Gerōn

Magazine on Ageing & Society

Interview with Herman Van Rompuy

– Max de Coole & Jan Willem van de Maat

Ageing of the population: A state of the art

– Lieve Vanderleyden

Do ageing societies reduce intergenerational justice and increase pro-elderly policy bias?

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SPECIAL
THE STATE OF THE ART OF AGEING IN EUROPE

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Gerōn

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The State of the Art of Ageing in Europe

In this special edition of Gerōn magazine, authors from several European countries shed light on aspects of *the State of the Art of Ageing*. We emphasize the words 'aspects of', because we realize that the articles in this edition reflect only a fragment of everything that is happening at the moment.

We present some comparative basic data about the older generation in different European countries as well as comparative data on subareas, such as health and care, employment and income and the domain that we characterize as 'the art of ageing'.

Furthermore we concentrate on subjects that are related to expertise and research in one specific country, centred on special themes such as informal care, intergenerational exchange, migrants and lifestyle.

Can we define European policies when it comes to ageing and the older generation? Is that desirable? Or is it essentially the task of individual countries and their governments to develop successful policies on ageing. The latter is necessary, as it is fundamental in order to create support and determine policy down to local levels.

These explorations in Gerōn have led to the impression that the overall impact of policy measures in this domain by the European Commission (and even more so of the European Council) is rather low. The essence is to initiate networks across countries that generate comparative data and new insights on the basis of which the European countries are stimulated to develop innovative policies. Scientists, support groups, civil servants and politicians could benefit from these networks which, by the way, already operate on a regular basis in a number of committees across Europe.

The *European year of Active Ageing and solidarity between generations* in 2012 is a good example of such an incentive to develop new policies.

Considering this, it will be important to determine which basic values are shared between the Member States and to what extent differences in opportunities as well as deviations in the level of services for older people are acceptable. Obviously taking into account, and with respect for, socio-economic and cultural differences between the Member States.

In the light of the future, the relations between the different generations play an important role. How sustainable is our European society with respect to the interests of older people, now and in the future?

The radical demographic change that is taking place in the twenty first century demands an inspiring – and sometimes confronting – European incentive.

Max de Coole, Joost van Vliet &
Henk Bakkerode (guest editor)

Translation: Angelique van Vondelen

IN THIS EDITION

Herman Van Rompuy

Immigration is inevitable if we want to maintain our population

MAX DE COOLE & JAN WILLEM VAN DE MAAT

For the European citizen, Europe is increasingly linked to the word crisis. From Greece to the boycott of Russia, from the climate to more refugees pouring in. The current generation of older people was the cradle of Europe or, rather, they looked on willingly from the sidelines when the idea of a united Europe was developed. Do you understand that even among older people there is a lot of disappointment about what Europe has brought them?

I am aware of how finite we are. We need to be 'prepared' for death, in that we need to be aware of it. Those who are aware, accept more

We live in turbulent times – not only in Europe – but also worldwide. For some political developments, the EU is dependent on what happens elsewhere in the world. Take for instance the wars in Ukraine or Syria, this is something we can hardly come to grips with. But the crisis in the Eurozone is our own responsibility. I do understand their disappointment, but this disillusionment holds true for national governments as well.

Europe tries to look at the ageing of the population mainly in terms of an opportunity for innovation and the economy. This is underlined by comprehensive subsidized programs such as 'Europe 2020' and the research program MOPACT (Mobilizing the potential of active ageing). What is, according to you, the major challenge for an ageing Europe?

The ageing of the population is indeed a challenge for our economy. We all have to stay active longer and we need creative solutions from a smaller group of younger people. If we want to maintain our population, immigration is inevitable. This could increase to 10 percent of the total population according to a study from the European Commission. On the other hand, we need to reserve budgets in order to cover public expenditure for health care and pension schemes. All in all this will add up to three percent of the gross domestic product (GDP) in 2013 and six percent in 2060.

Is the ageing of the population typically a subject for the European Commission and the European Parliament or does it also fit the agenda of the European Council in which the heads of state of EU countries are assembled?

In the first place, this is a task for the 28 heads of state because many of the authorities that can tackle the problem of the ageing population lie with national governments and national parliaments.

With respect to the previous question: to what extent is an overall European policy proportionate to the individual, national policies of the Member States in this domain? How comprehensive is the European agenda?
Europe should take its responsibility when it is not possible anymore for individual Member States to take action. The list of subjects increases: climate, terrorism, euro, common market, cybercrime, criminality et cetera.

Luuk van Middelaar, author of 'De passage naar Europa. Geschiedenis van een begin' (2009), states that there is a third Europe. Apart from the 'Europe of the Citizens' (European Parliament and European Commission) and the 'Europe of the States' in which the heads of state are assembled (European Council), there is a 'Europe of the Offices', in other words a Europe that is governed by bureaucracy. He poses urgent questions about the complicated issue of the democratic status of the European Union. Citizens do not recognize themselves anymore in the enormous offices, nor can they relate to the European Parliament that adopts legislative acts. How can we prevent the alienation of European citizens?
First of all, Europe should come with results in several fields: unemployment and economic growth, tax fraud, illegal immigration, financial speculation and so forth. Citizens judge every government - also the European government – on the basis of its results. And they are sometimes slow in coming. The gap between citizens and politics also manifests itself on a national level, judging by the ever changing election results. Where voters become disappointed in one party, they go and look for another 'better' party.

Which role should the older generation play within society, today and in the future? What does it ask of them and what are the demands on society?
There are many different kinds of older people. 'The' older generation does not exist. But society will need older people more and more. If not on a professional level, at least because

Herman Van Rompuy (1947) is internationally well known as the first permanent president of the European Council (2009-2014). At the time of his election as president in 2009, he served as prime minister of Belgium. From an early age on, he was politically active and during his career he has acted as a minister in several Belgian cabinets. He was also president of the Chamber of Representatives for several years, and in 2004 he was appointed minister of state.
Herman Van Rompuy studied philosophy and attained a master's degree in economics. In September 2015 he became president of the European Policy Centre in Brussels, an important independent not-for-profit think tank committed to making European integration work.
His ideas about the presidency of the European Council are reflected in characteristic statements, such as: "There is only one profile for the president: that of dialogue, unity and action." And: "I will listen carefully to everyone and I will make sure that our deliberations turn into results for everyone." (*Looking back, looking forward*, speech at the Conference Dove va l'Europa, Rome 2014).
In his role as president, he commented on the euro crisis: "Never waste a good crisis." To conclude that, because of the crisis, he was able to fulfill his position better "than some people had expected."
About the influence of power he ventilated: "Power makes a human being suspicious, but he who doubts makes the biggest mistake of all."
To conclude, Herman van Rompuy summarized his career concisely: "You will find what you have never been looking for."
(Other quotations are taken from the Belgian newspaper De Morgen).

of their importance for the civil society. What would the voluntary sector be without the contribution of older people?

The retirement age has been postponed, but when older people become unemployed they are no longer an attractive option for employers. At the same time, it is very difficult for younger people to find a job, especially in the South European countries where unemployment rates among the young are sky-high. Does a lack of jobs put pressure on the solidarity between the generations?

I do not need old age politicians in order to recognize myself in politics (…) The country needs to be well governed. That is what counts

Unemployment actually divides society. The only answer is to create more jobs, by being more competitive, innovative. It is no coincidence that in some countries unemployment rates are very low whereas in other countries they are unacceptably high. There are major differences within the EU. A strong economy is the basis for more jobs.

What is the best balance between paid and unpaid work? For example, in the care for older people: which services need to be paid for and what kind of tasks can be carried out by family, friends or volunteers? Can the North European countries learn something from their South European counterparts?

The taxpayer cannot pay for everything. A society without the voluntary assistance of parents, grandparents, family, and other people who are just willing to help is no longer a society. That is why, for a number of activities, a joint strategy or a set of regulations for unpaid carers is needed, the more so that they will not be 'punished' when they take on care tasks.

In 2010, when you were asked whether you ever considered your own retirement, you said that during your own life you were preoccupied with death and the end of life because it seemed more important. What did you mean by that? How do you reflect on growing old?

To grow old healthily and actively, as I do, is a privilege. But biology takes its course. I am aware of how finite we are. We need to be 'prepared' for death, in that we need to be aware of it. Those who are aware, accept more.

You started a new phase in your career last September when you became President of the European Policy Centre, a famous European think-tank. You have chosen for an active continuation of your career in a professional environment. Do you think it is necessary to abolish the statutory retirement age?

In Belgium there are no limits for 'working ' beyond the retirement age; this has no effect on the entitlement to pension benefits. Together with an increase in the retirement age I consider this a sensible policy. It is a win-win situation.

Politics is predominantly your domain, you showed initiative from an early age on. In the Netherlands (and Belgium?) active politicians seem to become younger and younger. There are hardly any pensioners in the House of Representatives in The Hague anymore. What are we about to lose when older people do not manifest themselves in politics any longer and what could be a new and inviting perspective for them?

Society will need the older generation more and more

I do not need old age politicians in order to recognize myself in politics. I do not have any

ambitions in that direction myself. The country needs to be well governed. That is what counts.

Older people should declare that they have 'enjoyed' seventy years of peace in Europe

What could or should the older generation contribute to the European political discourse?
Older people should declare that they have 'enjoyed' seventy years of peace in Europe. We may never forget that. Without the Union the chances of war are real!

The political stage is dominated by speeches and arguments. It is a world of many words. You are a practitioner of the Japanese Haiku, a classical verse consisting of three lines and 17 syllables (5-7-5). Would you end this interview with one of your own Haiku's about ageing?

An old dog shuffles
Slowly next to his old boss
Growing old with him

Postscript:
This interview was conducted by letter.
Translation: Angelique van Vondelen

The Ageing of the Population: A State of the Art

LIEVE VANDERLEYDEN

The population in Europe is ageing! This has been going on for a number of decades, but has accelerated because of the generation of baby boomers which is leaving the labour market. Furthermore, within the ageing population we see an increase in the number of very old people.

The fact that people are growing older changes the structure of the population and has, without a doubt, far-reaching consequences on society. For some, the ageing of the population poses a threat; according to others it is an opportunity or a challenge because never before in history has mankind experienced so many aged people in such good health (Schoenmaeckers & Vanderleyden, 2009). The structure of the population can differ considerably between the individual countries as a result of demographic changes, for instance in interaction with fertility or migration rates. Other factors, such as lifestyle or the availability and efficiency of health care services are relevant as well. It is impossible to cover all these aspects within the limited scope of this article, so we will confine ourselves to present a set of basic data that will help to explain the ageing of the population in Europe.

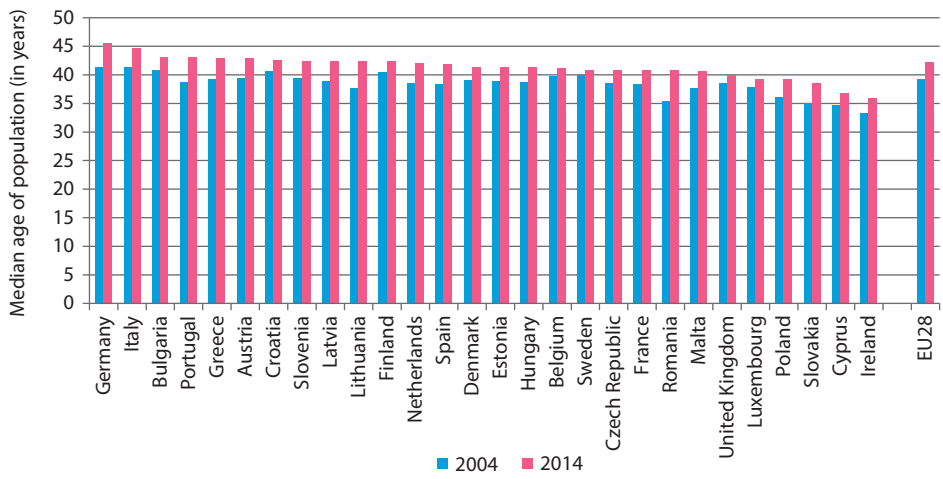

Figure 1. Evolution of the median age in the EU28 countries, 2004 and 2014, in years (Source: Eurostat).

Table 1. Percentage 65+ and 80+ in the EU28 Member States, 2004 and 2014, in %

Countries	2004		Countries	2014	
	Percentage 65+	Percentage 80+		Percentage 65+	Percentage 80+
Italy	19,2	4,7	Italy	21,4	6,4
Germany	18,0	4,2	Germany	20,8	5,4
Greece	18,0	3,6	Greece	20,5	6,0
Bulgaria	17,3	3,0	Portugal	19,9	5,5
Sweden	17,2	5,3	Bulgaria	19,6	4,4
Croatia	17,1	2,8	Finland	19,4	5,0
Belgium	17,1	4,1	Sweden	19,4	5,2
Portugal	16,9	3,8	Latvia	19,1	4,8
Spain	16,8	4,1	Estonia	18,4	4,9
Latvia	16,2	2,9	Croatia	18,4	4,5
Estonia	16,2	3,0	Lithuania	18,4	5,0
France	16,2	4,3	Austria	18,3	5,0
UK	15,9	4,3	Denmark	18,2	4,2
Finland	15,6	3,7	Spain	18,1	5,7
Austria	15,5	4,1	France	18,0	5,7
Hungary	15,5	3,2	Malta	17,9	3,9
Lithuania	15,4	2,8	Belgium	17,8	5,3
Slovenia	15,0	2,9	Hungary	17,5	4,2
Denmark	14,9	4,0	Slovenia	17,5	4,7
Romania	14,1	2,0	UK	17,5	4,7
Czech Republic	14,0	2,9	Czech Republic	17,4	3,9
Luxembourg	14,0	3,1	Netherlands	17,3	4,3
Netherlands	13,8	3,4	Romania	16,5	4,0
Malta	13,0	2,7	Poland	14,9	3,9
Poland	13,0	2,4	Luxembourg	14,1	3,9
Cyprus	11,9	2,6	Cyprus	13,9	3,1
Slovakia	11,6	2,3	Slovakia	13,5	3,0
Ireland	11,1	2,6	Ireland	12,6	3,0
EU28	16,4	3,9	EU28	18,5	5,1

Source: Eurostat

The median age increases

A simple indicator for the ageing of the population is the median age. Between 2004 and 2014 the median age within the EU28 increased with 7.7%: from 39.2 years to 42.2 years in 2014. This means that in 2014 half of the total population in the EU28 is older than 42.2 years, while the other half is younger. The increase in the median age occurs in all of the EU Member States (Figure 1).

If one would rank the countries according to median age in decreasing order, Germany tops the list with a median age of 45.6 years, followed by Italy with 44.7 years and Bulgaria with 43.2 years. Ireland, with a median age of 36.0 years is at the bottom and is preceded by Cyprus (36.8) and Slovakia (38.6). These are relatively younger populations. The largest relative increase in median age between 2004 and 2014 occurs in Romania with 15.3%, followed by Lithuania with an increase of 12.5%

and Portugal with 11.1%. Germany takes the 5th position with an increase of 10.1%. Sweden, Luxembourg and Belgium show the lowest score (increase somewhere between 2.5 and 3.5%). The Netherlands, which registered a lower median age than Belgium in 2004, show a higher score in 2014 resulting in a larger relative increase in the period under review (+ 9.1%).

Towards a growing number of over 65s and over 80s

During the period 2004-2014, the proportion of over 65s increased within the EU28 from 16.4 to 18.5%. This increase occurs in all EU Member States, except for Luxembourg where the share of over 65s remains stable somewhere around 14% (Table 1).

In accordance with the data about the median age, Italy and Germany are on top of the list of over 65s in terms of percentage. In both countries already 2 out of 10 people are over 65. This also holds true for Greece. Other countries such as Portugal, Bulgaria, Finland, Sweden and Latvia come close (between 19.9 and 19.1%). In Ireland, which has a high birth rate and a large share of younger people, the number of over 65s is 1 in 10. In 2014, for example, Ireland was the only EU28 country with more than 20% younger people in the age group of 0-14 years. In Belgium the share of over 65s did not increase by much during this period (from 17.1 to 17.8%). In comparison with Flanders and Wallonia, the Brussels-Capital Region has a younger population, partly because of a large number of immigrants; the share of over 65s decreased between 2003 and 2013 from 15.9 to 13.4% whereas the other two regions showed an increase (Vanderleyden, 2014). The Netherlands, characterized by a young population in 2004, was quickly confronted with the ageing of the population (increase from 13.8 to 17.3% in ten years' time).

Another phenomenon is an increase in the number of very old people within the ageing population, or the ageing of the population at the top. The share of the oldest generation especially, is growing. In the EU28, the share of over 80s increased from 3.9 to 5.1%. In countries such as Italy, Greece, Spain and France the over 80s comprise about 6% of the total population. Belgium comes close with a percentage of 5.3%. In the Netherlands the percentage is somewhat lower (4.3%). In comparison with 2004, the share of the over 80s has increased with one-third in many countries.

More females than males in old age

The average EU28 population, regardless of age, shows a slight predominance of females

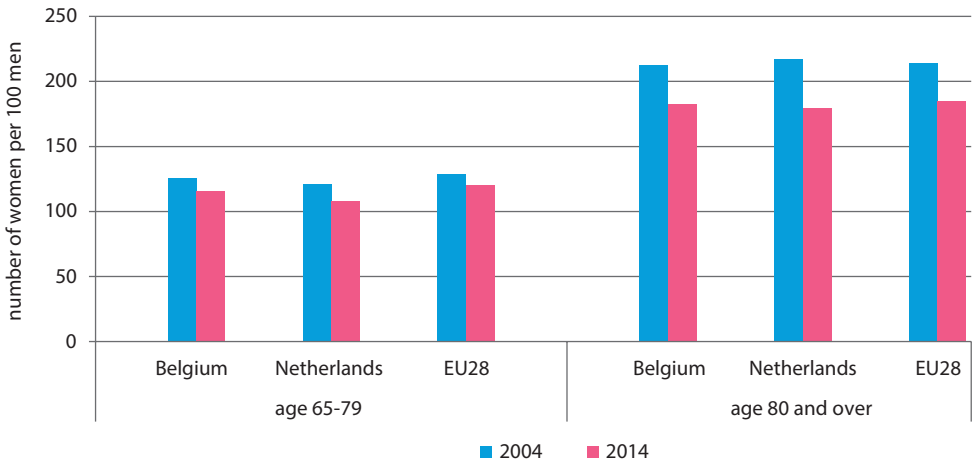

Figure 2. Number of females for 100 males in the EU28, Belgium and The Netherlands, 2004 and 2014 (Source: Eurostat).

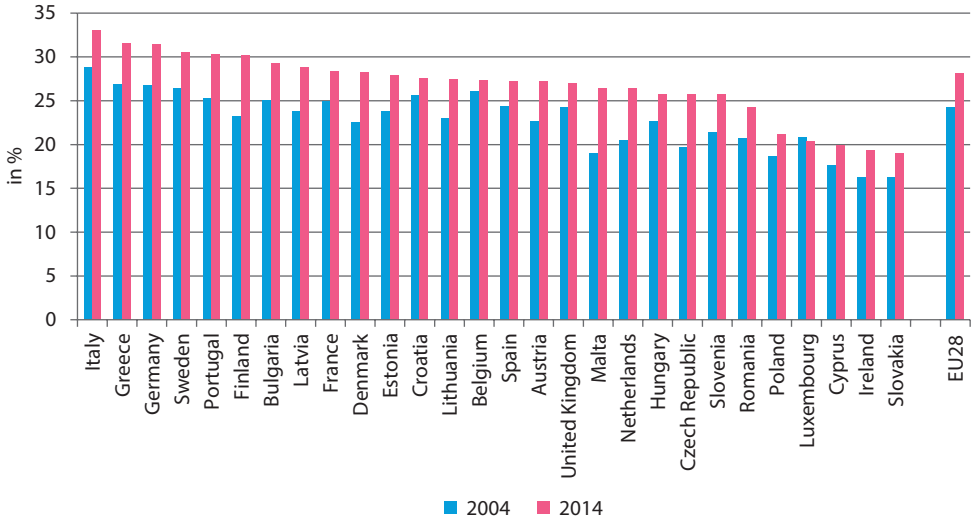

Figure 3. Old-age dependency ratio (65 years and +/15-64 years) in the EU28 countries, 2004 and 2014, in percentage (Source: Eurostat).

over males: 105 females for 100 males to be precise (2014). The predominance of females, however, increases with age, which can be explained by the fact that women live longer (see further on). In 2014 there are 120 females for 100 males in the age group of 65-79 years within the EU28 (for Belgium the figure is 118; for the Netherlands 108). In the age group of 80 years and over, there are almost twice as many females: 185 females for 100 males (183 for Belgium; 180 for the Netherlands).

