Netherlands

Research conducted in 01/10/2025

The Netherlands has a holistic approach to Alzheimer's disease care through both its diagnostic pathways and its residential innovations. Patients benefit from a streamlined diagnosis process, typically receiving a confirmed diagnosis within 2-3 months through memory clinics. Beyond this, the Netherlands developed and implemented the Hogeweyk, a pioneering "dementia village" which aims to provide residents with a safe yet familiar environment that mirrors everyday life, allowing them to maintain autonomy, dignity, and social engagement while receiving specialised care.

Highlights

Health system **Universal, Private Insurance (Mixed Provision)**
ADI member association(s): **Alzheimer Nederland**
National dementia plan: **National Dementia Strategy 2021-2030**
Dementia plan funding:
Dementia prevalence rate: **1620**
Dementia incidence rate: **280**
Population: **18358591**
Median age: **42**
Health expenditure (% of GDP): **10**

Diagnosis

Alzheimer's diagnosis in the Netherlands follows a GP-led pathway, with initial assessments and basic testing coordinated by general practitioners. Patients are referred to memory clinics or Alzheimer centres for multidisciplinary evaluation, including neuropsychological testing, imaging, and biomarkers. Standard cognitive tests include MMSE and Dutch-developed tools, while CSF analysis is routine and blood-based biomarkers are emerging. Genetic testing for familial Alzheimer's is available in specialised clinics. Wait times and access to dementia case managers vary regionally, though national standards aim for timeliness. Diagnostic costs are largely covered by mandatory health insurance, with minimal patient contributions.

Diagnosis pathway

Alzheimer's diagnosis follows a GP-led, guideline-based pathway. GPs perform initial assessments, cognitive screening, and basic blood or urine tests, coordinating referrals to memory clinics or Alzheimer centres for multidisciplinary evaluation. Memory clinics provide neuropsychological testing, neuroimaging, and biomarker analysis, while the GP remains responsible for care coordination.

The clinical pathway for Alzheimer's disease in the Netherlands is well-defined by national guidelines. It begins with the general practitioner (GP), who conducts an initial assessment using patient and family interviews, physical exams, and cognitive screening tools like the Mini-Mental State Examination (MMSE). The GP also performs blood and urine tests to rule out other reversible causes, such as vitamin deficiencies or depression. National guidelines from the Dutch College of General Practitioners explicitly encourage GPs to diagnose dementia within the primary care setting and to function as the gatekeepers for access to more specialised diagnostic testing in secondary care.

A referral to specialised care is indicated when there is a need for a more definitive diagnosis, a suspected treatable cause for the cognitive decline, dementia at a young age (defined as under 65-70 years old), or signs suggesting a specific type of dementia other than Alzheimer's disease or vascular dementia. Upon GP's referral to a specialist, patients are seen at a hospital-based memory clinic or a specialised Alzheimer Centre by a multidisciplinary team including neurologists, geriatricians, and neuropsychologists. This specialised phase involves more advanced diagnostics, such as in-depth neuropsychological testing, structural neuroimaging like Magnetic Resonance Imaging (MRI) or Computed Tomography (CT) scans to detect brain atrophy, and biomarker analysis. In this referral system, the GP remains the central coordinator of care, ensuring continuity between primary and secondary services, while memory clinics provide diagnostic confirmation and guidance for further treatment and support.

References

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Wait times

Status: Short wait time

National Treeknormen set four-week maximum waits for first specialist appointments and diagnostic tests. In practice, many hospitals exceed these standards. Access to dementia case managers varies, averaging 4.4 weeks nationally in 2024, with regional differences from two weeks to over eight months.

The Dutch healthcare system operates with a set of nationally agreed-upon maximum acceptable waiting times known as the Treeknormen. These standards, established by healthcare providers and insurers, serve as a benchmark for timely access to care. For the dementia diagnostic pathway, the most relevant norms are: 4 weeks for a first outpatient (polyclinic) appointment with a specialist, and 4 weeks for access to diagnostic procedures, such as an MRI or CT scan. Health insurers have a legal duty of care and can assist with finding a provider with a shorter waiting time through waiting list mediation if these norms are exceeded. Some providers meet these standards. For example, the Green Heart Hospital reports a 30-day wait for its memory clinic, and Radboud University Medical centre a 19-day wait for a CT scan. However, many hospitals frequently exceed these national standards. Reported waits for a neurology consultation can be as long as 105 days at Medical Spectrum Twente or 270 days at Treant.

