replace professional care; and
- the use of technology can help older people to live independently for longer.

The extent to which older people value self-reliance and independence varies. Research among older people in the Netherlands (Doekhie et al., 2014) shows that in 2014 46 % of people above 65 want to organise their own life and support the reform, 28 % value support and care over self-reliance and 26 % are not capable to take charge over their own care and wellbeing. The interviewees expressed support for the focus on self-reliance and view their members as wanting to be as self-reliant as possible, but do stress that government policies should help people more to remain self-reliant, for example by providing more preventative care and do more to a living environment that allows for self-reliance. The main driver of the reform and increased focus on self-reliance does not however seem to be the preferences of older people themselves – given that many would welcome more care – but rather the financial affordability of care for the elderly. The affordability of elderly care in the Netherlands is widely acknowledged to be under threat. On the one hand this is due to the increase in older people over 75, expected to be double today's share in 2040. With life expectancy on the rise, the complexity of care demanded also increases. On the other hand, there is an increasing shortage of care workers, combined with a decreasing availability of people able to offer informal care. Fewer and fewer people between the age of 50 and 74 are able to act as informal care-givers to people above 85 in need (The Netherlands Institute for Social Research, 2016). While the support for the shift of self-reliance varies widely among older people, there does seem to be a widely held preference to live at home for as long as possible (Ministry of Health, Welfare and Sport, 2018). Older people report preferring to stay in their familiar environment, close to relatives, and are reluctant to move, unless severe health issues make it impossible to stay.

### 3.4.2. Weaknesses in the system of long-term care

Currently, 4 out of 10 people aged 75 and older receive formal home care in the form of help with personal hygiene, household tasks, half receives help from friends, family and acquaintances and one third pays for help out of pocket. A major challenge in the system of elderly care in the Netherlands is that self-reliance, or the ability to organise care for oneself, is commonly overestimated in the elderly population (Netherlands Institute for Social Research, 2019). Part of the elderly population does not have the skills to arrange their own care and support and their network cannot provide sufficient informal care because they are overloaded. Also, care services are not pro-active enough, aimed at early detection of illnesses and needs. The need to pay individual contributions to obtain certain services also discourages some from the use of care. The increasing shortage of well-trained personnel and a lack of specific expertise (among general practitioners and community support teams among others) can lead to the situation where older people in at-home care are unnecessarily put in more severe forms of care (e.g. primary care facilities) (Netherlands Institute for Social Research, 2019).

The preference for homecare over residential long-term care in Netherlands has, however, resulted in a higher demand for live-in migrant care workers, albeit to a lower extent than in other Member States (e.g. Germany). Most of such care workers are mid-life women from the Central and Eastern European countries with varying degree of care training and experience (Bruquetas-Callejo, 2019).

### 3.4.3. Policies to support living at home

As part of the government programme Living at home for longer, led by the Ministry of Health, Wellbeing and Sport, the government supports people living at home for longer in various ways. These include:

- Two funding mechanisms to support digital innovation in long-term care. The first funding scheme supports the use of e-health at home, for example using medical care via video calls, medicine robots and sensors to prevent falls. The second is aimed at stimulating the exchange of information between formal and informal care givers and the receivers of care, so that all parties can access medical reports and can better organise the collective provision of care.
- Programmes to support informal caregivers. These vary from training programmes to help informal care givers organise their life around the demands of informal care, projects that aim to improve collaboration between formal and informal caregivers and pilot projects that aim to relieve some of the demands on informal caretakers. The latter include the option for formal caregivers to temporarily take over some of the care of informal caretakers, to give them the chance to respite care.
- Improving the transition from homecare to temporary residential care and back home when possible. With more older people living at home for longer, it is becoming more common for people to temporarily move out of the home and into formal care facilities. The government wants to increase the number of temporary places in facilities other than hospitals. Currently, too many older people spend too much time in hospitals because other placements are not available (Ministry of Health, Welfare and Sport, 2018).
- Funding the training and hiring of more medical specialists in elderly care to providing home health care services. Previously, these specialists were only hired in care homes.