In comparison with the data for 2004, the predominance of females over males has decreased (see figure 2). In 2004, the age group of 65-75 showed 129 females for 100 males within the EU28; in the age group of over 80s, there were 214 females for 100 males, in other words, more than twice the number of males.

Relation between the generations: stronger dependency of older persons on persons of working age

In order to determine to which extent the younger or older generation is supported by the working population, we make use of dependency ratios. The old-age dependency ratio reflects the relation between the number of over 65s and the number of people between 15-64 years.

On 1st January 2014, the old-age dependency ratio in the EU28 was 28.1%, a rise of 3.8 percentage points in comparison with 2004 (Figure 3). In essence, this means that in 2014 there are about 4 working persons for every older person. A high ratio can be seen in countries such as Italy, Greece, Germany, Sweden, Portugal and Finland, with levels above 30%, which comes down to about 3 working persons for every person over 65. A low ratio can be found in Slovakia, Ireland, Cyprus and Luxembourg with levels around 20%.

In all EU Member States, the old-age dependency ratio has increased between 2004 and 2014, except for Luxembourg which shows a slight decrease (from 20.8 to 20.4%). In most countries the old-age dependency ratio has risen considerably in the course of the decade; in some countries even with 25 to 40%. Examples are Malta (+ 39.0%), Czech Republic (+ 30.5%), Finland (+ 29.6%), the Netherlands (+ 28.8%). Only Croatia (+ 7.8%) and Belgium (+ 4.6%) show a modest increase.

Despite the rise, which is unmistakably present, it should be noted that not all people over 65 could be regarded as a 'burden'. The older generations today are a lot fitter and healthier than their peers in previous generations. What is more, a not unimportant number of older people engage in activities such as voluntary work, informal care and the care for grandchildren (Vanderleyden & Heylen, 2015). In order to measure dependency, the remaining life expectancy seems a better indicator than the pension age. Moreover, within the active age group of 15-64 years not everyone is employed. The actual working population is smaller than the potential working population. This calculation method, in which dependent people are defined as people with a remaining life expectancy of 15 years or less, and which takes into account the number of people that actually work, leads to a less drastic increase in the old-age dependency ratio. The calculation method for this 'adapted' old-age dependency ratio in the Netherlands and some other European countries can be found in Spijker & Macinnes (2014).

Positive developments in life expectancy at birth

During the course of one decade the life expectancy has increased with more than 2 years: from 78.4 years to 80.6 years. This increase can be seen in all EU Member States, but is more apparent in some countries than in others.

When ranking the 5 countries with the highest life expectancy and the 5 countries with the lowest life expectancy, it appears that the ranking is almost identical in 2013 compared with 2004 (Table 2). In 2004 Italy showed the highest life expectancy with almost 81 years; in 2013 Spain reaches the top with a life expectancy of 83.2 years; Italy takes a second place with 82.9 years. France and Sweden belong to the top 5 both in 2004 and 2013. At the bottom we find the Eastern European countries. In 2004 Latvia was at the bottom with a life expectancy of 70.9 years; in 2013 this questionable position is reserved for Lithuania with 74.1 years. Romania and Bulgaria are also near the bottom in this ranking. The gap in life expectancy between the top and bottom countries in 2004 is exactly 10 years;

Table 2. Life expectancy at birth (total for male and female) in the 5 countries with the highest and the 5 countries with the lowest life expectancy in EU28, 2004 and 2013, in years

Life expectancy in 2004		**Life expectancy in 2013***	
Highest		*Highest*	
Italy	80,9	Spain	83,2
Sweden	80,7	Italy	82,9
Spain	80,4	Cyprus	82,5
France	80,3	France	82,4
Malta	79,4	Sweden	82,0
Lowest		*Lowest*	
Latvia	70,9	Lithuania	74,1
Romania	71,4	Latvia	74,3
Lithuania	72,0	Bulgaria	74,9
Estonia	72,4	Romania	75,2
Bulgaria	72,5	Hungary	75,8
EU28	78,4	**EU28**	80,6

* 2014 not available.

Source: Eurostat

in 2013 this gap has been reduced with - more or less - one year.
According to the 2013 data, Belgium takes the 16th place out of 28 when ranking the countries from highest to lowest life expectancy; this is in line with the EU28 average rate. The Netherlands do better and are ranked 9th, with a life expectancy of 81.4 years.

Gains in life expectancy at 65

At age 65, gains in life expectancy are still possible. For the EU as a whole, the increase amounts to one year and a half: from 18.3 years in 2004 to 19.8 years in 2013 (both males and females). If we take a look at the countries that score high in the ranking for 2013, we see that France, Spain, Italy, Luxembourg and Greece belong to the top 5 with a remaining life expectancy at age 65 which varies between 21.6 and 20.2 years. For the Netherlands and Belgium the remaining life expectancy is close to 20 years. At the bottom we see nearly the same Eastern European countries as for life expectancy at birth, with Bulgaria as the Member State in last position. The difference between France (21.6 years) and Bulgaria (16.2 years) equals 5.4 years.

Do women still have a higher life expectancy?

It is widely known that females have a higher life expectancy than males. There is no clear-cut answer as to why this is the case. The difference in life expectancy between the sexes appears to be smallest in the developing countries and largest in the industrialized countries, which could indicate that environmental conditions could play a role. Researchers assume that the difference in life expectancy is influenced by both biological and social factors (see: *http//michielhaas.nl/waarom-vrouwen-langer-leven-dan-mannen/*).

The difference in life expectancy at birth between females and males tends to become smaller in the EU28: in 2004 it was 6.3 years and in 2013 5.5 years. In 2013 Italy shows the highest life expectancy for males with 80.3 years, followed by Spain and Sweden (80.2 years each), Cyprus (80.1 years); Luxembourg (79.8 years) completes the top 5. As for females, Spain is ranked on top with 86.1 years, subsequently followed by France (85.6 years), Italy (85.2 years), Cyprus (85.0 years) and Finland (84.1 years). A woman in Spain lives 7.5 years longer on average than her counterpart in Bulgaria (figure for 2013).

Even at age 65, there is a considerable difference in life expectancy between males and females. For females the life expectancy in 2013 varies from less than 18 years in Bulgaria to more than 23 years in France and Spain. For males it varies from less than 14 years in Latvia to more than 19 years in France, Spain and Luxembourg. The largest differences in life expectancy between males and females at age 65 are registered in Estonia and Lithuania (5.1 years each) and also in Latvia (4.7 years). The smallest differences can be seen in the United Kingdom (2.3 years), Sweden (2.5 years) and in Denmark and Ireland (2.7 years each).

Future developments

In general, it is to be expected that the ageing of the population will continue due to a persistent reduction in fertility rates and an increase in life expectancy. At the occasion of the International Day of Older Persons, the headlines of the Eurostat 'Newsrelease' of 29 September 2015 shouted: 'One out of every eight persons in the EU could be 80 or above by 2080'. The year 2080, however, is still far away and can be regarded as long term. Here, we will focus on the medium term.

It is probable that within the next 35 years, a considerable ageing of the European population will take place (Eurostat, 2014). The most important scenario of Eurostat for population projections (EUROPOP 2013) offers a context for likely developments. These projections show that the demographic shift towards an older population will result in an increase of the proportion of the over 65s in the EU28 from 18.2% at the beginning of 2013 to 28.1% in 2050. At the same time, the share of the people at working-age will decrease from 66.2% to 56.9 %. There will be

nearly 40 million people less in the working-age group. The number and share of the over 65s will continue to grow fast during the entire projection period, to almost 150 million people in 2050. For the number of over 80s, an even more rapid growth is predicted.
As a result of these developments in the age groups, the old-age dependency ratio - i.e. the number of people over 65 in relation to the number of people in the age group of 15-64 years - is predicted to increase by 27.5% at the beginning of 2013 to almost 50% in 2050. This means that within 40 years there will be 2 persons at working-age for every person at age 65, whereas at this moment there are still 4 persons at working-age for every person over 65. Although migration plays an important role in the dynamics of the population of the European countries, migration alone probably cannot stop the continuous process of the ageing of the population which is happening in many parts of the European Union.

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About the author

Lieve Vanderleyden obtained a PhD in Social Sciences at the Catholic University of Louvain and a qualification in Social Gerontology. She is affiliated with the Research Centre of the Flemish Government as a senior researcher and editor. She is also a member of the editorial board of Gerōn and Sociaal.Net (Flanders).

Translation: Angelique van Vondelen

The Impact of the European Year 2012 on Active Ageing and Solidarity between Generations: A Critical Assessment

ANNE-SOPHIE PARENT

Which were the results of the European Year 2012? Did it make older people more visible in EU policy?

Almost three years have passed since the European Year 2012 on Active ageing (EY2012) ended; the right length of time to assess what impact it has had both on EU policies, and at national and local level. In September 2015, the European Parliament adopted its own assessment of the Year (European Parliament, 2015), the European Commission published its report on the implementation, results and overall assessment of the Year already in September 2014 (European Commission, 2014).

The EY2012 has delivered significant positive outcomes

Overall, the EY2012 is perceived by the European Parliament, the European Commission and AGE Platform Europe as having had a significant impact, in particular at EU level and at local level where it has gathered momentum for active and healthy ageing and has promoted a more positive image of older people, who unfortunately are still often pictured by economists and in the media as a burden to society.

Being celebrated four years after the beginning of the worst financial and economic crisis the EU has ever experienced, the EY2012 helped raise awareness of the huge demographic challenge European countries are facing and of the need to adapt the way our societies are organized to cope with the changes in the population structure. This increased awareness is however double-edged and has triggered heated debates on intergenerational solidarity and fairness, and on the need to reform national social protection systems to make them more sustainable on the long term.

An important initiative, welcomed by AGE Platform Europe, is the European Innovation Partnership for Active and healthy Ageing (EIP-AHA) launched by the European Commission in November 2011 with the aim to increase by two the average healthy life span in Europe by 2020. Thanks to the political momentum of the EY2012, it managed quickly to gather a great variety of stakeholders interested to work together to support active and healthy ageing through grass-root initiatives and has helped a lot to raise awareness of the value of active and healthy ageing and the need to take action in various areas. A tangible positive outcome of the EY2012 is the growing thematic network set up by the AFE-INNOVNET project which brings together already more than 320 members: local and regional authorities, WHO, research centers and universities, civil society orga-

nizations and industries. This network will launch the European Covenant on Demographic Change in December 2015. Building on the outcomes of the AFE-INNOVNET project (*www.afeinnovnet.eu*), the Covenant will gather in a more formal structure all local, regional and national authorities, and other stakeholders, that commit to cooperate and implement evidence-based solutions to support active and healthy ageing as a comprehensive answer to Europe's demographic challenge. The EIP-AHA has also triggered initiatives at EU level to create a European 'silver economy' which is starting to take shape and should support the scaling up of innovative products and services for our ageing population.

Older people's rights remain invisible at EU level

On other areas, the EY2012 has been less successful, for example on combating age discrimination older workers experience in the labour market. The equal treatment directive in access to employment adopted in 2000 - and which forbids employers to discriminate against workers on the ground of their age - was starting to deliver positive results and the employment rate among the 55+ was improving in the mid 2000'. But since the crisis has started, older workers are again faced with age discrimination and those who lose their job tend to remain trapped in long-term unemployment.

Neither has the EY2012 helped move forward the debate on the proposal for an equal treatment directive in access to goods and services tabled by the European Commission in 2008, following an active campaign of EU non-discrimination NGOs. This draft directive is still blocked at the Council mainly due to some Member States' fear of its potential impact on public budgets since it covers equal access to goods and services for persons with disabilities and because of the complexity of age discrimination in access to goods and services.

Meanwhile however, the EU – which has acquired legal personality – has signed and ratified the United Nations Convention on the Rights of Persons with Disabilities (UN-CRPD), and so have 25 (out of 28) EU member States. This means that the EU and the 25 EU countries that have ratified the UN-CRPD now have the legal duty to take action to respect and promote the rights of persons with disabilities in their policies and practices.

The UN-CRPD covers also older persons who encounter functional limitations, frailty or disability. It requires states to provide services to prevent and minimize further disabilities among older people, and to ensure older people with disabilities have access to retirement benefits and programmes. It includes a number of provisions that illustrate the need to take into account old age and the specific situation of older persons, in particular on age-appropriate accommodations for access to justice, on age-sensitive assistance to prevent abuse, on health services to minimize and prevent further disabilities, and aiming to ensure access by older persons with disabilities to social protection programs and poverty reduction programs (AGE Platform Europe, 2015).

The UN-CRPD also requires that states consult with organizations of persons with disabilities and older people's organizations. However few older people in Europe know that both the EU and their national government have the duty to ensure that older people with limitations are equally protected by the UN-CRPD. This means that in some countries, older persons with disabilities continue to face age limits which prevent them from enjoying the same rights than younger persons with disabilities. This is a form of age discrimination that the EU should tackle by issuing guidelines to Member States reminding them that the UN-CRPD applies to persons with disabilities regardless of their age and how this can be translated into practice.

The EU has also taken quite a conservative position in the UN Open-Ended Working Group on Ageing since it was established in 2010 to "consider the existing international framework of the human rights of older

persons and identify possible gaps and how best to address them, including by considering, as appropriate, the feasibility of further instruments and measures " (*http://social.un-.org/ageing-working-group/*). The EU argues that there are no normative gaps in the existing legal framework, only implementation gaps, and older people enjoy the same rights as anybody else.

Despite all the work done internally during and after the EY2012 to raise awareness of the challenges faced by older people to enjoy their rights on an equal basis as other age groups, and despite the magnitude of the demographic change Europe is experiencing, the new European Commission has not included the rights of older people in its current work priorities and is concentrating its action on the rights of children, women, persons with disabilities. It was thanks to AGE repeated action that for the first time in 2015 the EC annual report on the implementation of the EU Charter of Fundamental Rights included a chapter on what the EU is doing with regard to Art. 25 on the rights of older people to live in dignity.

EU austerity measures have a negative impact on older people's rights

Although the European Charter of Fundamental Rights declares the rights of older people to live a life of dignity and independence, the pressure on public budgets through the European Semester reforms are increasing the risk of human rights violations against older persons. Their disposable income is decreasing as they have to spend more money 'out of their pocket' on various services e.g. health or long-term care, transport, etc. that used to be provided for free or highly subsidized.

Gender equality in old age is also endangered by pension reforms which impose a stricter link between contributions made and pension benefits. This is a crucial issue for older women. The gender pension gap is already around 40% and risks are rising if nothing is done to compensate for the inequalities women face all along their life due to caring career breaks and to bridge the gender pay gap which is still 19% on average.

To conclude we can say that the EY2012 has delivered positive outcomes but the impact of the on-going crisis and the current refugee crisis make older people more invisible than ever in EU policy debates.

Age Platform Europe is a European network with more than 150 organizations representing directly more than 40 million older people in Europe. AGE aims to voice and promote the interests of the 190 million inhabitants aged 50+ in the European Union and to raise awareness of the issues that concern them most.

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About the author

Anne-Sophie Parent is Secretary General of AGE Platform Europe. She is also a member of several EC-committees on ageing, demography, pension and health.

E-mail:annesophie.parent@age-platform.eu

Do aging societies reduce intergenerational justice and increase pro-elderly policy bias?

PIETER VANHUYSSE

Wide across the Western world, people are living longer lives and having fewer children. This has led to larger shares of elderly voters, who, many fear, are becoming an immensely powerful political pressure group. But what are the effects of population aging on public policy? This article reviews the state of the art in comparative political science and social policy. Adopting a political lens provides insights that are more theoretically refined than the increasingly shrill and alarmist assertions being voiced recently about 'gerontocratic' welfare states dominated by unholy baby boomer alliances of 'greedy grey' voters and 'myopic' or populist politicians.

New political logics, not (yet) gerontocracy

The increase of the share of elderly voters may have manifold implications for policy; not all of them straightforward or intuitive. Some researchers now claim that we live in a gerontocracy, in which the elderly rule the roost. But the latest evidence shows such strong claims to be either empirically incomplete or altogether wrong (Vanhuysse 2012). What is clear, however, is that population aging has very significantly changed electoral and policy dynamics (Goerres and Vanhuysse 2012). For instance, Tepe and Vanhuysse (2010, 2012) argue that, far from leading to more generous pensions as 'gerontocratists' expect, aging populations simultaneously lead to *delays* in large pension generosity cuts and to the *acceleration* of medium-size cuts. Aging populations today function as powerful 'alarm bell signals.' They put policymakers in a 'loss frame,' urging them to muddle through by implementing incremental cuts sooner rather than later – but perhaps only to be better able to delay electorally riskier large cuts. Politicians may thus jump to bite relatively small cutback bullets early to postpone biting larger bullets. Below, I focus on two momentous potential effects of population aging on public policy: intergenerational justice and pro-elderly bias.

Intergenerational justice: an empirical snapshot

Many people ask whether policies in aging democracies treat young citizens as fairly as elderly voters (Sabbagh and Vanhuysse, 2010, 2014). At the request of the Bertelsmann Stiftung in Germany, I have developed a simple four-dimensional snapshot indicator for 29 rich Western democracies: the *Intergenerational Justice Index,* henceforth *IJI* (Vanhuysse 2013). *Sustainability* is the moral starting point. 'Enough and as good' should be left by each generation for the next. So the equity question is really whether current policy pat-

terns towards different age groups appear sustainable.

The first *IJI* dimension, *ecological footprint,* is a measure of the total pressure put on the environment by all generations alive today and left for the next generations to tackle. Poland and Portugal are among the best performers on this measure; Denmark, the USA, Belgium, Australia, Canada and the Netherlands among the worst ones. Belgium and the Netherlands are even two worst performers with the largest *net* ecological deficit in the entire sample, once this ecological footprint pressure is compared with the capacity of countries' natural environment to absorb that pressure. The second *IJI* dimension captures the total central government *debt weighing on the shoulders of each child* aged 0-14; a fiscal burden left for this next generation to cope with. Here, Estonia and South Korea perform best, and Italy Greece and Belgium very badly, while Japan is literally off the scale with by far the highest levels of debt per child. The Netherlands rank in the middle of the sample here.

A third *IJI* dimension measures early-life starting conditions as measured by *child poverty levels.* Child poverty matters morally. Not just because children cannot be blamed for being born into poor families, but also because such poverty has powerful scarring effects all through their later adolescent and adult lives (Vanhuysse 2015). While Belgium and the Netherlands record an average performance, the best countries in the sample on this dimension are the Nordic countries, but also Slovenia and Austria. Austria, along with Nordic countries, also has one of Europe's lowest rates of severe material deprivation among very young children (7.5 percent among 0-6 year olds in recent years). And nowhere else in Europe are there fewer NEETs - young adults who are *not* in employment, education and training (7 percent among 15-24 year olds).

Pro-elderly policy bias: demography is not destiny

The fourth *IJI* dimension is an overall measure of the *welfare state's pro-elderly spending ratio.* It is calculated by comparing spending on a whole range of elderly-oriented social programs such as old age and disability pensions and elderly care, to spending on a whole range of nonelderly-oriented programs such as family benefits, active labor market spending, and unemployment benefits (Vanhuysse 2013). The least pro-elderly biased welfare states are New Zealand, Canada, and Ireland, but also demographically older countries such as South Korea, Denmark, Belgium and the Netherlands. These countries all spend on average less than two and a half times more per each elderly as per each nonelderly person. On the other side of the spectrum, in addition to the aging societies of Japan and Southern Europe, it is the (still) demographically younger Central and Eastern Europe that turns out to be highly pro-elderly tilting.

