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Advocated but Sidelined: Health promotion for the elderly in the Netherlands

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Abstract

Health promotion (HP) in the Netherlands is the responsibility of both the national (the Ministry of Health, Welfare and Sport) and local governments. Two government organizations are involved in the development, implementation and monitoring of HP: the Dutch Institute of Public Health (RIVM) and The Netherlands Organization for Health Research and Development (ZonMw). Within RIVM, the Center for Healthy Living (Loketgezondleven.nl) has been established. ZonMw subsidizes the Academic Collaborative Centers (ACC) in eight areas which together cover the whole of the Netherlands. ACC centers are responsible for transferring evidence based scientific knowledge into practical activities. Also, health promotion "thematic" institutes such as the TRIMBOS institute (Institute for mental health) and NISB (Dutch Insitute for Sport and Physical Activity), the GGDs (the municipal institutes for public health), general practitioners and work and health professionals (Arbo-coördinators) are actors in HP.

There are two laws that regulate the role of HP namely: The Public Health Law ("Wet publieke gezondheid") (Wpg), and the Social Support Act (Wmo).

Funding for HP comes from the central government, local municipalities, health insurance companies and regional care offices. Health insurance companies are mostly responsible for financing indicated and disease related HP. Evidence from Loketgezondleven.nl shows that only few HP are efficient and effective. Because of this both municipalities and insurance companies are reluctant to invest in HP. HP for elderly are mostly financed by public sources and, basic health insurance premiums but also through patient payments.

Key words: **financing, health promotion, The Netherlands**

Introduction: Health promotion in the Netherlands: developments, current organization and financing

Health promotion (HP) appeared in the Netherlands in the 1970s [1]. At that time, it was primarily the enthusiastic work of small group of health care professionals and volunteers. HP was focused on low-key interventions such as spreading information about a healthy life style [2]. The national government was responsible for the design and volume of HP. In the period 1980–2000, HP has grown [1]. The number of health professionals involved in HP has increased, the type and the extent of intervention have also grown and they have become a well-planned system of activities [3]. At the same time, it was recognized that HP should tackle the health problems specific for certain population groups and certain areas [4]. Because of this, the responsibility for HP – their planning, implementation and financing was shifted from the central government to the local level (municipality) [1]. Currently, HP in the Netherlands is an important part of the broader public health care system and consequently is related both central and local governments. However, in this paper we will not focus on the organization of Dutch health care system and the position of public health care and HP within it. We rather focus on HP (particularly those related for the elderly) and their financing within this system. Therefore we describe the organizations and stakeholders relevant for financing HP. The detailed description of the Dutch health care system can be found elsewhere (please see: Schäfer W.,

Kroneman M., Boerma W., van den Berg M., Westert G., Devillé W., van Ginneken E.V., *The Netherlands: health system review*, "Health Systems in Transition" 2010; 12: V–XXVII).

Similar to other services included in public health care system, HP services are the responsibility of both national and local government [2, 5]. The national government has established institutions for the development, implementation, organization, funding and evaluation of HP. The two most important institutions are The Netherlands Institute for Public Health (RIVM) and The Netherlands Organization for Health Research and Development (ZonMw) [5]. In 2006, the Dutch Ministry of Health, Welfare and Sport (VWS) has founded the center for Healthy Living (Loketgezondleven.nl) within RIVM (https://www.loketgezondleven.nl). The goal of this center is to strengthen the effectiveness and coherence, and to monitor HP in the Netherlands. All HP, including those that are not funded by public sources and those that are not evidence-based should be registered in one database available on Loketgezondleven.nl [6]. Registration also means complying with certain criteria's such as a theoretical background, epidemiological and health relevance, implementation plan and evaluation (including effectiveness of HP towards health problems and cost-effectiveness) [2, 6]. Each HP is assessed by a group of independent experts before is officially registered [6]. The Netherlands Organization for Health Research and Development (ZonMw) is another important stakeholder related to HP. ZonMw focuses on the effectiveness, funding and collaboration of all parties related to HP. In order to provide better collaboration between policy makers, practitioners and researchers involved in HP, with money received from the Ministry of Health, between 2008 and 2016 ZonMw has also subsidized the eight regional Academic Collaborative Centers (ACC) within the National Program Elderly Care ('nationaal programma ouderenzorg'). From 2017 onwards this is continued within the program 'Better Older' ('BeterOud') which focusses on improving the quality of life for elderly people. ZonMw is also directly funds HP interventions [1].

