Values on a grey scale

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Elderly Policy Monitor 2008

Cretien van Campen (ed.)

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Foreword

The theme of this year's Dutch Book Week, 'Old people...' (a reference to the Dutch naturalist novel *Old people and the things that pass*) and the debates which ensued from it, demonstrate yet again the wide diversity of perceptions of older people in society, ranging from older people enjoying a comfortable and worry-free 'Swiss Life' existence to neglected older people suffering from poor care nursing homes. The population aged 55 years and older which form the subject of this report encompasses several generations: workers, pensioners in the third phase of life and people in need of care who live at home or in an institution.

Policy discussions have concentrated not so much on this diversity as on the growth in the size of the older population – by 2030 a quarter of the Dutch population is projected to be aged 65 years or older. 'Population ageing' was the theme of this edition of the Report on the Elderly (Rapportage ouderen), which differs completely from previous editions. At the request of the Dutch Ministry of Health, Welfare and Sport (VWS), the Netherlands Institute for Social Research | SCP examined the results of the policy on the elderly over the last two years and explored how the results of that policy might be periodically monitored in the future.

A large number of databases were consulted in compiling this report, including those held by the Netherlands Institute for Social Research | SCP, Statistics Netherlands (CBS), TNO and the Ministry of Housing, Spatial Planning and the Environment (VROM). For the chapter on health we drew on data compiled by the Dutch Consumer Safety Institute (Stichting Consument en Veiligheid). We would like to thank Huib Valkenberg, Coby Draisma and Dr Marco Brugmans from the Dutch Consumer Safety Institute for their analyses of the data on fall incidence, and Dr W. Ooijendijk and Dr K. Vermeulen from TNO for supplying data on healthy mobility in the elderly. For the chapter on dying with dignity we are grateful for the expert advice received from Inge Jansen from Demeter hospice in De Bilt, Dr Anneke Francke and Dr Patriek Mistiaen from the Netherlands Institute for Health Services Research (NIVEL) and Professor Luc Deliens from VU University Amsterdam and the Vrije Universiteit Brussel. Thanks are also due for their constructive cooperation and useful suggestions to the civil servants working in the departments we consulted during the project.

Prof. Paul Schnabel
Director SCP

Summary

In 2005 the Dutch government set out its policy on the elderly against the background of population ageing in the policy memorandum *Nota '64' Ouderenbeleid in het perspectief van de vergrijzing* (TK 2004-/2005b; henceforth 'Memorandum 64'). The underlying principle is that the elderly are 'sovereign and valuable citizens, even if important resources for an independent existence disappear at some point in their lives'. The government derived basic values from this Memorandum in relation to health, contribution to society, purchasing power, mobility, housing, care dependency and end of life. The government wishes to reinforce these values and set out a number of policy objectives in the Memorandum, complete with targets, in order to achieve this. The government's intention is to track the achievement of the targets by means of an Elderly Policy Monitor (Monitor ouderenbeleid) published every two years.

The coordinating Ministry of Health, Welfare and Sport (VWS) asked the Netherlands Institute for Social Research/SCP to compile a first Monitor as a trial edition. The SCP remit was not only to test the extent to which the targets set out in the Memorandum have been achieved, but also to develop the Monitor further.

Memorandum 64 contains policy objectives and targets in seven domains:

1 Active contribution to society (paid and unpaid work);
2 Income;
3 Mobility (public and collective transport);
4 Housing (homes for the elderly);
5 Staying healthy (exercise, fall prevention);
6 Ensuring care for vulnerable elderly (sufficient care, quality of care);
7 Dying with dignity.

This study evaluates the targets set out in Memorandum 64 on the basis of two central questions:

1 Have the targets formulated by the government in 2005 been achieved?
2 Are the proposed indicators suitable for future monitoring or do they need improvement?

SCP in fact interpreted the remit more broadly and also looked at trends for the longer term, and where possible at subgroups of older people (e.g. 55-64 year-olds, 65-74 year-olds and the over-75s).

Achievement of targets

Paid work

The policy objective of active social participation by older people is translated into targets in relation to paid and unpaid work. The target of a labour market participation rate of 50% among people aged 55-64 by 2010 will be achieved if the increase

in the rate continues at its present pace. In 2003, 43.3 % of 55-64 year-olds were working for a least one hour per week; this had risen by more than three percentage points in 2006, to 46.7%. Analyses over a longer period show that the activity rates of men and women in this age group have developed differently. The turnaround in the labour market participation rate of working men aged 55-64 years began to change in around 1993/94, when the Dutch economy began to climb out of the economic decline. The activity rate of older women has by contrast shown a rising trend since the middle of the 1980s, though the starting level was very low.

Unpaid work
In addition to paid work, participation in unpaid work by volunteers is one of the policy objectives. The commitment to maintaining a constant share of volunteers among the over-65s has not been achieved in recent years. An analysis of long-term trends shows that, following an initial increase, the proportion of volunteers began to fall after 2002. The decline in 2006 relative to 2004 appears to have taken place mainly among older people who were not members of a religious community.

Income
The policy objective that older people must have a sufficient income to enable them to live independently is translated into a target for improving the purchasing power of older people living alone living and receiving only state retirement pension. The target of maintaining the purchasing power improvement (106%) for single elderly people living alone with only state pension relative to single social assistance benefit claimants under 65 years has been achieved. Up to and including 1994, social assistance benefits and the state pension were exactly the same. In 1995 the older person's tax credit (*ouderenkorting*) was introduced, and raised substantially in 1999. Currently, in 2008, the net state pension amounts to approximately 111% of social assistance benefit.

Mobility
The policy objective that the elderly must be able to move around freely and safely is translated into targets for the accessibility of public transport. Following consultation with the Ministry of Transport, Public Works and Water Management (V&W), it was decided not to include a separate chapter on mobility in this Monitor. The Ministry of V&W has developed a new set of indicators for the long term (from 2015 to 2030) for the accessibility of urban and district transport and railway transport; these replace the indicators used in the 2005 policy memorandum.

Housing
Older people must have access to adequate housing, which is tailored to their individual needs and supported by customised care provision. This policy objective is operationalised in targets for sufficient stairless homes, where all living areas can be accessed without having to climb stairs, and homes with local on-call care facili-

ties. The question of whether the targets for adequate homes have been achieved can be answered only partially. A change in the definition means it is not possible to determine the increase in the number of stairless homes. The number of homes for the elderly with on-call care facilities ('supported living') rose from around 101,000 to approximately 129,000 between 2002 and 2006. This increase of more than 7,000 homes per year was however not sufficient to achieve the target (14,000 per year). The main increase is apparent in households containing the 'youngest' and 'oldest' elderly and in households containing a person with moderate or severe physical disabilities.

Health

The policy objective of encouraging older people to remain fit and healthy for as long as possible is translated into a target for the proportion of people aged over 65 who undertake sufficient exercise and sport, and a target for the number of falls among the over-65s. The percentage of elderly people taking sufficient exercise increased between 2000 and 2005. For people aged over 18, the norm has been set at half an hour of moderately intensive physical activity on at least five days per week. The target of 45% of people aged over 65 attaining this norm was achieved in 2004, and the target of 50% by 2010 was achieved as early as 2005. It is only in the group of over-65s who assess their health as poor that a minority (21%) achieve the exercise normal.

After correction for population profile, a downward trend in the number of falls by the elderly can be observed in the period 2002-2006. This downward trend is in line with the target reduction of approximately 6%. One exception is formed by elderly people in institutions, where the number of falls increased sharply (by 17%) in the period 2002-2006.

Care

Older people who become vulnerable due to health problems must be assured of sufficient care of good quality. This policy objective is translated into the largest number of targets: one for sufficient care (waiting list reduction for nursing, care and home care) and four targets relating to quality, in particular in relation to nursing home care. It is unknown whether the target for waiting list reduction has been achieved, due to changed definitions and changes in the way waiting list data are recorded. Two of the quality targets have been achieved; in the case of the fourth this cannot be determined. As regards measuring client satisfaction through client surveys in nursing and care homes, the target of 100% was set to be achieved in 2007. Client satisfaction was measured in 87% of nursing and care homes in 2005, well above the derived target of 71%. The first care accommodation quality target, aimed at eliminating all nursing home rooms with more than two beds by 2006, has not been achieved. In 2006, 16,200 multiple-bed units (74%) had been eliminated. With regard to the second care accommodation target, aimed at creating small-scale living units for people with dementia, the government has set a target of 20% of the total capacity of psychogeriatric care by 2010. Forecasts suggest that this target will be achieved. In relation to the demand for places for people with dementia, the

proportion of small-scale living units will increase from 10% in 2005 to 25% in 2010. The target for quality of care delivery relates to the number of nursing homes which meet the professional quality standards set by the Dutch Health Care Inspectorate (IGZ). The IGZ and the field jointly developed new standards in 2006 and 2007, which means it is not possible to determine whether or not the target has been achieved.

Dying with dignity

The policy objective of enabling people to die with dignity is translated into four targets in relation to the facilitation and organisation of palliative care: 1) integration of palliative end of life care in networks of palliative carers, 2) national coverage by palliative care consultation facilities, 3) the setting up of palliative care departments in Integral Cancer Centres (IKCs); and 4) the creation of a new role for Integral Cancer Centres. At the time of the formulation of Memorandum 64, the targets for dying with dignity had already been achieved. For targets 2 and 3, the maximum score was achieved in 2005. Target 1 had achieved a score of 91% in 2006. As regards target 4, all Integral Cancer Centres are largely or completely fulfilling their role. The four-component target for palliative care has thus been achieved.

Critique and suggestions

In response to the second question, 'Are the proposed indicators suitable for future monitoring or do they need improvement?', we observe a number of shortcomings in the target-based approach set out in Memorandum 64, and put forward a number of suggestions for improvement. The shortcomings relate to the following points:

- The *Monitor* lacks a uniform unit of measurement. The targets in Memorandum 64 are based on dissimilar figures (on supply, demand, take-up, satisfaction, phase of policy implementation).
- The targets use different time horizons, varying from 2006 to 2030.
- Different age limits have been used in formulating the targets (over-55, 55-64 years, over-65), and in a few cases no age limit is applied ('care').
- The present *Monitor* describes the achievement of targets, but does not explain why they have or have not been achieved.
- The *Monitor* does not play a signal function with respect to new developments in the life situation and well-being of the elderly.
- There is a lack of cohesion between the targets in the different policy domains, whereas from the perspective of the elderly health, work, housing, transport and care are closely interrelated in their lives.

Based on these points of criticism, we put forward a number of suggestions for improving future *Monitors*:

- Choose measurement units that are related to the perspective of the elderly (e.g. use of provisions, choice of healthy lifestyles).
- Choose targets which can reveal changes over the medium term of between two and five years.

– Use the lowest age limit of 'over-55' for all targets and three phases of life based on three age categories: 55-64 years, 65-74 years and 75 years and older. Targets do not need to apply for every age group, nor do they all need to be the same.
– Offer more explanation on the achievement of targets by showing differences between subgroups of older people and by mirroring the changes found against trends in the longer term.
– In addition to targets and associated policy-specific indicators, also use a number of generic indicators which have a signal function in revealing how the elderly in the Netherlands are faring. For example, statistical trends in the life situation and happiness of the elderly highlight the fact that the material circumstances of the elderly have improved over the last ten years, but that a reversal has taken place in the perception of the elderly since 2001.
– Use a conceptual model indicating which domains could be tracked and what the relationship between the targets is.

Tracking changes in the future

The question of how the Monitor could be improved is related to the question of which information it should provide. In concrete terms, the party commissioning the Monitor could make a number of choices on two questions:

1 On which elderly people should the Monitor provide information? (All over-55s or just the care-dependent, vulnerable over-75s?);
2 Should the Monitor provide information on the process of realising policy or about policy outcomes in terms of the behaviour and perception of the elderly?

Aside from the choices that are made, we put forward proposals on the basis of this study for substantive indicators, some of which build on the indicators contained in Memorandum 64 and some of which are new. The indicators have been arranged using the life situation model (Boelhouwer 2007) by resources, provisions, setting, life situation and participation, and subjective welfare.

The most important resources for the elderly are health, income and education. Monitoring the theme 'staying healthy', in addition to the existing monitoring of healthy lifestyle (proportion of older people who meet the exercise fitness norm) and a relevant outcome measure (proportion of older people falling in one year), could also include a generic health measure which summarises many of the health aspects that are relevant for independent functioning. For monitoring income, the present indicator for purchasing power, which applies only for a small group of single older persons living only on state old-age pension, could be replaced by two indicators which apply for the entire elderly population: 1) the proportion of older people living below the poverty line; and 2) the proportion of over-65s who have a lower standardised income than the average standardised income of people aged below 65. Education could be added as a new indicator.

Under provisions we would include the themes 'sufficient care of good quality', 'dying with dignity', 'housing provision' and 'mobility'. The key with care is that people receive sufficient care of good quality. Whether or not older people in the

Netherlands who are in need of help are receiving sufficient care can be deduced with reasonable accuracy from the waiting list records for home care, care home and nursing home places (the nursing, care and home care sector). Quality of care can be accessed from two perspectives: that of the care professionals and that of the service-users. For monitoring dying with dignity, new indicators are being developed within the Netherlands Organisation for Health Research and Development (ZonMw) palliative care programme. In the area of housing provision, we would suggest that the existing indicators for stairless homes and 'supported living', both for older people living independently, be merged to create a set of housing and care indicators with the existing quality indicators 'single-person rooms in nursing homes' and 'small-scale living units for people with dementia', thus generating a profile of four indicators for the residential setting of the elderly, both the large group who live independently and the small group who live in institutions. A new indicator would need to be developed for mobility, which portrays how many elderly people are able to travel from A to B using different forms of private, public and collective transport.

The social setting often determines how long older people are able to continue living independently. Loneliness is one of the biggest complaints of the elderly and can be measured with the commonly used scale for loneliness (De Jong-Gierveld et al. 2008).

Social participation is tracked in the present Monitor in the domains of paid work and voluntary work. An indicator for the proportion of people providing informal care could be added to this. However, participation by the elderly in society encompasses more than just paid and unpaid work. To make the picture of participation by the elderly more complete, an indicator could be added for the proportion of older people taking part in cultural activities.

Conclusion

The main conclusion that can be drawn from this report is that it is possible to track the achievement of policy objectives (and targets) using an Elderly Policy Monitor, provided a number of conditions are met. First, the targets need to be empirically based on periodic research. Second, definitions and questionnaires must not be changed in the period being monitored.

This trial edition of the Elderly Policy Monitor has been published in place of the periodic SCP Report on the Elderly (Rapportage ouderen). When carrying out the research for and compiling this trial edition it became clear that there are substantial differences of nuance between an Elderly Policy Monitor and a Report on the Elderly. Since there is no integral policy on the elderly, the translation of policy on the elderly in different domains into targets that can be monitored empirically results in a fragmented picture of divergent and dissimilar indicators. The Reports on the Elderly, by contrast, have devoted attention to the interrelationship of policy from the perspective of the older citizen and have thus highlighted new developments and problem areas in the life situation and well-being of the elderly.

1 Introduction

Cretien van Campen

1.1 Younger elderly

The elderly seem to have been getting younger and younger in recent decades. Today's older people are physically fitter than their counterparts half a century ago. The days when someone reaching the age of 65 retired, old and worn out, are far behind us. Not only have the elderly become younger in terms of their health, but also in their behaviour. It is rare today for people around the age of 65 to move to a residential home for the elderly; rather, they embark on the third phase of life or what some have called the 'second adolescence' (Knipscheer 2005). People aged 65 today were born in around 1942 or 1943, while the post-war baby boom generation will reach retirement age within a few years. The youth pop culture is associated precisely with this generation, although the culture of behaving in a youthful way has now become commonplace among the over-65s, too. The predecessor to this Monitor, the government memorandum on policy on the elderly against the background of population ageing (*Ouderenbeleid in het perspectief van de vergrijzing*), was not coincidentally dubbed 'Memorandum 64', echoing the pop song by Paul McCartney, 'When I'm 64' (the entire lyrics of the song decorated the cover of the policy memorandum). The ex-Beatle is now 66 years old and has not yet shown any signs of retiring.

The media are regularly filled with images of 'young' older people; these images were extensively discussed during the recent Dutch Book Week, the theme of which was this year 'Old people...' (after Louis Couperus' 1906 novel, *Old people and the things that pass*). Book Week essayist Renate Dorrestein (2008) and others (De Lange 2008; Draaisma 2008; Geert Braam in *Trouw* newspaper, 29 March 2008) fired a broadside at the image of the 'young elderly' who pass their days in a comfortable, financially secure 'Swiss Life feeling' existence. They argued that the ease and lightness of such a life did not fit with the reality that faces many older people, especially those with chronic diseases and physical disabilities. Moreover, they argued that older people are not looking for hedonistic enjoyment, but a sense of fulfilment and meaning (De Lange 2008).

However, the majority of 'elderly-watchers' take the positive line. Some see the emergence of a new type of elderly person, for whom a new term has been coined, the *novogeront*, who is forced to retire whilst still in the prime of life (Sipsma 2008). Older people are more vital, happier and more satisfied than ever before, according to university researchers (Bergsma 2008) and 15 well-known Dutch people themselves aged over 65 (Falkenburg 2008). There is also a good deal of attention in the

media for older people with a positive attitude to life who actively take life in their own hands with self-help courses such as 'On the way to the golden age' (*Op weg naar de gouden jaren*) (see www.cvo.vu.nl), books such as 'Growing old more happily' (*Gelukkiger ouder worden*) (Van Kreij 2008) and magazines for older people such as *Plus Magazine* and *Zin*.

More pessimistic comments in the media about population ageing, sometimes also referred to as 'the catastrophe of population ageing', frequently refer to financial and economic aspects. According to the review by the Netherlands Bureau for Economic Policy Analysis (CPB) and the Social and Economic Council (SER), the fact that a shrinking labour force is having to pay for the state pensions of a swelling group of over-65s means that reforms are necessary (cf. Van Ewijk et al. 2006). It is also predicted that population ageing will make the Exceptional Medical Expenses Act (AWBZ) unaffordable (Van den Brink & Heemskerk 2006). Other authors counter this by referring to the social capital of people in the 65-74 age group and the pensions that are released (Schnabel 2006, 2007; Timmermans 2007; Knook 2008).

The media are inventive in presenting images and metaphors on the elderly, varying from the 'threat of population ageing' to 'the new bubble in our economy' (cf. Knook 2008). The message is however clear: older people are changing (and so is society).

1.2 *Changing elderly*

The number of older people in the Netherlands will continue increasing until 2030 to reach a total of around 4 million over-65s. That is a quarter of the population. This will transform the Dutch economy over the coming decades. The percentage of people in paid employment will be considerably lower in 2030 than today. The ratio between pensioners and workers has already changed in the last half-century; in 1955 there were 900,000 people aged over 65 compared with a potential labour force of 5.8 million 20-64 year-olds (a ratio of 1 to 6.6). In 2008, there are 2.4 million over-65s compared with roughly 10 million 20-64 year-olds (a ratio of 1 to 4.2). If policy remains unchanged, the ratio between the number of (potential) workers and pensioners will change further over the coming decades.

Not only is the number of older people increasing, they are also living longer. In 1955 the remaining life expectancy at age 65 averaged 14.6 years for women and 13.8 years for men. In 2005 this had risen to 18.1 years for women and 14.8 years for men. People aged 75 and older make relatively large-scale use of publicly funded provisions, especially in the area of health care (Bijl et al. 2007; De Boer 2006). Demand for these provisions will increase further in the decades ahead (cf. Jonker et al. 2007; Eggink et al. 2008). In 1955, 20% of older people were living with their children (because of the housing shortage); today this is almost unheard of. Compared with other countries in Europe, the Netherlands is only just at the beginning of the population ageing wave: roughly 14% of the total Dutch population is aged 65 or over; in Germany the figure is 18% and in Italy 19% (CBS 2004b).

1.3 Monitoring changes

These changes are referred to using the label 'population ageing' and were the reason that prompted the government to issue a standpoint on the policy on the elderly and ageing, leading to the publication of 'Memorandum 64' ('Nota 64': *Ouderenbeleid in het perspectief van de vergrijzing*), which sets out the government policy on the elderly against the background of population ageing (TK 2004/2005). The underlying principle is that the elderly are 'sovereign and valuable citizens, even if important resources for an independent existence disappear at some point in their lives'. The government derived basic values from this Memorandum in relation to health, contribution to society, purchasing power, mobility, housing, care dependency and end of life. The government wishes to reinforce these values and set out a number of policy objectives in the Memorandum, complete with targets, in order to achieve this. The government also announced that it wished to monitor the results of its policy in the fields of health, care, participation, income and housing, and their impact on society, and to report on them periodically.

The government's intention is to monitor the achievement of its targets by means of an Elderly Policy Monitor to be published every two years. The coordinating Ministry of Health, Welfare and Sport (VWS)[1] asked the Netherlands Institute for Social Research | SCP[2] to compile a first Monitor by way of a trial edition, as is also apparent from the dual remit: the Ministry asked SCP not only to test the extent to which the targets set out in Memorandum 64 have been achieved, but also to develop the Monitor further. The government realised from the start that the creation of good indicators was still in development and was an important policy challenge for the near future (Nota 64: 48).

1.4 Evaluation of targets

Memorandum 64 contains policy objectives and targets in the following domains:

1 Active contribution to society (paid and unpaid work);
2 Income;
3 Mobility (public and collective transport);
4 Housing (homes for the elderly);
5 Staying healthy (exercise, fall prevention);
6 Ensuring care for vulnerable elderly (adequate care, quality of care);
7 Dying with dignity.