Pairwise comparisons are illuminating on the particular unsustainability issues of pro-elderly welfare states in Central and Eastern Europe. The welfare state in 'middle-aged' Hungary (around 4 working-age persons per elderly) spent on average 4.8 times more on every elderly as on every non-elderly citizen in the late 2000s. But slightly older Estonia (with a lower old age support ratio, 3.6) spent only 2.9 times more. The still 'young-to-middle-aged' Czech Republic (old age support ratio 4.5) spent on average 5.9 times more on every elderly as on every non-elderly citizen, but equally young-to-middle-aged Australia spent just 3.7 times more.

In the same vein, the welfare state in 'young' Slovakia (old age support ratio 5.5) spent 6.6 times more on every elderly citizen, but in the equally young Ireland it spent only 2.7 times more. And Poland occupied pole position within the entire 29-country sample. This 'young-to-middle-aged' society (old age support ratio 4.8) spent 8.6 times as much on every elderly Pole as on every non-elderly Pole in the late 2000s. Yet in the equally young

New Zealand, the state spent only 2.7 times as much.

These findings can be explained largely as a result of legacies of early post-communist transition, including policy-induced, historically unprecedented exit into early and disability pensions. As I have shown in my 2006 book *Divide and Pacify*, Hungarian and Polish governments in the early 1990s reduced the threat of large-scale anti-reform protests by splitting up groups of at-risk workers by sending literally hundreds of thousands of working-age Hungarians and Poles into early and disability pensions by means of more generous and better protected pension benefits relative to 'younger' programs such as unemployment and family benefits. Such policies, and the pro-elderly political-electoral logics they have set in place, have prepared Central Europe badly for the coming three decades, as this region is today entering a period of accelerated demographic aging. The lack of preparedness of Central Europe is also evident in our four-domain, 22-dimensional Active Aging Index for Europe (Zaidi et al. 2013). Slovakia, Hungary and Poland occupy the bottom three positions in the 27-country sample, whereas the Czech Republic ranks in 11th and Slovenia in 21st position.

In other words, when it comes to age group spending patterns, demography quite simply is *not* destiny (Vanhuysse 2012). Two of the demographically oldest societies in the world, Italy and Japan, have high pro-elderly spending ratios. But another old society, Sweden, shows much more age group spending balance. This is because Sweden, like other Nordic countries, also invests massively in young programs such as early childhood, education, and family and active labor market programs. And it has the tax resources to do so, because labor market participation rates, including those of women and of elderly workers, are much higher than in continental or Southern Europe.

Alarm bells for human capital activating reforms

When put together, the four *IJI* dimensions combine into an overall *IJI* value. Here I show that among the most intergenerationally equitable OECD countries were Estonia, South Korea, New Zealand and all of Nordic Europe (Vanhuysse 2013). Among the least intergenerationally just countries were the USA, Japan, Italy, Greece and Canada. In a complementary study specifically on the material circumstances of young adults and very young children and educational outcomes (such as PISA results in mathematics, reading, writing and problem solving), I furthermore find that the years since the 2008 crisis have seen the emergence of a new 'North-East to core' good gradient in Europe (Vanhuysse 2015). This good gradient now ranges from Finland over Poland, Germany, the Czech Republic, and Slovenia to France. Outside of it, the new periphery regarding young Europeans' opportunities now includes the UK and Ireland, again all of Southern Europe, and Eastern but no longer Central Europe.

So, what to conclude? Clearly, an aging society need not be morally blamed for lower fertility; still less so for longer life expectancy. Living longer lives (of quality) is actually a yardstick of social progress. And moderately low levels of fertility may even be desirable – not least from an environmental point of view. But crucially, the way in which a society's public policies react to population aging *is* morally important. This is where the *IJI* results matter. *Unless* low-*IJI* countries such as the USA, Japan, Italy, Greece, and Canada can somehow, miraculously yet credibly, guarantee fast and sustainable productivity growth and rapid technological (including environmental technology) progress in the near future, not reforming current policy patterns would simply perpetuate a bad current deal for young and future generations (Vanhuysse 2013).

The demographic alarm bells currently tolling in many OECD countries indicate the need for urgent policy rethinks. And they appear to be imprisoning politicians in many

countries in ever-tighter electoral and fiscal straitjackets. But they need not provide grounds for alarmism (Goerres and Vanhuysse 2012). Good policies make all the difference in the nexus between aging populations and generational politics. Investing in early human capital is probably a key ingredient in safeguarding the fiscal foundations of welfare states in aging societies (Vanhuysse 2015). In addition, it is an efficient and effective way of boosting the opportunities and capabilities of young citizens, while simultaneously leveling the playing field especially for children born in disadvantaged circumstances.

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About the author

Pieter Vanhuysse is Professor of Comparative Welfare State Research at the Centre for Welfare State Research and the Department of Political Science and Public Management of the University of Southern Denmark.
Email*: vanhuysse@sam.sdu.dk*
Homepage: *http://findresearcher.sdu.dk/portal/en/person/vanhuysse*

Poverty among older people in the countries of the European Union

KAREL VAN DEN BOSCH

The European Union uses several indicators to assess the risk of poverty and social exclusion. This article will show, by means of the two most relevant indicators, how the risk of poverty and social exclusion among older people is divided between the EU Member States.

What is poverty in the EU?

Poverty is a delicate notion, also within the European Union (EU), and a multi-faceted phenomenon that exists in various forms. The European Commission, therefore, rather speaks of "the risk of poverty and social exclusion". This concept however, which is broader but also more vague, is linked to a very concrete goal, namely to reduce the number of people who are, or tend to become, "at risk of poverty and social exclusion" within the Union by 20 million. This is a decline of nearly 17,5%. Unfortunately, since 2010 poverty levels have risen instead of decreased, by which it becomes clear that the target will not be reached.

An important advantage of the EU2020-target with regard to the risk of poverty and social exclusion is that it is based on three concrete indicators, two of which are relevant for older people (the third concerns low work intensity).

1 The risk of monetary poverty, that is to say, a disposable household income which is less than 60% of the national median income per country. These incomes are corrected for the number of people within the household.
2 Severe material deprivation: this refers to households that cannot afford at least four out of the following nine items: unexpected financial expenses, one week's holiday away from home, household bills (rent, mortgage, utilities), a meal containing meat/fish every second day, heating to keep the home sufficiently warm, a washing machine, a colour TV, a telephone, a personal car.

The data for these calculations are derived from the EU Study of Income and Living Conditions (EU-SILC), which are annually collected by means of randomized surveys in all EU Member States. An important deficiency in the EU-SILC data, however, is that people who live in collective households, such as care homes or residential homes for older people, are not included in the surveys.

Countries in which people are largely at risk of monetary poverty

First of all, we take a look at the first indicator, the risk of monetary poverty. Figure 1 (blue bars) shows that of the Dutch older population hardly 6% is at risk of poverty, whereas for their Belgian contemporaries this percentage is no less than 18%. The Netherlands belongs, together with Luxembourg, Czech Republic, Slovakia and Hungary, to

the countries in the EU with the lowest risk of poverty among the older generation. In Belgium, on the other hand, the risk is higher than the average for the EU28. This is also the case in several South- and Central-European Member States, the Baltic countries and Bulgaria, but - perhaps surprisingly - we see this as well in welfare states such as Germany, Austria, Sweden and Finland. We should not forget, however, that the poverty threshold – the specific income level below which people live in poverty – varies strongly between the countries in the EU: From € 12,900 for a single person in Belgium, and similar or higher amounts in the Netherlands and surrounding countries as well as in Scandinavia, to € 5,000 in Greece, € 2,800 in Latvia and Lithuania and only € 1,800 in Bulgaria and € 1,200 in Romania. In other words, the reality below the poverty threshold is totally different in the rich North-Western European countries from that in the much poorer countries in the South and, especially, the East. According to some people, it would therefore be better in this respect not to speak of (a risk of) poverty, but rather of the extent to which countries succeed to lift households with the lowest incomes to a level that is not too far below the average national income. Or, in other words, the percentages in figure 1 indicate to which extent older people with the lowest incomes can share in the general prosperity of their country.

The red line in figure 1 indicates whether the risk of poverty for older people is higher or lower in comparison with the population under 65. In the Netherlands, roughly within the EU and in most countries the latter is the case. Because of extensive pension systems (private or by the government), the era in which the older generation was automatically at risk of poverty is far behind us. In the Netherlands, because of the AOW (Dutch government pension scheme), there are not many older people with an income below the

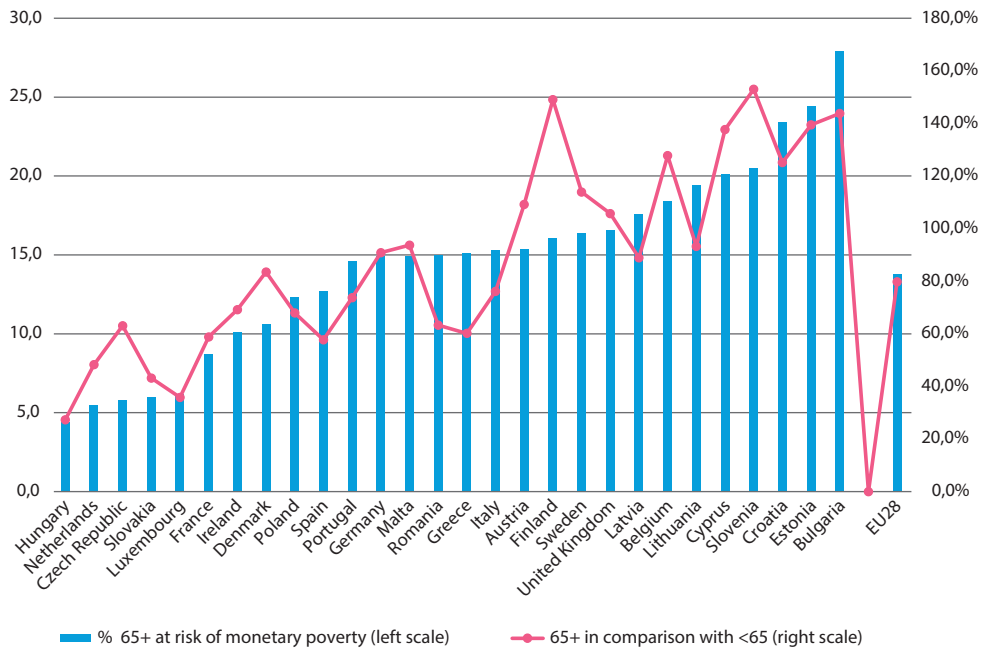

Figure 1: Older people (65+) at risk of monetary poverty in the EU countries in 2013, absolute and relative in comparison with the population under 65 (Source: Eurostat, edited)

Note: EU countries ranked according to the percentage of older people at risk of poverty

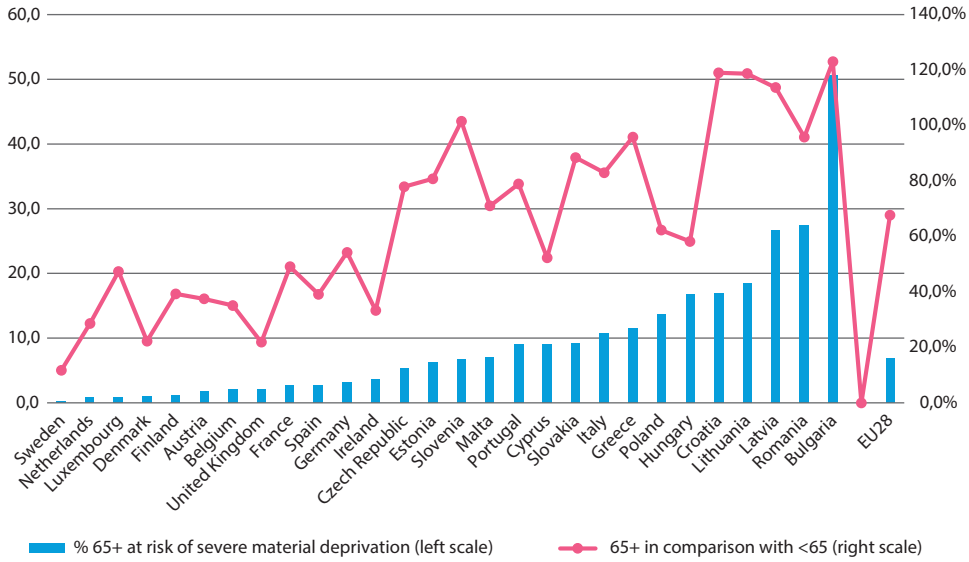

Figure 2. Older people (65+) at risk of severe material deprivation in the EU countries in 2013, absolute and relative in comparison with the population under 65 (Source: Eurostat, edited)

Note: EU countries ranked according to the percentage of older people at risk of severe material deprivation

poverty threshold. Belgium, however, belongs with Austria, Sweden, Finland, the UK, Cyprus, Slovenia, Croatia, Estonia and Bulgaria to a minority group of countries that show a higher risk of poverty for older people than for those under 65. The older generation in Belgium has, on average, a relatively low income when compared to the Netherlands and other neighbouring countries. In some respects, the pension system in Belgium has not been adapted to the demands of society today: the Belgian Committee on Pension reforms has therefore recently published a series of propositions to modernise the pension system.

Alternative forms of cohabitation also play an important part in explaining the differences between the countries: whereas most older people in North- and West-Europe live alone or as couples without children, in South- and East-Europe many older people live together with their adult children. In those countries, this probably has a mitigating effect on the percentage of older people that are at risk of poverty. However, the solidarity between adult children and their parents could work both ways: many employed children support their retired parents but, the other way round, we also see that many unemployed youngsters live with their parents because they are unable to start an independent household.

Severe material deprivation dominant in the new EU countries

The percentage of older people at risk of severe material deprivation is very small, both in the Netherlands and in Belgium (figure 2); this is also true for the other rich countries in North- and West-Europe. A much higher percentage can be found in South- and East-Europe, especially in Latvia, Romania and Bulgaria; in the latter country more than half of the older population is living in severely deprived conditions. Whereas the risk of monetary poverty for older people refers to the relative income position of people over 65 in a country, material deprivation is influenced by absolute purchasing power and depends strongly on the average living standards in a country. Because of this, older people in countries such as Hungary and Slovakia show a low risk of monetary poverty and a relative-

ly high risk of severe material deprivation at the same time. These two indicators are therefore complementary. We can see that in almost all EU-countries (with the exception of a few countries in East-Europe) older people are less susceptible to material deprivation than people under 65. This is also true for several countries where the risk of monetary poverty is higher for the older generation than for the younger, as is the case in Belgium. Various aspects play a role. In the first place, many older people - also those who have a low income – have paid off the mortgage on their house. As a result, their spending power is in fact higher than that of younger families with a similar income that pay rent or still have to pay off their mortgage. Secondly, it appears that the number of older people that do not own a car or do not take a week's holiday away from home is more or less the same as that of the under 65s. The older people claim, however, that this has nothing to do with financial difficulties but is rather based on other reasons. A decline in health could be a possible factor.

Poverty and deprivation among older people in Europe: a summary

It has become clear that the poverty circumstances among the older generation in the EU differ considerably between countries. They also differ among countries that are situated within the same European region, or countries that share a similar socioeconomic system and level of prosperity. Even so, it is possible to describe a general outline. Firstly, in most countries the risk of poverty among the older generation is lower than for the population under 65. This is even more so for the risk of severe material deprivation. Secondly, whichever indicator is used, the situation of older people in Bulgaria and some of the Baltic states is most precarious.

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About the author

Karel Van den Bosch obtained a Master's degree in Sociology at the University of Nijmegen and acquired a PhD in Political and Social Sciences at the Antwerp University. He works as a socioeconomic researcher at the Federal Belgian Planning Bureau and is also affiliated with the Herman Deleeck Centre for Social Policy (CSB) at the University of Antwerp. His research work concerns empirical studies on poverty, long term care and social policy. This article was written as part of his work at CSB and falls outside the area of responsibility of the Federal Belgian Planning Bureau.

Translation: Angelique van Vondelen

Employment participation of older workers

HENK BAKKERODE

What do we know about the employment participation of older workers in Europe? A European research project studied the gaps in knowledge and identified domains for further research in the field of employment participation at higher working age.

A European research project

In 2013 the European Commission launched the Joint Programming Initiative (JPI) *More Years, Better Lives* (MYBL) – *the potential and challenges of demographic change*. In this framework an European Strategic Research Agenda (SRA) was elaborated which identifies research gaps, defines implementation and formulates recommendations to stakeholders. A perfect example of cross-national and interdisciplinary research on a European scale!

Some 'fast-track activities' of the SRA have already been launched. One of these was a study on 'Understanding employment participation of older workers, creating a knowledge base for future labour market challenges'. The aim of this report is to present a review of research and an outline of research needs in the field of employment participation at higher working age. An interdisciplinary group of researchers from ten European countries (and Canada) analysed recent research evidence by topic and country. The project report, which was presented in Berlin, February 2015, presents their findings.

Increase in participation of older workers

Although differing in pace and magnitude, all European countries are witnessing increasing life expectancies and a shift from younger to older age groups. All countries display a clear upward trend towards higher participation rates of older workers. However, more adjustments to the new demographic realities remain important; the largest increases in the employment participation of older workers have to be implemented in those countries where the magnitude of the demographic challenge is large or very large, and where current participation rates are low (for example Austria, Belgium, Poland) or average (for example Canada, Germany, Netherlands).

Decisions about work and pensions

We should, however, not overlook that in many countries the past two decades have brought forward significant changes in retirement patterns and schemes. Retirement today is no clear-cut 'one-off' event, but is characterised by great diversity.

Many factors contribute to the complexity of retirement: Multilevel interacting influences of society, work and the individual and, not least, the heterogeneity of the older working population itself.

The framework of the JPI project was based on ten 'domains' that influence decisions about retirement and work. Following

the domain structure, experts identified research needs across these domains. At the same time, scientists also wrote national reports for each participating country which explicitly referred to the domains, and drew conclusions about specific national research needs. In an overall assessment of the findings, similar conclusions for research are drawn surprisingly often. These research needs to advance research on the employment participation of older workers, fall into three priority areas, namely

- to address *conceptual gaps;*
- to close *cross-national gaps,* and
- to fill *thematic gaps.*

Conceptual gap: the lack of a broad view

A broad view of retirement requires a conceptual framework, which locates retirement within the context of different determinants on micro, meso and macro level and allows for a life course perspective. However, most studies do not adopt a systems view and multi-factorial approach and thus may overlook the emerging theme of retirement fragmentation. This also relates to the frequent lack in specific longitudinal research approaches and the application of life course perspectives. Lastly, there is a poor coverage of important population subgroups like women, migrants or manual workers, who, in fact, should be at the centre of policy attention.

Closing cross-national gaps

The research on employment participation was found to be distributed very unevenly across the review countries. Across almost all domains, the countries with the highest research coverage are Norway and the Netherlands, followed by Canada and Finland. One reason for this unequal distribution of research is certainly that researchers in the Scandinavian countries and the Netherlands benefit from easy access to register data.

Filling thematic gaps

The group recommends to close the many thematic gaps by adopting a differentiated view in retirement research and by considering: the role of health in the context of retirement; potential domestic and household factors (care responsibilities!); new work exposures such as the increased use of technology or higher flexibility in work settings; the role of older women in retirement; the relation between migration and retirement; the opportunities for organisational intervention, and the societal costs and gains of policy changes. The topics listed are urgent but by no means exhaustive.

Report on the Dutch situation

Swenneke van den Heuvel c.s (TNO, Delft) and Jaap Oude Mulders (University of Utrecht, School of Economics) were responsible for the Dutch national report. Here are some of their findings.

Research on the determinants of employment participation

In general, research on employment participation of older workers here is well advanced compared to other countries. Many research domains are covered well, many disciplines are involved and different research approaches have been adopted. Three cohort studies of ageing persons are available that contain data on health, work, lifestyle and social factors. Statistics Netherlands is able to provide registered data, which are very suitable for scientific analyses.