The Dutch Ministry of Health considers health protection (Gezondheidsbescherming)and health promotion (Gezondheidsbevordering) as the main elements of public health policy [7]. The distinction between health promotion and health protection is based on the types of measures that are applied in order to implement the intervention. Health prevention includes measures that are applied routinely and that do not need active involvement of citizens (such as hygienic measures in preventing contiguous diseases). Health promotion includes measures that aim to affect both individuals and groups and that are applied in their social environment [16]. For the period 2014–2016, The Ministry of Health, Welfare and Sport has developed a national policy related to health prevention known as the Nationaal Programma Preventie (NPP) (https://www.rijksoverheid.nl/onderwerpen/gezondheid-en-preventie/inhoud/nationaal-programma-preventie).

The NPP is a strategy to secure collaboration between different partners including municipalities (gemeenten), health workers, health organizations, sport clubs and sport workers, health insurance companies, schools and NGOs. The main interest of NPP is to support HP related to prevention of obesity, alcohol consumption, and smoking and to increase participation in physical activities. NPP is also focused on prevention programs related to adequate use of antibiotics. NPP is widely known through the website "Alles is gezondheid" and focuses on several areas (sectors): work (*op het werk*), educational environments (*op school*), health environments (*in de zorg*) and neighborhoods (*in de wijk*). The evaluation of NPP is assigned to ZonMw, while the monitoring is done by the RIVM. Besides the health prevention strategy, the ministry of health also pays attention to health promotion. This includes promotion of a healthy life style, promotion interventions related to addiction, promotion interventions related to obesity, fall prevention and promotion of qualitative and accessible care [7]. Although NPP and other national policies officially overrule the local policy, municipalities are seen as main stakeholders for HP and local policies are also embedded within the national prevention policy [3]. Municipalities are responsible for social support arrangements, are involved in developing HP, their funding and involvement of all other important community members. Also, municipalities are responsible for HP through the Municipal Public Health Service -GGD (Gemeentelijke gezondheidsdienst) [5]. They are involved in different areas of HP relevant for their region and they are targeting different population and ageing groups.

The role of HP in the Netherlands and the responsibilities of national and local governments are defined by two laws: The Public Health Law ("Wet publieke gezondheid") (wpg) enacted in 2008 and the Social Support Act (wmo) that was enacted in 2007. The Public Health law regulates the responsibilities of national and local organizations in developing, implementing, evaluating and funding HP. Through this law it is also defined that the major role regarding the HP will be given to municipalities (gemeenten). The Social Support Act was extended in 2015 to include social support for people with disabilities and elderly to continue living in their homes and to enable them to participate in society. This law enables the development of HP that encourages social inclusion of older adults.

Some of the responsibility for financing and implementing HP is also given to the insurance companies in the Netherlands. This is defined by the Health Care Insurance Act (Zvw). Since 2006, the Dutch health care system is financed through the system of managed competition where the government has a regulatory role. Each citizen in the Netherlands is obliged to buy a basic insurance package from one of the nine private insurance companies. The government has the role of regulator and determines the necessary services that are covered by the basic insurance package. According to the Zvw, indicated prevention (interventions related to individuals that are not sick but have high risk to become sick in the future

according to their physician or GP) and diseases-related prevention (interventions related to individuals diagnosed with certain diseases in order to decrease the side effects of diseases such as physical activity on prescription (PARS)) can be covered in the insurance package. The minister of health decides on the content of the basic insurance package.

HP in the Netherlands, includes a broad scope of interventions that cover different areas of health such as mental health, healthy life style (prevention of smoking, alcohol consumption and obesity) and environmental health promotion, while special attention is given to youth population groups, vulnerable groups (migrants, homosexuals etc.) and older adults. HP follows an integrated approach that is also represented in curative care [3, 4]. This means that HP usually includes several different interventions proven to be effective.

Like in other European countries, within the Dutch health care system, a distinction is made between primary prevention (interventions to prevent the onset of diseases), secondary prevention (interventions to detect the diseases in early stage) and tertiary prevention (interventions to decrease negative effects of already diagnosed diseases). Based on the target groups that HP aim to address, a distinction is made between universal prevention (targeting the whole population), selective prevention (targeting the groups that are at risk to develop diseases), indicated prevention (targeting groups that are still not diagnosed with certain diseases but have high probability to be so), disease-oriented prevention (targeting population groups with already diagnosed diseases in order to decrease adverse effects). Indicated and disease -oriented prevention use individual interventions as a tool, while universal and selective prevention are mostly community based. We have also described other distinctions that are used to classify HP in **Appendix 1** [8]. These distinctions are also used by main stakeholders to describe responsibilities regarding the funding and financing of HP.