Six of the seven targets[3] were evaluated on the basis of two central questions:

1 Have the targets formulated by the government in 2005 been achieved?
2 Are the proposed indicators suitable for future monitoring or do they need improvement?

Table 1.1 summarises the social values formulated in Memorandum 64 and their translation into policy objectives, the selected indicators and targets, the target year and the age group concerned. The social value 'Active contribution to society', for example, is translated into the policy objective 'enabling older people to make an active contribution to society'. There is a target for paid work and one for unpaid work (voluntary work). The target for paid work is that 50% of 55-64 year-olds should be performing paid work in 2010.

Table 1.1

Summary of social values and associated policy objectives, selected indicators, targets, target years and age limits as set out in 'Memorandum 64' (TK 2004/2005)

social value	policy objective	indicator	target	target year	age limit
active social participation	enabling older people to make an active contribution to society				
paid work		labour market participation	50%	2010	55-64 yrs
unpaid work		participation in voluntary work	40%	continuous	≥ 65 yrs
adequate income	equipping older people to continue living independently	ratio of state pension to social assistance benefit	106%	continuous	≥ 65 yrs
adequate housing	older people have access to adequate housing, geared to their needs and supported by customised care	available stairless homes	255,000 extra homes	2010	≥ 55 yrs
		available homes with on-call care provision	99,000 extra homes	2010	≥ 55 yrs
mobility	older people are able to move around freely and safety	accessibility of bus, rail and collective on-call transport	[a]	2015	none
staying healthy	encouraging activities to help older people stay fit and healthy for as long as possible	exercise standard	50%	2010	≥ 65 yrs
		fall prevention	[b]	2010	≥ 65 yrs
caring for vulnerable elderly	older people are assured of adequate, good-quality care	waiting list for nursing and care	reduction of approx. 65% since 2000	2010	none
		client satisfaction	all care and nursing homes tested	2007	none
		reduction in multiple-bedded rooms	no multiple-bedded rooms	2006	none

Table 1.1 (cont.)

social value	policy objective	indicator	target	target year	age limit
		small-scale living for people with dementia	20% of total psychogeriatric capacity	2010	none
		professional nursing home care standard	not named	2010	none
dying with dignity	older people must be able to die with dignity	integration of palliative terminal care in networks	c	2007	none
		national coverage of palliative care consultation facilities	c	2007	none
		Integral Cancer Centres (IKCS) must have set up a palliative care department	c	2007	none
		fulfilling of new role by IKCs	c	2007	none

a See note 3.
b In consultation with the Ministry of VWS, a different target has been formulated (see chapter 6).
c Memorandum 64 assigns a score to the four components. These have not been translated into empirical targets.

These targets form the starting point for this Monitor. They are explained and discussed in the different chapters, with a great deal of attention being given to the underlying indicators. For example, to determine whether the target of increased labour market participation by employees aged 55 and older has been achieved, use is made of the percentage of 'persons aged 55-65 years performing paid work for at least one hour per week'. In this case, the indicator is a question from the Labour Force Survey from Statistics Netherlands (CBS).

The targets are not always based on empirical data; in a few cases, qualitative scores have been assigned to targets. We simply investigate whether the targets have been empirically achieved.

Table 1.1 presents different age thresholds. Setting these thresholds is always a difficult subject in reports on the elderly (cf. De Boer 2006; De Klerk 2001, 2004b; De Klerk & Timmermans 1998; De Haan 1996; Timmermans 1993; Timmermans & De Boer 1992). No one is really able to come up with a satisfactory answer to the question 'What is old?'. Generally the statutory retirement age of 65 is taken as a basis. According to tradition, this magical age of 65 dates from the 19th century, when Bismarck introduced the retirement age in Germany.[4] At that time, fewer than half the population actually reached that age.

Age is a difficult criterion for segregating the elderly, as has already been found in compiling earlier Reports on the Elderly. In a number of areas, such as labour market participation, the lower limit of 65 years is not usable. In Memorandum 64 and in recent Parliamentary debates, it has rightly been noted that the policy on the elderly also affects young adults who are making preparations for their pension. This also

applies in some other areas, such as preventive measures to ensure good health and the choice of a home where people wish to continue living until they reach old age. Seen from this perspective, this Monitor would have to focus on people of all ages, which is clearly not practical. From a purely pragmatic perspective, an absolute lower limit of 55 years has been chosen, but this may be higher depending on the specific topic in question. For labour market participation, for example, the focus is on 55-64 year-olds, while when it comes to care for terminal patients, those concerned are generally of a much greater age.

The remit was to look at changes between 2005 and 2007. We interpreted this remit broadly and also looked at trends in the long(er) term in order to be sure that any changes observed were not based on chance outliers.

A second broadening of the remit is that where possible we looked at subgroups in the older population. In this way was possible not only to determine whether the targets are being achieved for the older population as a whole, but also whether there are groups for whom the targets are not being achieved. This also reflects the heterogeneity of the older population highlighted earlier. Individualisation, differentiation in lifestyles and variation in activities is giving rise to an elderly culture which may be just as diverse as the youth culture (Rijkschroeff & Stavenuiter 2006; Baars 2007; Overbeek & Schippers 2004; RMO 2004; Hoeijmans et al. 2005c; Van der Leij et al. 2004; www.zilverenkracht.nl).

Memorandum 64 not only selected the targets, but implicitly also the associated indicators and data sources for this study. The targets vary somewhat in their nature, as we found during the study. For each topic we were tied to the use of specific data and calculation methods. As a result, the approach taken in the different chapters varies considerably. In a few chapters, such as the chapter on care, different methods and data sources were used. In addition, in some cases the targets could not be reproduced or the indicators showed trend breaks over time. These are gentle warnings in advance for the reader who has little interest in the more technical aspects of the Monitor. These technical passages are necessary in justifying the quest for alternative indicators, but can be skipped by readers who are interested mainly in the outcomes.

Several different sources were used to answer the questions in the six policy domains, such as surveys, records, policy documents, interviews and literature reviews. The sources vary from chapter to chapter, and we refer the reader to the chapters covering technical matters such as the operationalisation of the targets. In most chapters we used survey data. In the chapter on dying with dignity, however, survey data proved inadequate and interviews with experts were used to search for better indicators.

As stated earlier, the following thematic chapters each discusses two research questions for each social value[5]: to what extent have the targets being achieved, and which indicators are best suited to future monitoring? We also discuss subgroups of the older population as well as trends over the longer term. In the concluding chapter we evaluate the Monitor as a whole: what information has it produced and what information could future Monitors offer for policy?

Notes

1 The Ministry of Health, Welfare and Sport (VWS) coordinated Memorandum 64 (in close collaboration with the Ministry of Housing, Spatial Planning and the Environment (VROM), the Ministry of Finance and the Ministry of Social Affairs and Employment (SZW). Five other ministries were also involved via the Interdepartmental Steering Group on the Elderly (Interdepartementale Stuurgroep Ouderen). The Parliamentary committee for policy on the elderly carried out its own study of older people and published a report on this (*Lang zullen ze leven*) (TK 2005/2006a). These two documents were debated in Parliament early this year (TK 2007/2008b).

2 In the period 1992-2006, SCP reported every two years on the life situation of older people in the Report on the Elderly (Rapportage ouderen) (De Boer 2006; De Klerk 2001, 2004b; De Klerk & Timmermans 1998; De Haan 1996; Timmermans 1993; Timmermans en & De Boer 1992). This Elderly Policy Monitor (Monitor ouderenbeleid) replaces the Report on the Elderly 2008.

3 It was agreed with the Ministry of Transport, Public Works and Water Management (V&W) that a chapter on transport would not be included because the objectives relate to the long term and little can be said about them within a short period of two years.

4 Knook (2008) qualifies this tradition, arguing that the age limit predates Bismarck.

5 Two chapters are devoted to the value 'social participation', one on paid work and one on unpaid work (voluntary work).

2 Social participation: paid work

Jean Marie Wildeboer Schut (in collaboration with Edith Josten)

2.1 Labour market participation by the elderly

In 1990 the Swedish sociologist Esping-Andersen published his book *The three worlds of welfare capitalism*. Taking as a starting point the institutional arrangements which applied in the various countries until the 1980s, he divided a large number of Western welfare states into three categories. First there was the Anglo-Saxon type, made up of the United States, Canada, Australia and the United Kingdom. In these countries, the free market dominates; they are characterised by a meagre social security system with stringent access conditions and many private sector arrangements. The labour market policy is not very strongly focused on active integration; as much as possible is left to the free play of market forces. By contrast, the social-democratic cluster – Sweden, Denmark and Norway – have a large public sector. Benefits are generous; the government is intensively involved in the labour market; the high labour market participation rate of women is striking. The final cluster includes Germany, France and Belgium. Esping-Andersen classified these as the corporatist or continental type. These countries have sometimes very generous benefits for separate occupational groups, which are related to employment history. They are also characterised by a focus on the family, with relatively numerous arrangements for children and parenthood. Economic independence of household partners is not an aim, and the labour market participation of women is low. There are also arrangements designed to facilitate the exit of older workers from the labour market.

Esping-Andersen accords the Netherlands a place between the corporatist and social-democratic systems. On the one hand, the Netherlands showed social-democratic traits through its relatively generous social security arrangements and high minimum wage. On the other hand, the benefits paid pursuant to employee insurances were more corporatist in nature, being related to employment history and pay levels. In terms of its labour market, the Netherlands in the 1980s fitted in well with the corporatist profile; the labour market participation of women was traditionally very low and the Dutch system offered a number of generous exit routes – early retirement, disability benefit, unemployment benefit – for older employees. The early retirement (VUT) arrangements were introduced at the end of the 1970s, with the aim of reducing high youth unemployment: it was hoped that by enabling older workers to retire early, jobs would become available for young people. Although disability and unemployment benefit were of course not intended as vehicles for early retirement, in practice they were used as a means of shedding older workers who had become surplus to requirements.

In the early 1990s there was a revolution in the thinking about the labour market participation of older people in particular. Where in the *Social Memorandum 1993* the policy objective was still formulated in modest terms and the government first sought to direct its efforts towards reducing the number of older workers leaving the labour market early, as the decade progressed the government adopted a more robust stance. By the end of the 1990s the idea had taken hold that increasing the participation of older workers was one of the most important socioeconomic objectives for the coming years (cf. De Beer & Woittiez 1999). The reason for this turnaround lies in the ageing of the population. This will lead to an increase in the costs of the state pension and care provision and put a squeeze on the labour market. Having more people in work, including older people, means the costs of population ageing are borne by more people and shortages are less likely to arise on the labour market.

Memorandum 64 (TK 2004/2005) goes even further. Here, raising the participation of older people in the labour market is embedded in a more or less philosophical approach: their participation is a practical translation of two abstract objectives of general policy on the elderly, namely sovereignty and solidarity. This is also taken beyond the age limit of 65 years; ideally, people would work full-time up to that age, after which they could gradually reduce their participation and replace it with informal care, voluntary work, etc. The present commitment with regard to paid employment for 55-64 year-olds is ambitious:

> *As regards the labour market participation of 54-64 year-olds, the ideal target for the longer term [...] is a participation rate of 70%. [...] for the shorter term, the government conforms to the European target of 50% by 2010.*

This chapter shows how far the Netherlands has progressed towards achieving that 50% figure. In addition, we illustrate using figures that the picture painted by Esping-Andersen now belongs to the past, both as regards the labour market participation of older men and that of older and younger women; both sexes now work (considerably) more than at the end of the 1980s/early 1990s. Finally, this chapter discusses the extent to which increasing labour market participation is reflected in the performance of 'substantial' jobs by older workers.

2.2 *Achievement of the target*

Table 2.1 shows the net activity rate (labour market participation rate) of 55-64 year-olds in the period.[1] it takes into account both the percentage of older people who work for at least one hour per week – the usual international criterion and the basis for the European objective – AND the 'stricter' Dutch norm of at least 12 hours per week.

Table 2.1

Net labour market participation of 55-64 year-olds, 2003-2006 (in percentages)

	2003	2004	2005	2006
paid work for at least one hour per week	43,3	44,7	44,8	46,7
paid work for at least 12 hours per week	38,6	39,8	39,7	41,8

Source: CBS (EBB'03-'06)

In 2003, 43.3% of 55-64 year-olds worked for at least one hour per week. By 2006, this figure had risen by more than three percentage points to 46.7%. This increase took place chiefly from 2003 to 2004 and from 2005 to 2006. The 12-hour norm shows slightly lower percentages of working people. However, both criteria show the same trend: the 12-hour yardstick also shows an increase of more than three percentage points in the percentage of working older people between 2003 and 2006. If the increase in labour market participation continues at this pace, the short-term target of 50% by 2010 will be achievable.

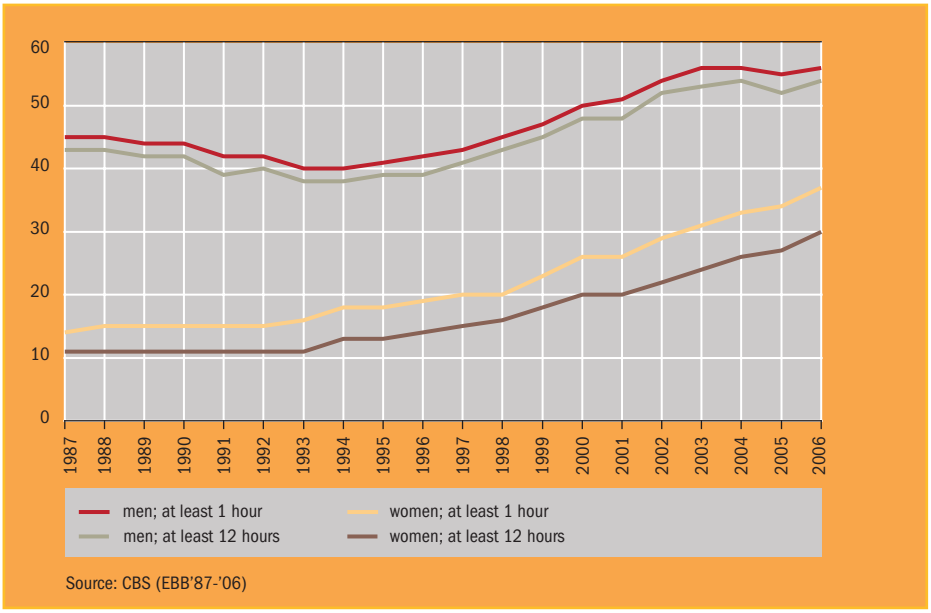
There are two disadvantages to using these figures. In the first place, net participation correlates strongly with the economic cycle: during periods of economic growth the number of people in work rises; during economic downturns the employment rate generally falls again. In the period after 2003 the Dutch economy was climbing out of a trough, and the growth in participation could be related to this. For a clear view of the future it would also seem necessary to answer the question of how the employment rate of older people develops in times of economic downturn. Secondly, the percentages in table 2.1 do not distinguish between the sexes. As Esping-Andersen pointed out, the employment rates of men and women have traditionally diverged widely in the Netherlands. According to Esping-Andersen, the Dutch labour market was akin to the continental corporatist system, with low labour market participation by women and the facilitation of exit routes for older men.

To accommodate these two objections, figure 2.1 shows the trend in the labour market participation of men and women separately over a longer period, from 1987 to 2006.

The sea-change in the participation of men aged between 55 and 65 began in around 1994, when the Dutch economy started to recover from its low point in the early 1990s. During those years, 40% of older men were in work; 38% performed paid work for at least 12 hours per week. In 2006 these figures had risen to 56% and 54%, respectively. The participation of older women has shown a rising trend since the middle of the 1980s.[2] In 1993, 16% of older women were in work for at least one hour per week and 11% for at least 12 hours per week; in 2006 these percentages had risen to 37% and 30%, respectively. The trend in both the male and female activity rate is thus unmistakably a rising one over a fairly long period. The reasons for the increase differ, however. For men it is probably caused mainly by the strong economic growth and the conversion of early retirement to pre-pension arrangements. The reform

of the Invalidity Insurance Act may also have played a role (CPB 2005; Euwals et al. 2005). The increase among women is probably due mainly to the fact that younger generations of women more often re-entered the labour market as their children grew older, or more frequently remained active in the labour market after the birth of a child (CPB 2005).

Figure 2.1
Net labour market participation rate of 55-64 year-olds, by sex, 1987-2006 (in percentages)



Source: CBS (EBB'87-'06)

The rise in the participation by older men notably faltered between 2003 and 2005. There are several possible reasons for this. In the first place, the weak economy meant that more people lost their jobs than in the preceding years. A second possible reason is the ending of the tax breaks for pre-pension arrangements which came into effect on 1 January 2006, combined with the still uncertain economic situation in 2004 and 2005. This may have prompted several employers to make rapid use in 2004 and/or 2005 of the last opportunity for fiscally advantageous exit arrangements for their older workers.[3] For women, the dampening effect of the weak economy and early exit schemes may be masked by the rising employment rate among younger generations.

Figure 2.1 also shows only a small difference throughout the entire period 1987-2006 between the percentage of men working a minimum of 12 hours per week and the percentage working a minimum of one hour per week. This suggests that most men who perform paid work do so for at least 12 hours per week. The difference is greater among women; even where they have no children or their children are older, women

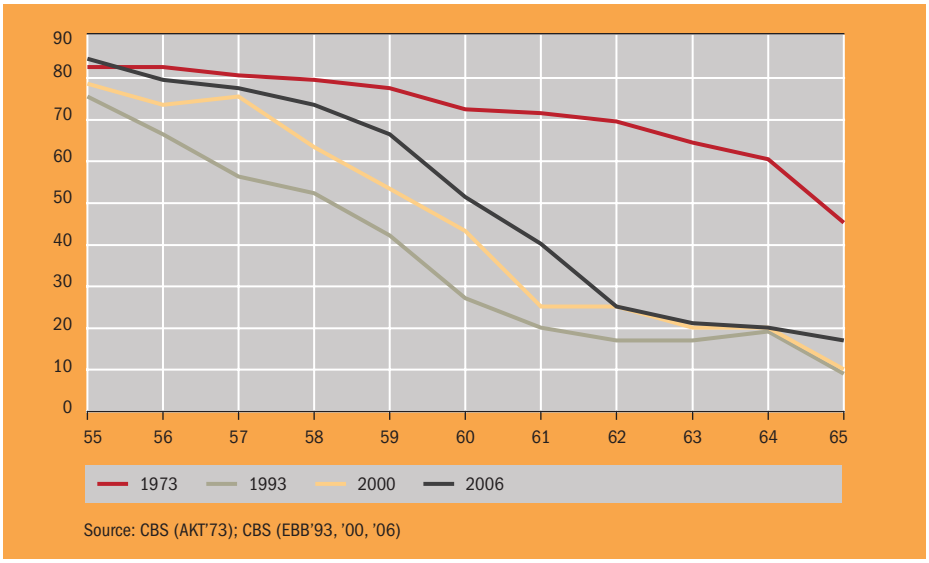
work part-time much more often than men (Portegijs & Keuzenkamp 2008), though the proportion of older women in paid employment for at least 12 hours per week has increased (2006: 80%, 1987: 74%).

It cannot be seen from figure 2.1 whether and to what extent labour market participation varies with age, nor whether any change has taken place in this over time. Figure 2.2 shows the percentage of men by age who were in paid work for at least one hour per week in 1973, 1993, 2000 and 2006. Figure 2.3 does the same for women.[4]

In the remainder of this chapter we take the (international) 'one hour per week' criterion as a basis.

Figure 2.2

Net labour market participation of men, by age, 55-64 year-olds, 1973, 1993, 2000 and 2006 (in percentages)



Source: CBS (AKT'73); CBS (EBB'93, '00, '06)

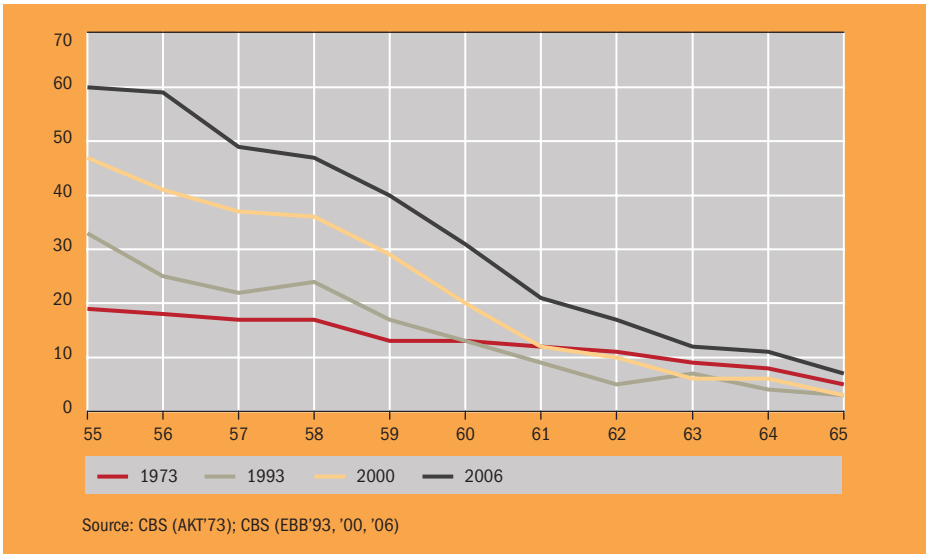
In 1973, before the introduction of the early retirement (VUT) schemes, 82% of 55 year-old men were in paid work. The participation rate reduced by a few percentage points for each year of advancing age; 77% of 59 year-olds were working in 1973, and 60% of 64 year-olds were still working. In the later years this decline became much steeper, reaching its low point in 1993-1994. In 2006 the participation by age increased again slightly, but came nowhere near reaching the 1973 level. The number of workers aged 61 and 62, in particular, fell rapidly.