Moreover, it is possible for some studies to link survey data to registered data from Statistics Netherland. Research related to employment participation often focuses on 'sustainable employability'. This widely supported topic leads to many initiatives and is attracting research funding.

Labour market

Most available studies do not empirically analyse employment participation of older workers. Organisations employ significantly more older workers than ten years ago but are not necessarily more likely to recruit older workers.

Legislation and its implementation
Most major policy changes are evaluated in a systematic way, except the implementation of an age discrimination law. Research shows that policies were successfully implemented to discourage early retirement and largely disable alternative ways of early retirement either through unemployment benefits or disability insurance.

Financial factors
Several studies confirm that financial factors play a critical role in determining the employment participation of older workers, especially low-wage earners.

Social position
Some studies exist on the relation between education (or socio-economic status) and employment participation with mixed findings. No studies are available on the influence of gender, ethnicity, income, or profession.

Domestic domain
Several studies link domestic factors to early retirement. Spouses are very important in the decision to retire.

Work factors
Several cohort studies are available. Among older workers, psycho-social factors at work seem to have greater effect on employment participation than physical load. This might be due to a healthy worker effect: Those with health problems due to a high physical load already left the workforce at an earlier age.

Health and health-related behaviour
Many studies are available on health and employment participation, but none on health-related behaviour. In general, good health is positively associated with employment participation. However, good health may also be an incentive for early retirement.

Appeal for an integral approach

Many research findings are derived from cohort studies. As a consequence, determinants are measured at a personal level and are based on the individual perspective. Data on the context are lacking or less reliable, the latter because workers are not the best source to derive this information from. Research in the field of employment participation would gain from a more integral approach, in which data from employers and employees are combined, ideally also including data on a macro-economic level.

What is more, the review sheds light on specific research gaps: No studies were found on the impact of age discrimination law on employment participation of older workers, nor studies on the influence of gender, ethnicity, income, or profession. No studies were found on the effects of health-related behaviour on employment participation. If they are available on this topic, these studies are not age-specific.

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The full report is published as:

Hasselhorn HM & Apt W (2015) *Understanding employment participation of older workers: Creating a knowledge base for future labour market challenges.* Research Report. Federal Ministry of Labour and Social Affairs (BMAS) and Federal Institute for Occupational Safety and Health (BAuA). BMAS/BAuA, Berlin, 120 pages.

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For the Strategic research agenda (SRA)*: More Years, Better lives; Strategic Research Agenda on Demographic Change; the Potential and Challenges of Demographic Change*. Brussels, chief editor Stephen McNair, May 2014; *http:// www.jp-demographic.eu*

About the author

Henk Bakkerode is a member of the Societal Advisory Board (SOAB) of the JPI-MYBL on behalf of Eurocarers. This article is based on the summary of the report.

Netherlands

TOPICS-MDS: a unique source of information on elderly people and family caregivers

LAURA VAN DER MARK

Anyone who is involved in health care can access the national TOPICS-MDS database for data on vulnerable older people and family caregivers. This database contains details on all of the participants to the NPO projects. "This is a unique source of information," according to project manager Dannie van den Brink and project leader René Melis of Radboud University Medical Centre. "The data set provides an important stimulus to cooperation in the field of elderly care research." This article describes their story about the creation and significance of the database.

Database enjoys broad support

TOPICS-MDS stands for 'The Older Persons and Informal Caregivers Survey Minimum Data Set'. As the name implies, this is a minimum data set containing details of 43,000 elderly people and 8,500 family caregivers who were involved in an NPO project. The data were collected by the project leaders of 53 NPO projects, who administered questionnaires to participating elderly and caregivers.

TOPICS-MDS consists of three sections. The first section contains information as described by the older adult or the caregiver, including gender, age and level of education. The second section contains information about the physical, mental and emotional health of the elderly persons. Finally, the third section records the use of care of each individual older person. The researchers administered the questionnaire at least twice; prior to and after completion of every project.

Having the respondents complete the TOPICS-MDS questionnaires was a grant requirement for all of the NPO projects. "Obviously, that provided a strong incentive," according to Melis, "but subsequently we took the initiative, together with researchers of the eight University Medical Centres, to form a consortium. Collectively, we determined exactly what this minimum data set should contain." The consortium, which was coordinated by Radboud University Medical Centre, developed standardized questionnaires and decided on the tools to be used. "This collective responsibility for the contents created broad support for the TOPICS-MDS survey and database."

Comparing interventions

The idea behind TOPICS-MDS was to compare the interventions that were implemented within the projects. Van den Brink explained: "This would enable us to differentiate effective elements from ineffective ones. The great variety in substance of the various interventions made it impossible to compare all of them properly, but we were able to group

Which data does TOPICS-MDS contain?

Data about elderly people:

- Demographic characteristics such as age, gender, origin, marital status, home circumstances, level of education, socio-economic status
- Health perceptions (according to the Rand-36 survey instrument)
- Quality of life (according to EQ-5D+C; Cantril's Self Anchoring Ladder, perceived change in quality of life)
- Multimorbidity (17 chronic medical conditions, largely based on the Local and National Health Monitor)
- ADL functioning (according to the Katz-15 instrument)
- Psychological well-being (according to the Rand-36 instrument)
- Social functioning (according to the Rand-36 instrument)
- Use of care (admissions to hospital and length of stay; emergency visits; admission to a care home or nursing home)

Data about family caregivers:

- Demographic characteristics such as age, gender, socio-economic status, type of (blood) relationship/residing with the elderly person
- Health perceptions (according to the Rand-36 survey instrument)
- Objective burden of informal caregiving (by number of hours per week)
- Subjective burden of informal caregiving (visual analogue scale and CarerQol)
- Perceived quality of life (according to Cantril's Self Anchoring Ladder)
- Perceived change in quality of life

relatively similar interventions together. This allows for a generalization of a much larger group that will indicate whether this particular type of intervention is effective or not. In addition, this approach would allow for a meaningful study of subgroups (such as older and younger elderly), which would constitute too small a group in each of the individual studies." Furthermore, it makes it possible to measure the results per intervention. Melis added: "Has care use declined among the elderly? And what did it cost? Has the quality of life improved? The outcomes can be analyzed for the entire population, or, alternatively, disaggregated along gender, age, or clinical picture, for instance."

In view of this success, the database has been made available also to external researchers, healthcare professionals and policymakers since early in 2014 – at home and abroad. "Anyone who is involved in elderly care can apply for access to the database," as Melis explained. "We will subsequently assess whether the data are relevant to the area of investigation. In addition, the social relevance of the study is important to us as our goal is to give the results back to society."

Family caregivers

According to Melis and Van den Brink, it is a logical choice to include not just the data on elderly people, but those of their caregivers as well. "It is very important to know how they are doing," Van den Brink explained. "We need to know, for example, how many hours they spend giving care, and how they perceive their quality of life and health condition. Linking these data to characteristics of the elderly, such as their perceived health condition, their use of care or their clinical picture, will yield highly valuable information." According to Melis and Van den Brink, it is very important for researchers to focus on more than just the elderly and to include information on the caregivers in their surveys as well. "If an intervention makes the older person feel better while the caregiver breaks under the pressure, it will not benefit society at all!"

Complexities in practice

Generating exposure for the database does, however, require considerable efforts on the part of the consortium. Melis stated: "There is a growing tendency among researchers to think that data must be kept available for re-use. In practice, however, researchers find this

Researcher Jeanet Blom (LUMC) uses TOPICS-MDS

"For a project within the NPO, we have conducted a primary care screening of elderly people for their vulnerability and subsequently performed an intervention on the elderly identified as vulnerable. The goal was to improve the responsiveness of care to the needs of the elderly and to improve the collaboration between all of the care providers involved. Other University Medical Centres have studied this type of intervention programme as well. Our own study results did not reveal any impact on the self-reliance and quality of life of these older persons. The next step was to verify whether the intervention was, indeed, effective for certain subgroups, such as care home residents or seniors over 85 years of age. Unfortunately, our research population was too small for this purpose, but if we were able to use the results of all University Medical Centres, we could do it. TOPICS-MDS helped us in this respect, as it contains all of these data."

"We prepared a proposal describing why we feel this research would be important. The TOPICS-MDS committee approved this proposal and gave us access to the data of all of the eight projects. Today, we are studying whether there are certain subgroups for whom the intervention is, indeed, effective. Furthermore, each project used a different tool for early detection of vulnerability. We will examine the differences. I hope that we will be able to discover for which elderly people a specific intervention is effective, so that we can improve the quality of life for that particular group. In addition, knowledge of the effectiveness of specific interventions is very useful information for general practitioners."

"I am very pleased with the single point of access to the data of various surveys that TOPICS-MDS provides. What is special in this respect is that the consortium's social council evaluates the relevance of research applications. A significant effect of this database is that it leads to cooperation and fruitful discussions with other researchers. After all, working with other people's data is conducive to starting discussions on their analyses and conclusions."

quite complicated. Those who possess the data are not always willing to share them for fear of being outshined by others who use their data. On the other hand, researchers who need data do not always think of using the data produced by others. Our TOPICS-MDS project shows that researchers are definitely willing to cooperate when it comes to sharing data. In addition, the project has taught us that it is important to keep the needs of future users in mind, and how you can encourage them to use these data, for instance through smaller subsidies for young researchers. This way, we can kill two birds with one stone; on the one hand, you promote the use and recognition of the data set while on the other hand, you promote the careers of young researchers."

In the meantime, the number of new requests has been growing steadily since the beginning of 2014. Over twenty applications have been submitted since then. "This concerns particularly healthcare researchers," Van den Brink explained, "but economists and sociologists are interested in our data as well." In addition, the researchers receive requests from abroad. Van den Brink said: "There is this American researcher who wants to analyse the differences between young and older family caregivers. She also wants to compare caregivers in the Netherlands and the United States." On a European level, there are other initiatives concerning similar minimum data sets. One example is the Geriatric Minimum Data Set, which compares geriatric care models on a European scale.

Ongoing relevance

Melis and Van den Brink feel that TOPICS-MDS can offer a significant contribution to the quality of life of elderly people. "If researchers start to collect data systematically, the importance of the database

as a source of information will grow. It will reveal more and more details of the physical, mental and emotional condition of older persons, and it will reveal which interventions are effective and which are not, and why, for instance, one group is doing better than the next."

Melis and Van den Brink have several plans to enhance the relevance of the data. Melis declared: "Parties such as municipalities and health insurers have a great need for the data we collect. They need to know how elderly people in the Netherlands are doing, and how we benefit from healthcare. It would be marvellous if we could collect such data on an ongoing basis, and if we could turn this into a large-scale monitoring instrument. Another idea we are entertaining is to have elderly people complete the questionnaires themselves. We are currently investigating options to achieve this. The list of questions we have developed is ready for further implementation."

The researchers also plan to link the data from TOPICS-MDS to other databases. "Just imagine how this could multiply the benefits!" Van den Brink stated. "This would enable us to link data to specific care groups and care methods, or to certain regional data sets, which would allow us to zoom in more specifically on the condition of elderly people in a defined area. Unfortunately, we do not yet have the permission of the participating elderly to do this. To avoid aggravating the burden of the process, we have not asked them initially, so that is something we need to do next. We take it step by step."

The National Care for the Elderly Programme (Dutch abbreviation: NPO)

The NPO is designed to improve care for elderly people with complex care needs in The Netherlands. For this purpose, numerous organizations have joined forces on a national as well as a regional level. The goal is to proceed towards a coherent care supply that is better tailored to the individual needs of the elderly. Within the NPO, some 75 transition experiments and research and implementation projects are currently being conducted. The results have been available since April of 2015 at *www.BeterOud.nl*. The NPO is a programme of ZonMw in conjunction with NFU (the Dutch Federation of University Medical Centres) and CSO (the umbrella organization for senior citizens' organizations). The NPO was launched in 2008 on the instructions of the Dutch Ministry of Health, Welfare and Sport.

Nationaal Programma
Ouderenzorg

Further details are available at: http://topics-mds.eu/.

About the author

Laura van der Mark is a content writer for Leene Communicatie, communications agency in Gouda, *www.leenecommunicatie.nl.*

Health and social participation of older people in Europe

SUZAN VAN DER PAS EN HENRIKE GALENKAMP

Older people play an important role in the social participation in our society. However, are these mainly the healthy and active older people that remain active or also those older people with health problems? To what extent does health affect the social participation of older people in Europe?

Social participation of older people

Stimulating social participation of older people is a major goal for both the Dutch government and European policy in general. A central issue for the European Commission is to promote active and healthy aging. With the introduction of the Social Support Act (WMO) municipalities in the Netherlands have become responsible for supporting the independence and participation of people with physical or mental health problems. This support aims to ensure that people can continue to live in their own home and community for as long as possible. Social participation is a broad concept, which often focuses on social activities such as paid work, involvement in political organizations, volunteering or providing informal care. Social participation also includes consumptive or social-cultural activities which involves one's personal development and wellbeing. Consumptive participation can include, for example, taking part in a sports activity, visiting a restaurant or museum, sporting event or amusement park. Also there is network participation where the contact with family, friends and neighbors is important. While social-cultural and network activities do not have direct economic value, they are important for the well-being and quality of life, and according to the WHO definition an important aspect of Active Ageing (WHO, 2002).

Despite the fact that older people often remain active into late old age, the number and diversity of activities decreases with age (van der Meer, 2008). This decrease is mainly due to a decline in physical and mental health. Especially functional impairment, depressive symptoms, and cognitive impairment affect the social participation of older people. Yet little is known about differences in social participation of older people in Europe, and especially the social participation of older people with health problems.

Social participation of older people in Europe

European countries show a large variety in the rate of of social participation. Figure 1 demonstrates social participation rates of people aged 65 and over in selected European countries, distinguishing between participation in consumptive activities (educational activities or taking part in sports or other clubs), providing informal care to adults or children outside the household, participation in volunteer work and participation in religious activities. Data come from the Survey

of Health, Ageing and Retirement in Europe, (*www.share-project.org)*. Compared with other European countries, the Netherlands shows the largest volunteer participation, but engagement in informal care and consumptive activities is also relatively high. Only Denmark has higher participation rates in these two kinds of activities. Poland and Portugal stand out with a high involvement in religious activities, while only a small share of older people in these countries participate in educational activities or in volunteer work. Each country has its own cultural context, which plays an important role in these differences. For example, the availability of care services and the extent to which the family is regarded as a source of care greatly influence the rate of participation in informal care in each country. In addition, large differences exist in the policies that promote Active Ageing at the European level.

The impact of health on social participation

Within the European project MOPACT (Mobilising the Potential of Active Ageing in Europe) research has recently been conducted on the effect of multimorbidity (i.e. the co-occurrence of at least two chronic diseases) on various types of social participation. Older people with multimorbidity had a lower chance of participation in almost all of the studied activities (except for religious activities). The impact of multimorbidity, however, depended on the type of activity. For participation in the labour market, in educational activities and in volunteering the negative effect of having multimorbidity was larger than for informal care and network participation (MOPACT, 2015).

Central in this research was the question if individual characteristics of active older people were different in people with and without multimorbidity. If so, interventions to promote social participation should also be different for older people who do, compared to older people who do not, have health limitations. However, predictors of participation were largely similar. In both the groups with and without multimorbidity, higher socioeconomic status, a larger social network and better physical and mental health were important for the rate of social participation.

Some predictors were only relevant for some of the participation domains. For example, older people with multimorbidity who

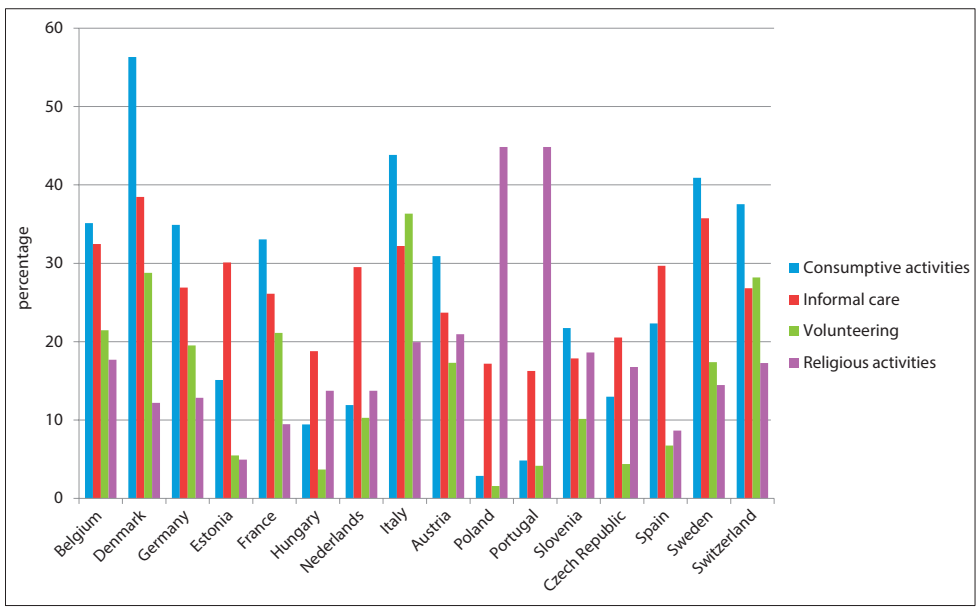

Figure 1. Social participation of older people in Europe (Source: SHARE wave 4, 2010/2011)

were widowed had a higher chance of providing care, but a lower chance of doing volunteer work. In addition, transportation possibilities (driving a car, public transport) seemed more important for consumptive activities for those with multimorbidity, compared with older people without multimorbidity. The domains of social participation were strongly associated. This implies that older people who are active in volunteer work are often also the ones who provide care (to grandchildren) or who take part in educational activities.

This study shows that interventions targeted at enabling social participation of older people with health problems should not necessarily be different than for relatively healthy older people. At the same time, people with health limitations – and those with a low socioeconomic status and a small social network - do participate less, and this warrants special attention to these groups.

Certain chronic diseases may have more or less impact on social participation. Osteoarthritis is one of the most common chronic joint disorders in older people (Vos et al., 2012) and causes major functional limitations in daily life (Brooks, 2002). Previous research from EPOSA (European Project on Osteoarthritis) show that older adults with knee osteoarthritis participated less often in consumptive activities compared with those without knee osteoarthritis, but there was no difference in participation in voluntary work or network participation (Van der Pas et al, 2014). There were no differences between European countries. The results were controlled for other chronic conditions, functional limitations and depressive symptoms. However, social participation is still high among older adults with knee osteoarthritis (86% consumptive participation, 57% volunteer work, 80% network participation). This study suggests that having knee osteoarthritis mainly affects activities requiring physical mobility (consumptive activities) and to a lesser extent activities that can be adjusted (network participation). These are activities that can also take place at home or via phone or social media.

Development in social participation

These findings show that older people who are active, often participate in different activities - consumptive activities, volunteer work, informal care and activities organized by religious organizations. Also, there are large differences between European countries. Older people with multiple chronic conditions generally participate less in consumptive activities and community activities such as volunteering and informal care than those who do not have a chronic condition. Furthermore, the same factors influence the social participation of older people with multiple chronic conditions compared with those with only one chronic condition. Netherlands is among the countries with the highest social participation, indicating that improvement may need to be sought in older people with health problems. Osteoarthritis mainly affects consumptive activities, but to a lesser extent network participation and volunteering. Having multiple chronic conditions did have an impact on volunteering. This may be due to the type of conditions involved, but these were not specified. Both studies seem to suggest a ranking of how the types of participation are influenced by health. Voluntary work and informal care seem to be abandoned before consumptive activities. Network participation is likely to be maintained the longest.
Voluntary work and informal care are precisely the activities that the Dutch government and the European Commission are currently focusing on, however there is no explicit focus on older people with chronic conditions. Both the type and the number of conditions appear to be important in this respect.

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About the authors

Suzan van der Pas is professor of social innovation and entrepreneurship at the University of Applied Sciences Leiden. She is also senior researcher at the department of Epidemiology and Biostatistics of the VU University Medical Center.

Henrike Galenkamp is postdoctoral researcher at the department of Epidemiology and Biostatistics of the VU University Medical Center.