HP for the older adults is organized in a similar way as HP in general. The national strategy that regulates HP for older adults is based on several policy documents and it is best reflected through integrated prevention based programs such as Nationaal Programma Ouderenzorg [9] and BeterOud (BeterOud.nl). The main goal of this program is to provide healthy independent living of older adults including fall prevention, mental health prevention and social inclusion [8, 10]. On the local level, the main role for HP for older adults is given to municipalities and the GGD. Many municipalities have already formed centers for older adults. Their goal is to provide information on health prevention, curative care and social support for older adults. Also, many different organizations are directly involved in HP for older adults. They include not only public institutions but also foundations, NGOs and semi-governmental organizations. Particular attention is paid to HP for vulnerable population groups such as

Based on target groups	**Description**
Universal prevention	targeting whole population
Selective prevention	targeting the groups that are at risk to develop diseases
Indicated prevention	targeting groups that are not diagnosed with a disease but have high probability to be according to their GPs
Diseases-oriented prevention	targeting population groups with already diagnosed diseases in order to decrease adverse effects or to influence the progress of the disease
Based on type of health care process	
Primary prevention	interventions to prevent the onset of diseases
Secondary prevention	interventions to detect the diseases in early stage
Tertiary prevention	interventions to decrease negative effects of already diagnosed diseases
Based on type of measures	
Health protection	Measures that are taken as a routine without practical involvement of citizens (safety roads)
Diseases prevention	Measures that are specifically focused on prevention of certain diseases
Health promotion	Measures that are focused on physical and social environment and life style of individuals and groups
Based on applied methods	
Organization of social and physical environment	smoke-free schoolyards, changes in the infrastructure of disadvantaged neighborhoods and social support residents
Regulations	Laws, taxes, advertising policies
Information and education for groups	educational programs on healthy lifestyle at school and national publicity campaigns
Signaling and individual advices	Screening programs in rural areas, prevention consultations
Support	GP advices

Appendix 1. *Divisions of HP based on different criteria.*
Source: Own work.

older migrants and older homosexuals [11]. The Social Support Act (Wmo) aims to promote self-reliance. For older people this means that they should be able to live independently in their homes as long as possible. The aim of the Social Support Act is to help them to stay independent. Most municipalities use social neighborhood teams to decide whether support is needed. These social neighborhood teams can allocate household help (for cleaning the house) or other forms of social support such as transportation (mobility) and access to social activities. Based on personal circumstances, the social neighborhood team can decide to provide a professional if informal support is not available and elderly people are not able to participate in society without help. Persons eligible for professional help can opt for in kind support or can use the monentary equivalent – a personal budget - to organize help by themselves. Since the aim of social support act is to secure that older people can live independently, they also have a role in HP [16].

For both HP in general and HP for older adults, the main challenges include providing stable funding, maintain health benefits and decrease health inequalities [4]. Institutionalization of the existing interventions is also one of the challenges. Those challenges are considered as the main obstacles to the sustainability of HP. The Ministry of Health provides most of the funding for HP, but HP are also funded through private and other types of sources (international funding such as EU projects) However, there is still reluctance from the side of main stakeholders to finance HP [16]. Their major concern is related to lack of data on the effectiveness of HP.

In the **Box 1** we present relevant indicators on public funding of HP. Since one of the main goals of HP is to decrease health inequalities reflected in epidemiological outcomes such as life expectancy at different age and among different income and education groups, we also present those data in **Box 2**.

	2013	2014	2015*	2016*
Total health care expenditure as a percentage of GDP	11.0%	10.9%	–	–
Public health care expenditure as a percentage of total health care expenditure	87.6%	87.9%	–	–
Health prevention expenditure as a percentage of public health expenditure	17,1%	21,4%	15.7%	15,4%
Health promotion expenditure as a percentage of public health expenditure	8,9%	11,1%	8,4%	7,9%
Data are obtained from: Het Centraal Bureau voor de Statistiek (CBS) through web-platform StatLine (statline.cbs.n)				

* Data for 2015 and 2016 are estimated not real values.

Box 1. *Indicators related to health care system funding and HP.*
Source: Dutch Statistical Office, http://statline.cbs.nl/Statweb/?LA=en; assessed: May 2016.