The participation rate of older women has increased sharply over the years; in 2006 there were more than three times as many women aged 55 working as in 1973.

The percentage of working women did fall more sharply with advancing age in 2006 than in 1973, however; as a result, the participation rate of the oldest women (63-65 years) was only a few percentage points higher than in 1973.

Figure 2.3

Net labour market participation of women, by age, 55-64 year-olds, 1973, 1993, 2000 and 2006 (in percentages)



Source: CBS (AKT'73); CBS (EBB'93, '00, '06)

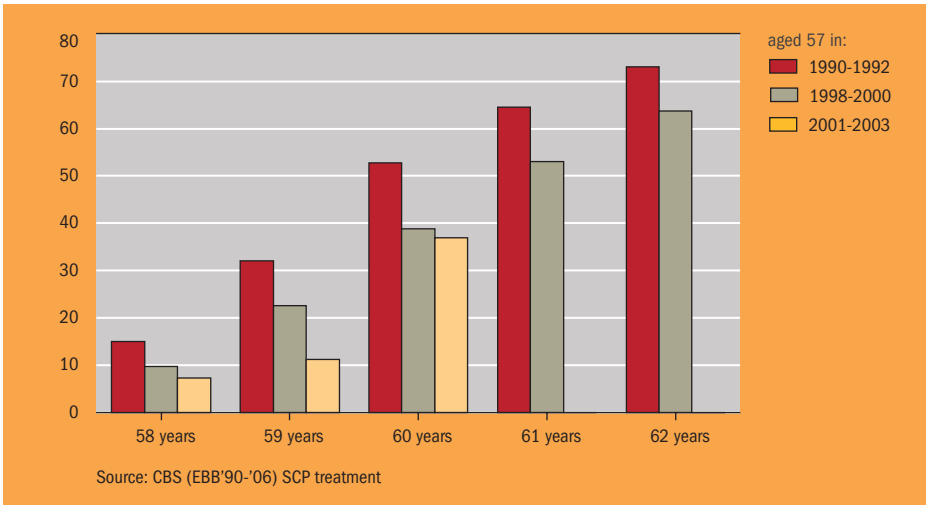
2.3 *Exit of older workers from the labour market*

Figure 2.4 shows the age at which people leave the labour market. It shows the percentage of people who were working at age 57 but were no longer working when they were 58, 59 and so on. The figures for men and women have been combined because the number of older women working is too low to establish their exit patterns separately.

The figure shows that the exit percentages are much lower today in particular below the age of 60. At age 60, roughly a quarter of people then stop working. It is likely that the exit ages will increase in the coming years due to changes in the pension arrangements.

Figure 2.4

Proportion of non-workers, by cohort, 1990-2006 (in percentages of people who were working at age 57)[5]



2.4 *Change in labour relations and working hours*

More men and women in the 55-64 age group have begun working in the last 15 years. This begs the question of what kind of employment contract these extra workers have. It would also seem to be of interest to explore not only whether more people have started working but also whether more people have also started working more. Table 2.2 provides an answer to both questions.

The increase in the labour market participation of both men and women took place mainly via permanent employment contracts between 1993 and 2006. Among men, the number of permanent contracts increased by 14 percentage points, from 17% to 41%. Among women, 27% had a permanent employment contract in 2006, 18 percentage points more than in 1993. The percentages of employees with a flexible contract and the self-employed remained virtually the same for both sexes.

Table 2.2 also shows that the jobs concerned were substantial in terms of the number of hours worked. The number of full-time jobs (35 or more hours per week) held by men increased from 33% to 42%; among women, the increase in participation mainly involved jobs for 20-34 hours per week.

Table 2.2

Position in the workforce and working hours of working 55-64 year-olds, by sex, 1993 and 2006 (as a percentage of the potential labour force)

	men			women		
	1993	2006	change 1993-2006 (in % points)	1993	2006	change 1993-2006 (in % points)
employee, permanent contract	27	41	14	9	27	18
employee, flexible contract	2	3	1	2	4	2
self-employed/co-working family member	12	13	1	5	6	1
< 12 hours	2	3	1	5	7	2
12 – 19 hours	2	2	0	3	7	4
20 – 34 hours	4	10	6	5	16	11
> 34 hours	33	42	9	3	7	4

Source: CBS (EBB'93, '06)

2.5 *Lagging groups?*

The above figures relate to all men and women aged 55-64 years. However, the labour market participation of non-Western ethnic minorities and people with a low education level is lower than that of their peers of indigenous origin and/or with a higher education level. Table 2.3 shows the percentages of workers by education and origin for 1996 and 2006.

In 2006, it was only highly educated men who scored above the average participation rate of 57%. The participation rate of people with an education at (pre-vocational) secondary level were below the average. The participation rate of older men with only primary school education lagged well behind. The same applied for members of non-Western ethnic minorities.

Among women, the upside outlier for those with a higher education level is striking: 55% of them were in paid work. The other groups follow more or less the same pattern as men, although women with a secondary vocational education level scored above the average.

In all groups, the percentage of working people increased substantially between 1996 and 2006.

Table 2.3

Net labour market participation rate of 55-64 year-olds, by education, ethnicity and sex, 1996 and 2006 (in percentages)

	men		women	
	1996	2006	1996	2006
education				
primary school	25	45	10	24
pre-vocational secondary	37	54	16	29
senior general secondary/pre-university/senior secondary vocational	44	56	24	43
higher professional/university	54	63	37	55
origin				
non-Western ethnic minority	20	42	14	28
other	42	57	19	37
total	42	57	19	37

Source: CBS (EBB'96, '06)

2.6 Conclusion

The results presented in this chapter suggest that the picture painted of the Netherlands by Esping-Andersen largely belongs to the past, at least as far as participation in the labour market is concerned. The virtual absence of participation by women and the low participation in paid work by older men, so characteristic of the corporatist welfare state, appear to have been banished to the past for good. Dutch women began their assault on the labour market in the mid-1980s. The recovery in the participation rate of older men came slightly later. After reaching a low point in the early 1990s (40%) this has been moving up again in recent years towards 60%. There are however subgroups of older people – non-Western ethnic minorities, people with a low education level – who participate relatively little in the labour market.

This chapter is based mainly on a minimalist definition of labour market participation; there are two reasons for this. In the first place, the government has committed itself to European objectives which are based on performing paid work for at least one hour per week; we investigated how the Netherlands fares on this criterion. Second, the usual norm used in the Netherlands of 12 hours per week for older Dutch men does not lead to essential differences; people generally work for more than 12 hours per week in any case. For the time being, the situation is different for women; the figures are several percentage points lower on both criteria. This means that a substantial proportion of older women are in 'small' (part-time) jobs. To what extent this is a temporary phenomenon remains to be seen. It has become apparent in this

chapter that the biggest increase in the participation of women has taken place in the area of 'larger' part-time jobs lasting 20-34 hours per week.

The question can be asked of whether the one hour per week criterion is not lacking in ambition. There will be few jobs where working for one hour per week will be enough to sustain people; many older people will still have to rely on social security. Moreover, where older people work for more hours, the financial supporting base for the ageing population is broadened. It is therefore recommended that a supplementary objective be formulated with a higher working hours criterion.

Notes

1 Net participation is understood as the number of working people. In the Netherlands, someone is regarded as working if they perform paid work for at least 12 hours per week. Internationally, the bar is set lower: those who do not meet this 12-hour criterion are still counted as working. The gross participation figures also include people who are actively seeking paid work. In the Netherlands, the reservation is applied here that this must again be for a job for at least 12 hours per week. The numbers of working people and (active) job-seekers aged 50-64 years together constitute the labour force. The entire population in this age category is described as the potential labour force. The ratios between net and gross participation, respectively, and the labour force are the net and gross participation rates. The government almost always formulates its objectives in terms of net participation. This chapter therefore focuses exclusively on this and, when discussing labour market participation, this means the net variant.

2 Compare De Beer & Woittiez (1999). Strictly speaking, this is the gross participation by women aged 50-64 years.

3 Statistics Netherlands CBS for example concluded that the exodus of older workers in 2004 was half as much again as four years earlier (CBS 2006).

4 The data for 1973 are taken from the precursor of the present Labour Force Survey (the Arbeidskrachtentellingen), which only records the birth year. All persons born in 1918 are regarded here as 55 year-olds, all those born in 1908 as 65 year-olds, and so on. Precise conclusions about the percentage of working people at a certain age are therefore not easy to draw. This is a particular problem with 65 year-olds; a proportion of them were actually still only 64 when the survey was carried out. A second reason for caution with precise conclusions is that the data are in fairly disaggregated form for each age. In other words, the numbers involved are not large. This applies not only for the data from 1973, but also for later years.

5 The proportion of non-workers aged 61 and 62 years cannot be calculated for the youngest cohort; this calculation requires data from 2007 and later, which are not available.

3 Social participation: unpaid work

Renske Hoefman

3.1 Unpaid work after age 65

Few people continue in paid employment after the age of 65, and a proportion of them begin (more frequently) performing unpaid work such as voluntary work or informal caregiving. For most people, working continues to be an important means of participating in society (cf. Knipscheer 2005), and the recently introduced Social Support Act (Wmo) in the Netherlands is intended to offer opportunities to older people who are in need of help to participate in unpaid activities at local neighbourhood or municipal level. For people in the later phases of life, unpaid work is at least as important as paid work (TK 2004/2005).

Policy in the period 2005-2007 was aimed at recruiting new volunteers and maintaining the enthusiasm of existing volunteers. The emphasis was mainly on removing legislative and regulatory obstacles for volunteers and voluntary organisations, as well as improving the quality of local policy and local support for volunteers. Campaigns to recruit new volunteers focused mainly on new target groups, including ethnic minorities and older people. Finally, the national knowledge (infrastructure) in relation to voluntary work has improved, partly thanks to the pooling of information for local voluntary organisations (TK 2005/2006b).

The policy paper on informal care and voluntary work in the period 2008-2011 (*Mantelzorg en Vrijwilligerswerk 2008-2011*) (TK 2007/2008f) lists a number of core policy objectives which are aimed, as in the previous period, at maintaining the present number of volunteers and mobilising those who are not yet participating in unpaid work to do so. Creating a good local support structure for volunteers is still a central tenet of the new policy paper. Local authorities have an important task here based on the Social Support Act (Wmo). The intention is to recruit new volunteers in the coming years via contacts with the business community (TK 2007/2008f). The government memorandum on policy for the elderly cites the main reason that people do not perform voluntary work as being that they are not asked to do so. The best way of encouraging people to do this is at local level, as close as possible to the citizen (TK 2004/2005; TK 2007/2008f).

In addition to a target for paid work, Memorandum 64 also included a target for participation in voluntary work. The government was thus emphasising its desire to encourage voluntary work as a form of social contribution (TK 2004/2005: 44):

> *As regards voluntary work by the over-65s, either in an organised or individual context, the ideal target in the government's view, taking into account age and the nature of the activities, is a participation rate of 50%. The government accordingly gives the present*

rate of 40% [in 2003] a score of 8 out of 10. The policy is aimed at maintaining the relatively high participation rate in voluntary work.

To what extent has the government succeeded in maintaining the high participation rate? What changes have taken place in the participation by the over-65s? Do some groups do more voluntary work than others? Given the relatively short period to which the target relates),[1] it is not easy to assess whether the rate of participation has changed. We therefore also used data covering a longer period (1993-2006) in order to establish the trend.

In this chapter, voluntary work is defined as 'the performance of unpaid work on behalf of organised by an institution or association'.[2] Participation in voluntary work has been monitored since 1993 in the *Cultural Changes in the Netherlands* survey (CV), one of the periodic population surveys carried out by the Netherlands Institute for Social Research | SCP.[3]

Research has shown that certain groups do more voluntary work than others. It is known from the literature that different factors influence participation. In the Netherlands, age, education, physical disabilities, social contacts, church membership and ethnicity all influence participation (Dekker et al. 2007; De Klerk & Schellingerhout 2006; De Hart & Devilee 2005; De Klerk 2007; Brink-Muinen et al. 2007; Van den Broek et al. 2007; Breedveld et al. 2004; Bekkers 2004; De Hart & Dekker 1999; Van Daal 2001). Among older people sex, age, education level, income, churchgoing and a high degree of social involvement are found to be determinant factors (Hoeymans et al. 2005c; Van der Meer 2006; Wiggers 2003).

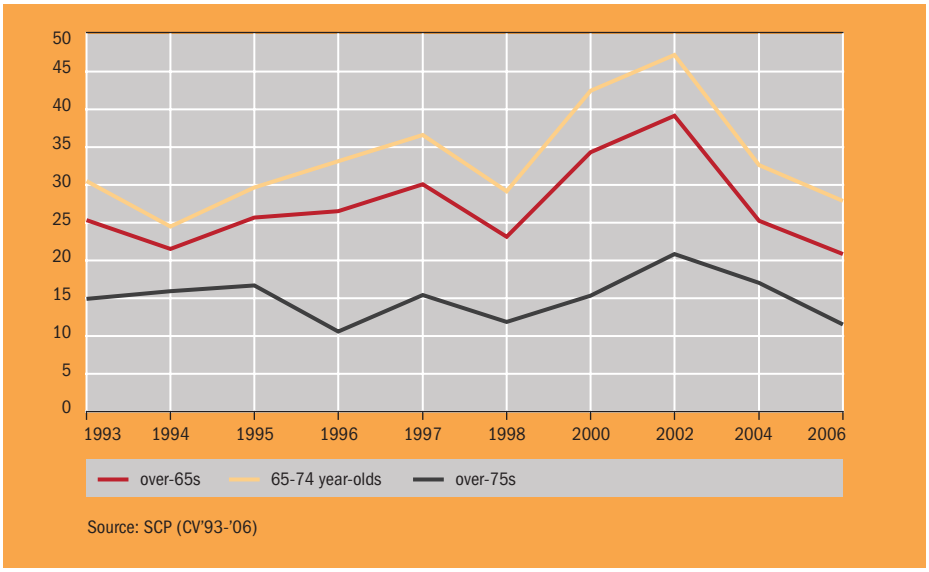
Analyses of our data (see appendix A at www.scp.nl) show that 65-74 year-olds, healthy people and members of religious communities do voluntary work more often than others. In addition to general changes in participation by older people, therefore, we also look at differences by age, health and membership of a religious community.

3.2 *Changes in participation*

Where in the 1990s the proportion of older people active in voluntary work fluctuated between 20% and 30%, in 2000-2002 the figure rose sharply before appearing to fall back again in the period 2004-2006 towards 20% (figure 3.1). Other researchers have also found that the percentage of volunteers in the Dutch population has been falling in recent years following a period of limited fluctuations (De Hart & Devilee 2005; Van den Broek et al. 2007; Dekker et al. 2007).

Figure 3.1

Proportion of volunteers among the over-65s, by age, 1993-2006 (in percentages)



Source: SCP (CV'93-'06)

This fall is probably due in part to the decline in church membership in the Netherlands. Older people mainly perform voluntary work for organisations focusing on providing help for neighbours, the elderly and disabled, as well as for religious or ideological organisations (not shown in table). The decline in 2006 compared with 2004 appears to have taken place mainly among older people who were not members of a religious community (table 3.1). Dekker (2006) suggests another possible explanation for the sharp fall after 2002. In 2004 the fieldwork for the Cultural Changes in the Netherlands survey was carried out by a different fieldwork organisation than in 2002, which may have made great efforts to achieve a high response. As a result it is possible that 'in that year the natural distortion of surveys in the direction of voluntarily cooperating citizens was rather less than in previous years' (Dekker 2006: 9).

If we look at the average number of hours invested by volunteers each week, we see that the intensity was roughly the same in 2006 as in 2004 (figure 3.2). The over-65s spent between eight and nine hours per week doing voluntary work. Among the over-75s, the variation over the years is bigger, but on average comes down to around the same level.

Table 3.1

Proportion of volunteers among the over-65s, by a number of background characteristics, 2004 and 2006 (in percentages)

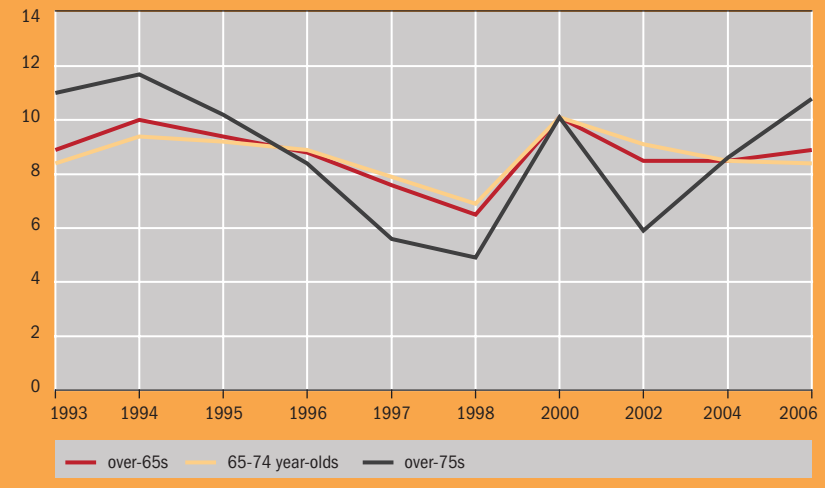
	2004 (n = 457)	2006 (n = 423)	2006-2004 (in percentage points)
age category			
65-74 years	32.6	27.9	-4.7
≥ 75 years[a]	17.0	11.5	-5.5
opinion of own health			
(very) good[a]	33.1	26.7	-6.4
(very) poor	16.5	12.8	-3.7
religious community			
member	28.4	26.8	-1.6
not a member[b]	20.4	12.1	-8.3
total[a]	25.2	20.8	-4.4

a Difference between 2004 and 2006 is significant at $p < 0.10$.
b Difference between 2004 and 2006 is significant at $p < 0.05$.

Source: SCP (CV'04, '06)

Figure 3.2

Average number of hours per week spent on voluntary work by the over-65s



Source: SCP (CV'93-'06)

3.3 Achievement of the target

The above figures show that the commitment set out in Memorandum 64 of maintaining the proportion of volunteers in the older population has not been achieved. After an increase at the start of this century, this proportion appears to have been falling since 2002. The ideal that half the over-65s would be performing voluntary work appears to be moving further away.

It should be noted here that the starting point for Memorandum 64 is that 40% of older people were active in voluntary work in 2003. The percentage we find on the basis of the Cultural Changes in the Netherlands survey is however lower. The explanation for this is that the target in Memorandum 64 is based on a different study, namely the Permanent Life Situation Survey (POLS) conducted by Statistics Netherlands (CBS). This database is less suitable for monitoring participation in voluntary work over time because it is unclear at the moment whether this survey will be continued.

Clearly, different data sets can lead to different results. For example, the percentage of adults doing voluntary work is relatively low (19%) in the European Values Studies and high (46%) in the Time Use Survey (TBO) (Dekker et al. 2007). According to Dekker et al., part of the differences can be attributed to a difference in the question formulation and, associated with this, the definition of voluntary work chosen in the studies. The associations evoked by the question formulation also play a role, for example whether or not examples are cited in the question. Moreover, the context in which the questions are put can have an influence. An example of this are questions prior to the question about voluntary work, which invite respondents to give a socially desirable response. Apart from the question formulation, the deviating results in different studies can also be explained by differences in sampling, approach to the respondents and ways of dealing with nonresponse. This gives rise to a difference in the degree of self-selection of volunteers in the surveys (Dekker 2006).

3.4 Better indicators for unpaid work

Voluntary work

The current definition of voluntary work which has been used in all official policy documents since 1980 ('work that is performed in any organised context without obligation and unpaid on behalf of others or the community') is coming under increasing pressure due to the emergence of new forms of voluntary work (Claassen & Welling 2006). An example is 'guided voluntary work' which involves activities that are not entirely voluntary, such as compulsory bar duty in a tennis club, or citizen initiatives and Internet-based initiatives, which are also becoming increasingly popular (Dekker et al. 2007). It is also worth noting that the term 'volunteering' is often used as an alternative for voluntary *work*. Despite the fact that the current definition is no longer entirely satisfactory, there is no broad support for a change (Claassen &

Welling 2006; Dekker 2006).Voluntary work is operationalised in different ways in research. Dekker argues that the use of differing questions to measure participation in voluntary work is valuable since it enables interesting trends and differences between population groups to be observed (Dekker 2006).

The definition used in the Cultural Changes in the Netherlands (CV) surveys is an exclusive one. Respondents are asked specifically about unpaid work which is performed for at least one hour per week in an organised context. The question formulation in another SCP database, the Amenities and Services Utilisation Survey (AVO) is comparable to that used in the CV surveys. In order to include marginal forms of voluntary work as well in a future Monitor, a broad, relatively inclusive definition could be used, such as that used in the Time Use Survey (TBO) and the Permanent Life Situation Survey (POLS). Respondents would then be asked, for example, whether they 'sometimes' perform voluntary work, or else this need not be done in an organised context. However, these latter surveys are less suitable as a basis for the Monitor (see note 3 in § 3.1).

This Monitor looked at whether older people perform voluntary work. What they do, or for whom, was not studied in any detail. The demand for and supply of volunteers varies from sector to sector, and in some sectors have a shortage. For example, a relatively large number of organisations in the care and support sectors, social and cultural work and ideological sectors reported that they had insufficient volunteers (Devilee 2005). In a subsequent Monitor it would be relevant to look at which sector has the most (and least) active older volunteers.

Informal care

In order to obtain the fullest possible picture of the social contribution made by older people, it is important to include the providing of informal care alongside voluntary work as an indicator in the Monitor. Memorandum 64 looks at this aspect briefly, regarding informal care as an activity which makes an essential contribution to society (TK 2004/2005).