Active Ageing of the 80+ generation

"I want to be meaningful to others"

LAURA CHRIST & KEES PENNINX

People at an advanced age are seldom asked to share their knowledge, skills and life experience. This conflicts with a strong need of the older generation to participate and play a significant role within their own community in later life. The European Active 80+ project and the Dutch project JointPower 80+ offer a new perspective on active ageing.

Active ageing in Europe

All countries of the European Union see an increase in the number of older people, and especially of the over 80s. Only 3.5% of the Europeans were octogenarians - or older - in 2001, but it is to be expected that this percentage will rise to at least 12% in 2060. In the past few years, the promotion of active ageing, volunteering and lifelong learning by older people have had a prominent place on the agenda of the European Union. In 2011, the European year of Volunteering, an important objective was the recognition of voluntary work as a fundamental part of active citizenship and democracy within the collective consciousness of the Member States. The voluntary contribution of older people was crucial in this recognition.

Marking the 10th anniversary of the Madrid International Plan of Action on Ageing, the European Union declared 2012 as *the European Year of Active Ageing.* Active ageing is described as participation in employment and the community by volunteering and active citizenship. Within the context of the European Year, several projects and activities were initiated. Remarkably, the focus lies primarily on the participation of people in their so-called Third Age (from 60 – 80). Little is known about the participation and contribution of the over 80s. The EU program Silver Economy, which outlines the EU strategy up till 2020, has placed active and healthy ageing high on the agenda and stimulates older people – from the age of 50 onwards – to remain active as long as possible, to participate independently, and to contribute to society and the economy. In this case, however, participation and lifelong learning refer to 'participation in the labour market'. These programs seem to forget the oldest generation and erroneously invoke an image of the over 80s as people who are solely in need of care or as consumers of healthcare and technology.

Europe: Active 80+

Possibly a change is about to come. October 2014 was the start of the European Active 80+ project, in which five countries participate: Austria, Germany, Italy, Lithuania and the Netherlands. The Active 80+ project is financed by the Erasmus+ program and resorts under the Adult Education program in which lifelong learning is one of the important ob-

"The most important thing is that I want to be recognized. I do not want to be overlooked, I want to feel like I do matter and be meaningful to others".
(Active80+: quote from an interview with an octogenarian)

jectives. The Active 80+ program *does* concentrate on the oldest generation. Its purpose is to create awareness and recognition of the knowledge and skills of the over 80s and to promote concrete opportunities to keep learning and to remain active within the community in a way that suits older people. A first step in the Active80+ project was to set up an inventory and analysis of current expertise and practical experience by means of desk research in the participating countries and on a European level. Central notions and search entries that were used in the inventory are: lifelong learning, volunteering and civil citizenship. These were linked to an advanced age and/or the Fourth Age (i.e. over 80s). The inventory and analysis showed that there is a lack of research and public debate about active ageing during the Fourth Age. It also revealed that there is a strong need among the older generation to keep participating at an advanced age and to be involved in their own community.

Keep learning, being visible and of importance

Following the desk research, in depth interviews were carried out and the over 80s state that to keep learning, to play a significant role in the life of others and to be involved in the community are prerequisites for a purposeful and happy life. For the respondents, however, it is not self-evident that they are acknowledged or that others take them seriously. People and/or organizations in their immediate surroundings hardly ever ask them to share their knowledge, skills and (life)experience. Although the quality of the living environment and access to existing services are of major importance to older people (Van Dijk, 2015) they participate less than the age group of 36-65 year olds (Engbersen & Snel, 2015). The result is that they become less visible as a positive force in society, they are not able to make a difference to others and are characterized as people that are only in need of care. This will undermine their quality of life.

The Netherlands: JointPower80+

Because their social network is usually smaller and their participation in public life diminishes, older people are often dependent on care workers and volunteers as their principal contacts. The latter are in a position to support the over 80s and facilitate them to discover their hidden talents and stimulate them to engage in useful activities. This asks for a different attitude towards older people and it also requires different skills from care workers and volunteers. Within the framework of the Active 80+ project, the participating countries developed a training for care workers and volunteers in residential care homes, activity centers or other local organizations that focus on the older generation. The Dutch partners in the European project Active 80+, the Older Women's Network Netherlands and ActivAge, have developed a special approach which is called JointPower80+. A short training-course of two half-days enables local organizations, with the help of practical guidelines, to start organizing their own activating dialogue with professionals, volunteers and the over 80s. JointPower80+ offers a clear approach in which not only knowledge, skills and life experience of the over 80s are being discussed, but also their social aspirations within the community. This is done by means of a structured dialogue which takes place in two separate meetings of two hours each. The participants join in a discussion about the central question: what does it mean to participate in society and play a significant role in the community? Multiple and creative work processes are used in order to establish in which way the over 80s could participate and to discover possible incentives or impediments. As well as: What can *I* do when participating becomes more difficult, what

can *WE* do? Are there enough opportunities in the environment of the over 80s? What could/should happen? At the end of the first meeting, every participant is asked to invite someone else (neighbours, friends, children), everyone is welcome.

The dialogue stimulates older people, as well as professionals and volunteers, to think freely so that new images, visions and concrete ideas emerge about the oldest generation and the role they could play within the community. The definition of 'community' depends on what the over 80s themselves indicate. This could be a single street, a neighborhood, a residential building, a care community, a religious group, friends or relatives. Professionals and volunteers, who are the main contacts of older people in this particular setting, will also join the dialogue. JointPower means that anyone can learn from everyone, regardless of age, and if everyone participates it is possible to seize opportunities and overcome barriers.

A fundamental human need

As becomes clear from our desk research and European policies and programs, the oldest generation is mainly depicted as vulnerable and as consumers of care. In his column in Geron 3 (2015) Frits de Lange takes one step further when he states that many people turn their back to the Fourth Age: *"We do not like older people, we hate being old because we are afraid of it… We distance ourselves en masse and turn our backs to the Fourth Age, which is dominated by vulnerability, decline and care dependency"*. We agree with De Lange that the increasing vulnerability which is inherent in later life should not be ignored. With JointPower80+ there is room to reflect and discuss. We think that during the Fourth Age, apart from vulnerability, decline and care dependency there is a counterpart which is more fundamental, namely a deep human need to be acknowledged and to make a difference to others, no matter how vulnerable someone is or how difficult the circumstances are. Being able to see, recognize, appreciate and help to realize this need contributes to a sense of joy, a feeling of connectedness and a way to find meaning in life. This should be the focus in the framework and daily repertoire of the professionals - in the Netherlands as well as in Europe - that look after the oldest fellow human beings.

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About the authors

Laura Christ is a social gerontologist and consultant Self Confrontation Method. She is project leader of Active80+ on behalf of the Older Women's Network - Netherlands.
Websites: *www.act-80plus.eu* and *www.ouderenvrouwennetwerk.nl*

Kees Penninx is an expert on change and owner of bureau ActivAge, developer of new concepts and practical applications with respect to social commitment, informal care, living arrangements and participation.
Website: *www.ActivAge.nl*

Translation: Angelique van Vondelen

Age and ageing in the theatre

HEIDI WILEY

We live in a time in which we daily face the dictates of the 'cult of youth', focused on perpetual rejuvenation and always seductive youthfulness. This is also reflected on the theatre stages throughout Europe. On the other hand modern society is rightly called the society of the 'elderly'. Our theatres are filled with viewers most often over sixty years old. Due to the complexity of this issue alone, which is surely predominant in the society in which we live, and about which we rarely or hardly ever speak, we decided upon the project "The Art of Ageing". With this theatre project we wanted not only to question the ways in which we age but also, at this time, to highlight the importance of theatres as places where we can still pose some of the essential questions which we encounter every day.

The two-year international artistic project, which was initiated by the European Theatre Convention in cooperation with eight theatres, brings the burning issue of global demographic change to Europe's stages.

The clock is ticking; *Strawberry orphans*; *Fen fires* and, finally, *I'm afraid that we know each other now*. Four new theatre plays, five new theatre productions. Multilingual, based on investigative artistic research and collaborative theatre-making in Europe, created in Germany, Slovakia, Croatia and Romania. They couldn't be more different from each other, yet they all have one thing in common: they are reflections on and positions towards the 'The Art of Ageing'.

When we first started to discuss the ideas in 2012 during the *European Year of Active Ageing*, our explicit desire was to add an artistic dimension to the public discourse and encourage a debate between artists, scientists, political and economic stakeholders as well as theatre audiences about the demographic challenges facing younger and older generations alike. Our aim was to develop new formats for European theatre suitable for exploring the vast topic from a sociological, historical, economic, physiological, philosophical and political perspective and through the creative art of theatre.

Which new artistic forms of expression and which skills do we need in order to join forces, learn from each other within Europe's public theatre sector and together tackle the challenging realities of our ageing society? Which stories can be told in today's theatres to reflect the effects of ageing in the twenty-first century?

During the artistic European journey we embarked on as part of our efforts to foster engagement with an ageing audience, we looked for new ways to encourage people from all

generations to actively take part in society. The plays tell the stories of how people age in Europe, how their lives and conditions for growing older are intertwined as part of our global economic and shared European political system.

The plays

The clock is ticking

This play explores the political implications of *Active Ageing*. The play is performed by The Romanian National theatre of Timisoara and The German State Theatre of Karlsruhe. The Romanian dramatist Peca Stefan conducted research in both countries to create his virtuoso comedy featuring four actors, two Germans and two Romanians. What was life like for older people in the past? What will happen in a society when the majority of the population is elderly? And when will the dream of eternal youth come true for the lucky few with the help of modern medicine? There are two contradictory forces currently at work in Europe: its young population continues to shrink and thus lose political sway, while the growing elderly population pursues its own interests and takes measures to ensure the preservation of its standard of living. All these questions are extremely serious, but they are treated in a playful manner. The playwright uses the stage as a platform for intergenerational dialogue, no set texts were written and as a result every performance becomes a premiere. *The clock is ticking* invites the public to serve as voters, regardless of age, to decide as a group the best way to spend the 60 minutes of the play's running time.

Strawberry Orphans, a journey to a lost generation

Strawberry Orphans is performed by the German State Theatre of Braunschweig and the Romanian National Theatre of Craiova and deals with the generation of children in Eastern Europe whose parents have left the country in order to find employment in countries like Spain, Italy, Greece or Germany. These parents are known as 'strawberryists' in Romania, regardless of whether they left to help with harvests or perform another kind of seasonal labour, or whether they work as health care aides for the elderly or infirm. Whenever the parents work abroad, it is the children who are left behind, often with their grandparents. Here is a fragment of a dialogue:

I don't feel like singing, I don't feel like anything, anymore.

The biggest wish would be them to find work and them to be in the country, to come in the evening to their children. That would be the biggest wish.

And mine would be, but I have to think also of them, to die at last.

For me it would be better, I'm 81 years old and I can't walk anymore. I don't want to see anymore how the children struggle.

And if they find work, I'd like to die right away, maybe I would die with my heart at peace, 'cause they wouldn't suffer anymore. Maybe I wouldn't know, if I died. But what shall I do?

My husband, there are 21 years since he died. And I stayed behind, to take care of all…..

Projects like *Strawberry orphans* are necessary, because they remind us not to become used to a tough situation, even if it has been going on for such a long time that we barely notice it anymore. Habit leads to negligence, forgetfulness and indifference. The theatre must

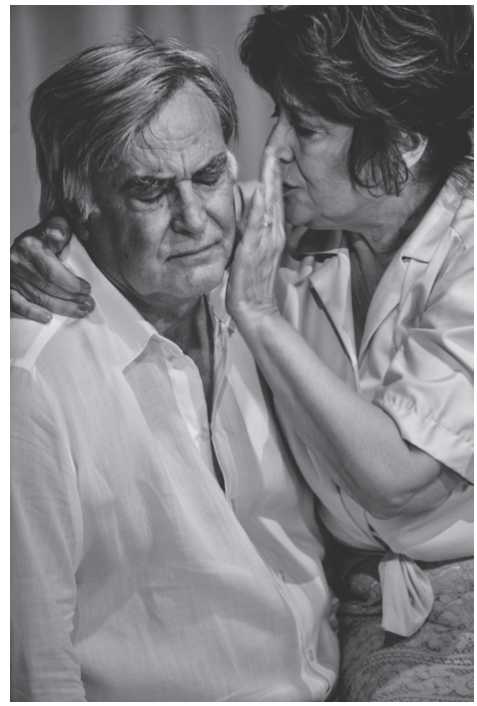
take on a social role as well, like any of the arts, which is the main importance of this performance.

Fen Fires

This play probes the history of two European nations, Slovakia and Germany, that couldn't be more different. The starting point is this history along with the real-life issues dominant in each country, both on the political level and in how they affect the lives of ordinary citizens. The main focus is on two female protagonists who grew up in very different societies. Now senior citizens, their paths cross as the esteemed jurist from the West becomes dependent on a home health care aide, who in her past life was a well-known musician in the East. During rehearsals in Germany and Slovakia, a team of Slovakian and German actors and theatre makers considered both the real history of the two countries as well as the fictional biographies of the two characters to create a moving, bilingual theatrical event.

I'm afraid that we know each other now

This play raises the question: is it even possible to live without a history? To exist exclusively in the here and now? Both of these things – remembering and forgetting – seem to serve some essential human need. "Remembering everything is like a disease. You must forget in order to live", says one of the characters in the play. What does this mean for the art of ageing? What are the limits of language? How can you live a meaningful life? Director Miriam Horwitz, who worked in close collaboration with the playwright Ivor Martinić states: "We took a very theoretical approach to finding the topic that best described ageing and our view thereof: memory. Remembering is part and parcel of our identity: it shapes us, writing a history that allows us to situate ourselves in the world and at the same time lets us redesign our future based on memory."



How art can stimulate the public debate

In order to increase the impact of our project, we organized '*Art of ageing* – the European Theatre and Science festival' in Timisoara, Romania. We were frequently asked why we had decided to bring theatre and science together in one project. There are three reasons for this: In the first place, the creative research project was developed to contribute in an artistic way to the discussion about demographic change in Europe. We presented the results of our research in a special setting and all new productions were performed in one theatre. What is more, the plays were put within a broader social framework via contributions of invited experts scientists and experts in the field. Secondly this was an opportunity for interdisciplinary exchange and dialogue with experts and artists about the role of the theatre in our culture and society. Finally, the festival offered new insights to come to a new innovative form of theatre in which educational and social programs were developed in collaboration with an intergenerational audience. The festival inspired us to develop new methods,

especially based on interactive and participative concepts.

Storytelling

Stuart Kandell, American pioneer of the *Creative Ageing Movement* and founder of Stagebridge, the nation's oldest senior theatre in California, states: "it is not to them, but to us", by which he emphasizes that it is important that the attitude of older people changes. Art is being called upon 'to pose questions' about ageing, even if science cannot provide the answers. Art can influence the public opinion about age and ageing. Kandell is an advocate of intergenerational communication by means of the theatre. This fits in with Erikson's 'generativity': a concern for establishing and guiding the next generation. There is a need in society to offer young adults role models. We also see that older adults need inspiration. *Storytelling* is a perfect instrument to bring these two together. We see, for instance, that many schools are desperate for programs that help reduce violence and create stronger family and community bonds. The Stagebridge *storytelling* project brings elder storytellers and professional older adult teaching artists into classrooms to mentor at-risk elementary school children through storytelling, oral history and performance. By bridging the arts institutions and community, we serve everyone's needs and it is truly a "winwin-win" for all.

Theatre against segmentation

Based on our experiences and shared insights, it is possible to conclude that it is time for a change of mind in our society. We need to develop new theatre productions which address intergenerational themes to build bridges between the generations. We need a better understanding of each other, this is urgent in our segmented and competitive society. And art is one way to meet this challenge. Because the theatre is a place to build a society, inclusive and together. A place to experience the art of ageing.

About the author

Heidi Wiley is project manager of *The Art of Ageing,* a project that is supported by the European Commission. She is also General Secretary of the European Theatre Convention, Paris.

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Finland

Hot topics in ageing research

JENNI KULMALA

Finland is one of the leading countries in thorough scientific ageing research. Several universities and research institutes in Finland have been conducting large population-based longitudinal studies for decades, investigating especially the lifestyle risk factors for old age physical and cognitive functioning. This brief overview describes some of the recent and ongoing projects that have gained interest in Finnish ageing-related research

Labour related studies

Large prospective cohort studies with follow-up periods extending up to over forty years, as well as recent qualitative randomized controlled trials (RCTs) have provided groundbreaking new knowledge on lifestyle factors that contribute to old age health and functioning. These studies highlight the importance of a life-course perspective when aiming to promote a healthy and active old age. One of the recent interests in Finnish ageing research has been occupational gerontology. It refers to research that investigates the relationship between working life and old age (Goedhard 2011). It provides knowledge on how to promote the work ability of older workers and it also investigates, whether working life and working conditions have longitudinal effects on later life health outcomes. The research area provides further understanding how working life affects life after retirement.

The Finnish Longitudinal study on Municipal Employees (FLAME) is an ongoing prospective longitudinal study. The study was initiated by the Finnish Institute of Occupational Health in 1981 and is currently a collaboration study in which several research institutes in Finland participate. The baseline cohort in the beginning of 1980s consisted of 6257 occupationally active middle-aged persons, whose work ability, working conditions and health-related factors were assessed with postal questionnaires (Tuomi et al. 1997). This cohort has been followed for almost thirty years, which has provided a unique opportunity to assess the long-term effects of working life. The FLAME study has resulted in several interesting findings. For example, studies published in 2013-2014 showed that perceived work-related stress significantly increases the risk of old age functional and mobility decline (Kulmala et al. 2013). Compared to persons who did not report work-related stress in midlife, those who suffered from stress symptoms during their working life, such as negative reactions to work and depressiveness, perceived decrease in cognition, sleep disturbances or somatic stress symptoms, had a significantly higher

risk of developing difficulties in walking and mobility as well as difficulties in basic and instrumental activities of daily life in old age.

In addition to mental stress, physically straining work was associated with poorer physical functioning in old age (Hinrichs et al. 2014). The FLAME study has also provided evidence that mental and physical strain during work may modify the future mortality risk. The results published in 2012 showed that low job control in men increased, whereas high job demand in women decreased the mortality risk during the following decades (von Bonsdorff et al. 2012). These findings clearly demonstrated that unfavorable working conditions may have detrimental effects on health in later life and also increase the vulnerability of the elderly for physical disabilities or even premature death.

Dementia prevention

Finland has also been one of the leading countries in dementia prevention studies. Large prospective studies with follow-up periods extending up to thirty years have provided knowledge on several lifestyle factors that either increase or decrease the dementia risk (physical activity and fitness, dietary factors and cardiovascular risk factors). Recently, Finland has gained wide national and international attention after publishing the results from the large randomized controlled trial FINGER (Finnish Geriatric Intervention Study to Prevent Cognitive Impairment and Disability) in the highly respected medical journal the Lancet. The FINGER study is the first large randomized controlled trial in the world that showed that multidomain lifestyle-based intervention (changes in diet, increasing physical activity, cognitive training and vascular risk monitoring), significantly decreases the risk of old age cognitive decline (Ngandu et al. 2015). These results gave the first scientific evidence that by modifying the lifestyle habits of the elderly, it may be possible to maintain cognitive capacity in later life. Since dementia is one of the main public health concerns in Finland and also across the world, these findings give hope that cognitive decline and dementia may be partly prevented, or at least that the onset of the disease may possibly be postponed.

Unique research possibilities

As briefly described above, several earlier - work-related - life events and lifestyle factors are key determinants of a healthy and active old age. In order to investigate these lifestyle effects in relation to old age health and functioning, there is a need for large population-based datasets, where the same persons have been followed for several decades. It also requires well-conducted randomized controlled trials in order to really test the effects of interventions. This kind of research provides opportunities to identify the risk and protective factors and causal pathways that influence old age health and wellbeing. Finland has a long tradition in conducting such studies, and prospective large population-based datasets used in the Finnish aging studies are rare worldwide. Finnish well-organized register-based data also give unique research possibilities. Several studies related to ageing and life-course epidemiology are currently in progress in Finland. Therefore, remarkable research news is also expected in the future.