Remaining life expectancy at	Age 55		Age 60		Age 65		Age 70		Age 75		Age 80	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Lowest income	23.3*	26.3	19.5	22.2	15.8	18.1	12.4	14.4	9.4	10.8	6.6	7.4
Low income	26.3	31.0	22.2	26.7	18.3	22.6	14.7	18.8	11.5	15.1	8.6	11.8
Middle income	28.1	31.8	23.8	27.4	19.7	23.2	15.9	19.1	12.4	15.1	9.3	11.6
Higher income	28.4	32.4	24.3	27.8	20.1	23.4	16.0	19.2	12.4	15.1	9.2	11.4
Highest income	29.8	31.9	25.2	27.2	20.8	22.7	16.7	18.3	12.8	14.2	9.4	10.4
Remaining life expectancy at	Age 55		Age 60		Age 65		Age 70		Age 75		Age 80	
	Male	Female	Male	female	Male	Female	Male	Female	Male	Female	Male	Female
Basic education	25.0	28.1	20.9	23.9	17.1	19.8	13.6	15.9	10.5	12.1	7.7	8.6
Vmbo	26.1	30.1	21.8	25.7	17.8	21.5	14.1	17.4	10.8	13.6	8.0	10.2
Havo vmo mbo	27.0	31.7	22.7	27.2	18.6	22.9	14.9	18.8	11.3	14.8	8.3	11.3
Hbo university	29.1	33.0	24.6	28.4	20.3	23.9	16.2	19.6	12.6	15.8	9.5	12.2

Box 2. *Population ageing indicators.*
Source: Dutch Statistical Office, http://statline.cbs.nl/Statweb/?LA=en; assessed: May 2016.

Source of funding	Beneficiary	Additional Comments
Taxes *Including:* – general taxes – local taxes – earmarked taxes	**General taxes** are used by Ministry of Health for funding health promotion activities. In 2015, it was estimated that around 53.554.000 euros was spent on HP. Money is particularly allocated to HP related to prevention of unhealthy behavior (smoking, obesity, alcohol consumption) and to promotion of physical activities such as: Sport en Bewegen in de buurt by Sportimpuls [7]. **Local taxes** are used by municipalities to fund HP relevant to the particular areas [7]. **Earmarked taxes** are not used to fund HP [7].	Ministry of Health, Welfare and Sport use general taxes to fund HP through different patterns. In some cases like in cases the money is send to ZonMw and from ZonMw to thematic institutes who then fund particular HP. In some cases resources coming from general taxation are also sent to municipalities who then fund particular HP [2]. The ministry of health uses different instruments to fund HP. One is subsidies. Major subsidies for mental prevention are given to TRIMOBOS (Dutch institute for mental health). For decreasing obesity Ministry of Health subsidize Het Convenant Gezond Gewicht which is a cooperation that involves 26 different parties: governments, businesses and different civil society organizations that work together to achieve a decrease in overweight and obesity. The subsidies for fall prevention for older adults are given to non-profit foundation de Stichting Veiligheidnl and they approximately 4 million of euros [7]. Besides subsidies, Dutch Ministry of Health also gives contributions to RIVM and ZonMw particularly for HP and contributions to municipalities.
Health insurance premiums *Including*: – voluntary and/or private insurance	All citizens in the Netherlands pay for the basic health insurance. The package includes many services and among them access to GPs. All HP that are prescribed by GPs are available through this basic packages [12].	Some HP although prescribed by GPs include small amounts of out-of-pocket patient payments [13].
Other public institutions	RIVM and ZonMw as well as thematic institutes (TRIMBOS, NISB) can also act as funding agents for HP. They use public money that is received from Dutch Ministry of Health. GGD receive subsidies from municipalities and governments. They can also use those sources to fund HP.	
Other sources:		
Funds from the employers		
Households	"Eigen bijdrage" is Dutch term for out-of-pocket patient payments. Those payments related to HP are present but include small nominal amounts up to 50 euros per person per year. Some of these payments can be also refunded [14].	
Foundations	There are many foundations that are involved in funding HP. They use donations that they receive from business organization but also subsidies that they receive from government and/or municipalities. Some of those foundations are consider as semi-governmental organizations.	**Vilans** is a specialized organization that provides knowledge related to long-term care. It is also, involved in prevention of loneliness and dementia among elderly. The Groninger Active Life Model **(GALM)** exists 17 years. GALM has been able to develop thanks to start-up grants and cooperation with various parties: the Ministry of Health; the Dutch Heart Foundation; ZonMw; NOC * NSF; Elderly Assistance Fund; Dutch Institute for Sport and Exercise; Royal Dutch Gymnastics Union; GALM is also part of four national campaigns of the Ministry of Health namely "Netherlands on the Move", the "FLASH campaign", the "Sports For Plus50"and the "Dutch Action Plan for Sport and Exercise". Additionally GALM is funded through municipalities and by the contribution of the participants. The GALM Foundation also collaborates with the University of Groningen – Interfaculty Center for Human Movement Sciences.
Foreign	Resources coming from European projects.	The problem with HP that founded by European funds is that they cease to exist after the projects are over. The lack of sustainable funding is the main obstacle although some of these HP are considered as valuable for older adults.
Others		