It is known from the literature that the proportion of informal carers in the Dutch population has remained reasonably stable over the last decade (De Hart & Devilee 2005; Van den Broek et al. 2007; De Klerk & De Boer 2005). The percentage of people aged over 65 providing informal care has increased, from 9.9% in 1991 to 12.9% in 2003 (De Klerk & De Boer 2005). De Boer and Timmermans (2007) believe it will increase further based on projections up to 2020. The Amenities and Services Utilisation Survey (AVO) conducted by SCP could be used to identify trends in informal caregiving by older people in a subsequent Monitor. The survey is conducted every four years, with the most recent version containing data from 2007.

3.5 Conclusion

In order to monitor the social participation of older people via unpaid work, it is desirable first and foremost to look at whether they are active in other areas in addition to voluntary work. It will then be possible to monitor not only the trend in their participation in voluntary work, but also in providing informal care.

Secondly, the shares taken in the total by different subgroups could be monitored. An analysis of the trend data by age, health status and membership of a religious organisation would increase the insight and offer starting points for a differentiated target group policy.

Finally, it is important that figures on participation in voluntary work and other forms of unpaid work such as informal care are not presented as absolute key figures. To be able to compare data between years it is crucial that they are gathered using the same question formulation each time. A change in that formulation can render it impossible to calculate trends over time. It is therefore desirable to formulate the targets in relative rather than absolute terms. The present targets are based on a percentage which, as discussed in section 3.3, is partly influenced by the question formulation used in a particular study. The suggestion is that this problem could easily be circumvented by not using absolute percentages but changes in percentages. In other words, the Monitor could highlight rises and falls in the participation in unpaid work by (sub)groups of older people.

Notes

1 The targets have been formulated for 2007 and 2010. Due to a lack of data for 2003 and 2007, in this Monitor we use data from 2004 and 2006.
2 The question used to measure participation in voluntary work was: 'How many hours per week on average do you spend doing voluntary work, i.e. unpaid work on behalf of or organised by an institution or association?' If respondents do this for at least one hour per week, they are regarded as volunteers.
3 The Cultural Changes in the Netherlands survey (CV) is the most suitable for measuring voluntary work in this Monitor. It contains the most recent data on social participation and is repeated frequently (every two years). SCP also has other databases containing similar data, but these are less suitable for the Monitor. The Time Use Survey (TBO) is conducted less frequently (once every five years), the Amenities and Services Utilisation Survey (AVO) is held every four years and only the most recent edition contains data on participation in voluntary work, and the continual Permanent Life Situation Survey (POLS) conducted by CBS no longer contains data on unpaid social participation.

4 Adequate income

Jean Marie Wildeboer Schut

4.1 State pension, occupational pensions and private arrangements

The Dutch pensions 'cake' is made up of three 'layers'. First, there is the basic state pension. This is funded from national insurance contributions, is paid from the general coffers and is universal: everyone receives a state pension and, depending on the type of household, everyone receives the same amount,[1] regardless of any other income or assets. Supplementary occupational pensions come next. These are funded pension schemes which, in principle, are built up by workers themselves during their working life. Accordingly, these supplementary pensions are organised between employers and employees. There are wide differences between the various schemes. Moreover, not everyone is entitled to them; in the first place, this applies for those who have not been in waged employment. In addition, there are a number of blank spots on the 'pensions map' (Pensioenkamer 1987). Some companies have no pension provisions, but some categories of workers are also sometimes excluded from participation. The number of blank spots is however reducing.[2] The final layer of the Dutch pensions 'cake' consists of private pensions (annuities, single-premium policies, pensions for the independent professions), which supplement the first two provisions.

In Memorandum 64 the government focuses particularly on the state pension (TK 2004/2005). The aim is to protect older people with a low income and to prevent distortion creeping into the income distribution between generations:

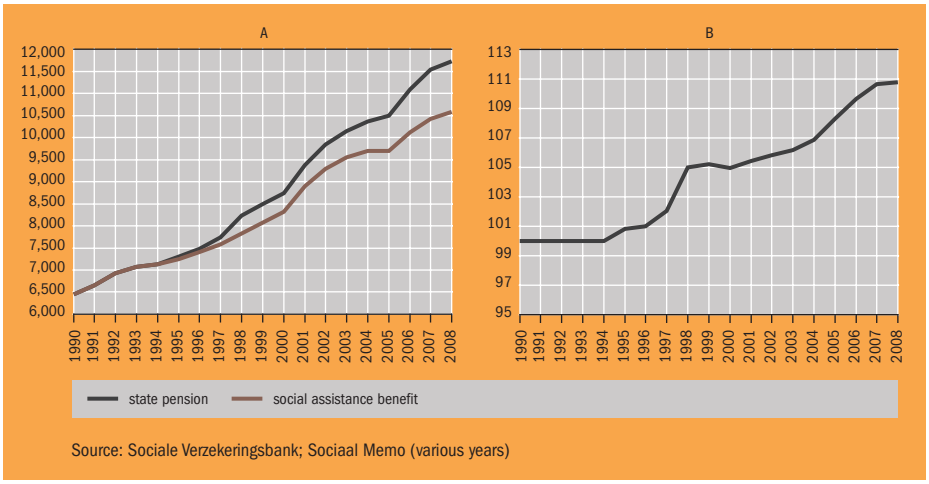
> *The government believes that the purchasing power of people living only on state benefit fulfils a key role here. With regard to the purchasing power of a single person on social assistance benefit aged below 65 years, the generic purchasing power of a single older person living only on state pension increased from 100 in 1994 to 105.9 in 2002. The government wishes to maintain this relative improvement [...].*

This chapter first discusses the trend in the indicator set out in Memorandum 64. It can be seen clearly that from 1995 the state pension has increased more and more relative to social assistance benefit. The chapter then turns to the development in income inequality between 1990 and 2005. The trend in poverty rates over the same period is then explored. We conclude the chapter with a proposal for a number of new indicators.

4.2 Achievement of the target

Memorandum 64 uses the relationship between the generic purchasing power of someone living only on state pension and a single social assistance benefit claimant as an indicator. The term 'generic purchasing power' refers to the purchasing power of a standard household, in this case a single person, without all kinds of additional sources of income. In reality, therefore, the indicator refers to nothing more than the level of the (net) state pension relative to that of a single social assistance benefit claimant. Figure 4.1a shows the trend in the two amounts over the period 1990-2008; figure 4.1b shows the relationship between the level of the two benefits.

Figure 4.1
State pension and net social assistance benefit for a single person, 1990-2008 (in euros per year) and as a ratio (in percentages)



Source: Sociale Verzekeringsbank; Sociaal Memo (various years)

Up to and including 1994, the amount of a single person's social assistance benefit and the state pension were exactly the same. In 1995 the older person's tax credit was introduced, and this was greatly increased in 1998. Throughout the entire period 1990-2005 both benefits increased, with the exception of 2004-2005, when social assistance benefit was frozen. It can however be seen clearly in figure 4.1a that the state pension increased more steeply. Today, in 2008, the net state pension is approximately 111% of social assistance benefit. The purchasing power of the state pension is thus above its level in 1979, the year in which purchasing power reached its peak (SZW 2006).[3]

A few qualifying comments appear to be in order in relation to this indicator, all relating to the representativeness of the above picture. In the first place, it is rare for people's income to come entirely from just one source; over the decades, not only have more and more over-65s built up a supplementary pension, but in a welfare

state such as the Netherlands a large number of supplementary provisions, contributions and allowances have been created for social assistance benefit claimants in particular. For people at the minimum income level, in particular, but also for people above this level, the income from these sources has a substantial influence on their purchasing power. Secondly, and as a supplement to the foregoing, virtually every person aged over 65 receives state pension, but by no means all other residents receive social assistance benefit. If the intention is to compare the purchasing power of older people with that of the rest of society,, this means that only a very partial picture is created. Finally, society does not consist only of single persons, but also of couples, families with children and single-parent families. The indicator in Memorandum 64 leaves the purchasing power of these groups out of consideration.

In the rest of this chapter, income is seen as the sum of a potentially large number of (positive and negative) components. Pay, gross benefits, imputed income from home ownership, interest, etc., are all added to income. Tax and social insurance premiums are deducted from it. In all, there are dozens of income sources. That is not to say that these will be relevant for everyone; for a given person the level of most sources could very well be nil.

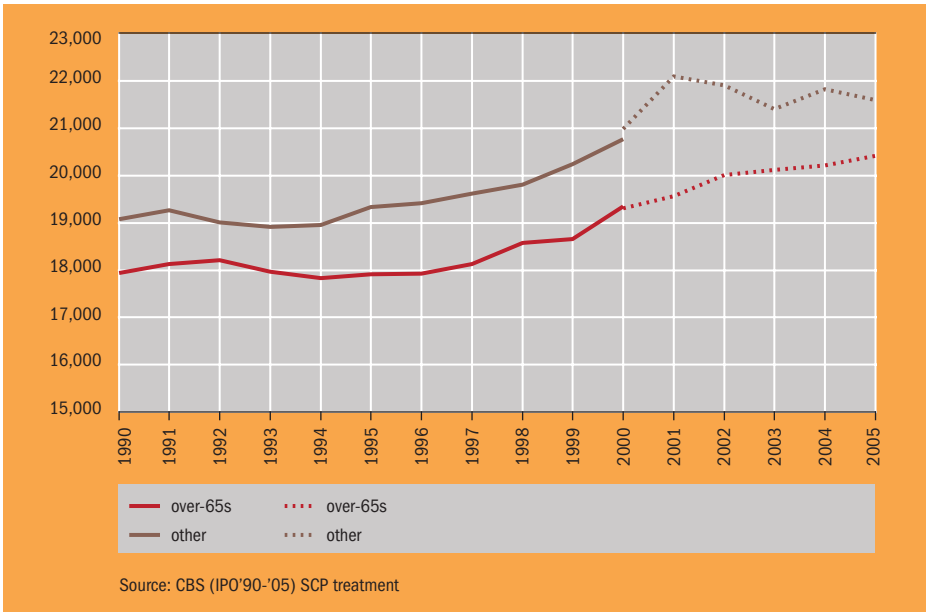
A number of these income sources are paid to households rather than individual persons. Social assistance benefit is one such source, as is rent benefit. It is therefore usual to add together the incomes of all members of a household. The sum of all individual incomes is then the household income. However, in some households more people will have to live from the one household income than in other households. What is more than sufficient for a single person may be barely enough to enable a family with several children to keep their head above water. In order to render the different household incomes comparable, they have been standardised: divided by a factor that makes allowance for the household type and the number of children.[4] The resultant amount enables the incomes of people belonging to different types of household to be compared. By allowing for inflation, these incomes are also comparable over time. The amount that ultimately results is the real standardised household income. Figure 4.2 shows the trend in the average of this income for people aged over 65 and for those who are younger.[5,6]

From a plateau in the mid-1990s, the average income of the over-65s has increased steadily. The economic downturn after 2003 appears to have bypassed the average incomes of this group. The level of the state pension is determined by policy interventions, which since 1995 have been favourable for pensioners. In addition, individual pension funds make decisions on whether or not to index-link pensions. Moreover, new cohorts of over-65s are added each year who – probably, given the reduction in the blank spots – have a better pension than their predecessors, while mortality reduces the proportion of those having to live from a small pension or with no pension at all.

The trend in the incomes of people aged below 65 shows a much more a regular pattern, especially after 2000. This group encounter far more dynamic changes (divorce, household formation, incapacity for work, unemployment). The peak in

2001 appears to have been caused by the tax reforms. The government raised the employed person's tax credit substantially in that year, and it was in this year that the difference in the average income between the over-65s and the under-65s reached its maximum.

Figure 4.2
Trend in average real standardised household income of over-65s and under-65s, 1990-2005 (in euros per year)



Source: CBS (IPO'90-'05) SCP treatment

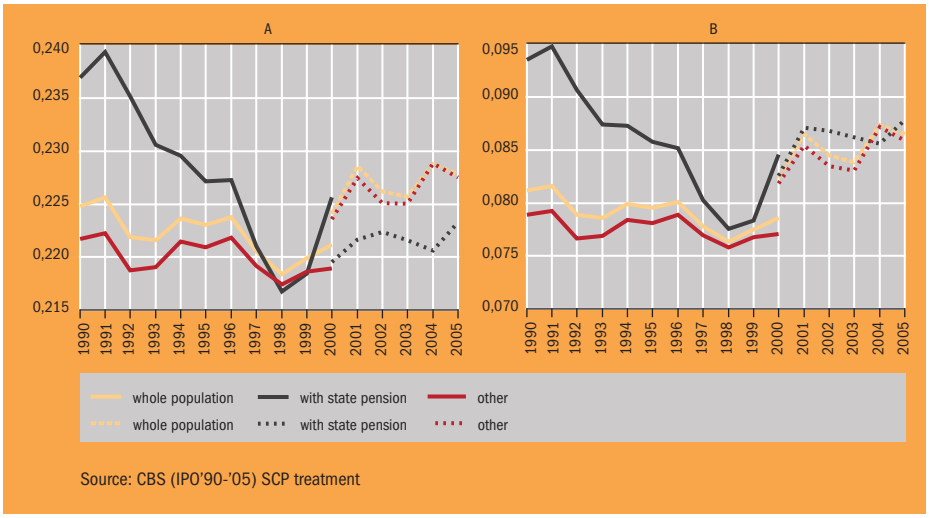
4.3 *Income inequality*

The authors of Memorandum 64 express concerns about the distortion of the income distribution, not only between generations, but also between different groups of pensioners. Figure 4.3a shows the income inequality across the entire Dutch population, those in receipt of state pension[7] and other households according to the Gini coefficient; figure 4.3b does the same thing according to the Theil coefficient.[8]

The two graphs show roughly the same pattern. In the early 1990s there was relatively wide income inequality between the over-65s and the rest of the population. Where the latter followed a rather variable pattern in the years that followed, with small changes from year to year, the income differentials between older people declined rapidly. This continued until 1998, the year in which the inequality among state pension recipients reached its lowest point. From 1998 onwards the inequality increased again, with a very marked rise between 1999 and 2000. From 2001 it reduced again little by little, but in the final year, 2005, there was another (small) increase.

Figure 4.3

Inequality in real standardised incomes, 1990-2005 (in Gini and Theil coefficients)



Source: CBS (IPO'90-'05) SCP treatment

In what follows we try to look more closely at the trend in the income inequality among the elderly. We distinguish three periods. The first runs from 1992-1998; income inequality fell sharply during these years. The second period is 1998-2000 (data from before the change in the Income Panel Survey; see note 6), with rapidly increasing income differentials. Between 2000 (after the change in the Income Panel Survey) and 2005 there was a slight increase in the net inequality. These years comprise the final period.

The measure of inequality used here is the Theil coefficient. This decreased steeply by 17% between 1990 and 1998, before rising again within two years by 9%. Finally, between 2000 and 2005 is increased by 6%.

The Theil coefficient makes it possible to analyse the change in income inequality into inequality between groups and inequality within groups. Three factors are important here: the share taken in the population by the groups concerned, the inequality within those groups, and the average incomes of the groups. The change in total inequality can be traced directly to changes in these three factors (Mookherjee & Shorrocks 1982; cf. Pommer et al. 2003).

Table 4.1 shows the effects of two group classifications on the changes in the Theil coefficient during the three periods. The underlying data are presented in table B.1 in the appendix (available at www.scp.nl). This divides the older population into people with and people without a supplementary pension, and into people with and without a positive income from their own home.[9]

Table 4.1

Effects on the change in the Theil coefficient during three periods, by presence or absence of a supplementary pension or income from own home, over-65s, 1990-2005 (in percentages)

	effect of changes in:			
characteristic	shares in the population	average incomes	inequality within groups	total
with/without supplementary pension				
1990-1998	-4	5	-18	-17
1998-2000	0	0	9	9
2000-2005	-4	4	6	6
with/without income from own home				
1990-1998	2	-4	-16	-17
1998-2000	0	4	5	9
2000-2005	0	-2	8	6

Source: CBS (IPO'90-'05) SCP treatment

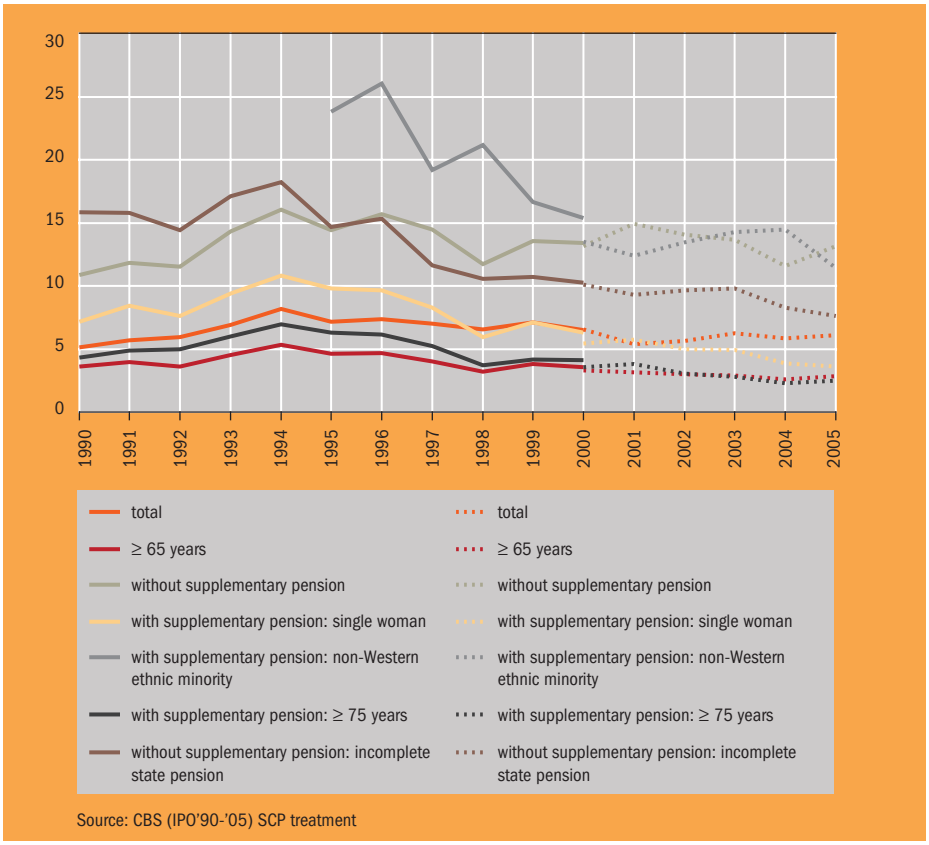
The reduction of 17% in income inequality among the elderly during the period 1990 and 1998 appears to have been caused mainly by two factors: the rise in the number of people with a supplementary pension and a decline in the inequality both within the group with and the group without a pension. The growing differences between the average incomes of the two groups increased the inequality.

The role of home ownership during this period is more difficult to interpret. In itself, the rise in home ownership slightly increased income inequality; however, the change in average incomes between homeowners and others reduced inequality.[10] The role of home ownership is easier to interpret when it comes to the increase (by 9%) in inequality during the second period (1998-2000); this appears to be mainly the result of the increased differences in average incomes between those with and without their own home, and the increasing inequality among homeowners (table B.1 in the appendix).[11]

The final period for which data are available (2000-2005) again shows an increase in income inequality among the elderly (6%). Owing to the change in the Income Panel Survey, these figures are not entirely comparable with those from previous years; in particular, the imputed rental income from home ownership is now calculated differently.[12] Once again, the levelling effect of the increased percentage of people with a supplementary pension can be seen, as in the period 1990-1998. Just as then, however, this is cancelled out by the effect of the increased difference in average incomes. The greater inequality within the group with supplementary pensions ultimately proved decisive in determining the increase in total income inequality among the elderly.

Figure 4.4

Proportion of poor people in the Dutch population as a whole, among the over-65s and in a number of subgroups of the over-65s, 1990-2005 (in percentages)



Source: CBS (IPO'90-'05) SCP treatment

4.4 Poverty

Not every older person has a supplementary pension or a home of their own. Over the years the average income of people without a pension or their own home has lagged behind that of other groups of older people. At the same time, the inequality within the group without a supplementary pension, in particular, is relatively marked. This begs the question of which groups of older persons find themselves below the poverty line, and by how much. We have drawn a distinction here between people with and without a supplementary pension, people without a supplementary pension and an incomplete state pension, non-Western ethnic minority elderly persons with a pension, over-75s with a pension and single women with a pension. Filling in the blank spots in the pensions landscape has been an incremental process. A relatively high proportion of people aged over 75 and women were consequently for a long time not members of a pension scheme. This is reflected in the relatively low average

incomes of these groups (table B.2 in the appendix). Members of non-Western ethnic minorities also have gaps in their pension build-up, where they receive a supplementary pension at all. For the same reasons, members of ethnic minorities also receive an incomplete state pension.

Figure 4.4 shows the trend in poverty rates. We have used the budget-related poverty line developed by SCP for this (the 'modest but adequate' variant; cf. Soede 2006).

The percentage of poor people aged over 65 was clearly lower than among the population at large throughout the period. The population aged over 75 also had fewer poor members than the total population, though the figure was higher than in the total group of over-65s. Also notable is the declining percentage of single women with an income below the poverty threshold. Since the end of the 1990s this has been lower than for the Dutch population as a whole.

Three other, partially overlapping groups also stand out clearly: non-Western ethnic minorities, people with an incomplete state pension and people without a supplementary pension. However, where the poverty rates in the first two groups declined, the poverty rate among people without a pension is stable.

4.5 Conclusion

Compared with the social assistance benefit for single person aged below 65, the net state pension for a single person has increased sharply since 1995. Today, in 2008, the difference is more than 11%. Adjusted for inflation, the average (standardised) income of the Dutch elderly also increased from the middle of the 1990s onwards. Although these averages are not as high as among the younger generations, the income of older people is less susceptible to economic fluctuations.