### 3.4.4. Improving residential care

Weaknesses in the system of residential care in the Netherlands are known to be a lack of person-centred care as well as a lack of skilled personnel in elderly care. To redeem these shortcomings, the Ministry of Health, Welfare and Sport started a programme called "At home in the care home"[6] based on three pillars: increasing the level of personalised care and attention per resident, increasing the number of skilled care workers and introducing time-saving technology that support care workers. The latter focuses on technology that reduces the administrative burden on care workers.

### 3.4.5. Impact of COVID-19

COVID-19 has substantially affected the provision of both home and residential care. Care homes have been struggling to deal with the virus, reporting a lack of protective gear as well as high level of stress among care workers. In care homes, the government[7] is trying to assist by providing manuals for dealing with crisis situations including how to manage staff, guidelines for monitoring work pressure among caretakers and testing policy regarding COVID-19, training materials for personal protection materials and monitoring of cases and psychosocial effects of COVID-19 on residents.

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[6] Ministry of Health, Welfare and Sport (Ministerie van Volksgezondheid, Welzijn en Sport). *At home in the care home (Thuis in het verpleeghuis)*. Available at: https://www.waardigheidentrots.nl/hoofdlijnen/meer-tijd-en-aandacht-voor-de-bewoner/.

[7] Ministry of Health, Welfare and Sport (Ministerie van Volksgezondheid, Welzijn en Sport). *Care homes and corona (Verpleeghuizen en corona)*. Available at: https://www.waardigheidentrots.nl/corona/.

Regarding home care, COVID-19 led to a big decrease in formal home care services and daycare provision, with an estimated 31 % of formal home care and 87 % of daycare services for elderly halted during the first wave in 2020[8]. This led to increased pressure on informal care provided by friends, family and acquaintances.

## 3.5. Supportive environments

### 3.5.1. Housing for the older population

As mentioned in the chapter on long-term care, more and more older people remain in their own house as opposed to moving into care facilities, with the percentage of those 75 and over decreasing from 16 to 8 % in the past 20 years and set to decrease more in the near future (Ministry of Health, Welfare and Sport, 2018). This highlights the importance that older people can find suitable housing which is adjusted to their needs. The approach of the Dutch central government to improve the housing situation of the elderly is threefold.

First, the housing needs of elderly are monitored carefully. According to research commissioned by the Ministry of the Interior, of the Dutch population over the age of 55, 91 % live in suitable housing to age in, meaning it is either suitable already or can be made suitable at a relatively low expense, meaning less than EUR 10,000 (Ministry of the Interior and Kingdom Relations, 2021). Of older people (55 and above) without functional limitations 9 % live in non-suitable housing. For those with functional limitations, the share of those living in non-suitable housing is slightly higher and the share of elderly with limitations in the Netherlands is projected go up by 25 % up to 2040. These numbers imply that there is a need for at least part of the older population to move into different, adjusted housing. However, willingness to move decreases with age. Up to 55, 15 % of Dutch respondents indicate that they expect to move within 2 years, compared to 4 % aged 65-74 and 3 % 85 and over. Second, the government supports initiatives aiming to offer new forms of housing for older people. Among those over 75, the desire to move often comes out of a need for increased care. However, placements in care homes are reserved only for those most frail. In recent years, several initiatives have been launched to provide new forms of housing that fill in the gap between traditional homes and care homes, such as communal housing around shared courtyards aimed to increase social interaction. The availability of these forms of housing is currently very limited (Netherlands Environment Assessment Agency - PBL, 2019). Those trying to set up such initiatives often run into problems, such as the lack of willingness of banks and investors to provide financing. For that reason, the central government offers subsidies for small-scale housing initiatives for the elderly, recent examples being the transformation of a school building into shared housing for elderly, communal forms of living in apartment complexes and the building of housing around courtyards. Third, the central government stimulates municipalities to help older people become more aware of their housing needs and to support them in moving to suitable housing. An example is a programme run by the municipality of Haarlem together with social housing corporations[9]. Older people using social housing can indicate that they want to choose suitable housing out of the housing stock of the corporations, get preferential treatment when such housing becomes available, can receive a compensation for moving costs and can retain their old rent unless the rent of the new house is lower.