Box 3. *Potential sources of funding HP – who is funding HP.*

Source: Own work.

- **Financing of health promotion interventions for older adults**

The central government and the municipalities are the main stakeholders responsible for providing funding for HP (**Box 3**). Municipalities are also involved in the implementation and financing of HP. They are the main stakeholders in financing universal and selective HP and they also play a role in financing disease-related HP. Besides municipalities responsibilities to finance HP are also given to health insurance companies (zorgverzekeraars). Health insurance companies are mostly responsible for financing indicated and disease related HP. Besides their responsibilities given by law, health insurances companies and municipalities may also have a financial interest to finance HP. Evidence shows that older adults who have a healthier life style live longer (on average 7 years more), than those with unhealthy life style. However, their average health expenditures are similar. Since older adults with healthier life style live longer, they also pay premiums to the insurance longer [16]. Taking in account that HP have higher social than individual effects, municipalities may also benefit from financing HP. From the point of view of municipalities, investing in HP will not only lead to a longer and more happy life of older adults, but will also decrease the need for formal social support provided by the municipalities.

The evidence from Loketgezondleven.nl shows that only few HP are efficient and effective [16]. This means that both municipalities and insurance companies are reluctant to invest in HP. Many municipalities find it important to allocate sources to more proven cost-effective interventions within their social support arrangements such as youth care, than to invest in HP with unclear benefits. Also, within the Dutch health care system there are several negative incentives for both municipalities and insurance companies that make them more reluctant to invest in HP [16]. Those incentives are related to the organization and/or financing of the health care system. For example, municipalities can invest in HP, but benefits may be higher for insurance companies than for municipalities itself. This is for example the case within HP that aims to monitor homeless people. In this case in Den Haag, the municipality has invested 26.696 euros while the financial benefit is 30.420 euros. On the other side, health insurance companies did not invest in this HP, but they also have benefits estimated at 15.000 euros [16].

The Dutch health care system is carried out by 9 insurance companies of which the 4 largest have a market share of more than 90%. An insurance company that decide to invest in HP has to take in account that people may change insurance company and that other companies also benefit. This is related to the nature of HP-most of them yield benefits only after a longer period of time. According to the Dutch law, once per year during a period of 6 weeks each individual can change insurance company. Another negative incentive is related to the Risk Equalization Fund. In the Netherlands, health insurance is compulsory and health insurance companies are obliged to provide basic insurance to everyone irrespectively of health status. To avoid risk selection and to create a level playing field among insurance companies, the government has established the Risk Equalization Fund. The fund is financed by income - related premiums. The funding insurance companies receive from the risk equalization fund are to a large extent based on costs for health care made in the past. This provides a disincentive to engage in prevention to avoid making costs for health care.

In order to provide more structural and stable financing for HP, several new models have been proposed. These include:

Regional funds for prevention – it aims at shared responsibility between health insurance companies and municipalities. Also, this fund guarantees that the costs related to HP are also equally shared.

Health impact bond is a contract between the government (central or local) and the organization that implement HP. The sources for HP are obtained from external investors. The government pays to the organization only if the HP has some social impact. The example is the contract between Buzinezzclub, ABN Amro, Start Foundation and local municipality Rotterdam. ABN Amro and Start Foundation invest in Buzinezzclub that provides jobs for young unemployed and unqualified people. The municipality pays back to investors using the savings in social benefits.

Shared savings refer to the situation when the insurance company and/or provider receive a portion of the saved costs because of HP. This portion is usually predetermined.

Although attention for these social innovations is high, none of these alternative financial arrangements have been truly implemented.