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About the author

Jenni Kulmala is PhD teacher and Adjunct Professor at the Gerontology School of Health Care and Social Work of the Seinäjoki University of Applied Sciences, Seinäjoki, Finland.

Email: *jenni.kulmala@seamk.fi*

Austria

The quality of life of the older generation

MONIKA ALTENREITER

GfK-Austria, a market research institute, has investigated how content Austrians are with their life, which is defined as the 'individual perception of the quality of life'.

Social class

The poll shows that 60-year olds and older are most content with their life. It has been found that contentment and quality of life are positively influenced by education, physical exercise and, not surprisingly, social class. Furthermore, the findings show that travel, the environment, art and culture are among the top interests of the generation 50/60+.

An attempt has been made to find *typology* for the generation 60+. Four categories have been set up to classify this generation: smart and swift (11%), established (39%), committed and active (25%), stay-at-home (25%). Differentiating characteristics for these types are their *affinity of social networks*, *social life and hobbies*, *use of new media*, and *physical activity and contentment*. Those who are *established* are on average 69.5 years old, they like to work on and in their homes and gardens, have hobbies and seek the company of people their own age. They feel financially

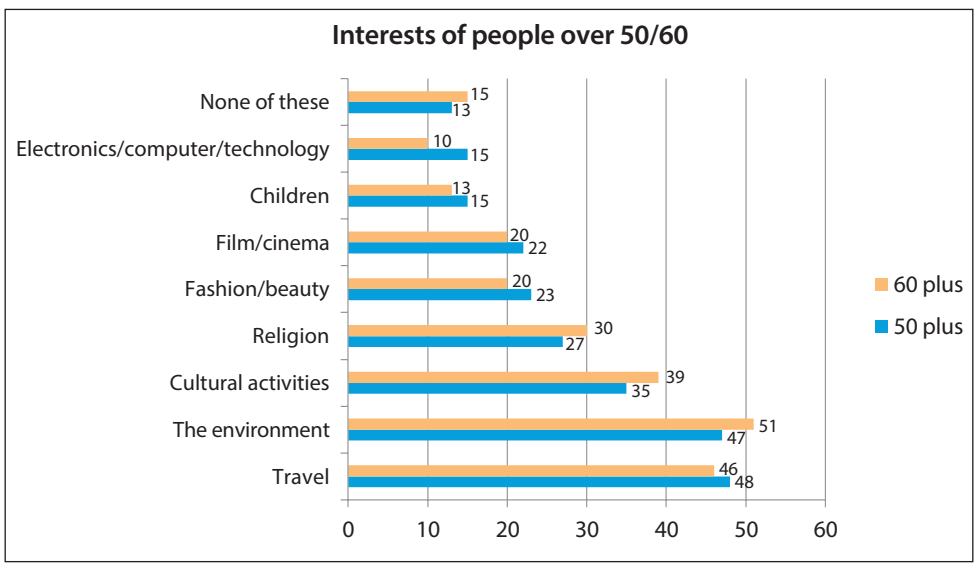

Figure 1. Question posed: 'Which topics are very interesting to you?' (source: GfK-Austria, 2015)

secure and are content. The ones called *stay-at-home* are 70.2 years old, like to rest and spend time with their pets, sometimes they feel lonely and would like to be younger. They are also fearful of the future. The *committed and active* make up 25 % of the generation 60+; they like cultural activities and want to participate actively in society. They see themselves as active and able to achieve goals. Their average age is 69.5. The *smart and swift* type makes up 11% of the examined generation. Their average age is 66.5; they still have goals in life, are enthusiastic about new media and the internet. They like to go out and take on odd jobs (Seniorenbund, 2015). As mentioned previously, social class, which goes hand in hand with income, has to be stated in this context as well. The average amount of money at free disposal for the various types of the generation 60+ is as follows: the *smart and swift* have € 652,- per month on average, the *established* have € 641,-, the *committed and active* have € 616,- and the *stay-at-home* type has the least amount of money per month, namely € 435,-.

Insight into the 80+ generation

A further study has tried to shed light on the life quality of Austrians aged 80 and over (Martin, 2015). A general conclusion from this study is that the image of age and ageing needs to be re-thought. The public image of the older generation in Austria is often negative and deficit-oriented. While it may be the case that many older people have some physical or mental impairments, it has to be pointed out, however, that the majority of people aged 80 and older can live a self-determined life. In 410 interviews with elderly people between 80 and 85 both qualitative and quantitative data regarding health, accommodation and care have been collected. While most interviewees could be described as vulnerable and/or frail from a medical point of view, more than half of them estimate themselves to be reasonably healthy and content. Georg Ruppe, Chairman of the Austrian Interdisciplinary Platform on Ageing, states that: "More than three quarter of the interviewees are generally content with their lives. […] We need to learn more about this generation in order to plan, support and react to their needs."

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About the author

Monika Altenreiter is a teacher-researcher affiliated to the August Aichorn Institute of Social Work at the University of Applied Sciences JOANNEUM, Eggenberger Allee 1, A-8020 Graz, Oostenrijk.
E-mail: *monika.altenreiter@fh-joanneum.at*

Spain

Worrying perspectives

LOLA CASAL

In contrast to several other European countries, Spain was not an 'old' country until quite recently. In 1970, people over 65 years of age or older represented 11% of the population. This percentage increased to 18.2% in 2014 and if population projections continue, Spain will be the third oldest country in Europe in 2050, with almost 30% of its population older than 64 years (European Commission, 2012). This implies big challenges for Spanish authorities to take the necessary measures in or order to provide for the older population now and in the future.

Aging is a population phenomenon that affects all public spheres, but it is also an individual reality and experience. Furthermore, senior interests or issues that Spanish seniors consider most important are influenced by the following differences: life expectancy at birth (women 85.13 years, and men 79.38), the average pension (women receive 38% less than men; Comisiones Obreras, 2014), household composition (the number of older women living alone is twice that of men - 9% vs. 14 %; IMSERSO, 2014). In addition, the current socioeconomic context of Spain has a direct impact on matters that worry the elderly the most, such as economic status, health, family, isolation, and physical and psychological dependence.

Different roles for older people

Keeping up their economic status is important for older adults. The effect of the socio-economic crisis, together with a reduction in income (people lose 9% of their purchasing power after retirement; IESE & La Caixa, 2014), worry older adults because of uncertainties about possible future health problems or disabilities. In fact, half of the seniors consider their economic situation to have become worse since the crisis started (IMSERSO, 2014). The economic status of seniors has also been affected by changes in the role of elderly people. They have moved from being cared for, to being caregivers of both other seniors and grandchildren. Six in ten seniors provide economic support for family or friends (19.1 points higher in comparison to 2012 and 44.4 points with respect to 2011). In fact, the number of households that depend on retirement benefits as a main source of income has increased during the crisis and now represents 20 % of total households in Spain (IMSERSO, 2012). The support that seniors provide to the rest of the family has become a source of security for factors such as pension, home ownership and maintenance of family relationships.

The quality of health care

To remain in good health is also important for seniors. However, the reforms that the government has introduced since the beginning of the crisis have had a direct impact on the quality of healthcare and health insurance coverage for seniors, who are indeed the main users of healthcare systems. In fact, one third of the aging population think that healthcare quality has decreased (Comisiones Obreras, 2014). Seniors consider it important to be properly cared for when situations of physical and psychological dependence arise. Between 2013 and 2014, the dependency ratio of people over 64 years has increased from 26.7 to 27.6 per thousand.1. Seniors want to be cared for and to continue living in their own homes and demand sufficient resources to adapt their houses to their needs. Unfortunately, cutbacks have led to 117,000 people dying while waiting for their dependency benefit (Comisiones Obreras, 2014).

The possibility of remaining at home relates to the idea of being alone/isolation and participation in society. Seniors want to maintain their role in the family and want to have equal opportunities for participating in society through cultural, political and social activities. They manifest a clear interest in being involved in matters that directly affect them and an awareness about legal issues—incapacitation, guardianship, confidentiality (Comisiones Obreras, 2014).

Being involved

In conclusion, Spanish older adults consider it important to have a healthy, successful and productive old age. They seek to attain active ageing and control of their own well-being, and want to be involved in decision-making processes, especially in the areas that affect them directly (Moraleda, 2015)

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About the author

Lola Casal-Sanchez is a multicultural-oriented sociologist and social worker with experience in working for different governments and NGO's in the Netherlands, USA, UK, Portugal, Spain and Venezuela. She works as a Programme Manager at the 'Consejo General del Trabajo Social', the Spanish General Council for Social Work.

Email: *casal.sanchez.lola@gmail.com*

Germany

Mehrgenerationenhäuser: a meeting place for generations

PETER DE LANGE

In Germany the older generation is growing faster than in the Netherlands. There are more ageing people and they live longer. Older people in Germany have a longstanding tradition of remaining at home as long as possible. There are no care homes and the number of nursing homes is limited. Nevertheless, Germany also faces a growing number of older people who struggle to manage at home on their own.

Where generations meet

Family care and responsibility for aged people in Germany tend to be more compulsory than in the Netherlands. Support by neighbours and friends, on the other hand, is something that ageing people have to arrange themselves. There are quite a few independent older people that find it difficult to do so. They can be lonely or socially isolated, they struggle to spend the day alone and are unable to take up activities or make contact with others. How do they find help and support to improve the quality of life and make life acceptable?

When it comes to housing, welfare and care in Germany, we often come across two concepts: *Mehrgenerationswohnen* and *Mehrgenerationenhäuser*. They are usually regarded as two different names for one and the same concept, but this is not the case. The first refers to (multi generation) housing whereas the latter refers to (multi generation) community houses. These are a kind of local community centres that are open to everyone. That is to say, they offer a place where generations can meet. This is a new form of social welfare at a local level which has evolved in Germany. In this article we will concentrate on the *Mehrgenerationenhäuser*.

Mehrgenerationhäuser

Meanwhile, there are over 500 *Mehrgenerationenhäuser* in Germany and they have spread all over the country. The community houses are situated in small villages, or districts in larger towns and cities. Everyone is welcome and both the young and the aged can meet each other, they can participate in joint activities and are able to get - or give - help and support. The underlying idea is that different generations help each other and try to look after one another. In this way, the community houses provide an alternative form of social welfare.

The essence of the *Mehrgenerationhaus* is that it functions as a meeting place. Every house has its *Offene Treff* (open meeting place), often a bistro or café where people can meet and make contact with others. This is the starting point for further activities. *Mehrgenerationenhäuser* are characterized by their visitors. Differences in age, origin, and cultural background are not important. Apart from elder care (nursing facilities, coping with de-

mentia) and child care, the community houses offer a variety of creative and cognitive activities. For example for children, in which older people help out, but also activities for people in their forties. Support and care provisions are not limited to older people or people who need care. Informal carers (volunteers) can ask for advice and support, migrants can follow language courses. The *Mehrgerationenhäuser* work together with local, cultural and educational organisations and with churches, as well as with local businesses. They offer training courses which stimulate people to find employment. In this way, the houses are firmly embedded within the local community and form an integral part of it. Altogether, this makes them an attractive place for citizens to pay a visit.

Mehrgenrationenhäuser work with many volunteers and the houses have a lot to offer them. In general, most people are prepared to do something for others, they feel the need to be of use to their community but they often do not know how to go about it. The *Mehrgenerationenhäuser* actually offer a place where this is possible. Volunteers can do what they enjoy and/or think is necessary. An extra bonus is that they have an opportunity to meet other people; they help each other and can learn from others. This creates a sense of solidarity and people feel less lonely.

The importance of the *Mehrgenerationenhäuser* has been recognized by the Federal Government in Germany. Last year, Manuela Schwesig (Minister for families, older people, women and youth) opened the 'Day of the *Mehrgenerationenhäuser*' in Berlin. She pointed out the quality of local networks in which these houses play an important role. Removing the barriers between the different generations with respect to care, help and support has proved to be successful and it has led to new prospects how to approach this in the future.

As indicated above, an interesting aspect of the *Mehrgenerationenhäuser* is the combination of child care and elder care. Over the past fifty years, the existing welfare services in Germany have been professionalized, but they have become too expensive. Initially, the *Mehrgenerationenhäuser* were considered illegal as they pushed out traditional care services. Just as in the Netherlands, child care and elder care in Germany are regulated by the government. The German government, however, decided to adjust legislation in order to end the illegal character of the *Mehrgenerationenhäuser*. Politicians discovered that the concept of the houses could contribute to society in a major way. The Federal Government realized that actions speak louder than words and decided to pay an annual grant to all *Mehrgenerationenhäuser*. In addition, the houses receive funds from the European Social Fund and from local or federal state governments. The latter contributions can also be made in the form of personnel or infrastructure. Although the organisation works primarily on the basis of volunteers, the essential coordination is in the hands of professionals.

Salzgitter

At the beginning of this year, a Dutch documentary paid attention to a *Mehrgenerationenhaus* in Salzgitter, a small town just under Braunschweig, some fifty kilometers from Hannover. This is one of the oldest houses in Germany and its initiator, Hildegard Schooß, is still largely involved. In March 2015, The Aedes-Actiz Kenniscentrum Wonen-Zorg (a Dutch knowledge centre for housing and care) organised a study day called 'Expedition Begonia', a journey to discover new concepts in combining housing and care. Hildegard Schooß presented a workshop in which she emphasized that a *Mehrgenerationenhaus* is not a form of combined housing. There is, however, a clear interest in living arrangements because older people should be enabled to live independently, even if they are confronted with illness and disabilities. A welfare provision such as the *Mehrgenerationenhaus* creates the necessary conditions for them to remain living at home.

In the documentary, as well as during Expedition Begonia, Hildegard Schooß explained the philosophy behind the concept. By uniting all generations under one roof,

you fall back upon an old fashioned structure, that of the 'grand family'. People are able to associate with others, they help out and care for one another and this gives them a sense of solidarity. The reason behind this choice is that professional care has become too expensive and, due to cuts in the care budget, there are not enough care workers available. What is more, it seems that society nowadays is in need of a different social structure in which generations are more connected with each other. Hildegard Schooß mentions three factors that make the houses successful:

- The Mehrgenerationenhäuser are 'open houses'; they are accessible to everyone who wants to make use of the services. This does not only comprise care for the elderly or daily activities, but also the possibility to meet others and look for company, as well as the opportunity to organize activities spontaneously.
- The houses are not meant for one particular focus group, but everyone is welcome: youngsters, people who live nearby and older citizens.
- Anyone can join in all activities. There are no separate activities for specific target groups, such as the older generation. An interesting example is the fact that older people help out with day care activities for children.

One of the benefits of this approach is that people tend to be less lonely. They can meet others in the *Mehrgenerationenhaus*, which is not only open during the week but in the weekends as well. The Salzgitter house also offers services such as a hairdresser, a laundry and a shop.

The *Merhrgenerationenhäuser* are in need of money and although they are eligible for grants from the governments, they do not want to be dependent on state subsidies. The fees for child care and elder care are compatible with regular rates. The shops bring in extra money and at the same time stimulate visitors to the houses to become active and productive. A breakthrough, away from institutionalised thinking, is needed.

Finally, the *Mehrgenerationenhäuser* provide a unique opportunity for the unemployed to gain experience. Troubled adolescents, such as the group of unemployed teenagers that need strict guidance, will also be recruited in order to help out in the kitchen and with other household tasks. They mingle with older people and are treated as equals. Allowances are made for youngsters who are less productive due to cognitive problems or mental handicaps.

Inviting prospect

The *Mehrgenerationenhäuser* could be an inviting prospect for other European countries. They are a perfect example of a welfare provision which promotes participation of the population. This is exactly why they could be important for the Dutch care system. Because of the decentralisation of care provisions to local councils and subsequent cuts in care budgets, many of the services have to be realised with lower budgets. This asks for a new, fresh approach by welfare organisations. The original idea behind the Dutch Social Support Act (WMO) was to stimulate people to participate and become more involved in the community. When the Act became effective, however, it was overshadowed by accompanying cuts in care budgets. But welfare is about the structure of communities, about participation, about being recognized and, in the end, about the quality of life of our citizens. *Mehrgenerationenhäuser* constitute a new working process that could actually contribute to this quality of life.

About the author

Peter de Lange is an independent advisor specialized in diverse living arrangements for older people.

Translation: Angelique van Vondelen

Belgium

Duty of care and care practice in Flanders: Differences according to origin

LIEVE VANDERLEYDEN

This article focusses on two aspects of familial solidarity in Flanders, especially the duty of care of children towards their parents and care patterns between children and their parents/ in-laws. We will consider differences in duty of care and care practice among Belgians and people from Western Europe, Eastern Europe and countries outside Europe. We use the 2011 survey of 'Social and Cultural changes in Flanders', a yearly research project by the Research Centre of the Flemish Government among Flemish people of 18 years and over. Besides views and attitudes towards various social issues or themes, factual behaviors are measured.

Solidarity in non-Western cultures

In non-Western cultures, the solidarity within the family, especially the duty of care of children towards their parents and grandparents – also called filial obligation – is strongly emphasized. This observation is often ascribed to the difference between cultures: are either collectivist or individualistic values accentuated? (Triandis & Suh, 2002). Research in the Netherlands shows that there are also differences within the group of migrants. Immigrants from Moroccan or Turkish origin show a higher score on the familial responsibility index than people with an immigration background from former Dutch colonies such as Suriname or the Dutch Antilles. For the latter, there is much more interaction with Dutch culture than for people from Turkey or Morocco (Merz et. al., 2009). Research in Belgium has also shown that filial obligation among migrants is felt strongly and more consciously than among the native population (Lodewijckx & Pelfrene, 2012). More so than the group with an exclusively Belgian origin, the group with migrants from countries such as Turkey, Morocco, Algeria or Tunisia put family first when it comes to receiving care or financial support.

A different view on origin

In our 2011 research, every respondent living in Flanders was asked whether he/she was of Belgian origin. Due to research procedures, the origin was determined by means of the nationality of the father and mother at birth, respectively (for more information: Vanderleyden & Moons, 2013). The countries of origin were grouped together which resulted in a variable consisting of three categories:

1 Both parents of the respondent are of Belgian origin;
2 Both parents – or at least one of them – come from an EU15 country (this reflects the assembly of the EU as of 1st January 1995 - except for Belgium – including North-America); for the sake of conveni-

ence we will call this Western Europe (though it also includes some Southern European countries);

3 Both parents – or at least one of them - come from the EU12/Eastern Europe (i.e. the new countries that entered the EU27 in 2004 and 2007) or both parents – or at least one of them – come from an African, Asian or a non-specified country that does not belong to any of the other categories; this will be called Eastern Europe or outside Europe.

Duty of Care

The answers to most questions about filial obligation point out that the majority of respondents – more or less – endorse the idea of duty of care. More than half of the respondents disagree with the statement that it is not the task of the children to care for their parents; half of the respondents do not agree with the supposition that you cannot take care of your parents when you have small children. Almost half of the respondents agree that older people only belong in a residential or nursing home when no one of the family is able to care for them. Four out of ten respondents disagree with the statement that it is better for older people to live in a residential or nursing home than to be dependent on the care of their children. The table shows that there are remarkable differences according to origin.

People from Eastern Europe/outside Europe agree more often than Belgians with the statements – except for one - that support traditional family solidarity. People from Western Europe conform to the Belgians. For example: Two out of three persons from Eastern Europe/outside Europe disagree with the statement that it is better for older people to live in a nursing home than to be dependent on their children. Among the Belgians, 40% does not/does not at all agree with this statement; for people in Western Europe this percentage is 35%.

Differences according to origin are confirmed via the synthesis index which was calculated on the basis of 5 items (0 = lowest score for duty of care; 5 = highest score). Multivariate analysis shows that a more traditional view on family solidarity is indeed influenced by origin. The people who originate from Eastern Europe/outside Europe show a significantly higher score on the scale of filial obligation and those who originate from Western Europe do not differ from the Belgians, which also becomes clear from the response to the individual statements. Other personal characteristics also have an impact on the adherence to traditional values with respect to familial solidarity, especially age, religion and having children or not. People who call themselves religious have a more traditional view of familial solidarity, and compared to aged people, youngsters are more traditional in their attitude. Contrary to expectations, people with children seem to be less attached to family solidarity.