[8] Mantelzorg NL. *Coronavirus: decrease of professional care significantly impacts informal caretakers*. Available at: https://www.mantelzorg.nl/nieuws/coronavirus-afname-professionele-zorg-heeft-grote-impact-op-mantelzorgers/.

[9] Elan Housing Corporation (Elan Wonen). *Programme to stimulate moving of those 65 and over in Haarlem (65+-verhuisregeling Haarlem)*. Available at: https://www.elanwonen.nl/owpw.

### 3.5.2. Accessibility to transport

If one is unable to use public transport, based on the Social Support Act people can apply for special forms of transport, arranged at the municipal level. Within municipal borders, a shared taxi service is offered at a reduced rate. For longer trips, another, nationally organised service is available. Other services are meant for those that cannot arrange transport independently or with the use of family or friends, for example if one is unable to use public transport due to physical or mental limitations[10]. Most municipalities also support older people with other forms of remaining mobile. The municipality of Amsterdam[11], for example, offers rental services requiring a small out-of-pocket fee – with a maximum of EUR 15 a month – for adjusted bikes for older people with limitations, scooters or wheelchairs.

### 3.5.3. Financial independence

People above 65 are at a higher-than-average risk of poverty in the Netherlands. For those between 65 and 80, 2 to 3 % have an income below the poverty rate, which is lower than the average of 6 to 7 % for all age groups. However, for those over 90, the rate increases to 11 % due to the increase in costs for health care. Another at-risk group of elderly concerns those with a migration background (The Netherlands Institute for Social Research, 2019). The statutory pension in the Netherlands is based on the number of years of residency in the Netherlands. Older people above pension age with a migration background have often lived part of their lives outside of the Netherlands and therefore receive a reduced pension. Additionally, women with a migration background often lack an income-based supplemental pension due to not having been active on the labour force. In total, the number of people above 65 in the Netherlands struggling with poverty is estimated to be around 92,000. The Dutch central government offers financial assistance to elderly in the form of benefits for housing and health care[12]. These, however, are not always sufficient, because the way eligibility for these subsidies is assessed excludes certain groups. For example, older people living in a house they own are deemed not to need financial assistance because the value of their house is counted towards their wealth. In practice, however, these people cannot access those funds because they are unable or unwilling to sell their house and move into cheaper housing[13].

[10] Zorgwijzer. *Special transport (Wmo-vervoer)*. Available at: https://www.zorgwijzer.nl/faq/wmo-vervoer.

[11] Municipality of Amsterdam (Gemeente Amsterdam). *Additional public transport/adjusted transport (Aanvullend Openbaar Vervoer/Aangepast vervoer)*. Available at: https://www.amsterdam.nl/zorg-ondersteuning/aov/vervoer/.

[12] Dutch Tax Authority (Belastingdienst). *Benefits (toeslagen)*. Available at: https://www.belastingdienst.nl/wps/wcm/connect/nl/toeslagen/toeslagen.

[13] National client council (Landelijke clientenraad). *Poverty among senior citizens (Armoede onder senioren)*, 05 November 2020. Available at:http://www.landelijkeclientenraad.nl/Content/Downloads/LCR-20-0089%20Brief%20LCR%20Armoede%20onder%20senioren%2005112020.pdf.