Besides the financial models mentioned above, there are many other pilot models that try to aim to provide sustainable financing of HP. They include prevention costs groups in risk equalization, long term policies for prevention and health transfer systems. The evidence from RIVM shows that the majority of HP is financed by municipalities and/or insurance companies, while some of them also include financing from regional funds.

- **Health Promotion for Older Adults**

HP for Older Adults include fall prevention, HP related to physical activities, HP related to social inclusion and mental health of older adults and HP related to healthy life style of older adults [7]. In the **Table I** we present HP that are registered by the RIVM Center for Healthy Living and that are targeting adults older than 55. Also in the text below we present two HP that are targeting older adults and we describe their mechanisms of financing.

We present two examples of HP related to older adults: GALM which is a HP intervention related to physical activity of older adults and Pink Buddies, which is a HP intervention related to support and assistance of older homosexuals.

The Groningen Active Life Model (GALM) is a HP intervention that aims to increase the participation of older adults in physical activity. The target group is defined as individuals between 55 and 85 years. Interventions

include several different programs related to physical activities but also to diet advice and training advice. Activities are done in cooperation with sport leisure centers, local communities and within the houses of older adults. To finance the HP, GALM group use subsidies from national government, municipalities and ZonMw. The group also uses donations from different foundations such as NSF and the Elderly Assistance Fund. The group is also an active participant in the Dutch national program 'Netherlands on the move' ("Nederland in beweging") and has managed to obtain additional resources through this campaign. GALM is also cooperating with University of Groningen in order to obtain better quality of HP. Participants of the different programs might be asked to contribute financially – for example to be registered within the groups. Amounts vary and go from 1–3 euros. GALM exists now for 17 years and present a successful case of private-public financing of HP.

Roze Buddyzorg Amsterdam is HP for homosexual older adults. The HP intervention was launched by the Schorerstichting – a foundation established in 1968. The goal of HP was to provide a buddy-a regular visitor to older homosexual people in their homes. The buddy can provide care but also do activities together with older adult. The foundation received funding from the municipality of Amsterdam approximately 350 000 per year and subsidies from Dutch government approximately 650 000 euros per year (http://rozebuddyzorg.nl/?page_id=177). The foundation also received donations from members and business organizations to finance HP. However, the foundation did not cooperate with public institutes and other organization responsible for monitoring and evaluating HP. This resulted in suspension of public funding from both local municipality and from the state. Without this funding, it was not possible to finance HP since 2012. Nowadays, Roze Buddyzorg Amsterdam HP exists within the organization that has the same name: Roze Buddy Stichting, and is also funded by the government and private donations (http://rozebuddyzorg.nl/?page_id=177).

- **Organizations involved in Health Promotion**

National level institutions:

- ✓ **RIVM** – Dutch institute for public health with specialized centers such as **Centrum Gezond Leven** (www.loketgezondleven.nl). This is the center for health promotion and prevention. The main role is to emphasize the effective local health promotion activities.
- ✓ **ZonMw** – The Netherlands Organization for Health Research and Development. It is involved in the design, implementation, monitoring, and evaluation and funding of HP for older adults.
- ✓ **Health promotion "theme" institutes:** the TRIMBOS institute (Institute for mental health), NISB (Dutch Insitute for Sport and Physical Activity), VeiligheidNL (Dutch foundation for fall prevention), Soa Aids Nederland (Dutch foundation for sexually transmitted diseases), Pharos (Dutch foundation for migrant health).

Regional level:

Academic Collaborative Centers (ACC)-assist in the cooperation between policy makers, researchers and street-level health promotors.

Local institutions:

- ✓ **GGDs** are local institutes for public health. They are involved in prevention of infectious diseases, prevention of sexually transmitted diseases, vaccination programs, environmental health, tuberculosis control, public mental health, assistance with natural disasters, forensic care, health screening and health education, general hygienic, youth health, epidemiology, and policy development They are also involved in community health prevention activities related to the elderly (wpg).The GGD is responsible for the health education and for developing, support and realization of health promotion and health prevention activities for elderly such as prevention of depression, loneliness, promotion of active movements, prevention of accidents and fall prevention, promotion of healthy nutrition and informal care (mantelzorg). GGDs also monitor the health status of the (elderly) population.
- ✓ **Professionals related to specific districts and towns** such as social workers or workers within institutes for family care. Those professionals help specific groups of older adults such as elderly migrants, homosexual older adults etc.
- ✓ **GPs and health professionals involved in home care** (thuiszorg) – their role is to inform and encourage older adults to participate in HP, when applicable. Health care professionals in home care also encourage HP related to social inclusion of older adults, healthy eating and may help them to live in their home as long as possible.
- ✓ **Medical specialists** are usually involved in HP for older adults that are already diagnosed with a chronic disease. Medical specialists may encourage HP of the patients.
- ✓ **Professionals specific for work – Arbo-coördinators** are health professionals involved in HP for working older adults.
- ✓ **Health insurance companies** also contribute in implementation and financing of HP for older adults. They contribute by providing the donations for some HPs or by financing HP included in the basic insurance package.