Some delays also occur after diagnosis. Additionally, as of January 2024, the average wait for a crucial dementia case manager (a professional who coordinates care, support, and services for people living with dementia and their families after diagnosis) was 4.4 weeks, but there are regional disparities. For instance, the average wait in the Haaglanden region was reported to be 36 weeks, whereas in Limburg, it was only two weeks.

References

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Diagnosis cost

Status: Mostly or fully covered
Mandatory basic health insurance covers GP visits, specialist consultations, cognitive assessments, and imaging, with out-of-pocket costs capped at €385 annually. Private or non-covered services may cost more.

In the Netherlands, the direct cost of an Alzheimer's disease diagnosis is managed through the mandatory basic health insurance (Basisverzekering). This covers general practitioner visits, specialist consultations, cognitive assessments, brain imaging, and other diagnostic procedures necessary for identifying dementia. The patient's out-of-pocket expense is predictably capped at the annual mandatory deductible, which is €385 in 2025. While GP visits are exempt from this deductible, any subsequent specialist care or tests are subject to it. Costs may be higher in private clinics outside the standard insurance network or for services not covered by the basic package.

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- https://www.ihch.nl/about-the-ihch/dutch-healthcare

Cognitive tests

Status: Available

GPs and specialists in memory clinics employ various tests. The Mini-Mental State Examination (MMSE) is commonly employed by GPs as a screening instrument for dementia. However, the NHG working group advises against using the Montreal Cognitive Assessment (MoCA) for dementia diagnosis in general practice, as its superiority over the MMSE has not been demonstrated in primary care populations. In specialised memory clinics, both tests are used, but their performance and diagnostic accuracy may vary across different settings. Dutch centres and researchers have also developed specialised tools, such as the informant-based Amsterdam Instrumental Activities of Daily Living Questionnaire (A-IADL-Q) to assess functional decline and the non-verbal Cross Cultural Dementia Screening Test (CCD) for use in migrant populations.

The Netherlands doesn't have a single, centralised public dementia screening programme, but instead is implementing a national TAP-dementia (Timely, Accurate, Personalised diagnosis of dementia) research project to improve diagnosis.

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Imaging tests

Status: Used in specific cases

Structural brain imaging with either Computed Tomography (CT) or Magnetic Resonance Imaging (MRI) is a standard and available part of the diagnostic evaluation for patients with suspected dementia. Positron Emission Tomography (PET) imaging technology, including amyloid-PET, is available in the Netherlands but is generally restricted to public specialised centres and academic hospitals.

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Genetic tests

Genetic testing for familial Alzheimer's disease (i.e., linked to mutations on APP, PSEN1, PSEN2 genes) is available. Access is typically restricted to specialised memory clinics, such as the Alzheimer Centre Amsterdam, and is offered to patients who meet strict eligibility criteria. However, traditional criteria are too stringent and fail to identify many individuals who carry these mutations in the Netherlands. In other countries where the health care systems differs and in other genetic ancestry groups, the performance of the criteria may be different. Testing for the APOE gene, a common risk factor for late-onset Alzheimer's disease, is not recommended for routine clinical diagnosis or risk prediction, but is used in research settings.

References

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Biomarker tests

Analysis of cerebrospinal fluid (CSF) is an established diagnostic tool used in Dutch specialist memory clinics. As a less invasive, cheaper, and more accessible alternative, blood tests are poised to become a standard tool in Dutch memory clinics. The Dutch researchers are developing and validating blood-based biomarkers, which are currently only utilised in a research context.

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Treatment & care

Memory clinics and specialised diagnostic services are widely accessible across the Netherlands, coordinated by GPs with support from dementia case managers and nurses. Long-term care is managed by the CIZ, complemented by day programs, care farms, and over 275 Alzheimer Cafés. Innovative residential models like De Hogeweyk and Green Care Farms provide homelike, publicly funded care, while Buurtzorg delivers holistic home support. Medications are fully covered, and nursing home services are funded through the Long-Term Care Act. Caregiver support includes Personal Budgets, case managers, respite care, and guidance from NGOs like Alzheimer Nederland.