Income inequality among the elderly shows a varied picture. In the years 1990-1998 it declined sharply; between 1998 and 2000 it rose again sharply. In the most recent years (2000-2005) there was a slight net increase.

The poverty rate among the elderly population is lower than in the Dutch population as a whole. Members of ethnic minorities and people with an incomplete state pension (without supplementary pension) are by contrast more often poor than the rest of the Dutch population, though the percentage of poor people in these groups is declining. The basis for building a pension is lacking in these groups.[13] That basis consists of the years during which people have lived in the Netherlands and therefore been able to build up a state pension and a supplementary pension. As a result, the first two layers of the pensions 'cake' are very thin: the incomplete state pension means that many of them fall below the poverty line and their average income is low compared with other pensioners. Often, partly due to the smaller number of years for building a pension, their supplementary pension will also be incomplete. There thus appears to be a group of older people whose income lags some way behind that of the rest of the retired population: non-Western ethnic minorities, people with an incomplete state pension and people without a supplementary pension.

This latter fact is missed when focusing exclusively on the indicator set out in Memorandum 64 (the relationship between the net state pension and social assistance benefit). It would therefore be logical to replace this indicator with the following indicators:

1 The level of average standardised real income, both in absolute terms and in relation to the rest of society.
2 The percentage falling below the poverty line.
3 It would also be best not to focus just on all over-65s, but also on the vulnerable groups among them: people without a supplementary pension, members of non-Western ethnic minorities and people with an incomplete state pension.

Notes

1 This applies for people who have built up a full pension. Most people build up their pension by being a resident for a period of 50 years, between the ages of 15 and 65 (and not working abroad). Each year less than this total reduces the state pension by 2%.
2 The Dutch Pensions Board (Pensioenkamer) established in 1987 that 18% of employees were not members of a pension plan (Pensioenkamer 1987). Just under ten years later this percentage had fallen to 9% (Research voor Beleid 1997). A quick scan carried out by the Social and Economic Council (SER) for 2001 (SER 2002) suggests that the blank spots are still reducing. A new survey has been announced for 2008 (TK 2007/2008d).
3 The amount of the state pension was raised in 1964 to the same level as the guaranteed minimum income. The biggest improvements thereafter took place in the 1970s, reaching a peak in 1979. Measures on pay and the ending of the linkage between pensions and pay due to the recession in the early 1980s (Wassenaar Agreement 1982) subsequently led to a steep reduction in the purchasing power of the guaranteed minimum income and the state pension. The introduction of the (single) older person's tax credit in the 1990s has since restored the purchasing power of the state pension. The same does not yet apply for the guaranteed minimum income.
4 These factors are described as equivalence factors. The budget method devised by CBS (see CBS 2004a) is used to determine these factors here.
5 To be counted as over-65s, both the head and/or partner of a household must have reached the age of 65.
6 The Income Panel Survey (Inkomenspanelonderzoek) on which most of the data in this chapter are based was revised in 2001. The data for 2000 have been calculated both before and after the change.
7 Here, the head and/or partner of the household is in receipt of state pension.
8 It is very difficult to express the inequality between a large number of incomes in a single figure. Every attempt to do this leads to some loss of information. A large number of criteria have been proposed in the literature, each of which stresses a certain aspect of the income distribution more than others. The Gini coefficient chosen here is relatively sensitive to differentials in the middle segment; the Theil coefficient is sensitive to differences in the extremes of the distribution. Since outliers are treated slightly differently here, both the Theil and the Gini coefficients deviate slightly from those in *The Social State of the Netherlands 2007 (De sociale staat van Nederland 2007)* (Bijl et al. 2007).
9 In addition to a supplementary pension, older people have many other sources of income. One of these is income from home ownership, another is income from other assets. A reduction in these other sources of income can contribute to a fall in the average income of people without a supplementary pension. It is also logical that over a period of several years (and especially for the period 1990-2005), the composition of the various groups will change. A relevant factor here is the increase in the number of non-Western ethnic minorities reaching the age of 65; this group often have an incomplete state pension and an incomplete or no supplementary pension.
10 The changes in average incomes are too small to be visible in thousands of euros.
11 The average imputed income from home ownership of the over-65s rose between 1990 and 2000 from € 4,206 to € 4,808.
12 From the change onwards the value according to the Value of Immovable Property Act (WOZ) is used; prior to this the 'estate agent method' was used.
13 In the 1950s, when the state old-age pension was created, this was of course difficult to foresee.

5 Housing

Renske Hoefman

5.1 Adequate housing for the elderly

As people grow older and start to be confronted with physical impairments, their housing needs change. They then often opt for a dwelling on one floor, and care-dependent older people prefer independent living with care input in the neighbourhood over admission to a care home (Kullberg & Ras 2004). Since moving house is not a minor undertaking, people in the 'third phase of life' already begin looking around them from the age of 55 at dwellings where they could grow old. The children have usually left home and their parents face the choice of keeping on their present home or looking for a more suitable dwelling with an eye to possible physical impairments in the future. The government also sets the age limit for its housing policy for the elderly at 55 years. Questions that play a role here include: What kind of homes do the over-55s want? How many homes are suitable for older people, with adaptations and care provision in the neighbourhood are available, and how many still need to be built or adapted?

The government invests in suitable homes through new-build, remodelling of existing homes (adapting and making them accessible), creating neighbourhood support centres and targeted allocation of homes (*Investing in the future* action plan (*Investeren in de toekomst*, TK 2003/2004 and *Better (at) home in the neighbourhood* (*Beter (t) huis in de buurt*) action plan, VROM/VWS 2007). *Investing in the future* is a joint action plan by the Ministry of Housing, Spatial Planning and the Environment (VROM) and the Ministry of Health, Welfare and Sport (VWS). It states that 40% of the shortage of homes for older occupiers must be met through new-build. An average of 30% of new-build housing in the period 2002-2005 was internally and externally accessible for people with physical impairments (Sogelée & Van Galen 2007).[1]

Within the existing housing stock, it is estimated that between 92,000 and 279,000 homes, both rented and owner-occupied, would be suitable for adaptation, such as the installation of a stair lift. A large part of the target in relation to stairless homes could be achieved by adapting all these homes. One qualification here is that it is not clear whether these homes could actually be adapted in practice, for example because they are scheduled for demolition (Sogelée & Van Galen 2007) or because the occupiers do not wish to have their home adapted.

Housing associations have an important task in the allocation of housing (TK 2003/2004; VROM/VWS 2007). In practice, the method of allocation varies considerably; some housing associations allocate homes in a targeted way through a personal allocation system, whereas others prefer to let the market do its work.

In recent years, many housing associations have been working on improving their system for allocating their scarce housing stock (Kuijpers 2007; Sanders 2004). They now make allowance for the fact that people with physical disabilities need suitable housing, so that a large part of the available housing is reserved for the most urgent target group.

The target for housing for older persons as set out in Memorandum 64 is that the over-55s must have access to adequate housing, geared to their individual needs and supported by customised care provisions ('supported living') (TK 2004/2005). The programme for achieving this objective is set out in the action plan *Investing in the future* (*Investeren in de toekomst*) (TK 2003/2004), which formulates targets for the coming years. Memorandum 64 makes use of this action plan:

> *In accordance with the VROM/VWS Action Plan, the task up to the year 2009 is to create 255,000 stairless homes, equivalent to 32,000 per year.*
> *For the period after 2009 the government wishes to review this rate of adaptation in a new action plan based on the need as measured at that time. Standing still in the face of an ageing population is effectively going backwards, because population ageing is a moving target. Given the ambition of striking a balance between supply and demand in 2009, the objective set out in the Action Plan warrants a score of 7 out of 10.*
> *The shortage of care-supported housing is currently approximately 41,000 out of a total stock of 415,000, or 9%. This is an unsatisfactory situation whose cause lies in a shortage of stairless homes, inadequate local care provision or a combination of the two. We give this situation a score of 5 out of 10. According to the Action Plan, 99,000 homes with care input will become available up to and including 2009, thus meeting the demand. This warrants a score of 7 out of 10. The overall score for care-supported housing is then 6.0.*[2]

Memorandum 64 formulates targets for two types of housing for older people: 'stairless homes' and 'care-supported housing'. Stairless homes are homes which are accessible both internally and externally. They are regarded as an accessible internally if the living room, kitchen, toilet, bathroom or shower room and at least one bedroom can be accessed without having to use stairs; they are externally accessible if the living room can be accessed from the street without having to climb stairs (VROM 2007).[3] Care-supported housing is designed especially for older occupants, with standby care facilities on call. Care on call means that people can receive care or nursing within their home from a residential care home, home for the elderly, service centre or support centre in their local neighbourhood.[4]

The targets for the number of stairless homes and care-supported homes are derived from estimates of the housing need, and represent the task in relation to suitable housing for older people. That task comprises three elements: eliminating the shortage (this is evident from the 2002 Housing Needs Survey); meeting the demand that arises due to the trend in the population (organic growth); and meeting the demand that arises due to policy (care in the community) (Sogelée et al. 2006).[5]

In this chapter we investigate on the basis of periodic population surveys (Housing Needs Survey 2002 (WBO'02) and Netherlands Housing Research 2006

(Woon'06)) for the period from 2004 to 2006 how the use of homes for older occupants has changed. No national data are available on the supply of stairless homes and care-supported homes. Note the difference of emphasis in that the targets in Memorandum 64 are formulated as available homes for older occupants whereas the analyses in this chapter refer to the use of these homes by households containing a person aged 55 years or older. In 2006, 40% of households in the Netherlands contained at least one member who was aged 55 or older. Over 15% of these households lived in a home designed for older occupants. Of these households, approximately 30% had access to care on call. Just under 32% of the over-55 households lived in a stairless home (not necessarily specially designed for older occupants) in 2006 (not shown in a table).

When evaluating the targets attention was also paid to subgroups in the older population. Based on analyses of the data (see appendix C at www.scp.nl), the over-55 households were subdivided by age (of the oldest member of the household), motor impairment (of the most care-dependent household member) and household composition.

5.2 *Achievement of the targets*

Memorandum 64 formulates the target of creating 255,000 additional stairless homes for older people by 2010 in order to meet the demand for this type of dwelling. This means that approximately 36,000 stairless homes must be added each year.[6] We cannot present a definitive answer as to whether or not this target will be achieved, because the data from the WBO'02 and the Woon'06 on the use of stairless homes cannot be compared; a stairless home is defined differently in the WBO'02 questionnaire than in Woon'06. It is known from other research that the total number of new-build stairless homes increased in the period 1995-2000 by 220,000 to almost 1.5 million (Singelenberg 2003). Research on the housing stock in the subsidised rental sector[7] suggests that the number of stairless homes in the Netherlands rose from approximately 605,000 in 2005 to more than 615,000 in 2006 (VROM-inspectie 2006). These figures are based on key data from housing institutions accredited under the Housing Act.

The second indicator for suitable homes in Memorandum 64 consists of homes with care input ('supported living'). The estimated number of such homes needed up to 2010 is 99,000, or 14,000 per year.[8] figure 5.1 shows a rising trend in the absolute number of households with a member who is aged 55 or older who is able to obtain care on call within their home, such as help with dressing, provided by a caregiver from a care home in the local neighbourhood.

Table 5.1 shows that significantly more over-55 households were living in care-supported housing in 2006 than in 2002 (up from 24.4% to 30.4%). The percentage who make use of care on call increased between 2002 and 2006 mainly among households with a member suffering from a physical impairment; this applied for all age groups and all household compositions (table 5.1). These results appear to sug-

gest both proactive and reactive housing behaviour. The youngest elderly will have decided to opt for care-supported housing with a view to the possible development of physical impairments in the future. The increase among the 'older' elderly suggests that they moved to a care-supported home because of problems with looking after themselves in their previous home due to physical impairments. In absolute terms, the number of homes for older occupants for which care on call is available rose from approximately 101,000 to 129,000) table 5.1). This is an increase of just over 7,000 homes per year – not enough to meet the target.

The use of care-supported housing is possibly underestimated because of the question formulation used to measure it. Respondents had to indicate themselves whether they were able to call on nursing or care services in their local neighbourhood. Some older people may not be aware that they live in the catchment area of a care institution. Moreover, this question was put only to those living in homes designated for older occupants, and it is quite possible that they were not aware that their home fell into this category. In addition, people who do not live in a home designated for older occupants but who are still able to make use of care on call, are left out of consideration. The Ministry of VROM/Housing, Communities and Integration and the Ministry of VWS plan to carry out a study in 2008 of the coverage of the available on-call care in the Netherlands. This will not be based on user numbers, but will be calculated on the basis of the supply, for example the presence of care centres in a district (*Better (at) home in the neighbourhood* (*Beter (t)huis in de buurt*) action plan, VROM/VWS 2007).

Figure 5.1

Homes for older people where care on call is available, households with a member aged at least 55 years, by age, 1993-2006 (in absolute numbers)

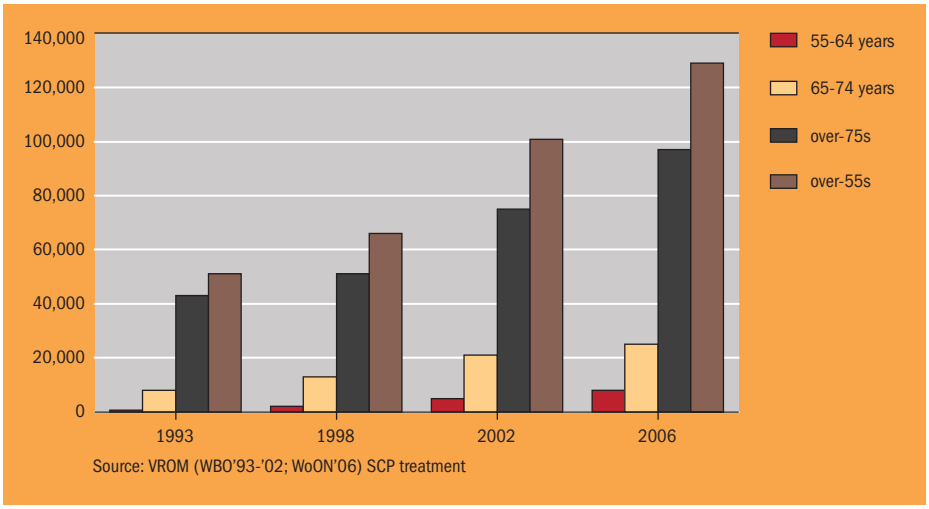


Table 5.1

Share of older[a] households living in a home for older occupants, with care-supported housing,[b] by a number of background characteristics, 2002 and 2006 (in percentages and, between brackets, estimated absolute numbers x 1,000, n = 4,485; 3,338)

	2002		2006	
age				
55-64 years[c]	9.2	(5)	12.7	(8)
65-74 years[c]	16.6	(21)	20.9	(25)
≥ 75 years[c]	32.2	(75)	39.3	(97)
motor impairment				
no impairment	21.4	(32)	20.1	(30)
slight impairment[c]	21.0	(11)	29.0	(8)
moderate impairment[c]	24.4	(31)	33.7	(50)
severe impairment[c]	32.1	(27)	41.9	(40)
household composition				
partner[c]	17.6	(23)	24.3	(35)
single person[c]	27.5	(78)	33.6	(94)
total[c]	24.4	(101)	30.4	(129)

a At least one member of the household is aged 55 or older.

b 'Care-supported housing' means that people live in a home for older occupants where they can obtain care on call from a nearby support centre.

c Difference between 2002 and 2006 is significant at $p < 0.05$.

Source: VROM (WBO'02, WoON'06) SCP treatment

5.3 Better indicators

In order to meet the objective as set out in Memorandum 64, namely that homes must be adequately equipped to meet the needs of older occupants, those homes must as a minimum be accessible for them. The vast majority of people aged over 55 attach great value to an easily accessible home (De Waal-Saulais et al. 2004). The indicator 'stairless home' measures the accessibility of the home, but does not cover this concept completely. It is true that in a stairless home the main rooms can be reached without having to climb stairs, something that is problematic for many people with a physical impairment (De Klerk & Schellingerhout 2006; De Klerk et al. 2006). However, the mere absence of stairs is not enough to make a home accessible; other aspects, such as (excessively high) thresholds or doorways that are too narrow, can also be obstacles. Almost 13% of the over-75s with a physical disability have difficulty moving around on the same floor (De Klerk 2007), and this is especially problematic for people who use a rollator or a wheelchair: more than 7% of

people with a physical disability who regularly use a wheelchair find that their own home is not accessible for a wheelchair or rollator (De Klerk & Schellingerhout 2006). The WOON contains data on minor adaptations, such as modified thresholds or the widening of doors, as well as on the need for these adaptations on the part of the occupant(s). In addition to minor adaptations, more radical interventions, such as the installation of a stairless, can also improve accessibility. The WOON contains data on this. It is recommended that access to minor and major home adaptations be included in a subsequent Monitor as an indicator for accessibility.

A second condition which must be met by a home if it is to be suitable for occupancy by older persons is that they must have access to care provisions geared to their needs. A suitable indicator for this is that used in this Monitor, namely care-supported housing (see also Sogelée & Brouwer 2003). In addition, Sogelée and Brouwer identify another type of housing, namely housing with (welfare) services. These services comprise domestic help, meal provision and 'light' services such as having a caretaker. Care-supported housing is a better indicator for measuring homes with customised care provisions, because not all provisions that fall into the category of housing with services will be necessary for enabling older persons to continue living in their home.

A third indicator which enables older persons to continue living independently for longer is the presence of technology in the home. This can take on very diverse forms, such as a personal alarm system, domotics or telemedicine. Most of these facilities are currently only offered on an experimental basis in the Netherlands, and owing to the low user numbers are not suitable for monitoring. The use of alarm systems can however be measured. Almost a fifth of homes for older occupants were equipped with personal alarms in 2002 (De Klerk 2004), and the WOON contains a question on this.

This chapter devotes attention only to homes for older persons living independently. In chapter 7 we look at two forms of housing for the elderly in institutions for which targets have been formulated: small-scale housing for people with dementia and multiple-bedded rooms in nursing homes.

5.4 Conclusion

It proved possible with the available data to evaluate the growth in the number of care-supported homes: the annual increase of just over 7,000 is too low to meet the targets set in Memorandum 64.

It is not really possible to assess whether there were more stairless homes for the over-55s in 2006 than in 2002. Owing to the changed question formulation in the WOON compared with the WBO, these two surveys do not measure the same thing and the data can therefore not be compared. In accordance with the ideas of VROM (Sogelée & Van Galen 2007), we would suggest using the data from WOON 2006 as a zero or reference measurement. It is then recommended that the same question for-

mulation be used in subsequent editions of the survey. It is of course also important that questions on housing provisions are incorporated in this survey.

Our analyses have shown that some subgroups in the elderly population receive more care on call than others (see appendix C). Some groups have more need for this care, for example because of physical disabilities. In order to assess whether the envisaged groups are making sufficient use of suitable homes, it would be desirable in a subsequent Monitor not only to look at the housing task for all older persons, but also that for specific subgroups. Research has shown that people with physical disabilities and people aged 55-74, in particular, would like to move home if they are living in an unsuitable home and are in poor health. The majority of older persons wishing to move house would like to live in a stairless home (Kulberg 2004). It would moreover be desirable in a subsequent Monitor to draw a distinction between occupants of rented or owner-occupiers dwellings. A better insight into which subgroups of the elderly population are appropriately housed could help in achieving (more) efficient solutions to the shortage of suitable homes, for example through the targeted allocation of homes in the rented sector to people with physical disabilities.[9]

Notes

1 The contribution from new-build to care-supported housing cannot be determined due to a lack of data on the building of care support centres (Sogelée & Van Galen 2007).
2 The Investing in the future monitor cites a different percentage shortage, namely 41% (demand for 42,000 with an available stock of 101,000 homes in the category 'care-supported housing').
3 External accessibility is described differently in the 2002 WBO than in its successor, the WOON from 2006. In the WOON, external accessibility means that the living room can be accessed from the street without having to climb stairs. In the WBO a home was classed as externally accessible if the front door could be reached without having to climb stairs (VROM 2007).
4 The definition of care-supported housing used here differs slightly from the definitions used in Memorandum 64 and the accompanying Parliamentary papers (TK 2002/2003; TK 2003/2004; TK 2004/2005). In those documents, care-supported housing is not by definition aimed at older people. It was not possible to use precisely the same definition in this Monitor as in Memorandum 64, because a 'routing' has been built into the questionnaires which means that the question on receiving care on core can only be answered by people who have stated that they live in a home designated for older occupants.
5 The task for suitable homes is based on information from the national Housing Needs Surveys (WBO) and the Primos population forecast (2005) (Sogelée & Van Galen 2007). The first element of the calculation of the task, namely the shortage, is the difference between the existing (supply) and required (demand) housing stock. The demand consists of the present occupants and those who would like such a home, less the households who wish to leave (Sogelée & Van Galen 2007). The supply is derived from a question in the WBO on the suitability of the home in which respondents live. To determine the organic growth of suitable homes, the user percentages of suitable homes from the WBO'02 was multiplied by the size of the future population in 2015, making allowance for a distribution in terms of age, household composition, sex and education level (Sogelée et al. 2006). The final element of the task consists of the influence of care in the community. In calculating the task, allowance was made for the reduction in the institutional capacity of care homes in the disabled sector and the mental health care sector, and the additional demand this creates for other types of housing, such as care-supported housing (Sogelée et al. 2006).
6 The number of homes needed per year differs from the numbers referred to in Memorandum 64. In this Monitor it is assumed that the task begins in 2003 and ends in 2010. Instead of dividing the task into eight years, it is therefore divided into seven years.
7 Homes in the subsidised rented sector make up just over 34% of the total housing stock in the Netherlands.
8 The task for care-supported housing and stairless dwellings has also been calculated on the basis of the new definition. The task for stairless homes then amounts to 72,700 homes per year up to 2010 (Van Galen & Sogelée 2007). The task up to 2015 is 45,100 stairless homes per year.
9 Apart from ensuring that there are sufficient suitable homes for older people with impairments, it is also necessary that there are enough homes for older people with no impairments or only slight impairments. It is desirable that a proportion of

these homes should not be allocated to specific subgroups, but should be left 'to the market', so that older people are able to respond proactively to a future where they may be dependent on care (Sanders 2004). Moreover, there are older people without impairments living in a home that is suitable for someone with impairments because they have (had) a partner with impairments. This means that the supply of suitable homes will have to increase further, not only because older persons who need suitable housing because of their physical disabilities (would like to) live in these homes, but also the more vital elderly persons. There is also a risk that a larger share of other target groups will occupy homes suitable for the elderly, for example starters on the housing market. Responding to the housing needs of the elderly through new-build programmes could partially alleviate this problem (VROM-raad 2005).