- **Social Assistance Sector**

The Social Assistance Sector is included in HP for older adults through municipalities. Municipalities organize HP together with GPs and social sector institutions. The social sector is mostly focused on HP related to social inclusion of older adults and independent living [10].

- **NGO Sector**

There are NGOs specifically oriented towards HP for older adults as the main contributor or as a co-partner. The majority of the NGOs work together with municipalities and they are very often subsidized by municipalities.

	Type of activity	Responsible organization	Who is funding	Organizations that are involved
In de put, uit de put 55+: zelf depressiviteit overwinnen	Healthy life style Physical activity	No data available	No data available	No data available
Vallen Verleden Tijd	Fall prevention Motor development	Sint Maartenskliniek	ZonMw (The Netherlands organization for Health Research and Development)	Nederlands Paramedisch Instituut
Blijf Staan	Physical activities Fall prevention	VeiligheidNL	No data available	Actiz
Zicht op Evenwicht	Depression Physical activity Fall prevention	Trimbos institute	Government	Trimbos institute
Op verhaal komen	Depression Stress	University Twente	Health insurance	No data available
Functionele Training Ouderen (FTO)	Fall prevention Physical activity	TNO Behavioral and Societal Sciences	Health insurances ZonMw	No data available
Halt! U valt	Fall prevention	VeiligheidNL	No data available	No data available
	Type of activity	**Responsible organization**	**Who is funding**	**Organizations that are involved**
In Balans: valpreventie programma voor ouderen	Fall prevention Healthy life style Rheumatology	VeiligheidNL	Own resources from foundation and participants fees Government National funds	Municipalities Thuiszorg (home care) Health insurance companies
Denken en Doen	Sport Social inclusion	Nederlandse Bridge Bond	Municipalities	No data available
Valanalyse 65+ voor de eerstelijnszorg	Fall prevention Sport activities	VeiligheidNL	Government Own resources from organization	V&VN NVvPO
Sociaal Vitaal	Healthy life style Physical activities	GALM foundation	Municipalities National government Regional government Tijdelijke stimuleringsregel	Local welfare funds GGD (Dutch regional institutes for public health) Health institutions Sport organizations GGZ-instelling Local GPs
Het OTAGO thuisoefenprogramma	Fall prevention Physical activity	VeiligheidNL	No data available	No data available
	Type of activity	**Responsible organization**	**Who is funding**	**Organizations that are involved**
Ouderen in Beweging	Healthy life style	Yalp	Municipalities Organizational resources	Commercial organizations
Beweegtuin voor ouderen	Outdoor physical activity	Nijha b.v	Resources provided by organization	Zorgcentrum Beringhem Huize Salland Zorgcentrum Zandhove

Verbeterde zelfzorg in de thuissituatie voor Turkse mannen met diabetes	Life style Diabetes Overweight	GGD Hart voor Brabant	No data available	No data available
GALM	Physical activity Healthy life style	GALM foundation	Regional funds Municipalities National government Regional government	GGD Local organization for older adults Local welfare foundations
SCALA	Physical activities Chronic disorders Life style	GALM foundation	Regional funds Municipalities National government Regional government	GGD Health institutions Local organization for older adults Local welfare foundations
SMALL	Healthy life style Social inclusion	GALM foundation	Municipalities National government Regional government	Local welfare foundations Local sport organization Local organization for older adults
	Type of activity	Responsible organization	Who is funding	Organizations that are involved
Beweegpret 55+ aan zet	Healthy life style	Huis voor Beweging	Government Own resources by organization	No data available
Elke stap telt	Depression Healthy life style For older women	SportZeeland	Own resources by organization Regional government Sponsored by industrial companies	Welfare foundations IVN (instituut voor natuureducatie en duurzaamheid) KNBLO Woonzorgcentra voor senioren
Body-Mind Fit met aikido	Psychological health Fall prevention Healthy life style	Aikido Nederland	No data available	No data available
Ouderenzorg in Beweging	Healthy life style Physical activity	Sportief Besteed	Own resources	No data available
Oldstars/Walking Football	port Healthy life style	Eredivisie Media en Marketing CV	No data available	No data available
Fit4Life	Healthy life style	IJslander	Own resources	Top Health Partners
Goldensports	Fall prevention	Stichting GoldenSports	Municipalities	No data available
Zeker Bewegen	No data available	No data available	No data available	No data available