Specialized facilities and services

Memory clinics and specialised diagnostic services are accessible throughout the Netherlands, with major centres at Amsterdam UMC, Leiden UMC, Erasmus MC, Maastricht UMC, and Radboud UMC. General practitioners coordinate care, supported by dementia case managers and nurses, while the Dutch Memory Clinic Network provides a national directory. Long-term care access is managed by the CIZ, ensuring equitable eligibility, complemented by day and community support, including care farms and over 275 Alzheimer Cafés for peer support.
Innovative residential models include De Hogeweyk, a dementia village with themed group homes, and Green Care Farms like Reigershoeve, offering homelike, full-time care in safe, small-scale settings. Both are publicly funded. Additionally, Buurtzorg, a nurse-led neighborhood care model, delivers holistic home support, including mental health services for complex dementia symptoms.
Lastly, palliative and end-of-life care is integrated across nursing homes and specialised hospices, providing comfort-focused care adapted to dementia, ensuring local access in all provinces.

Memory clinics and specialised diagnostic services are accessible across the Netherlands, not just in major cities. Major Alzheimer's disease care and research centres include Amsterdam UMC, Leiden University Medical centre, Erasmus MC in Rotterdam, Maastricht University Medical centre, and Radboud UMC in Nijmegen. Patients benefit from a primary care network, with GPs playing a central role in coordination, and access to case managers or dementia nurses who guide families through care options. The Dutch Memory Clinic Network offers a directory to locate services throughout the country at:
https://www.geheugenpoliklinieken.nl/over-het-ngn/overzicht-geheugenpolis

Access to significant long-term care is then determined by a national assessment body, the Centrum Indicatiestelling Zorg (CIZ), which provides an indication based on need, ensuring equitable access for all residents. A wide range of day and community support is available nationwide, often arranged through local municipalities. This includes over 1,350 care farms, with around 400 specialising in dementia care, which offer structured activities in an agricultural setting. For peer support, there are over 275 Alzheimer Cafés spread across every region, in both large and small towns. These monthly gatherings for people living with dementia and Alzheimer's disease and their families or friends provide a welcoming space to ask questions to experts, share experiences with others in similar situations, and learn more about dementia and coping strategies.

The Netherlands is also known for innovative residential models like De Hogeweyk (dementia village), publicly

funded facilities through the national long-term care act (Wlz) and are accessible to anyone with the appropriate CIZ indication. Opened in 2009, De Hogeweyk is a purpose-built neighborhood where residents living with severe dementia live in a safe, enclosed, yet open environment. The core concept is to create a familiar social world. Residents live in small group homes of six to seven people, with each house decorated to match one of several distinct lifestyles. Residents are free to wander the village, visit the supermarket, café, or theatre, and participate in social clubs, all staffed by nearly twice as many trained caregivers who wear plain clothes and interact as neighbours or assistants.

Another innovative model is the 24-hour residential Green Care Farm. Building on the day care concept, facilities like Reigershoeve provide full-time residential care in a small-scale, homelike farm setting for people living with dementia. At Reigershoeve, 27 residents live in four group homes, participating in farm chores and enjoying the freedom of a safe, rural environment. Like De Hogeweyk, these facilities are funded through the public insurance system, making them an accessible alternative to traditional nursing homes.

Buurtzorg, meaning “neighborhood care”, is a Dutch home-care organisation that operates on a nurse-led model. It utilises small, self-governing teams of up to 12 nurses who provide holistic care to 50-60 patients within a specific neighborhood, eliminating traditional layers of management. This approach allows nurses to deliver a full range of services, from medical care to personal support, fostering strong relationships with clients and their families to help them remain independent. The model is designed for individuals living with chronic conditions, including dementia and those needing end-of-life care. Additionally, Buurtzorg has a specialised mental health branch, Buurtzorg T, which works with the community nursing teams to provide integrated psychiatric treatment and coaching for dementia patients experiencing complex behavioural symptoms at home.