# 4. RECOMMENDATIONS FOR THE EU-LEVEL

In the Netherlands, throughout all recent policy initiatives one can identify a focus on independence and self-reliance. Key developments in different aspects of ageing policies are:

- **Economic participation**: Early retirement used to be highly common in the Netherlands. To stimulate people to work until a later age, the retirement age has been increased and access to early retirement schemes has been curtailed. Labour participation of older workers has since increased steadily. Most Dutch workers however would still prefer an early retirement.
- **Social participation**: Policy initiatives focus on loneliness among the elderly and include yearly visits to all above the age of 75 to inform about needs and group activities. COVID-19 negatively affected social participation, but did lead to some innovative solutions, such as increased use of video calling with relatives and concerts performed in front of care homes, as well as showing that not all older people equally benefit from such activities. Especially people with dementia benefited from a low-activity environment with few visitors.
- **Health and well-being**: The Netherlands conducts various experimental programmes aimed at introducing innovation in the care of people with dementia. Other initiatives focus on improving cooperation between health-care providers, such as data-sharing and multidisciplinary teams, and supporting preventative care, involving GPs referring patients to dietary and fitness programs. COVID-19 led to a substantial scaling down of regular care, but also made possible an increase in digital care, increased data-sharing and a critical analysis of which care is truly necessary.
- **Long-term care**: The Netherlands prioritises homecare over residential care and expects informal care-givers to partially replace formal care. This approach is more cost-efficient, but faces several challenges: not all elderly are self-reliant, care services lack a pro-active approach and the increasing complexity of health issues among the elderly would benefit from more and better-trained formal care-workers. COVID-19 led to an increased pressure on informal care-givers, for example due to the halting of day-care services for the elderly. The use of e-health at home, such a sensors measuring movement, is shown to reduce the burden on informal care-takers.
- **Supportive environments**: The Netherlands monitors and supports the availability of suitable housing to age in through research and funding small-scale housing initiatives. Those unable to use public transport can make use of shared taxi-services and rent adjusted bikes or scooters at a low fee from municipalities. For older people with financial difficulties, the Dutch government offers housing and health care benefits.

Recommendations based on the Dutch context to the EU-institutions include:

- **Economic participation**: While pension reforms and removing early pension schemes have resulted in the average retirement age of people in the Netherlands going up from 61 to 66 within the past two decades, this does not mean the subsidiary goal of having more people work beyond retirement age is easily obtained. Many workers in the Netherlands indicate preferring to have an early retirement and interest in working beyond retirement age is low, in many instances because work is experienced as highly demanding physically or mentally. Member States can focus on findings ways to make working more appealing at a later age.
- **Social participation**: To prevent loneliness, Member States can take as an example the Dutch pro-active approach which acknowledges that many are hesitant to ask for help, while also

acknowledging that needs for social activities differ significantly between older people. Initiatives that can be looked upon for inspiration include actively seeking out older people to ask about their needs and general practitioners referring elderly to subsidised social activities. Another good practice is acknowledging the benefits of cultural participation of older people, such as museum visits and performances, and finding ways to stimulate this.

- **Health care**: The Netherlands stands out in developments surrounding dementia care. The EU-level action can benefit from the use of the Dutch knowledge of innovative solutions of care to people with dementia to help implement similar tools in other Member States. It is also important to promote the sharing of insights on digital approaches to care gained during the COVID-19 pandemic. Thus, in terms of telemedicine and the use of technology, other Member States could benefit from Dutch knowledge and experience in the design of e-health solutions.
- **Long-term care**: Most older people in the Netherlands receive care at home. Over the past decades, the Netherlands has shown a change from formal and residential care to informal and at-home care. While challenges remain, this model can be useful for other Member States to study given the shortage of care workers.
- **Supportive environments**: Apart from funding opportunities for small-scale housing developments for older people, the Netherlands stands out in the extent to which municipalities provide the rental of bikes and scooters that enhance the mobility of older people. At EU-level, guidelines could be made to increase the suitability of the housing stock for the older populations as well as minimum requirements for transport services to the elderly and funding options to secure these services in Member States in need.

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The study provides an overview of the most recent developments with regards to ageing policies and access to services by older people in the Netherlands. It focuses on six areas: active ageing, economic participation, social participation, health care, long-term care, and supportive environments. The study includes examples of best practices regarding access to services and assesses the impact of COVID-19 pandemic on the well-being of older people.

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