Table I. *HP interventions for older adults in the Netherlands-data provided by RIVM Gezonde Leven.*
Source: Own work

- **Health**

Welfare organizations, GPs, health centers, sports service agencies, general hospitals and other healthcare providers and emergency, together with health insurers and municipalities are involved in improving the health and increasing the participation of older people in the HP. The main activities for older adults are related to the use of the help of these integrated teams in order to live independently in their homes. One example of such HP is the intervention provided by Care Innovation Center Brabant. This organization helps older adults to use new technologies and new devices in order to stay living in their homes as long as possible. Special role is given to GPs. The older adults perceived them as trustworthy persons. HPs that are advertised or implemented by GPs usually have better success among the older adults, than large national interventions [8].

- **Sport and education**

NISB is the main stakeholder involved in HP for older adults through the sport sector. Other sport institutions mostly have executive roles - this means that they are involved in HP that are already designed by other stakeholders. Some institutions (leisure centers) receive subsidies from the Ministry of Health, while some others are involved voluntary, usually through municipalities.

- **Work places**

Healthy adults can work full time at older age, but work can also contribute to better health during the aging process. This is the main paradigm of RIVM related to HP for older adults. Main stakeholders in this area involve work doctors and company management. Companies are encouraged to provide healthy restaurants and facilities for physical activities [15].

- **Neighborhoods**

There are huge differences between neighborhoods in the Netherlands when it comes to the physical and socioeconomic environment. In deprived neighborhoods for example, there is high unemployment, people eat unhealthier and children cannot always safely play outside. This causes health inequalities. Obesity, chronic illnesses and unhealthy behaviors lead to negative outcomes: in these neighborhoods, people live on average seven years less. GPs, district associations and health organizations, are jointly engaged in tackling the problems such as obesity, diabetes and loneliness in deprived neighborhoods. District organizations also help people to obtain better collective health insurance and to obtain better access for HP related particularly to older adults-for example leisure centers accessible to older migrant's women.

Conclusion

Health promotion in the Netherlands is financed through different institutions and combines public and private resources. This means that HP for elderly is financed by public sources, basic health insurance premiums but also through patient payments. This mix financing is useful to provide enough resources necessary for HP. Nevertheless, HP is financed more by public means than by private payments.

This is in accordance with organization of HP in the Netherlands. The main responsibility for HP is given to the central government and local municipalities. It is expected that local municipalities can best recognize the needs of their citizens. The role of local municipalities is particularly important for financing of HP for older adults. Following the introduction of the Social Support Act (wmo), the Dutch Ministry of Health has emphasized the importance of preventive measures for elderly that allow them to remain living independently in their homes and to actively participate in their communities. Municipalities can use the financial resources available through the wmo regulations for this.

Health insurance companies are also involved in financing of HP. Health insurance companies are mostly responsible for financing diagnosed and disease related HP that are covered by basic insurance packages,

The evidence stored at the Loketgezondleven.nl shows that only few HP are efficient and effective. This means that both municipalities and insurance companies are reluctant to invest in HP. In order to stimulate both insurance companies and local municipalities to invest more in HP, it is necessary to develop better tools for evaluating the HP and to assess their effects on target population groups.

For both HP in general and HP for older adults, the main challenges include providing stable funding, maintain health benefits and decrease health inequalities [4]. As we have mentioned above, in order to provide for sustainable funding, it is necessary to provide incentives for both health insurance companies and local municipalities. One way is to provide better information about the effectiveness of HP. Also, the use of financial incentives such as small user payments can contribute to sustainable funding of HP. Institutionalization of the existing interventions is also a challenge. This means that many HP are developed and implemented for certain period of time, but they do not become regular prevention programs within institutions. Those challenges are considered as the main obstacles to sustainability of HP. In order to make HP for older adults more sustainable and more adjusted to the needs of users, it is necessary to provide better data related to their effectiveness.

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