Palliative care is integrated into the Dutch system, with a focus on comfort throughout the disease progression, especially within nursing homes. For the terminal phase, hospice care is available for individuals with a life expectancy of three months or less. While many traditional hospices lack facilities suitable for patients who wander, the system is adapting with specialised hospices tailored or designed for dementia patients’ needs, such as Hospice Kamillehof in Eindhoven. Furthermore, many standard nursing homes with dedicated dementia units provide integrated palliative and terminal care services. These facilities, along with standalone hospices, are distributed across all provinces, ensuring end-of-life care is accessible locally.

Approved medication

Generic Name

Donepezil;Official National Product Information; https://www.hma.eu/fileadmin/dateien/Human_Medicines/CMD_h_/Pharmacovigilance_Legislation/RMPs/HaRP_ARs/Donepezil_2019_06_
Rivastigmine;Official National Product Information; https://www.ema.europa.eu/en/medicines/human/EPAR/exelon

Galantamine;Official National Product Information; https://ec.europa.eu/health/documents/community-register/html/ho17801.htm
Memantine;Official National Product Information; https://www.ema.europa.eu/en/medicines/human/EPAR/ebixa

Lecanemab;Official National Product Information; https://www.ema.europa.eu/en/medicines/human/EPAR/leqembi
Donanemab;Official National Product Information; https://www.ema.europa.eu/en/medicines/human/EPAR/kisunla

*Namzaric = combination of Donepezil and Memantine

** MHRA: Medicines and Healthcare products Regulatory Agency - UK medicines regulator;

SPC: Summary of Product Characteristics - detailed product information

Treatment cost

Medications are fully covered, with minimal co-payments capped at €250 annually. For intensive, 24-hour care under the Long-Term Care Act (Wlz), patients contribute based on income and assets, while nursing home services, including therapy and dental care, are fully covered.

All medicine is fully covered by the insurance in the Netherlands. For some medications, an additional personal co-payment may be required, though generally this is capped at €250 per year.

As the disease progresses and the need for intensive, 24-hour care arises, funding shifts to the Long-Term Care Act (Wlz). The primary cost becomes a monthly personal contribution that is calculated based on the patient's (and often their partner's) income and personal assets, such as savings and investments. This contribution has two tiers: a low contribution (up to €1,076.60 per month in 2025) which applies to those receiving care at home or for individuals in a nursing home whose partner still lives at home, and a high contribution (up to €2,954.40 per month in 2025) for single individuals in a care facility. Under Wlz, all care associated with nursing home care is covered. This includes physiotherapy, occupational therapy, a dietician assistance, or dental treatments.

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Caregiver support

Caregivers in the Netherlands receive modest annual appreciation through municipalities and can be paid via the Personal Budget, though this income is taxable and lacks pension or unemployment benefits. Support includes dementia case managers, respite care, and services funded under the Social Support Act (Wmo), Long-Term Care Act (Wlz), and Healthcare Insurance Act (Zvw). NGOs like Alzheimer Nederland and MantelzorgNL provide guidance, advocacy, and peer support, though no direct financial aid is offered.

The annual caregiver appreciation, a modest payment or gift voucher, is provided by municipalities under the Social Support Act (Wmo), with the amount varying by location. The primary way for a caregiver to receive regular payment is to be formally hired by the care recipient through their Personal Budget. However, this transforms the caregiver into a service provider, and the income is taxable, can affect social benefits, and does not accrue pension or unemployment rights. There are no special tax deductions for caregivers themselves; tax benefits for healthcare costs can only be claimed by the person receiving care, providing an indirect benefit at best.

The Netherlands has several schemes and care levels designed to support caregivers, which in turn enable better care for the patient. One example is the dementia case manager, a professional guide for the patient and caregiver who provides emotional support, coordinates services, and helps navigate the complex system. Another scheme is respite care, which provides temporary relief to prevent caregiver burnout through services like day programs or short-term stays in a care facility. This support is structured within three main legislative pillars. The Social Support Act (Wmo) provides municipal-level support like home help and day activities to help people live at home longer. Long-Term Care Act (Wlz) funds intensive, 24-hour care for those living with advanced dementia, either at home or in a residential facility. The Healthcare Insurance Act (Zvw) covers essential medical care and the case manager.