6 Staying healthy

Maaike den Draak and Cretien van Campen

6.1 Mobility without falling

Staying healthy is naturally important to the over-55s, particularly since growing older usually leads to impairments. 'If you don't want to get old you must above all stay healthy' seems to be the motto of many present-day over-55s. Health is of course a multifaceted phenomenon. On the one hand, many factors influence health (Hollander et al. 2006), while on the other hand health problems impact on different areas of life, as can be read elsewhere in this Monitor (see also Hoeymans et al. 2005c). From the many possible options, in Memorandum 64 the government opted for two indicators for the Elderly Policy Monitor: the proportion of older people performing sufficient exercise (a lifestyle indicator), and the proportion of fall incidents among the elderly which have received medical treatment (an outcome indicator) (TK 2004/2005: 49). In other words, the government is monitoring the group of older people who are mobile without falling.[1]

Physical activity has a clear positive effect on health. Regularly taking sufficient exercise reduces the risk of a number of long-term diseases and can improve the course of those diseases, including coronary heart diseases, diabetes mellitus, intestinal cancer, osteoporosis, stroke and depression (CDC 1999; Schuit & Van Leest 2005). Physical activity also has a positive effect on the (cognitive) functioning of older people and on the immune system (Gezondheidsraad 2005). Physical exercise is thus a determinant of health. At the same time, a deterioration in health and an increase in impairments are important reasons why older people cease taking part in sport (Deeg & Visser 2007).

Fall incidents are regular occurrences among older people and can lead to serious injuries, including hip fractures. Conversely, many hip fractures occur as a result of falls. They have often serious consequences and are a major cause of hospital and nursing home admissions, loss of independence and reduced quality of life. They often lead to higher medical and care costs and are accompanied by an increased risk of death within a year (CBO 2004; Van den Berg Jeths et al. 2004; Bulstra 2006; Lanting et al. 2006b; Saltzherr et al. 2006). This increased mortality cannot be ascribed exclusively to hip fractures or their direct consequences, such as surgery with anaesthetic, postoperative complications or immobility. Fall incidents often mask a wide range of health problems which increase the risk of a fall. The poor general health status of an elderly person before the fracture, and the frequent comorbidity, also influence the prognosis (CBO 2002; Bulstra 2006; Lanting et al. 2006b). Fall incidents which result in a hip fracture are thus a familiar determinant

of mortality and of loss of independence and mobility. At the same time, they are the outcome of a pre-existing health status.

Both indicators are therefore relevant for older people being and staying healthy. Moreover, there is a relationship between physical exercise and fall incidents. Sufficient physical activity keeps the muscles in condition, so that the risk of falls and fractures is relatively small. Physically active older people moreover have faster reaction times, reducing the risk of falling (CDC 1999; Gezondheidsraad 2005). A number of fall prevention programmes accordingly include exercises, such as the 'In Balance' (In Balans) programme. In some cases these have been proven to be effective (Cbo 2004; Faber et al. 2006; Hamerlynck et al. 2006).

6.2 *Exercise*[2]

Memorandum 64 states the following:

> *With regard to sport and exercise, the government takes half an hour of moderately intensive exercise at least five times a week as a standard. Approximately 43% of the over-65s currently meet this norm. Objectively, of course, it will never be possible to reach 100%, but 70% should ultimately prove attainable in the foreseeable term. The government accordingly scores the present situation at 6.1 on a scale from 1 to 10. That is barely adequate. The target in the first instance is to raise the score to 7 out of 10, which means that roughly 50% of the target population would have to be meeting the exercise standard. In the policy memorandum on sport, exercise and health (Nota* Sport, bewegen en gezondheid*) (2001) the government set a target of 45% of the population complying with the standard in 2005 and 50% in 2010.*

The indicator used in Memorandum 64 for exercise and sport is the percentage of over-65s living independently who according to the continuous monitor 'Exercise and health' (*Bewegen en gezondheid*) by TNO meet the Dutch Standard for Healthy Physical Activity (NNGB). In 2003 the figure was 43% (Ooijendijk et al. 2004). The NNGB indicates the minimum amount of physical exercise that is needed to maintain and improve health (Kemper et al. 2000). For adults (aged over 18), the standard has been set at half an hour of moderately intensive physical activity on at least five days a week.[3]

The *Exercise and health* monitor forms part of the broader research project 'Accidents and Exercise in the Netherlands' (*Ongevallen en Bewegen in Nederland*) (OBIN) and is a continuous survey held among a sample of the Dutch population aged 12 years and older (Ooijendijk et al. 2004; Verweij et al. 2005). These respondents are asked two questions on how many days per week they undertake moderately intensive exercise such as fairly fast walking or cycling for at least 30 minutes per day. One question relates to the summer and the other to the winter period.[4] The exact number of minutes that people spend on exercise is not asked, nor are respondents asked to specify the activities further.

6.2.1 *Achievement of the targets*

The specific target set out in Memorandum 64 is to increase the percentage of over-65s who comply with the healthy exercise standard to around 45% in the short term and to around 50% by 2010. These targets are the same as those set out in the 2001 policy memorandum on sport, exercise and health (Nota *Sport, bewegen en gezondheid*) for the whole Dutch population (VWS 2001).[5]

Several projects have been continued or set up in recent years to encourage exercise by older people. Examples include the Groningen Active Living Model (GALM) and its variants (e.g. SMALL, GALLOM and SCALA), the Taskforce 50+ Sport and Exercise and its local variants, 'Exercise with Pleasure' (Bewegen met Plezier) (part of the FLASH! campaign in 2005) and 'Exercise and Health for Seniors' (Bewegen en Gezondheid voor Senioren) (see www.nisb.nl) (Stiggelbout et al. 2005; VWS 2005; Willemsen 2006; NISB 2007a). The interventions and any contribution they make to achieving the targets are not evaluated here. We do however present a general picture of developments between 2000 and 2005 in the percentage of older people meeting the healthy exercise standard.

The percentage of older people taking sufficient exercise increased between 2000 and 2005 (table 6.1). The target of 45% over-65s meeting the exercise standard was obtained in 2004, i.e. before the target year of 2005, and the objective of 50% had already been achieved in 2005.[6]

Table 6.1

Meeting the Dutch Standard for Healthy Exercise, population aged 65 years and older, 2000-2005 (in percentages)

year	percentage
2000	42
2001	39
2002	42
2003	43
2004	45
2005	52

Source: TNO (OBiN'00-'05)

Most sections of the older population achieved the 45% target in 2005, regardless of their sex, age, education level or perceived health (table 6.2). It was only among those over-65s who perceived their own health as poor that a much smaller percentage (21%) met the healthy exercise standard. For older people, a deterioration in health generally means an increase in functional impairments, an important explanatory factor for giving up sport (Deeg & & Visser 2007). At the same time, physical activity has a positive effect on chronic diseases and (cognitive) functioning (CDC 1999; Gezondheidsraad 2005). Cause and effect thus interfere with each other.

The group with poor perceived health lagged behind the observed increase in the taking of adequate exercise between 2000 and 2005, while older people with good perceived health increased the amount of exercise they take a great deal relatively speaking (table 6.2). The growth is slightly lower among the better educated, narrowing the gap between well-educated and low-educated over-65s.

Table 6.2

Meeting the Dutch Standard for Healthy Exercise, by background characteristics, population aged 65 years and older, 2000-2005 (in percentages and difference 2005-2000 in percentage points)

	2000	2001	2002	2003	2004	2005	2005-2000
sex							
male	44	41	45	43	48	52	+8
female	40	38	40	43	43	52	+12
age							
65-74 years	43	42	47	45	49	54	+11
≥ 75 years	39	36	37	41	40	49	+10
education level[a]							
high		46	48	47	54	55	+9[b]
medium		44	40	43	48	54	+10[b]
low		36	41	43	42	50	+14[b]
perceived health							
good	42	45	46	46	53	58	+16
moderate	35	31	38	38	36	47	+12
poor	19	17	24	23	34	21	+2
total	42	39	42	43	45	52	+10

a High: university/hire professional; secondary: senior general secondary/pre-university and senior secondary vocational; low: pre-vocational secondary, junior general secondary and primary.

b Difference 2005-2001.

Source: TNO (OBiN'00-'05); Ooijendijk et al. (2007)

The question is whether the observed upward trend in exercise is a genuine increase, a one-off outlier (52% in 2005 is a big difference compared with 45% in 2004), or whether other factors are at work. In recent years exercise has attracted a great deal of interest, partly thanks to campaigns such as FLASH! (encouraging cycling, walking, action moments, sport and household work) and the association of lack of exercise with overweight. The increased awareness of the importance of exercise and the growing awareness of the Dutch of the healthy exercise standard will have an influence on the way in which people answer questions about exercise. Taking enough exercise has become the social norm, and people will be more inclined than in the past to answer questions in such a way that they appear to meet that norm

(Ooijendijk et al. 2007: 26-27), including older people. These aspects are however also of interest for policy and monitoring: Memorandum 64 states and that the Ministry of Health, Welfare and Sport (VWS) also supports projects designed to boost the image of sport and exercise by the over-50s (VWS 2005: 50).

According to Ooijendijk et al. (2007: 27) the TNO figures nonetheless provide a clear indication of the amount of physical exercise, and probably partly take into account the social importance that people attach to exercise. Between 2000 and 2005 the proportion of adults (aged over 18) meeting the healthy exercise standard in the Netherlands increased from 44% to 56%. This trend is confirmed by the increase in the average amount of time spent by the over-12s on physical activity (Ooijendijk et al. 2007; Tiessen-Raaphorst et al. 2007).

6.2.2 *Better indicators for exercise*

In the previous section it transpired that in 2005 more than 50% of the over-65s were taking sufficient exercise. Even among the over-75s, almost half were taking sufficient exercise. The objective for 2010 was thus achieved early, indicating that the targets were perhaps not ambitious enough and should be adjusted. At the same time, consideration could be given to choosing an alternative exercise indicator, the 'combinorm' (see below and appendix D, available at www.scp.nl).

In addition to the NNGB and the OBIN from TNO, alternative indicators and methods have been developed for measuring exercise, such as the combinorm. Appendix D contains a comparative analysis. Below we look briefly at a number of the alternatives. The National Institute for Public Health and the Environment (RIVM) is currently working on a project to compare different methods and standards with an objective criterion (ActiHeart measurement). At the end of 2008 it should be possible to make statements about the differences between the different methods and standards, their validity and their suitability for specific purposes.

Like TNO, Statistics Netherlands (CBS) publishes data each year on the proportion of the Dutch population who comply with the NNGB. The Permanent Life Situation Survey (POLS) published by CBS, includes the SQUASH questionnaire devised by RIVM. The SQUASH figures published by CBS are higher than the date are from TNO in the OBIN survey, but the SQUASH percentage of people aged over 65 meeting the healthy exercise standard has remained stable since 2001 (table D.1). A third data source facilitates comparison: the Time Use Survey (TBO) from the Netherlands Institute for Social Research | SCP (see appendix D).[7]

The Netherlands Standard for Healthy Exercise (NNGB) is not the only indicator used for measuring the degree of physical activity in the population. The NNGB indicates the minimum amount of physical exercise needed to maintain and improve health. In addition to this standard, there is a guideline for achieving optimum fitness and good condition, the fitness standard. For improving fitness, the intensity of the physical activity is more important than it is for improving health. The fitness standard advises adults to undertake *very* intensive activity for 20 minutes on at least

three days per week. To ensure that older persons who meet the fitness standard but not the exercise standard within the group of older persons who meet the standard, the combinorm is a good alternative. This combines the exercise and fitness standards and assesses whether people meet at least one of them (Kemper et al. 2000; Tiessen-Raaphorst et al. 2005; Wendel-Vos et al. 2007).

In comparison with younger adults, the difference between the healthy exercise standard and the combinorm is not large for older people (see appendix D). The trend in the combinorm between 2000 and 2005 (table 6.3)[8] is more or less the same as for the healthy exercise standard (table 6.2).

Table 6.3

Meeting the combinorm, by age and perceived health, population aged 65 and older, 2000-2005 (in percentages and difference 2005-2000 in percentage points)

	2000	2001	2002	2003	2004	2005	2005-2000
age							
65-74 years	47	46	51	49	55	58	+11
≥ 75 years	42	37	38	43	43	51	+9
perceived health							
good	47	48	48	50	59	61	+14
moderate	36	31	40	43	38	51	+15
poor	19	17	24	23	34	21	+2
total	45	42	45	46	50	55	+10

Source: TNO (OBiN'00-'05); Ooijendijk et al. (2007)

More recent policy documents on sport have adjusted the targets for Dutch adults. The policy memorandum 'Time for Sport' (*Tijd voor Sport*) from 2005 sets as a target that by 2010 65% of adults will comply with the combinorm, while the policy document 'The Power of Sport' (*De Kracht van Sport*) from 2007 talks about 70% of people aged over 18 by 2012 (VWS 2005; VWS 2007a). Older people are implicitly included in these targets. The exercise standard applied is no longer the NNGB, but the combinorm.

Another, negatively formulated indicator for the degree of physical activity is the proportion of older people who are inactive. Physical inactivity is regarded as one of the main risk factors for chronic diseases (Wendel-Vos et al. 2007). Inactivity reduces muscular strength and control of movements, and leads to changes in the muscular and skeletal system, the cardiovascular system and the brain (Gezondheidsraad 2005). Increasing the amount of exercise also benefits people in poor health. An inactive lifestyle by people with long-term diseases increases their risk of overweight, functional impairments and loss of independence (NISB 2007b). An increase in the activity level will have a greater effect on the health and fitness of inactive

people than on those who are already active. In the NNGB for people aged over 55, it is therefore stated more explicitly that any amount of physical activity is better than none for people who are inactive, whether or not they have physical impairments (Kemper et al. 2000).

Inactivity is often defined as not being sufficiently physically active on any single day of the week (Ooijendijk et al. 2007; Wendel-Vos et al. 2007). The indicator is thus focused on people about whom we should be concerned in view of their exercise pattern. Some of them will be prevented by poor health from being (more) physically active, and the indicator is therefore also an indicator for poor health in general. The healthy exercise standard, fitness standard and combinorm are that too, but are more refined. On the other hand, as an indicator inactivity is not focused on the set policy objective of sufficient exercise.

In 2003 no fewer than a quarter of the over-75s and one in eleven 65-74 year-olds were inactive (table 6.4). The difference between the two groups correlates with differences in health and the degree of impairment. The proportion of inactive over-65s reduced between 2000 and 2005.

Table 6.4

Inactivity, by age, population aged 65 and older, 2000-2005 (in percentages and difference 2005-2000 in percentage points)

	2000	2001	2002	2003	2004	2005	2005-2000
65-74 years	12	11	12	9	9	8	-4
≥ 75 years	28	28	30	25	25	19	-9

a Inactivity: not undertaking moderately intensive physical activity for at least 30 minutes on any day of the week in summer and winter (exercise standard).

Source: Ooijendijk et al. (2007)

Virtually all older population groups, regardless of their sex, age, education level and perceived health, were already meeting the Memorandum 64 target for 2010 in 2005 (table 6.2). However, the low percentage of older people in poor health meeting the standard (21%) deserves special attention, as does the high percentage of inactive over-75s (19%, table 6.4). Deeg and Visser (2007: 187) rightly comment on the importance of limiting the reduction in physical activity by older people and people who suffer a deterioration in health, for example by offering more support to older people with chronic diseases or impairments. Memorandum 64 recognises this importance and encourages the development of tailored exercise programmes which meet the specific wishes and capacities of different groups, such as older people with physical disabilities. But the specific policy objective set out in Memorandum 64 and the associated indicator and targets ignore this. The present objectives could therefore be tightened up by adding additional targets for the percentage of inactive over-75s. For the coming years, there is an additional chal-

lenge in sustaining the high percentage of over-65s who comply with the norm and continuing the rising trend.

6.3 Fall incidents and hip fractures[9]

The second target for health is formulated as follows in Memorandum 64:

> *With regard to fall prevention, the government is particularly concerned about the severity of the consequences of falls. At present approximately 40,000 older people end up in hospital each year as a result of falls. Of these, 15,000 are admitted with hip fractures. Given the often serious consequences of a hip fracture, the government's aim is to halve the number of hospital admissions due to falls over time, which means that the present situation can be scored a 5 on a scale from 1 to 10. The estimated efficacy of fall prevention programmes is 10%. For 2010 the government is aiming at a reduction of 1,500 fractures, leading to a score of 6.*

Memorandum 64 proved to be insufficiently clear regarding the indicators used and the operationalisation of the targets.[10] These were therefore re-established in consultation with the Ministry of Health, Welfare and Sport (VWS) and the Dutch Consumer Safety Institute. In addition to fall incidents, we have incorporated hip fractures as an indicator, because many of the hip fractures in older people are due to falls. Moreover, a hip fracture often has serious consequences for an older person and leads to high medical and care costs.

The newly adopted targets are in line with the objectives of the Ministry of VWS in terms of preventing injury. The injury prevention policy, which is monitored by the Dutch Consumer Safety Institute, has the following objectives: a 10% reduction in treatments in accident and emergency (A&E) departments for injuries in the period 2001-2008 (see VWS 2003: 41) and a 5% reduction in treatments in A&E departments for injuries in the period 2008-2012. This means working towards a reduction in 2005-2010 of around 6% (after correction for the changing population profile).

There are several sources in the Netherlands containing frequently collected data on fall incidents and accidents-related injuries. Two important sources are the Injury Surveillance System (LIS) from the Dutch Consumer Safety Institute, and the National Medical Registration (LMR) produced by Prismant. The LIS records victims who have been treated in the A&E of a sample of Dutch hospitals after an accident, violence or self-harm (Den Hertog et al. 2005). An estimate can be made of the figures at national level; to enhance reliability, five-year periods are chosen for this. In the LIS, the cause of the injury, such as a fall, is recorded. The LMR contains data on all admissions to virtually all hospitals in the Netherlands as well as the associated diagnoses (Den Hertog et al. 2005). The diagnoses are coded using the ICD-9 system (International Classification of Diseases, 9th revision). The LMR is a less reliable source of information on the cause of the injuries.

The LIS and LMR thus provide an insight into A&E treatments for fall incidents and hospital admissions with hip fracture as the diagnosis. Together, these sources and indicators make a good combination. The age threshold we apply for these indicators, 65 years and older, is the same as that used for the indicator for exercise.

We selected data from the LIS on all A&E treatments due to personal fall incidents. We also drew a distinction between accidents taking place in nursing or care homes (assuming these affect residents) and accidents elsewhere. The LMR provide data on all hospital admissions due to hip fractures following a personal, sports-related or occupational accident (Valkenberg & Draisma 2007).

Both the LIS and the LMR provide data on the absolute number of treatments. However, trends in those figures show a distorted picture. The growth and ageing of the population means that the absolute number of hip fractures in the over-65s will increase in the future (Van den Berg Jeths et al. 2004; Lanting et al. 2006a). This sensitivity to the population structure means that absolute numbers are not suitable as indicators. It is therefore better to look at percentages that are adjusted for the population structure.

To determine whether the data on falls change over time, the Dutch Consumer Safety Institute has developed a method that can be applied to the LIS and LMR data.[11] The trend over the last five-year period is expressed by the Dutch Consumer Safety Institute in a percentage. To reflect trends over a period longer than five years, index figures are used for each five-year period. In principle, the trend is adjusted for changes in the population structure and, where necessary, for seasonal and weather influences (Valkenberg & Draisma 2007).

6.3.1 Achievement of the targets

A number of fall prevention projects for older people have been continued or set up in recent years. Examples include the 'Stop! You'll Fall' (Halt! U Valt) method, the 'In Balance' (In Balans) course, the 'Fall Prevention Improvement Programme' (Verbetertraject Valpreventie), part of the 'Caring for Better' (Zorg voor Beter) programme in long-term care institutions, and the 'More Exercise, Fewer Falls' (Bewegen Valt Goed) programme for elderly members of ethnic minorities (www.kennisnetwerkvalpreventie.nl, www.veiligheid.nl, www.zorgvoorbeter.nl). The interventions and any contribution they make to achieving the objectives are not evaluated here; we do however present a general picture of the trends in fall incidents and hip fractures.

The Dutch Consumer Safety Institute has performed an analysis for the years 2002 to 2006 inclusive. The figures presented relate to the annual average numbers and percentage increase or decrease. Rounding off means that the total in the table can differ from the sum of the individual numbers.

Table 6.5

Accident and emergency treatments after a fall, over-65s, 2002-2006

		2002-2006
A&E treatments	average number per year	66,000
trend in A&E treatments	adjusted for population structure	−6%*

* Significant ($p < 0.01$).