Care practice: a surprising outcome

We formulated the following question: Do care practices differ according to the origin of the people involved? Or: Do people from foreign origin, and especially those who come from Eastern Europe/outside Europe - in accordance with their traditional views on family solidarity - care more often for family members who are ill, impaired or old than, for instance, Belgians?

Within the group of caregivers, we selected only those persons that provide care for parents/in-laws (this comprises 43% of the cases in which care is provided). By means of a multivariate analysis, we looked at predicting factors for informal care by children with regard to their parents/in-laws in comparison with the group that does not provide any care at all.

In an initial model we only added origin as an independent variable. Do persons from Western Europe, Eastern Europe or outside Europe provide more care? The answer is clear: care practice is not influenced by origin. The variable does not provide an explanation and is totally insignificant. In a second model we added different background characteristics

Tabel 1. Response to the statements about filial obligation according to origin (in %; n=1.440)

Statements	Appreciation	Origin			Total
		Belgian	*Western Europe*	*Eastern Europe/ Outside Europe*	
It is not the task of the children to take care of their parents.	Agree Disagree	30 51	33 57	25 65	30 52
It is not possible to take care of your parents if you have small children.	Agree Disagree	29 49	25 50	22 69	28 50
Older people belong in residential or nursing homes if there is no one in the family that can look after them.	Agree Disagree	48 37	39 44	47 39	47 38
It is better for older people to live in a residential or nursing home than to be dependent on their children.	Agree Disagree	34 40	38 35	16 65	33 41
If older people need care, they should first appeal to professional care organizations that provide nursing facilities or domestic help before asking their children to help out.	Agree Disagree	47 33	48 41	28 60	46 35

The percentages with 'neither agree nor disagree' were not printed.
Source: SCV-survey 2011.

such as gender, age, marital status, education and employment. It is remarkable that gender is not significant when controlling for the other variables, whereas some studies point out that it is (still) primarily women who provide care (see, among others, Hoefman, 2009). Does the identity of the care recipient have anything to do with this? When it comes to a parent or in-law, care is provided and apparently sons figure in this as much as daughters. As for age, it is the age group of 45-64 that mainly provides care, but in comparison to the oldest age group of over 65s, the younger age category provides care more often. The marital status also shows significant differences. Compared to those who are married, the chance that unmarried people provide care is less probable. People who are widowed or divorced do not significant differ from those who are married. Education is not significant when controlling for the other variables, but employment is. In comparison with people who work full time, those who are retired or work part time appear more often as informal caregivers. Adding a network variable, namely whether someone functions as a volunteer or not, does add an extra explanation of the model. Finally, we wanted to know whether

filial obligation, the way in which people think about the traditional family solidarity, influences care practices. This variable shows a significant effect under the control of all other variables. Taken together, personal characteristics, the network and the set of values with regard to filial obligation explain 18% of the total variance, which is, in itself, not so much. All in all, this indicates that there are other important factors that determine whether informal care for a parent/in-law is provided. Sadiraj et. al (2009) state that in fact there is only one reason why informal care is provided, namely that someone in the social network needs this care.

Overall, we can conclude that family solidarity is a broad concept with various dimensions, such as duty of care and care practice, that have to be looked at separately. Because people feel that they have a responsibility, this does not necessarily mean that they will put it into practice.

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About the author

Lieve Vanderleyden obtained a PhD in Social Sciences at the Catholic University of Louvain and a qualification in Social Gerontology. She is affiliated with the Research Centre of the Flemish Government as a senior researcher and editor. She is also a member of the editorial board of Gerōn and Sociaal.Net (Flanders).

Translation: Angelique van Vondelen

Italy

Elder care by migrant workers in private households

DEBORA GIAMPIERI & GIOVANNI LAMURA

Migrant workers who are hired by private households play an increasingly important role in long-term care in Italy. This article discusses the ins and outs.

Italy is, after Japan, the oldest country in the world in terms of share of the older population on the total (i.e. aged either 60 years or older: 28.6%; or 80 years or older: 6.8%; United Nations, 2015). This means that the demand for long-term care (LTC) is comparatively high. Traditionally, in case of need older Italians have always preferred to be cared for by family members (mainly wives and daughters), rather than refer to residential or home care services. In the last two decades, however, a new phenomenon has deeply changed the Italian LTC sector: the increasing role of care workers who are privately employed by older people. In most cases, they are migrants and mainly women. In this article we analyse the phenomenon, and its recent developments.

Figures and trends

Of the 2.7 million older Italians in need of LTC, only just over 200.000 use residential care facilities (1.8% of the population over 65), compared to 2.5 million living and receiving care at home (Censis, 2015). In an increasing number of cases, the latter group has limited access to home care services (which reach only 5,6% of the population over 65), and generally quite a limited number of hours per week (Barbabella et al., 2015). Although there are no exact and reliable figures on the number of care workers privately hired by families with the specific purpose of providing care to an older person, available estimates report that in 2011 over 2.6 million Italian households (10,4% of the total) have privately employed someone to provide household-based services (such as housekeeping, personal and elder care or babysitting; ISTAT, 2014). In combination with this figure, we should consider that officially 945.000 domestic workers (the professional category that closely approximates that of a personal assistant in daily care) were registered in 2013, of which 80% had a foreign nationality and a similar share was represented by women (INPS, 2014). Other estimates, however, hint that this number amounts to over 1,65 million domestic workers, including those hired as undeclared staff. This represents a jump of 53% compared to the 2001 figures, with projections suggesting that their number might reach over 2,15 million workers by 2030 (Censis and Fondazione ISMU, 2013).

The reasons behind this phenomenon

The number of migrant care workers privately employed by Italian households finds its origin, on the one hand, in the availability of a large reservoir of cheap labour force coming especially from Eastern Europe in the 90s and in the first decade of the new millennium, following the collapse of the Soviet Union (what

we might call a *push factor*). At that time, the Italian border was most easily crossed along the former 'iron curtain' between Eastern and Western European countries. On the other hand, the growing number of older Italians in need of care was becoming an increasing challenge for the traditional familial model, which was based on care provided mainly by women in their 50s (i.e. daughters and daughters-in-law of the person who is cared for), but who had been entering the formal labour market more and more (what we may consider as *pull factors;* Lamura et al., 2009). In this perspective, the extensive presence of migrant care workers has relieved many Italian women from the burden of everyday care for their own older parents and relatives, allowing them to remain actively engaged in the labour market (Censis, 2015). However, an additional, peculiar aspect is the approach adopted by Italian policy makers, who considered this 'revolution from the bottom' not so much as a trend to be fought, but rather as a development that had to be facilitated further via a series of financial and other legal measures.

Financial and legal measures

Generally speaking, the employment of (migrant) care workers by households is based on the private purchase by the latter of care services performed by individuals. This is mainly funded through the personal income of the household members (i.e. the older person receiving care, but often also of his/her caregivers) – for a total expenditure which currently reaches over 9 billion euros per year – and integrated by cash-for-care payments (Censis, 2015).

These payments are a longstanding component and feature of the Italian welfare system. Since the early '80s Italian citizens who are no longer independent (as assessed by local assessment units) have the right to apply for either a disability pension (if they are at working age, until 65) and/or for a care allowance (at any age above 18). The latter is a *yes/no* benefit (it has no intermediate levels, either all or nothing), and amounts to circa 500 euros per month. In 2014, over 12% of older Italians benefitted from such a measure (with a strong regional variation), for a total amount of 9,6 billion euros, equivalent to almost half of the whole public LTC expenditure (Censis, 2015). In addition to these benefits provided by the State, many municipal, provincial and/or regional administrations pay local allowances between 200 and 500 euros (in many cases these are integrated and paid on top of the State allowances) to low income families, often with the explicit purpose of preventing undeclared working conditions (see below), and in combination with accreditation and training schemes for migrant care workers (Barbabella et al 2013).

The combined effect of the different benefits allows many older Italians with a severe disability to count on allowances that accumulated from 500 to1000 euros per month. This amount is not accidentally close to what is often paid to migrant care workers who are hired on an undeclared basis as live-in care staff (they cohabit with the person they care for, sharing board and lodging). In addition to the monetary benefits, households that regularly hire a care worker can deduct taxes up to 1.550 euros per year for the social contributions paid, while low-income households (less than 40.000 euros per year) can also deduct 19% of the salary paid (up to 2.100 euros per year).

Migrant care work in times of crisis

Despite the benefits made available by national and local welfare schemes, the costs of employing a (migrant) care worker are to a large extent still paid by the households. According to available estimates, only about 31% of all households employing a care worker receive public support (20% the State care allowance and 9,4% by fiscal deduction; CENSIS and Fondazione ISMU, 2013). Under such circumstances, it is no surprise that, in the last few years - which were characterised by the longest and deepest economic crisis since the Second World War - the role of migrant care work in the Italian LTC system has also been affected and has started to change. More and more Italian families actu-

ally report financial difficulties, and 561.000 households state that, in order to ensure appropriate care for their dependent older members, they have been forced to either break into their savings, run into debt or sell their own home (Censis, 2015). An additional 910.000 households report they have been making economic sacrifices to meet the expenditures related to the LTC needs of older family members. This includes payments to privately employ migrant care workers, especially if they are hired on a regular basis with a fixed-term (and therefore more costly) contract.

The empirical evidence seems to indicate, though, that only a minority of migrant care workers are hired on a regular basis. Because of financial reasons, not many Italian families are prepared anymore to stipulate a regular contract with them (Pasquinelli and Rusmini 2013). This is partly due to the fact that the available fiscal deductions are considered too limited in their extent (as they cover only part of the additional costs of the social contributions). Another reason is the obligation to hire care workers from a list of accredited ones (a step which is often required to receive local benefits). This prevents families from choosing their own care worker, while they would rather select one by word of mouth as this is considered to be the most reliable way to ensure that the employed care worker is a valuable one (Pasquinelli and Rusmini, 2009; Tidoli and Marotta, 2011).

It can therefore be stated that this phenomenon – which is actually quite common to many other countries and especially (but not only) to the Mediterranean area – rests mainly on a structural, reciprocal convenience for the two parties involved. That is to say, families pay less and care workers receive more for the same number of working hours - a vicious circle that has become stronger by the economic recession (Pasquinelli, 2012). A recession which, it has to be underlined, has recently caused more and more Italians to (re) enter this sector as care workers, as a result of the difficulty to find jobs in other areas. It also suggests that this not entirely new segment of the Italian welfare system - once considered a temporary solution to the lack of appropriate and timely responses by Italy's LTC sector - is now likely to remain a structural component of it for a long time.

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About the authors

Debora Giampieri & Giovanni Lamura are affiliated with INRCA (National Institute of Health and Science on Ageing), Ancona, Italy.
Website: *www.incra.it*
E-mail: *g.lamura@incra.it*

Who cares in Europe?

DEBBIE VERBEEK-OUDIJK, ISOLDE WOITTIEZ, EVELIEN EGGINK & LISA PUTMAN

Recent reforms in Dutch long-term care have brought about a transition from publicly financed care to unpaid care. This means that older people in the Netherlands have a greater responsibility to try and arrange care themselves or with the help of their family before turning to publicly financed care. By making an international comparison, we will put the Dutch long-term care system into a European perspective.

A comparison of long-term care in Europe

Reforms in Dutch long-term care are aimed at enabling older people with disabilities, who need support with daily living activities over a prolonged period of time, to live independently as long as possible with the help and support of their own social network. By comparing the Dutch situation to that of other European countries, we get a grasp of where Dutch long-term care stands in Europe. We compare the Netherlands with fifteen other European countries (Verbeek-Oudijk et al., 2014). In this way we can study a wide range of different care systems. We use data from the 2011 Survey of Health, Ageing and Re-

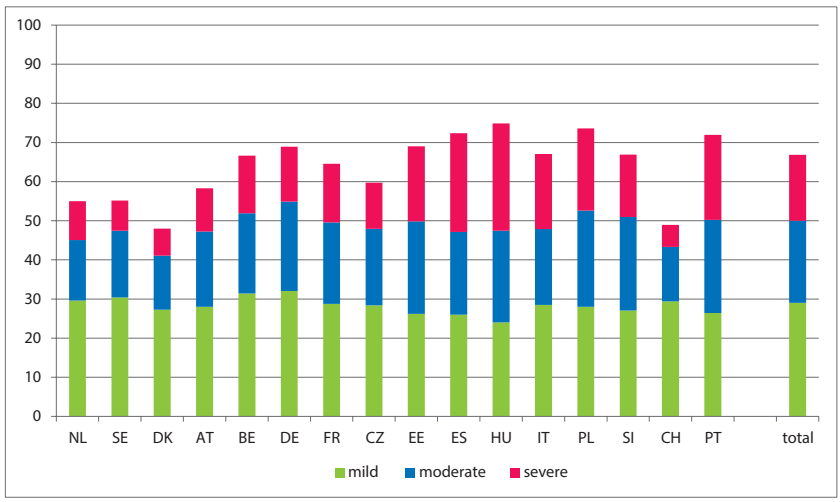

Figure 1. Percentage of people over 50 with impairments in different EU-countries, 2011 (Source: SHARE 2011, edited by SCP)

tirement in Europe (SHARE) about the care situation of people who are over 50 and who *live independently* . This means that we focus on home care, which includes domestic help, but also nursing facilities and care services that are delivered at home. We do not take into account residential care.

Physical, psychological and cognitive impairments

When people grow older, they will need more care. The ageing of the population in the Netherlands is still in its infancy. It is to be expected that the ageing of the population reaches its peak around the year 2040. By that time, the percentage of older people in the Netherlands will equal the European average.

Impairments also play a role with respect to the need for long-term care. These include both physical impairments (for instance in daily living activities such as personal hygiene, preparing a meal or mobility) and psychological impairments (feeling depressed) or cognitive impairments (memory loss). Of all the people over 50 in the Netherlands, 55% have impairments and about 10% suffer from severe impairments (Figure 1). This percentage is less than average, which is also the case in Northern-Europe and Switzerland. Poland, Spain, Portugal and Hungary however, show a much higher percentage of people with impairments.

Family networks

When it comes to providing support to older people in need of help, family members – partners or children - seem to be the most obvious persons. However, they are not always in a position to offer this support. For instance, when the partner of the person in need of care also has health impairments. Or when the children have fulltime jobs, do not live close enough to their parents or need to look after their own small children. In this respect, almost 70% of the Dutch population over 50 have access to a family network which is not inhibited from giving support (Figure 2). This percentage is higher than in almost any of the other countries. Even though there is no impediment for the members in the family network to provide care and support, this is not a guarantee that they will actually do so. The family network in the Netherlands mainly consists of the partner of the person who is in need of care. This makes the network fragile, as the partner in question could become dependent on care as well. What is more, unpaid caregivers are often overburdened already (Oudijk et al., 2010). It is therefore important not to expect too much

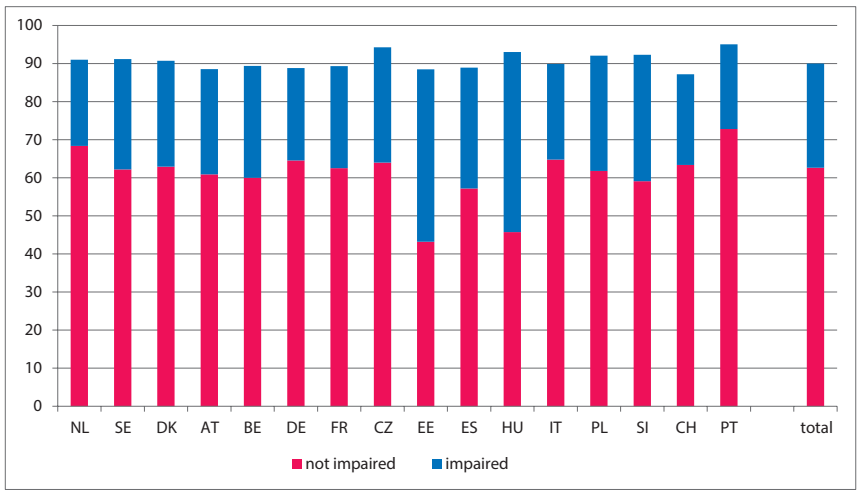

Figure 2. Number of people over 50 with a family network that is (not) inhibited from providing unpaid care, 2011 - in percentage (Source: SHARE 2011, edited by SCP)

of the reforms in Dutch long-term care with respect to the potential of the family network.

Paid and unpaid care

The over 50s who are in need of care will receive either paid or unpaid care. Paid care consists of publicly financed care, but also of private care arrangements. On estimate, 64% of the Dutch people over 50 receive paid and/or unpaid long term care; this more or less equals the average of all the countries in our study (Figure 3). The use of paid care in the Netherlands is about 10% – which is above the average (7.5%) – and equals that in Northern and Central-European countries. However, the use of unpaid care in the Netherlands is relatively low – just over 60% – especially when compared to most Southern and Eastern European countries. A relatively large number of people in the Netherlands receive both paid and unpaid care. This suggests that these forms of care are complementary in this country. In other countries, such as Germany, people generally receive either one or the other form of care and it seems that here paid care can be replaced by unpaid care.

The quality of Dutch public care is high (Biró, 2013). However, the growing tendency to resort to unpaid care seems to involve a risk: this could become detrimental to the high quality of the present Dutch public care. A good interaction between paid and unpaid caregivers is therefore essential.

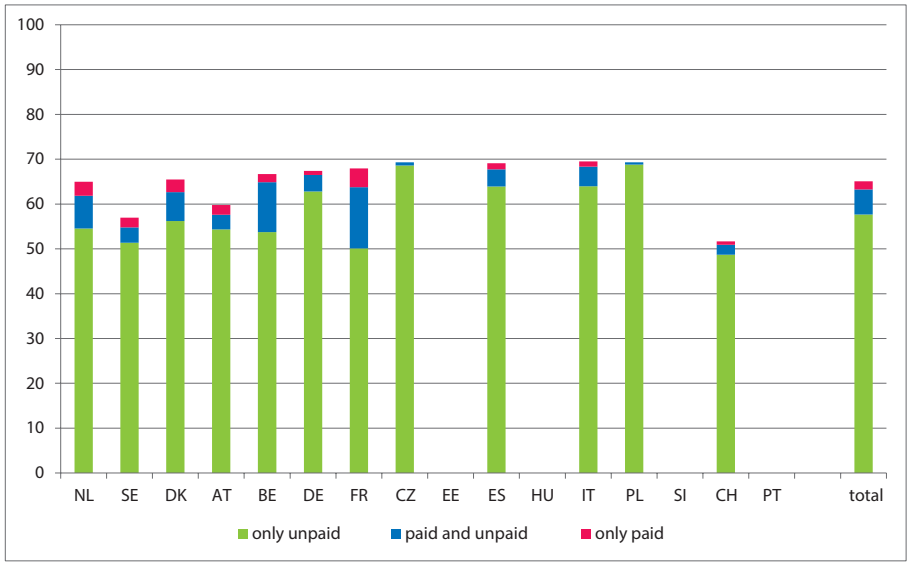

Figure 3. Estimate of the use of paid and unpaid care by people over 50 in 2011a,b (Source: SHARE 2007, 2011, edited by SCP)

a For Estonia, Hungary, Slovenia and Portugal no data were available for the year 2007. It was therefore impossible to present estimates for these countries with respect to paid care. They do not play a role in the average percentages indicated in the column marked 'total'.

b De data on paid care in the database of 2011 were incomplete, so the percentages are based on estimates.

The percentage of people that received paid care is derived from the percentage of people that received unpaid care in 2011, and the ratio (per country) between paid and unpaid care in 2007. The overlap between paid and unpaid care in 2011 is derived from the share of the people that received paid care in 2007, that also received unpaid care (per country).

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About the authors

Debbie Verbeek-Oudijk, Isolde Woittiez, Evelien Eggink & Lisa Putman are affiliated with the Netherlands Institute for Social Research and conduct research into long-term care.

Translation: Angelique van Vondelen

Towards a European strategy on informal care

Enabling carers to care

CHRISTINE MARKING

Addressing challenges in long-term care will require a comprehensive approach covering both policies for informal carers as well as policies addressing the formal provision of long-term care services and its financing.