Although the Non-Governmental Organisation (NGO) sector doesn't offer direct financial help to caregivers, Alzheimer Nederland and MantelzorgNL offer invaluable practical information, advocacy, and peer support through resources like helplines and local Alzheimer Cafés.

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Policy

The Dutch National Dementia Strategy 2021–2030 focuses on advancing research, reducing stigma, and delivering person-centered, coordinated care supported by technology and informal caregivers. While no new strategies are planned, gaps remain: fragmented care, bureaucracy, limited support, voting restrictions, and cultural stigma, especially affecting minority communities, highlight the ongoing challenges in translating policy into improved daily experiences for people with dementia and their carers.

National dementia plan

The Dutch National Dementia Strategy 2021–2030 centres on three key priorities. It advances research across the full spectrum, from understanding causes to developing treatments, with national and international collaboration. It works to reduce stigma, promoting awareness, respect, and inclusion so people with dementia can remain active in their communities. Moreover, it focuses on person-centered support, ensuring care is tailored, coordinated across services, enhanced by technology, and reinforced with robust assistance for informal caregivers, guiding individuals and families from early diagnosis to end-of-life care.

The Dutch National Dementia Strategy 2021-2030 centres around three core themes:

1. Advancing dementia research (A world without dementia): This long-term goal focuses on stimulating and strengthening the entire chain of dementia research, from fundamental studies into its causes to clinical trials for new treatments and prevention strategies. The strategy calls for significant investment in research infrastructure and talent development. The goal is to not only improve the understanding of dementia but also to translate research findings into tangible benefits for patients, such as more accurate and timely diagnoses and effective, personalised treatment plans. The strategy emphasises both national and international collaboration to maximise the impact of this research effort.
2. Reducing stigma and prejudice (Persons with dementia matter): The strategy promotes the idea that people living with dementia are valuable members of society who should be able to continue to participate in their communities for as long as possible. This involves raising public awareness and understanding of dementia, promoting respectful and supportive interactions, and ensuring that the voices and experiences of people living with dementia are heard and integrated into policy and practice. The ultimate aim is to create an environment where individuals living with dementia feel respected, supported, and empowered to live meaningful lives.
3. Improving support and services (Tailor-made support when living with dementia): This pillar emphasises a person-centred approach, where the specific needs and preferences of the individual living with dementia are at the forefront of all care decisions. It calls for a comprehensive and integrated system of support, from early diagnosis to end-of-life care, that is coordinated across different healthcare and social service providers. The strategy also highlights the importance of innovation in care, including the use of technology to enhance independence and quality of life, as well as providing robust support for informal caregivers who play a crucial role in the lives of people living with dementia.

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Upcoming plans

There are no upcoming AD or dementia strategies on the horizon because the country is currently implementing its comprehensive National Dementia Strategy 2021-2030.

Policy gaps

Legal barriers

Despite the National Dementia Strategy, people with dementia and their carers face fragmented care, bureaucracy, and limited support. Voting restrictions exacerbate exclusion, though a proposed bill may allow assisted voting for dementia patients by 2026.

Legal barriers: Despite the Netherlands having a National Dementia Strategy, a gap persists between policy intent and the lived experiences of individuals living with dementia and their carers. Detailed reports from the National Ombudsman, together with two relevant research articles – a systematic review on barriers to accessing dementia care services in Europe and a study examining post-diagnostic dementia care access disparities in England and the Netherlands – highlight persistent systemic problems. These include fragmented care, excessive bureaucracy, inconsistent tailored support, and limited guidance following diagnosis.

Dutch electoral law explicitly disallows voting assistance for those with cognitive impairments who cannot vote ”without help”, effectively disenfranchising some individuals with dementia and reinforcing negative stereotypes. However, the Dutch government proposed a bill that would allow assistance inside the voting booth for people living with intellectual disabilities and dementia, potentially as early as 2026.