Source: Consument en Veiligheid (LIS'02-'06)

Table 6.6

Hospital admissions due to hip fracture, over-65s, 2002-2006

		2002-2006
hospital admissions	average number per year	14,000
trend in hospital admissions	adjusted for population structure	−6%*

* Significant ($p < 0.01$).

Source: Prismant (LMR'02-'06)

An estimated 66,000[12] over-65s are admitted to an A&E department each year for treatment after a fall (table 6.5), while 14,000 are admitted to hospital because of a hip fracture (table 6.6). After adjustment for changes in the population structure, a downward trend can be observed in both areas in the period 2002-2006. These falls are in line with the targeted reduction of around 6%.

Table 6.7 draws a distinction by sex. The number of A&E treatments after a fall and the number of hospital admissions due to hip fracture is found to be greater among women than among men, though the number of hospital admissions has fallen more sharply among women than among men in recent years.

Table 6.7

Accident and emergency treatments after a fall and hospital admissions due to hip fracture, over-65s, by sex, 2002-2006

		men	women	total
A&E treatments fall	average number per year	16,000	50,000	66,000
trend in A&E treatments fall (%)	adjusted for population structure	-7*	-6*	-6*
hospital admissions hip fracture	average number per year	3,200	11,000	14,000
trend in hospital admissions hip fracture (%)	adjusted for population structure	-3	-7**	-6**

* Significant at $p < 0.05$.
** Significant at $p < 0.01$.

Source: Consument en Veiligheid (LIS'02-'06); Prismant (LMR'02-'06)

Table 6.8 draws a distinction between two age groups in the number of fall incidents: 65-74 years and 75 years and older. The number of A&E treatments is twice as high among the over-75s as among 65-74 year-olds, and the reduction in the number of fall incidents is substantially smaller in the oldest group. A similar pattern is seen for hospital admissions due to a hip fracture; the number of over-75s treated is almost six times as great and the reduction in the numbers over time is smaller than among 65-74 year-olds.

Table 6.8

Accident and emergency treatments after a fall and hospital admissions due to hip fracture, over-65s, by age, 2002-2006

		65-74 yrs	≥ 75 yrs	total
A&E treatments fall	average number per year	22,000	44,000	66,000
trend in A&E treatments fall (%)	adjusted for population structure	-12**	-3	-6**
hospital admissions hip fracture	average number per year	2,100	12,000	14,000
trend in hospital admissions hip fracture (%)	adjusted for population structure	-9*	-6**	- 6**

* Significant at $p < 0.05$.
** Significant at $p < 0.01$.

Source: Consument en Veiligheid (LIS'02-'06); Prismant (LMR'02-'06)

Finally, table 6.9 analyses the number of A&E treatments might housing situation.[13]

Table 6.9

Accident and emergency treatments after a fall, over-65s, by housing situation, 2002-2006

		living at home	in nursing/residential home	total
A&E treatments fall	average number per year	61,000	4,900	66,000
trend in A&E treatments fall (%)	adjusted for population structure	-7*	17*	-6*

a The trend percentages for living at home and living in a nursing/care home are calculated on the basis of an analysis period of ten years, whereas the total trend percentages calculated on the basis of an analysis period of 20 years.
* Significant at $p < 0.01$.

Source: Consument en Veiligheid (LIS'02-'06); Prismant (LMR'02-'06)

Table 6.9 shows that, although the number of fall incidents has fallen in the group as a whole, it has risen sharply among residents of institutions. This is probably linked to the increased vulnerability of older people who have an indication for admission to a chair or nursing home. The stringent norms which apply for such an indication

and the policy of enabling people to continue living at home independently for as long as possible means that the self-reliance of residents of care and nursing homes has declined over the last ten years. The chance that these vulnerable elderly persons with diminished motor skills will fall is relatively great. Despite this, the 'Fall Prevention Improvement Programme' demonstrates that the number of fall incidents can be reduced if institutions take appropriate measures. In the institutions which took part in the programme, the number of people suffering falls fell by an average of 30%, and the number of health complaints resulting from falls also declined (www.zorgvoorbeter.nl).

6.4 *Spectrum of indicators for staying healthy*

In 2005 the two indicators 'exercise' and 'falls' were chosen as a means of monitoring the health of the elderly. These indicators have been critically reviewed in the foregoing sections. In this section we look at whether they are appropriate indicators for achieving the objectives of the health policy and whether there may be other relevant indicators.

The indicators chosen are both closely linked to the policy pursued and assign a figure to (the effects of) the policy. One disadvantage is that the indicators reveal only two aspects of health and leave others out of consideration, such as food consumption (lifestyle) and the prevention of underweight and overweight (health outcome). As a result, the present Monitor could produce a distorted picture if the situation in other areas developed in a different direction. For example, older people may be doing well according to the selected indicators for exercise and falls, while at the same time poor dietary habits could be leading to an increase in the proportion of older people who are overweight.

An indicator is expressed in a figure which summarises a series of basic data on a particular topic, enabling a trend to be followed uniformly (De Hollander et al. 2006). The conditions which must be met by an indicator are that it must be relevant, valid, reliable and measurable (IGZ 2007: 8). Ideally, the necessary data are readily available and there is continuity in the past, present and future, enabling a comparison to be made over time.

There are a number of data sources in the Netherlands which provide information at regular intervals on a large number of health indicators. Examples include the annual Permanent Life Situation Survey (POLS) by Statistics Netherlands (CBS), the four-yearly[14] Amenities and Services Utilisation Survey (AVO) by SCP, and the Local and National Health Monitor (*Lokale en Nationale Monitor gezondheid*) published by the federation of municipal health services (GGD Nederland) in collaboration with RIVM, TNO Quality of Life and ActiZ.[15] The latter is still under development and includes a specific Elderly Health Monitor (GZO), which offers a reasonably complete overview of indicators. More detailed information on the GZO Monitor and the POLS can be found in appendix E (available at www.scp.nl). It should however be noted that the POLS, the AVO and the GZO Monitor contain data on people living indepen-

dently. Older people living in institutions and homes are thus left out of consideration in these sources.

Memorandum 64 (2005) opted for two specific, policy-related indicators. As staying healthy has many aspects, it would also be possible to opt for a generic indicator of the health status of the elderly. In this section we explore two pathways, one in the direction of a number of specific indicators linked to core elements in the policy on the elderly, and the other towards a broad indicator for the health of the elderly.

6.4.1 *Specific, policy-related indicators*

In addition to policy in relation to exercise and fall prevention, Memorandum 64 also announced measures aimed at the early identification of geriatric disorders (in particular dementia, see also chapter 7) and unfavourable social circumstances. The government wished to examine whether health centres for the elderly contribute to helping them stay healthy for longer, with attention for the relationship between different geriatric provisions (including the municipal health services, the general practitioner and the practice nurse) (Nota 64: 52). However, no specific objective was attached to this proposal. If the outcome of this study should prove positive and more such health centres were established in the Netherlands, objectives and indicators could be adopted at a later date. Examples might include structural and process indicators which could for example make clear what proportion of the Dutch elderly population is reached with early identification measures and to what extent the various provisions work together. Health indicators, such as the GZO Monitor, could be used for the (indirect) measurement of the outcomes.

One concept which could contribute to the early identification of problems and the care needs of the elderly, is frailty (Fried 2004, 2001). Frailty is a good predictor of poor functioning, falls, increasing dependence, reduced social contacts, hospital admission, institutionalisation and mortality. Frailty is associated with limitations and functional loss in several domains, and with comorbidity. Despite the many studies and publications devoted to the topic, however, the concept has not been clearly teased out and several different definitions are in existence (Gezondheidsraad 2005; Gobbens et al. 2007).

There have also been a number of research projects in the Netherlands concerned with frailty and its predictive value, including by Gobbens et al. (2007) and by Q-consult in collaboration with the Geriatrics department at Radboud University Nijmegen (Q-consult 2007). In the future, after further development and operationalisation, and after being included in population surveys, frailty could play a role in monitoring the health of the elderly population. Possible interventions would then come within the domain of frailty centres and could in principle be changed, such as the treatment of depression, increasing the feelings of control and encouraging physical activity (Deeg & Puts 2007).

Memorandum 64 also describes the theme of nutrition and overweight as an important focus area, but does not set specific objectives. The GZO Monitor (GGD Nederland, RIVM, TNO and ActiZ), the POLS (CBS) and the Food Consumption

Survey (RIVM and TNO) could perhaps serve as data sources for such an indicator (see also appendix E).

All in all, a large number of specific health indicators is available from the various data sources, such as the GZO Monitor (see appendix E at www.scp.nl). These could relate to health status (outcome indicators) or to determinants of health (such as physical activity) and prevention and care (e.g. fall prevention). There are however too many to include them all in an Elderly Policy Monitor such as this. Naturally, a selection can be made from the total, but the question then is which. Moreover, each indicator provides information on only a limited aspect of the health of the elderly. As stated earlier, this could give rise to a distorted picture. A question to be addressed here is therefore which summarising indicator of health would be suitable for monitoring the general health of the elderly in the Netherlands.

6.4.2 *Generic health indicators*

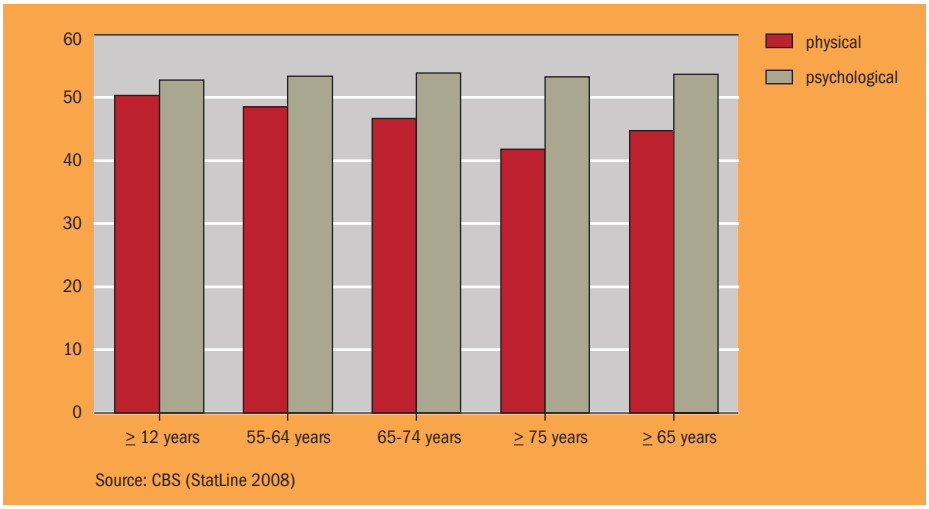
The World Health Organisation (WHO) defines health broadly as a state of complete physical, mental and social well-being and has more than a mere absence of disease and impairments (Young 1998). Health thus has many dimensions. This being the case, it is not simple to find a single indicator which is able to measure and quantify fully all aspects of the elderly being and remaining healthy for as long as possible.

A summarising outcome indicator which covers several dimensions (physical, psychological and social) and which measures both relatively objective and subjective aspects, is the Medical Outcomes Study 12-Item Short Form Health Survey, known as SF-12, a generic tool that is widely used at international level to measure health-related quality of life in population surveys. The SF-12 comprises 12 questions, which in the Netherlands have been included annually since 2001 in the POLS population survey conducted by Statistics Netherlands (CBS). The questions relate to the subdomains physical functioning, physical role limitations, physical pain, general evaluation of own health, vitality, social functioning, emotional role limitations and mental health. Two standard scores are then calculated, a physical and a psychological component. These scores are calculated in such a way that they both achieved an average score of 50 in the general American population in 1998 (Ware et al. 1995; Hoeymans et al. 2005a; Van Campen et al. 2006).

In 2007 the Dutch population aged over 65 scored 44.8 on the physical dimension and 53.7 on the psychological dimension. Compared with the total population aged 12 years and older, they have a poorer quality of life physically, but are doing slightly better psychologically (figure 6.1). Among the over-55s it can be seen clearly that physical quality of life declines with advancing age, the over-75s in particular scoring relatively low. Psychological quality of life shows no correlation with age. However, based on the other measurement instruments, cognitive disorders are found to increase with age (Hoeymans et al. 2005b).

Figure 6.1

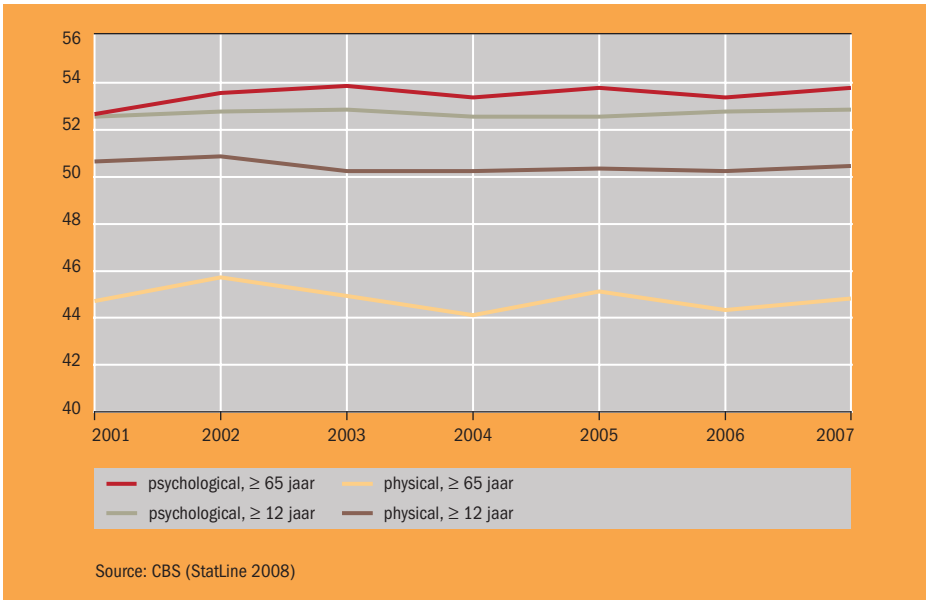
Health-related quality of life, by age, population aged 12 years and older, 2007 (score SF-12)



Source: CBS (StatLine 2008)

Figure 6.2

Health-related quality of life, over-12s and over-65s, 2001-2007 (score SF-12)



Source: CBS (StatLine 2008)

Between 2001 and 2007 the physical quality of life of the over-65s fluctuated around 44.8. In the Dutch population aged 12 years and older, physical quality of life remained stable (figure 6.2). The over-65s assessed the psychological aspects of their quality of life slightly higher between 2001 and 2007 (see also Van Campen & Den Draak 2007).

Measured using the SF-12, health-related quality of life could be used as an indicator for the degree to which older people are and remain healthy, thanks to its summarising character and the availability and continuity of the required data. On the downside, it offers few pointers for actual interventions.

6.5 Conclusion

Memorandum 64 (TK 2004/2005) and this Monitor opt for the lifestyle indicator 'meeting the healthy exercise standard' and the health outcome 'fall incidents and hip fractures' to monitor the health of the elderly over time. Targets for the subsequent years were formulated for both indicators in 2005. As regards exercise, the target was achieved earlier, except by people with poor perceived health, whose functional impairments prevented them from achieving the standard. Because the targets for 2010 have already been achieved, the normal percentages could be raised for the coming period. Recent sports policy memoranda have in fact adjusted the targets for the adult Dutch population. Those targets could be explicitly adopted for the older section of the population.[16]

The indicator and target value for 'falls' adopted in 2005 proved to be insufficiently clear. In consultation with the Ministry of Health, Welfare and Sport (VWS) and the Dutch Consumer Safety Institute, the indicator has been modified. The total group of elderly people meet the adjusted target. This does not however apply for residents of nursing and care homes, probably because of the increase in the intensity of care or dependency on help of older people living in institutions over the last ten years or so. Despite this, fall prevention programmes show that the number of falls can be reduced considerably in institutions, too.

The norms for exercise and fall incidents enable two aspects of the health of the elderly to be monitored adequately. However, a number of key aspects are left out of consideration. Owing to the policy emphasis in Memorandum 64, nutrition and underweight and overweight also warrant a place in the Monitor. The same applies for the early identification of problems and care needs, for which frailty can serve as an indicator. Another specific recommendation is to monitor the inactivity among the over-75s.

To gain an insight into the health status of the elderly in the Netherlands, it is also recommended that a summarising indicator be included, which combines information on many domains to form one or two figures. The Short Form 12 survey administered periodically by CBS and the municipal health services would be a reliable and valid measurement instrument for this.

Finally, health is a complex phenomenon and none of the indicator chosen is capable of portraying the direct effects of government policy: the degree to which older people stay healthy is too much the result not only of government choices, but also of other factors including life choices by people themselves and the treatment and care choices made by care institutions and health professionals.

Notes

1 Memorandum 64 (p. 49) set a general objective with respect to 'staying healthy', in which the emphasis is on a healthy lifestyle: 'Being healthy – and above all staying healthy' is the most important condition enabling older people to participate in society. In section 4.1. [of Memorandum 64], staying healthy is cited as the first operational objective. A healthy old age begins with a healthy lifestyle in earlier life. A healthy diet, exercise, smoking and alcohol use all demand attention. Factors such as overweight, unhealthy diet and lack of exercise are gradually displacing smoking as causes of health problems. This is storing up major health risks for the future.

2 With thanks to W. Ooijendijk and K. Vermeulen from TNO for supplying data from OBiN.

3 According to the NNGB, moderately intensive activity for 18-54 in year-olds includes things such as walking briskly at a speed of 5-6 km/hour or cycling at 15 km/hour. The norm for people aged 55 and over is lower: walking at a rate of 4 km/hour and cycling at a speed of 10 km/hour are for example sufficient. Moreover, the standard specifies that for inactive people aged over 55, with or without impairments, any extra physical activity is useful (Kemper et al. 2000; Stiggelbout et al. 2004).

4 In order to meet the NNGB, people must be sufficiently active in both summer and winter.

5 The sports memorandum target of 45% for 2005 (VWS 2001). Memorandum 64, by contrast, aims for 45% in 2007 and takes the situation in 2003 (43%) as a starting point for 2005 (TK 2004/2005).

6 The figures are weighted by sex, age, education, household size, activity, degree of urbanisation and region.

7 Due to its low frequency (once every five years), the TBO is less suitable as a source for this Elderly Policy Monitor.

8 The figures in the table are taken from the OBiN, but on the basis of the POLS (CBS), too, it is possible to calculate the percentages who comply with the combinorm.

9 With thanks to H. Valkenberg, J.A. Draisma and M. Brugmans from the Dutch Consumer Safety Institute for supplying data and advice.

10 The origin of the figures quoted in Memorandum 64 is unknown. In addition, the objective was formulated in absolute figures and related only to hip fractures.

11 Multiple regression analyses of monthly figures were used to fit a model consisting of one or more connected lines, each covering a period of five years.

12 The national estimate is based on 38,580 recorded cases in the Injury Surveillance System.

13 It was not possible to distinguish by housing type in the data on hospital admissions.

14 Due to its low frequency (once every four years), the AVO is less suitable as a source for this Elderly Policy Monitor.

15 ActiZ is the sector organisation for care providers.

16 Percentages and trends vary considerably depending on the method and data source chosen. In 2008 RIVM will work on a study of the mutual differences, validity and suitability.

7 Adequate care of good quality

Cretien van Campen

7.1 Care for the vulnerable elderly

The number of older people needing care is set to increase considerably over the coming decades (Berg Jeths et al. 2004; Jonker et al. 2007). The task is of course not only to deliver more care, but also care of good quality, in other words care which adequately meets and is geared to the individual needs. Memorandum 64 on policy on the elderly against the background of population ageing (TK 2004/2005: 72) puts this as follows: 'ensuring that adequate care of good quality can continue to be delivered for those vulnerable elderly who genuinely need it'. The Memorandum formulates targets for both 'adequate care' and 'care of good quality'.

The targets for adequate care have been operationalised in terms of national waiting list figures for nursing and care (broadly home care, care from residential care homes and nursing home care). The targets for quality of care are focused on institutionalised care for the elderly, in particular nursing home care.[1] They relate to the satisfaction of residents, the quality of the residential environment and the quality of the care delivered in nursing homes.

The purpose of this Monitor is not only to test the extent to which the targets formulated in Memorandum 64 have been achieved, but also to develop the Monitor further (see chapter 1). The analysis is limited on the one hand by the availability of data and on the other by the choices made in Memorandum 64. As a result, this chapter deals only with older people who make use of care for the elderly, while some of the indicators relate only to nursing home residents. The emphasis is on the care sector, and in particular nursing home care. This means that curative care for the elderly, such as geriatrics, as well as provisions falling under the Social Support Act (Wmo) are left out of consideration. In contrast to the other chapters, no age limits are applied in this chapter due to data constraints.

7.2 Adequate care

The government justified its choice of a target for adequate care in Memorandum 64 as follows:

> *In order to measure the policy impact of measures aimed at 'adequate care of good quality', the government looks first at the availability of care compared with the need. Of the total of approximately 50 5000 older people on waiting lists for nursing and care, around 20,000 are currently not receiving any care at all. Since the year 2000 a specific policy has been pursued to reduce waiting lists. A great deal of extra money has been set aside for*

this, and waiting lists have fallen considerably since then. The first survey in May 2000 indicated that there were a total of around 102,000 people on the waiting list, of whom around 50,000 were not receiving any form of 'bridging' care. On the assumption that waiting lists (i.e. people waiting longer than the accepted norm periods) should not exist at all, the overall trend in waiting lists since 2000 is 54%, while the waiting list of people not receiving any care at all account for 60% of the deficit to be made good. This produces an average score for both measurements of 5.7. The government believes the deficit must have been made up further by 2010, to achieve an average score of 6.5.