Carers are defined as persons of all ages who provide care (usually unpaid) to someone with a chronic illness, disability or other long lasting health or care need, outside a professional or formal employment framework.

Research has pointed out that approximately 80% of care across the European Union (EU) is provided by families (spouses, parents and children) neighbours and friends. Even in countries with a well-developed supply of formal long-term care, the number of informal carers is estimated to be at least twice as large as the formal care workforce. Informal care provision is under pressure due to a combination of various demographic and socio-economic developments (such as lower birth rates, smaller families, increasing mobility, greater physical distances between relatives, the rising number of women entering the labour market, prolonged working life due to delayed retirement, et cetera). Rapidly increasing strain on carers is the result of the growing demand for care, the increasing shortages of formal caregivers and a decrease in the unpaid care potential. Sustainable care provision is rapidly becoming a major issue in the majority of EU Member States.

Caring for a loved one can be a source of personal satisfaction and emotional gratification. It can also – if not adequately supported – have many challenging consequences for carers, such as an impact on the (physical and mental) health and well-being, social participation, integration and inclusion, financial difficulties and even poverty, due to cut backs in social provision and direct costs of care. Moreover, difficulties in relation to balancing paid work with care responsibilities can impact on labour market participation and social protection rights later in life. For young carers, caring can have a negative impact in terms of natural socialization processes as well as their formal education and a significant impact on family relationships and employment prospects in later life.

Providing informal care can also have negative consequences for society and the economy, as it can result in lower productivity for those carers who combine care and work in an unsupportive environment. It can also lead to increasing health and welfare costs, due to carers' physical and mental health problems.

Rationale for an EU-level strategy on carers

All Member States are facing the same challenges in terms of long-term care provision, both with respect to the development and implementation of effective care provision

models as well as in relation to financial sustainability. While care provisions differ greatly between (and sometimes within) Member States, it is clear that all countries need the resource provided by informal carers to prevent a collapse of the entire care system. Fortunately, recognition of the importance of carers and their contribution to care and well-being, society and the economy as a whole, is slowly on the increase: some EU member states have specific policies for carers or carers' strategies in place.

However, the fact remains that health and long-term care provision remain the responsibility of the Member States themselves. The current EU Treaties leave the EU institutions with limited possibilities for action in these areas, as Member States feel that these areas are best addressed at national level. Yet, there is a growing recognition that the challenges posed by the provision and financing of long-term care are the same for all Member States, and therefore, that there is the potential for mutual learning and cooperation. The great variation between Member States in terms of care provision models and the roles of formal and informal care within these, means that there is a huge potential for exchange of experiences and ideas and good (as well as bad) practices.

This recognition is reflected in the fact that, at EU-level, both the European Parliament and the European Commission have made efforts to put carers and their issues on their policy agendas:

- The Parliament has supported direct references to carers under the EU's PROGRESS programme (now called EASi) budget lines since 2011; the European Parliament Interest Group on Carers is continuing to act as a forum for discussion on EU policy, assessing the impact of EU policy developments on carers. This group was set up and is coordinated by Eurocarers, the European organization advocating on behalf of carers.
- The European Commission is concerned too; carers and their issues have been explicitly referred to in three major initiatives over recent years, i.e. the European Innovation Partnership on Active and Healthy Ageing, which explicitly targets carers as one of the main stakeholder groups; the Employment Package, which includes a specific policy paper on the employment potential of household and personal services; and the Social Investment Package and its Staff Working Document on Long-Term Care, explicitly recognizing the huge contribution of carers and acknowledging their main issues and challenges. While this is to be welcomed, more action is needed to ensure that carers receive the recognition and support to enable them to keep on providing care.

As the impact of being a carer can be felt in many different areas and at different times of life and work, this action - a comprehensive EU-level carers strategy - should be multi-dimensional and longitudinal. It should address:

- social inclusion and societal participation of carers;
- accessible and reliable information and advice to promote self-care and self-management solutions in family care;
- emotional support and counseling;
- practical support;
- respite breaks for carers;
- health promotion and protection for carers in health services and delivery;
- measures that enable working carers to combine their care and work responsibilities;
- ensuring that carers do not lose their financial and social security rights as a result of their caring responsibilities;
- training in core caring skills;
- information and communication technology (ICT) products and services;
- empowerment and capacity building of carers and their representative organisations.

While the EU remit in the field of care provision is limited, as outlined above, the EU has a number of 'tools' that could be used to facilitate recognition and support for carers:

Inclusion of carers issues in health and social policy development: mainstreaming

The fact that the European Commission is referring to carers in the Active and Healthy Ageing Partnership, the Social Investment Package and the Employment Package is a useful start. Nevertheless, carers and their issues could be included more explicitly in a number of further current and future programmes and initiatives for employment, health programming, disability strategies, assisted living programs, gender- and youth policy etc.

Awareness-raising

A specific EU action programme on carers could be put in place, based on previous EU-level action programmes e.g. on ageing, disability, etc. This could ensure and coordinate an effective exchange of information, experience and good practices between relevant stakeholders. Another option would be to consider designating one of the coming years as the European Year of Carers.

Financial support

A number of these initiatives hold the potential for funding. This funding could contribute to capacity building of carers in relation to provision of support (e.g. emotional support, exchanges) and advocacy (e.g. policy development, practical solutions). It could also support exchange of information, research and networking.

Data collection and monitoring

The Horizon 2020 research programme could include research on carers in future calls for proposals under the action 'Tackling Societal Changes', section 'Health, demographic change and well-being'. This research could be built on earlier major EU-funded research projects such as Eurofamcare, thus allowing for an updated picture of the achievements and challenges characterizing this crucial area of EU-citizens' life.

Legislative measures

While most of the legislative competence in the relevant areas lies at the national level, there are some areas where legislative action could be taken, such as legislation relating to carers leave and retraining and re-entry into the labour force. Action in other areas could be explored and experiences disseminated between countries, while recognizing and respecting the principle of subsidiarity.

Inclusion of carers in relevant consultations, fora and advisory boards

Carers and their representative organizations could be included in social and health consultations as well as in relevant fora and advisory boards as a relevant stakeholder. This could help assess proposed policies and initiatives for their impact on carers and their cared for persons.

As the information and data reported above clearly show, sustainable health and care provision systems simply do not work without carers. Carers are:

- a highly relevant stakeholder group in society, providing day to day care provision for those in need of care (of all ages) and, at the same time,
- the largest contributors to the sustainability of our health and social security systems.

If carers are expected to keep providing care – and they are – their needs and requirements should be an inherent part of health and social policy development, and their contribution should be properly considered as part of the economic equation.

About the author

Christine Marking (Brussels) is EU-level health, social and older people's policy consultant, working for various patient and health organisations and companies. She works as Policy Advisor to Eurocarers and coordinates the European Parliament Interest Group on Carers.

cmarking@skynet.be

Training enhances quality care in Europe

WeDO too!

SOFIE VAN REGENMORTEL, LIESBETH DE DONDER, DENNIS VAN DEN BRINK, HENK SMETS, LENA HILLENGA EN JOSÉ BROERS

Rights of older people in long-term care situations are sometimes violated, which might lead to elder abuse. WeDO2, a European project concerned with the Wellbeing and Dignity of Older People developed a training to keep on improving quality in care.

Working on quality care

In Europe there are different projects that take the ageing population as a starting point. An EUropan Strategy to Combat Elder Abuse (EUSTaCEA), WeDO and WeDO2 are three examples of such projects. Furthermore these projects build on each other. All three projects aim to (1) guarantee the rights of older people in need of long-term care, (2) enhance the quality of long-term care and (3) fight elder abuse in care situations.

The European Charter of the rights and responsibilities of older people in need of long term care and assistance (EUSTaCEA project, 2008-2010) states that: "*Human dignity is inviolable. Age and dependency cannot be the grounds for restrictions on any inalienable human right and civil liberty, acknowledged by international standards and embedded in democratic constitutions. Everybody, regardless of gender, age or dependency is entitled to enjoy these rights and freedoms, and everybody is entitled to defend their human and civil rights.*" Advancing in age does not involve any reduction of a person's rights, duties and responsibilities but it is possible that a person could end up in either a permanent or temporary state of incapacity and is therefore unable to protect his/her own rights. As we grow older and may come to depend on others for support and care we continue to have the right of getting respect for our human dignity, physical and mental wellbeing, freedom and security. It is our shared responsibility to promote and protect these rights as stated in the EUSTaCEA document.

The European Quality framework for long-term care services (WeDO project, 2011-2012) introduces 11 quality principles and 7 areas of action that define what quality care is and where effort is needed to guarantee the wellbeing and dignity of older people in need of long term care and assistance.

Belgium launched this quality framework on the 18th of February 2014 and it was signed by five ministers.

Working on quality care, a never ending story

To further quality care and meanwhile building on the EUSTaCEA charter and the European quality framework, the European partnership WeDO2 was created. This partnership, funded by the Grundtvig programme, comprises 8 organisations from 7 different countries (Austria, Belgium, Germany, Greece, Poland, Netherlands and UK), and one European organisation (Age Plat-

Quality principles – A quality service should be:

1. Respectful of human rights and dignity
2. Person-centred
3. Preventive an rehabilitative
4. Available
5. Accessible
6. Affordable
7. Comprehensive
8. Continuous
9. Outcome-oriented and evidence based
10. Transparent
11. Gender and culture sensitive

Areas of action – A quality service should contribute to

1. Preventing and fighting elder abuse and neglect
2. Empowering older people in need of care and creating opportunities for participation
3. Ensuring good working environment and investing in human capital
4. Developing adequate physical infrastructure
5. Developing a partnership approach
6. Developing a system of good governance
7. Developing adequate communications and awareness-raising

form Europe). Each partner is engaged to strengthen stakeholder's (e.g. older people, formal and informal care providers, volunteers and professionals) ability to participate in the process of long term-care and consequently in combating elder abuse. Besides, the partnership aims to foster learning experiences between organisations in the field of formal, non-formal and informal adult education.

To contribute to quality care in long term care, the partnership developed and tested an innovative train the trainer toolkit about quality care. The training is flexible, can be adapted and used for various groups (older people, formal and informal caregivers, volunteers) and in different fields. The training is based on the two former projects that are described above.

The WeDO2 train the trainer toolkit was created using a co-creative methodology in the complete process from concept to implementation: from the development of the content of the trainings to testing and evaluating the training, etc. The WeDO2 train-the-trainer toolkit is freely available in 7 languages and downloadable from: *http://wedo.tttp.eu/quality-care-training-package*. The quality care training package includes: an introduction guide, a manual for trainers, and the training material itself (e.g. movies, pictures, quiz questions,).

The WeDO2 toolkit is aimed at everyone. It will be of particular interest to those who are linked to or engaged with providing services to older people and are committed to improving the quality of life for older people in need of care and assistance. This includes family and friends as well as small locally run groups and clubs, regional organisations, national bodies and Europe wide establishments. These target groups can be both learners and become trainers themselves.

European exchange

To stimulate learning experiences between partners, the partnership first collected and presented good practices of training material on quality care on the first transnational meeting in Brussels (November 2013). Besides, six study visits were done between November 2013 and June 2015. For these study visits, the partnership focused on good practices concerning quality care. Various initiatives were visited, both residential care services and supporting services regarding health, wellbeing and social services at home. The partnership visited for instance domaine des Rièzes et Sarts à Couvin, a *living home* in Belgium where human beings are central and not the care they receive, and Hogeweyk in the Netherlands, a living arrangement for people with dementia who live according to different life styles. In Greece the partners

gained insight in how Nestor Psychogeriatric Association supports older people and their informal caregiver to enable them to continue living at home by using a holistic approach.

A WeDO2 movement?

In total, the partnership tested the toolkit in more than 30 trainings. To date, the training and project influenced the participant's ability to think and talk about their expectation of and vision on quality care. Furthermore participant's vision on quality care was enlarged and made them realize "*that it can be different*". The next quote illustrates how the training changed the view of a geriatric nurse in a Belgian care home:

"WeDO brought a new, innovative perspective to quality care. In my professional life I am responsible for quality control, but I mainly have to focus on medication safety and the physical aspects of care. When talking about 'quality care' it was about feeling at home, happy, having freedom of choice, etc. Things that at this point don't have our full attention. We say we often lack time for this or 'it is not possible in a nursing home', but in the workshop I heard several examples that did work."

Besides, the project and the training also raised the awareness of older people that they have rights and the importance of intergenerationality. A Greek older participant suggested: *"Our children/young people should be the ones to be aware of these rights, they should get the same training."* Because this opinion was shared in other countries, the partnership decided to involve society and youngsters as target groups of the training as well. Finally, efforts of the Polish partners resulted in political support to finance the project in Poland and to include the training in the curriculum of schools in the province Lublin.

Although the project has ended, working on quality care still continues. The partners will distribute the training material in their own country. What is more, new countries will be involved in the future.

Further information

http://wedo.tttp.eu/wedo2

LOC Zeggenschap in zorg is committed to the improvement of quality in care in the Netherlands, based on their vision on valuable care. Valuable care is about the values of (care dependent) people. For more information you can contact the WeDO2 project leader (*d.vandenbrink@loc.nl*).

Website Dutch partner: *http://loc.nl*
Website Flemish partner*: http://www.belgianageingstudies.be*

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About the authors

Sofie Van Regenmortel & Prof. dr. Liesbeth De Donder work at the Free University, Brussels and are both members of the research group Belgian Ageing Studies. *Dennis van den Brink, Henk Smets, Lena Hillenga & José Broers* are affiliated to LOC Zeggenschap in zorg.

A look behind the (former Iron) Curtain

Palliative care in Europe

MARINELA OLĂROIU

A resolution by the Council of Europe in 2008 was a major boost for palliative care. Palliative care should be an integral part of health care policy of each member state of the Council. In Central Eastern Europe palliative care is often a luxury, if available at all.

Transitions in Healthcare in Central Eastern Europe after 1989

After the opening of the Iron Curtain, many Central Eastern European countries transformed slowly, and often painfully, into a social health insurance system and have tried - on the advice of the World Bank – to strengthen primary care, to reduce the many hospital beds and to privatise health care delivery. At the same time they cut back tax-based costs in health care. These changes - or at least attempts - in countries such as Bulgaria, Hungary, Poland, Romania and Slovakia brought a lot of uncertainty, especially for old people. In addition, old habits remained (payment under the table, priority treatment through connections) as well as old traditions such as family care (Tambor, 2013).

Bulgaria, Poland and Romania have the lowest health care spending as a percentage of the gross national product (<7%) in Europe. There is a shortage of doctors and nurses (who, once educated, prefer to work abroad). In Bulgaria and Romania, the number of old people is growing fastest, whereas the share of young people decreases (Ghinescu 2014).

The health care system is malfunctioning in many Central Eastern European countries and particularly frail older people and those with a chronic illness, are its victims. The national health insurance only reimburses a limited number of medications and laboratory results. If patients need more, they need to supply these themselves. There is hardly any home care or respite care and palliative care is piecemeal, often made possible by support from foreign charities. It is up to the family to find a solution to the many problems that arise when someone needs long-term care.

Poor health of people living at home

The health status of the older generation in Central Eastern European countries is poor compared to that of Western European countries. Research among older people in Croatia, Poland, Romania, and the Netherlands showed that those who live at home in the first three countries have more difficulties in performing daily activities than the Dutch who live at home. Besides, the subjective and psychological health of the older generation in these three countries is worse than in the Netherlands and the number of self-reported chronic conditions were more frequent (Ghinescu 2014).

In Romania, for example, frailty of older people who live at home is significantly higher than in the Netherlands: an average frailty

score of 5.5 and 3.4 respectively, as measured by the Groningen Frailty Indicator. A score of 4 or more is considered frail. The average score of frailty among older Romanians who live independently comes close to Dutch older people who live in a care home or nursing home (5.5 respectively 6.0; Olăroiu 2014). This is not surprising because there are only a few care homes and nursing homes in Romania, so frail older Romanians do not have much choice. Caring for ill and dependent persons is a family duty.

Development of palliative care in Central Eastern Europe

At the beginning of this century palliative care has been developed in Central Eastern Europe with funding from Western European countries, often through charity funds and non-profit institutions. Projects were funded to teach doctors and nurses competencies in palliative care. Many doctors, particularly general practitioners, acknowledged that their knowledge and skills concerning palliative care were inadequate. Moreover, with the help of the European Department of the World Health Organization, legislation was adapted in order to provide better access to resources for pain control in terminally ill patients.

Foreign grants also ensured that palliative care could actually be delivered, in general on a small scale, for example in a department of a hospital. In the last ten years, this development has continued, but there are still large differences between European countries, as is shown by the Global Atlas of Palliative Care (Connor, 2014; see Table 1).

Most palliative care services are available in Northwest Europe. The number of facilities per 1 million inhabitants amounts to approximately 15. Countries have different models of palliative care. In West-European countries various types of facilities are used. In Central-Eastern European countries, there is often either institutional care or home care. This partly depends on the foundations that helped set up palliative care, and partly on the presence of a well-organized primary care. In Central-Eastern European countries palliative care has (slowly) been developed over the last decade, with sometimes spectacular results such as in Poland. There is a clear correlation between palliative care provisions and the

Table 1. Number and types of palliative care provisions in selected European countries, in 2013

Country	Hospice	Home care team	Hospital unit	Mixed provision	Total provisions	Provisions per million inhabitants
West-European countries						
Belgium	2	28	165	0	195	18,7
Netherlands	55	44	157	0	256	15,4
Sweden	11	94	27	26	158	16,6
Switserland	6	19	33	3	61	7,1
United Kingdom	189	337	339	104	969	15,4
Central-East European countries						
Bulgaria	22	15	5	8	50	6,6
Croatia	0	4	0	0	4	0,9
Hungary	1	69	15	0	85	8,5
Poland	137	321	16	2	476	12,4
Romania	11	15	16	0	42	1,9
Slovakia	10	0	1	0	11	2,0

socio-economic development of a country. This is true in Europe as well as worldwide.

In Western European countries, palliative care is part of the medical curriculum. In Central Eastern Europe, it is not. However, there are 'elective' courses in some education programmes and there are training programmes for doctors and nurses – following their professional education - to gain competencies in palliative care. In Poland and Slovakia, palliative medicine is a sub specialisation.

The European Association for Palliative Care (EAPC) has developed a benchmark, the EAPC Index with a maximum score of 100, in order to compare palliative care between European countries. Given the above, it may be expected that there are clear differences within Europe. Western European countries score highest on the EAPC index. Sweden and the Netherlands, for instance, score 84 and 81 points respectively, Poland 77 points, and Hungary and Romania 44 and 40 points respectively. Romania comes in 22th place in Europe.

Another notable difference between Western and Central-Eastern European countries is the role of volunteers in palliative care. In Western Europe, volunteers play a major role in shaping palliative care and they are selected, trained and coached. In Central-Eastern European countries volunteers play no role in palliative care. Attempts to set up volunteer networks usually fail. It is up to the family to take care of the terminally ill.

Lack of expertise and support

Palliative care is slowly developing in most of the European countries that were formerly behind the Iron Curtain, but it is not (yet) part of the regular health (care) policy. The resolution of the Council of Europe remains without response in many of these countries. Because structural solutions fail to appear, the supply of palliative care is insufficient and the most vulnerable people in society, including many elderly people, suffer unnecessary.
Major barriers are a lack of political support, the absence of training programmes in the regular professional training of doctors, nurses and social workers, limited reimbursement for drugs and inadequate funding for palliative care provisions.

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About the Author

Dr. Marinela Olăroiu was trained as a medical doctor in Romania, where she obtained a PhD and worked as a general practitioner for 20 years. In the Netherlands, she specialized as a nursing home doctor (specialist in geriatric medicine) and worked eight years in various health institutions. Between 2002-2009 she was stimulating palliative care in Romania with support from the Dutch Ministry of Foreign Affairs. She is editor of the online journal PALIATIA and editor of the Romanian Handbook on Palliative Care.

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Arbeidsmarkt:
Peter de Jong, Sr. Accountmanager
Telefoon: 030-6383888/06-10946138
E-mail: p.dejong@bsl.nl

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