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Cultural barriers

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https://nltimes.nl/2024/01/28/minister-wants-voting-assistance-people-intellectual-disabilities-sooner

An analysis of Dutch language tweets related to dementia found that around 9% of the collected tweets contained ridicule. This use of ridicule in a public forum actively propagates stigmatising attitudes and suggests a cultural discomfort or lack of empathy towards individuals living with dementia, even within a society often perceived as progressive. Minority ethnic communities encounter challenges where dementia stigma intersects with cultural

beliefs, language barriers, systemic inequities, and sometimes negative conceptualisations of the condition (e.g., as "childlike" or "crazy"). Even among the general Dutch population, while self-stigma might be comparatively lower than in some other countries, a desire for secrecy and feelings of internalised shame can negatively influence comfort with disclosing a dementia diagnosis. Dutch cultural values, such as the high premium placed on independence (zelfredzaamheid), may paradoxically exacerbate stigma when these capacities are lost due to dementia. Furthermore, healthcare professionals have been found to hold stereotypical beliefs about people living with dementia, especially those from minority ethnic communities.

Research

The Netherlands leads in Alzheimer's research and care, with projects like ABOARD, genetic studies, TearAD biomarkers, gene therapies, and innovative models such as De Hogeweyk, advancing personalised diagnosis, treatment, and person-centered environments for dementia patients.

Selected academic institutions

Alzheimer centre Amsterdam | Netherlands Institute for Neuroscience | Brain Research and Innovation centre | UMC Utrecht | Alzheimer centre Erasmus MC | Maastricht University Medical centre+ | Leiden University Medical centre | Radboud UMC in Nijmegen

Clinical trials and registries

Hersenonderzoek is a national, online platform where individuals, both healthy volunteers and those with brain conditions, can register their interest in participating in scientific research. It functions as a matchmaking service. After a user registers at hersenonderzoek.nl/alzheimer/, researchers from Dutch universities and medical centres can then search the database for suitable candidates for their studies and invite them to participate.

The Netherlands has a network of university-affiliated Alzheimer Centres, which are centres of excellence for diagnostics, patient care, and scientific research. These centres are where most clinical trials take place. Information about their research can often be found on their individual websites. The list of these centres is available at:
https://www.alzheimercentrum.nl/wetenschap/lopend-onderzoek/tap-dementia/#1621940272306-ffa498dd-30c1

The official government registry for all medical research involving human subjects is maintained by the Central Committee on Research Involving Human Subjects (CCMO). This portal contains details of all authorised clinical trials in the Netherlands:
https://www.onderzoekmetmensen.nl/nl/proefpersonen

Hersenonderzoek is a national, online platform where individuals, both healthy volunteers and those with brain conditions, can register their interest in participating in scientific research. It functions as a matchmaking service. After a user registers at hersenonderzoek.nl/alzheimer/, researchers from Dutch universities and medical centres can then search the database for suitable candidates for their studies and invite them to participate. The Netherlands has a network of university-affiliated Alzheimer Centres, which are centres of excellence for diagnostics, patient care, and scientific research. These centres are where most clinical trials take place. Information about their research can often be found on their individual websites. The list of these centres is available at: https://www.alzheimercentrum.nl/wetenschap/lopend-onderzoek/tap-dementia/#1621940272306-ffa498dd-30c1 The official government registry for all medical research involving human subjects is maintained by the Central Committee on Research Involving Human Subjects (CCMO). This portal contains details of all authorised clinical trials in the Netherlands: https://www.onderzoekmetmensen.nl/nl/proefpersonen

References

- https://www.onderzoekmetmensen.nl/nl/proefpersonen

Selected innovative methods

Developed in the Netherlands and later adopted in other countries, the model called Meeting Centres offers community-based social, emotional, and practical support for people with dementia and their caregivers, while platforms like InLife help families coordinate care through their personal networks.

Alzheimer Centre Amsterdam leads the public-private project ABOARD, short for “A personalised medicine approach for Alzheimer’s disease”, to develop, among others, biomarker tests that allow for an early and precise diagnosis of Alzheimer’s disease.

Researchers at Amsterdam UMC and Maastricht University are leading research that uses protein analysis to identify distinct genetic risk variants of Alzheimer’s disease. This work redefines Alzheimer’s not as a single illness but as a collection of subtypes with different underlying causes, which could lead to personalised treatments.

Researchers at Amsterdam UMC and Radboud University investigated the feasibility of integrating APOE genotyping into the Dutch Brain Research Registry, an online platform for recruiting participants into Alzheimer’s disease studies. Their results show that both the technical process and participant acceptance were high, suggesting that large-scale genotyping through registries can streamline pre-screening and accelerate the recruitment of genetically defined cohorts for dementia research.

At Amsterdam UMC, a clinical trial is testing a repurposed, low-dose version of the HIV medication Efavirenz. This research is based on the discovery that the drug can reverse the accumulation of cholesterol in brain cells, a process that leads to the buildup of toxic amyloid and tau proteins.

UMC Utrecht worked on the ABIDE project that investigated the best applications of MRI scans, cerebrospinal fluid and PET scans, and focused on involving patients and caregivers in diagnostic dilemmas. To support clinicians during this process the online ADappt tool has been developed that can be used by professionals to interpret and discuss Alzheimer’s disease diagnostics test results with their patients and caregivers.

Utrecht University is developing a gene therapy that protects the vital connections between brain cells (synapses) from damage. The strategy uses harmless viruses to deliver genetic code that instructs brain cells to produce their own protective mini-proteins, essentially turning them into tiny “drug factories” to shield themselves from Alzheimer’s-related toxicity.

The TearAD study, with involvement from Maastricht University, is investigating tear fluid as a completely non-invasive source for Alzheimer’s biomarkers. Early results from this multicentre study show that key proteins like amyloid-beta and tau can be measured in tears and correlate with disease severity, potentially opening a new path for simple screening.

A group of Dutch research institutions, companies and civil society partners led by UMC Utrecht has received 4.5 million euro to develop new, advanced MRI techniques. The goal is to “better visualise the brain processes that play a role in dementia, so that the development and testing of a possible treatment becomes more effective”.

The Netherlands champions innovative care models such as De Hogeweyk, a purpose-built village for people living

with advanced dementia that allows residents to live in a more normalised and less institutional environment. This approach has garnered global attention for its person-centred philosophy.

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- https://research.umcutrecht.nl/news/4-5-million-for-mri-innovations-against-dementia/
- https://hogeweyk.dementiavillage.com/

Support

Meeting Centres, created in the Netherlands and adopted internationally, provide community-based support for people with dementia and caregivers. InLife aids care coordination, while Dementie.nlpublishes Alz magazine with advice, stories, and practical tips.

Organizations are listed for informational purposes based on publicly available sources. Inclusion does not necessarily indicate affiliation with or endorsement by Alzheimer's Disease International (ADI).

Selected national associations, patient family associations, NGOs:

Alzheimer Nederland MantelzorgNL

Selected initiatives

Developed in the Netherlands and later adopted in other countries, the model called Meeting Centres offers community-based social, emotional, and practical support for people with dementia and their caregivers, while platforms like InLife help families coordinate care through their personal networks.

Meeting Centres

Meeting Centres are community-based facilities that offer a supportive environment for people living with dementia and their caregivers to socialise, engage in meaningful activities, and access practical and emotional support. Developed in the Netherlands, this model has been implemented in several other countries and is supported by research demonstrating its positive effects on the well-being of both people living with dementia and their families.

InLife

InLife is a platform designed to help caregivers organise support from their social network.

References

- https://interlinks.euro.centre.org/model/example/MeetingCentresForPeopleWithDementiaAndTheirInformalCaregiver
- https://pubmed.ncbi.nlm.nih.gov/15254924/
- https://pubmed.ncbi.nlm.nih.gov/29513909/
- https://www.maastrichtuniversity.nl/news/inlife-care-caregivers

Dedicated media outlets

Dementie.nl is an extensive online platform that is a cornerstone for anyone affected by dementia. It provides reliable information, practical tips, and a space for connection. They also publish a magazine called Alz issued several times a year, providing a mix of personal interviews, expert columns, research updates, and practical advice for daily life with dementia.

References

- https://www.dementie.nl/brochures