This Monitor is based on the national waiting list records, which have been updated annually since the beginning of this decade. Figures are available for the period from 2000 to 2007 inclusive. A distinction is made in the total number of people on the waiting list for nursing and care (i.e. home care funded under the Exceptional Medical Expenses Act, nursing and care home care) according to the waiting list standards which applied at the time ('Treeknormen') – longer than six weeks waiting for home care for nursing home care or longer than 13 weeks for residential care home care – and then the number of people on the waiting list who are or are not receiving some form of interim care (see table 7.1). In 2005 the system was changed and the waiting list records became part of the care records for the whole of the care funded under the Exceptional Medical Expenses Act (AZR). Table 7.1 presents an overview of the national waiting list figures for nursing and care in the period 2000-2007.[2]

Table 7.1
Waiting lists for nursing and care, 2000-2007 (in absolute figures x 1,000)

	15 May 2000	1 October 2003	1 January 2005 (AZR)	1 January 2007 (AZR)
waiting list for nursing and care	102	55	52	61
waiting list standard for nursing and care	85	39		
waiting list standard people not receiving care	50	20		

Source: Van Rooij et al. (2007); Vernhout et al. (2007); Van Vliet et al. (2006)

The target formulated in Memorandum 64 and the associated score relate to the number of people on the waiting list in 2003 according to the waiting list standard ('Treeknorm') which applied at that time.

Owing to a trend break in the waiting list records due among other things to changed definitions, different data sources and the introduction of the AZR, it is impossible to determine whether the target has been achieved. Both the Dutch Health Care Insurance Board (CVZ) (Van Rooij et al. 2007: 14) and the National Institute for Public Health and the Environment RIVM (Westert & Verkleij 2006), which have analysed the waiting list figures, come to the conclusion that it is not possible to establish a reliable trend in those figures.

Another limitation is that the total number of people on the waiting list does not say anything about how many people are receiving inadequate care. The latter figure includes people who have opted for a different form of care from that for which they have an indication. In the last two years the Ministry of Health, Welfare and Sport (VWS) has commissioned research into how many people on the waiting lists are receiving inadequate care (Vernhout et al. 2007; Van Vliet et al. 2006). This group of people are classified as 'problematic waiting list clients', i.e. people with a valid indication for whom appropriate care cannot be found within the applicable waiting list standards and for whom mediation is required by the care office or care provider. The note 'mediation' in a patient file means that the patient, the caregiver or the care office has indicated that the present care is inadequate or inappropriate in relation to the care indicated by the Care Needs Assessment Centre (CIZ). According to surveys of the care offices, this occurs for around 5,000 people nationally, including between 3,000 and 3,500 older people with dementia. This means that approximately 90% of clients with an indication have received the indicated care within the applicable waiting list standard times (TK 2007/2008c).

The relationship between the Exceptional Medical Expenses Act (AWBZ), the Social Support Act (Wmo) and the Care Insurance Act have changed several times in recent years. As a result, eligibility for AWBZ-funded care has changed. Since 1 January 2007, for example, domestic care has been transferred from the AWBZ to the Wmo. The waiting list figures consequently do not always refer to the same group of people who have received an indication for nursing and care.

A final disadvantage of the present AZR is that if care institutions do not report the commencement of care delivery, it can seem on paper as if the client is still waiting for care. This occurred in more than 100,000 cases in 2007 (Van Rooij et al. 2007). The Ministry of VWS hopes to avoid this in the future by linking the funding of care to the records in the AZR (TK 2007/2008c).

7.2.1 *Better indicators for adequate care*

Broadly speaking, there are two possible solution pathways for the identified problems: 1) improve the reliability of the waiting list records so that they become usable for trend analyses; and 2) develop additional indicators which make clear whether the care offered is 'adequate'.

The Dutch Health Care Insurance Board (CVZ; Van Rooij et al. 2007) and RIVM (Westert & Verkleij 2006) have expressed the hope that if all institutions submit waiting list figures in accordance with the AZR method, the problem will resolve itself. Investments in the continuity of the existing national records should lead to 'further harmonisation of waiting list records and reports so that an overarching picture is obtained' (Westert & Verkleij 2006).

An additional proposal is to focus attention on people who themselves or via another person have indicated that they are receiving inadequate care – the problematic waiting list clients referred to earlier. As yet, however, it is difficult to determine the size of this group with any accuracy. Ideally, all people on the waiting list would

have to be asked about this. One practical solution would seem to be to count the number of files of clients on waiting lists with the note 'mediation'.

It may be that sample-based survey research among the waiting list clients could offer an insight into the size of the group who are receiving inadequate care. In various national surveys, such as the Amenities and Services Utilisation Survey (AVO) by the Netherlands Institute for Social Research | SCP and the Housing Research Netherlands study (WOON) by the Ministry of Housing, Spatial Planning and the Environment (VROM), a population sample was questioned in detail about their need for nursing and care, the indications received for AWBZ-funded care and the use of various care services. One advantage of this type of research is that it throws light on the actual care deficit because of the ability to compare the subjective care need, the objectively indicated need and the actual take-up.

7.3 Care of good quality

Based on the idea that 'quality of care is determined primarily by 1) the way in which clients are approached by professionals; 2) the setting in which the care is given; 3) the quality and connectedness of the care itself', Memorandum 64 opts for three targets in the area of institutionalised care for the elderly (care homes, nursing homes and small-scale housing). We discuss these targets here in three sections: client satisfaction (§ 7.3.1), quality of the care setting (§ 7.3.2) and quality of nursing home care (§ 7.3.3).

7.3.1 Client satisfaction

The Dutch Client & Quality Foundation (Stichting Cliënt & Kwaliteit) has carried out client satisfaction surveys since 2000 in – by now all – care and nursing homes in the Netherlands. This data set is taken as a basis in Memorandum 64 for the formulation of the target for client satisfaction:

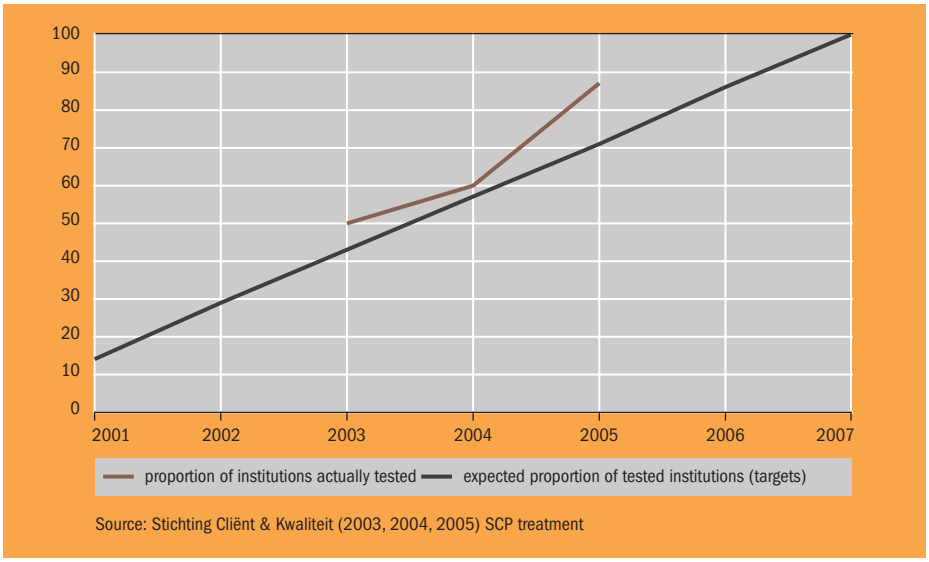
> *With regard to client satisfaction, measured using client surveys, the government would be satisfied if a point were reached in 2007 where all institutions have been tested at least once. Based on an even pace of testing, roughly 70% should have been tested since 2000. That figure is currently 50%. The score on the first measurement point is therefore 7.1.*

Memorandum 64 refers to the situation in 2005 based on figures from 2003. At an unchanged pace, roughly 70% of care in nursing homes should have been tested by 2005. The 'actual' figure of 50% cited in the Memorandum dates from 2003, however. We therefore calculated a new series of targets based on equal growth for the period 2001-2007, in which all institutions must be tested at least once. Based on 100% testing in 2007, a straight line can be drawn between the initial year 2000 and 2007, which shows the (projected) target for each year and which can be compared with the actual value. Figure 7.1 shows both the (projected) series of targets for the

period 2001-2007 and the actual scores for the period 2003-2005 (Stichting Cliënt & Kwaliteit 2003, 2004, 2005).

The figure makes clear that the actual values in 2003 and 2005 were consistently higher than the targets. In 2005, client satisfaction surveys had been carried out in 87% of institutions, well above the projected target of 71%. At this rate, the target of 100% should have been achieved by 2007.[3]

Figure 7.1
Target and actual testing of client satisfaction in care homes and nursing homes, 2001–2007



Source: Stichting Cliënt & Kwaliteit (2003, 2004, 2005) SCP treatment

A number of qualifying comments need to be made about the choice of this indicator. In the first place, the indicator says nothing about how residents of institutions perceive and appreciate the care they receive. Secondly, the indicator provides no information on the satisfaction of the users of home care services, who constitute roughly three-quarters of the users of nursing and care services. And thirdly, the indicator will have to be replaced after 2007 if the 100% figure is achieved (or else a new series of measurements will have to begin because the previous ones are seven years old).

Alternative indicators

The above criticisms create a need to look for a substantive indicator which covers a broader domain. In the national budget for 2007, the Ministry of Health, Welfare and Sport (VWS) has already begun using a more substantive indicator: the proportion of institutions which in the view of clients/residents score satisfactorily on quality of care. According to VWS, this was the case for 72% of institutions in 2004

(VWS 2007b). In 2008 that percentage should have risen to 81%, and in 2011 to 90% (VWS 2007b).

RIVM presents a time series for client satisfaction based on data from the surveys carried out by the Dutch Client & Quality Foundation, which shows that the level of satisfaction remained roughly unchanged between 2001 and 2004 (table 7.2). Residents of care homes were on average more satisfied than residents of nursing homes.

Table 7.2
Average satisfaction with care and services, clients/residents of nursing homes and care homes, 2001-2004 (scale score 0-4)

	2001	2002	2003	2004
nursing homes	2.53	2.64	2.59	2.60
care homes	2.77	2.75	2.77	2.77

Source: Stichting Cliënt & Kwaliteit (2005) RIVM treatment (http://www.rivm.nl/vtv/object_document/o5197n26737.html)

For the period 2001-2007 the data from the Client & Quality Foundation are the most important source for establishing client satisfaction in nursing and care homes. This year the national data set on this issue will change radically. With effect from 2008, all institutions providing nursing and care (i.e. including home care organisations) will submit data on client satisfaction in the responsible care annual reports. Additionally, all institutions will use the Consumer Quality index (CQ index) for this, a standardised system for measuring, analysing and reporting on client experiences in the care system. Using a questionnaire, home care users and residents of nursing and care homes will be asked about their experiences in a large number of areas such as the care plan, physical care, safety and atmosphere. Based on the responses, quality scores can then be calculated (Wiegers et al. 2007; see also www.centrumklantervaringzorg.nl).

7.3.2 *Quality of the residential setting*

For the second aspect of the quality of care, Memorandum 64 focuses on homes for people who make use of institutional and 'transmural' (shared care between primary and secondary medical providers) nursing home care. In 2005, the government saw two important tasks: reducing the number of multiple-bedded rooms in nursing homes and promoting small-scale residential facilities for the elderly.

Reducing the number of multiple-bedded rooms in nursing homes

Since the privacy memorandum published a in 1996 by the then State Secretary Terpstra, policy has been put in place to improve privacy in nursing homes. That policy has been operationalised in the elimination of existing three and more-bedded rooms and the creation of one and (divisible) two-bedded rooms in nursing homes (CBZ 2006). In 2005 approximately 10,600 beds out of total of around 61,000 places

were in rooms designed for more than two people (Nota 64: 78). Memorandum 64 formulates the following target:

> *The policy of reducing the number of multiple-bedded rooms dates from 1995. At that time there were 22,000. Following the wishes of Parliament, all rooms containing more than two beds should have been eliminated by 2006. If progress had continued at the same pace, almost 20,000 beds would have been removed since 1995. The actual number is 11,500. The present situation thus scores 5.8.*

Table 7.3 shows the actual figures for the reduction of multiple-bedded rooms in nursing homes in the period 2003–2006 (CBZ 2006).

Table 7.3
Number of places in multiple-bedded rooms in nursing homes, 2003-2006

	2003	2005	2006
3 beds	1,100	1,600	1,600
4 beds	14,400	14,600	13,200
5 beds	900	600	400
6 beds	1,500	900	200
total	20,900	17,700	15,400

Source: CBZ (2006)

Table 7.3 shows that the desire of Parliament that all multiple-bedded rooms should have been eliminated by 2006 has not been achieved. In that year there were still 15,400 places in multiple-bedded rooms in nursing homes. The achievement of the target was subsequently deferred by the State Secretary to the year 2010 (TK 2007/2008a).

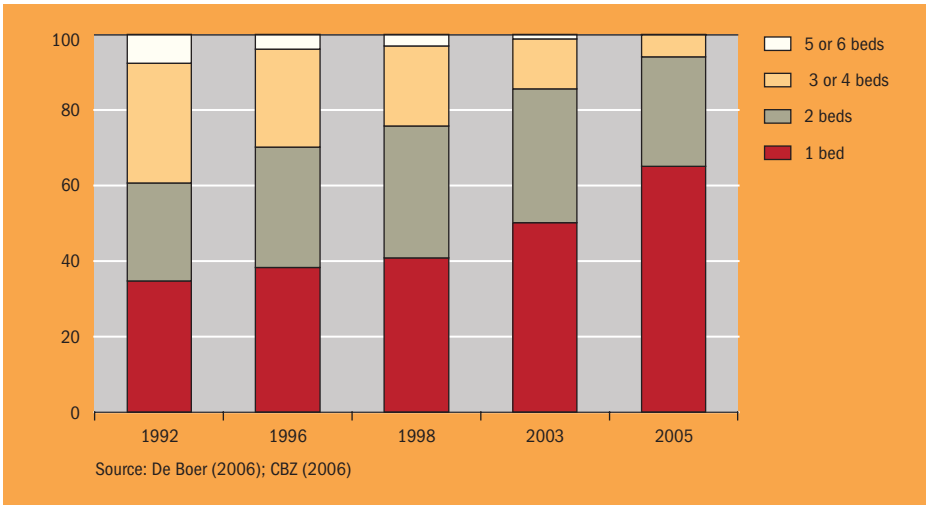
The Netherlands Board for Healthcare Institutions (CBZ 2006) observed that the reduction in the number of multiple-bedded rooms had continued apace in recent years, but also that the rate of reduction needed to be stepped up further in order to achieve the target (no more multiple-bedded rooms at all) by 2010.

If we look at the trend over the longer term (figure 7.2), we see that since 1992 there has been a clear upward trend in the proportion of rooms with one or two beds and a decline in the number of multiple-bedded rooms in nursing homes.

Reducing the number of multiple-bedded rooms is a specific, readily quantifiable indicator for use in the Monitor. The data are clear, reliable and valid, as borne out by the analyses by CBZ (2006), and it is not necessary to look for other indicators. The proportion of single and double rooms in nursing homes still seems to be the best indicator for monitoring the privacy of residents in a simple and reliable way.

Figure 7.2

Number of beds per room in nursing homes, 1992-2005



Source: De Boer (2006); CBZ (2006)

Small-scale residential facilities for patients with dementia

The other aspect of the quality of the residential setting is small-scale residential provision for patients with dementia.[4] Research shows that people with dementia feel happier and are able to live more independently in small-scale residential facilities than in an institution (Wijnties 2004; Huijsman & Ludwig 1995). The Netherlands was a late beginner in converting nursing home beds to places in small-scale group housing for people with dementia. Sweden had already reached 70% in this area when the Netherlands still had to begin, according to Singelenberg (2007). Memorandum 64 formulates the following target for this theme:

> *With regard to the small-scale residential concepts for people with dementia, the government's aim is that these should account 20% of the total capacity by 2010. At present the figure is 10%; this produces a score of 5.*

The number of people with dementia will increase between 2005 and 2030 from just under 200,000 to more than 300,000 (Van Waarde & Wijnties 2007). 65% of all people with dementia live at home; 18% live in a nursing home and 17% in a care home (Gezondheidsraad 2002). Around 35% of people with dementia thus require intensive, residential psychogeriatric care (Van Waarde & Wijnties 2007). As the data on some people in need of care are not known, Van Waarde and Wijnties estimate the number of people requiring nursing home care. Table 7.4 presents figures from this and translates them in terms of the targets from Memorandum 64.

Table 7.4

Supply and demand for small-scale living units for patients with dementia (in absolute figures x 1,000 and percentages)

	2005	2010
persons with dementia	194	212
persons needing nursing home care	45	49
production agreement on psychogeriatric places in nursing homes	37	38
small-scale residential places	4	12
target small-scale places/total capacity (%)	10	20
achieved versus capacity (%)	12	32
achieved versus demand (incl. waiting list for psychogeriatric departments of nursing homes)	10	25

Source: Van Waarde & Wijnties (2007) SCP treatment

Table 7.4 shows that the number of places in small-scale residential units for people with dementia increases between 2005 and 2010 from 4,000 to 12,000. As a proportion of the total capacity for people with psychogeriatric disorders, small-scale living rises from 12% in 2005 to 32% in 2010. The share also increases relative to the (growing) demand, albeit to a lesser extent, from 10% in 2005 to 25% in 2010. The target of 20% relates to the latter and is achieved according to this forecast. The State Secretary tightened up the targets in response to this, as expressed in her letter to Parliament of 31 May 2007 (TK 2006/2007a):

> *In order to be able to meet the growing demand for care for people with dementia and to continue increasing the choice, I would like to see an intensification of the transformation to small-scale living. Partly in view of demographic trends, residential places should be created for 6,000 people in the period 2008-2011, or approximately 1,500 people per year.*

For the Monitor, improving the indicator does not appear necessary, provided the total institutional and non-institutional capacity for people with dementia is adequate. The indicator is usable and realistic, and can be tightened up, as the State Secretary has recently done. If more than 70% of the target group live in small-scale residential places in Sweden (Singelenberg 2007), while in the Netherlands an estimated 95% of nursing home residents with dementia could do so (5% cannot do so or are moved back to institutions because of behavioural problems, Van Waarde & Wijnties 2007), the target of 20% by 2010 could be adjusted upwards in stages in the coming years.

7.3.3 Quality of nursing home care

In 2004 the Dutch Health Care Inspectorate (IGZ) published a report on the quality of nursing home care which caused quite a stir (IGZ 2004). Only 40% of nursing homes met the quality standards set by the Inspectorate. The concerns about nursing homes are reflected in the choice of quality indicators in Memorandum 64. Three of the four targets are concerned only with nursing home care; the fourth (client satisfaction) covers both nursing and care home.

In 2005 Memorandum 64 chose the following indicator for the quality of professional care:

> *The Health Inspectorate report showed that institutions generally meet 67% of the standards. Only 22% of nursing homes comply with all standards. In order to emphasise the importance of all standards, the government is taking the average of these percentages as a measurement point, so that the score on the indicator for professional quality comes out at 4.5.*

Memorandum 64 does not formulate a target for professional nursing home care, though does give an average target for all chosen quality indicators – although no targets can be derived from this for this component.[5]

New standards

After the 'disaster year' of 2004, the Health Care Inspectorate (IGZ) tightened up its supervision and revisited nursing homes which had scored below par in 2005. The proportion of nursing homes which complied with all IGZ standards had risen from 22% in 2004 to 85% in 2005 thanks to intensive supervision by the IGZ (IGZ 2005, 2006).[6] In 2006 and 2007 the IGZ developed new standards (Plexus 2007), which were incorporated in the new Quality Framework for Responsible Care (Kwaliteitskader verantwoorde zorg) (Stuurgroep Verantwoorde Zorg 2007). A comparison of the quality scores under the old and new standards showed that there was virtually no relationship between the two; the correlation between the opinions on nursing homes in 2004 and 2006 was found to be low (Plexus 2007).

The national figures from the new assessment system will be published for the first time in the summer of 2008 in the annual reports on responsible care (Stuurgroep Verantwoorde Zorg 2007). From that moment onwards, a new start can be made on monitoring the quality of nursing home care.

Data for two types of indicators will become available. First, there will be substantive care or professional indicators on subjects such as bedsores, falls and incontinence. The care organisation will measure these itself, partly at client level and partly at organisational level based on registration questions. The second type are the client experience indicators; these are measured by asking clients or their representatives about their experiences with the care delivery using a standard questionnaire. The client consultation will be carried out once every two years by an accredited research bureau, which will measure the client-specific indicators from

the Quality Framework using a specially developed CQ index for nursing, care and home care (Wiegers et al. 2007).[7]

From the summer of 2008, all care institutions in the nursing and care sector will submit standard quality data. These will be collected at central level and published on the website www.zorgvoorbeter.nl, so that clients will be able to compare care institutions. The aim is to aggregate the data from individual institutions into a national database from which monitoring data can be drawn.[8]

Our conclusion is therefore of that different indicators (and associated targets) for the quality of professional care will need to be developed for future Elderly Policy Monitors. It is recommended that these indicators are not restricted to nursing home care, but are extended to cover the entire nursing and care sector and, in the future, also the curative sector, especially clinical geriatrics. Data on these areas will be available from individual institutions from the summer of 2008 in a database compiled from the annual reports on responsible care. In the next section we will look at ways in which these data could be used as a source for monitoring the quality of care for the elderly in any future editions of this Monitor.

7.4 Conclusion

Memorandum 64 gave two scores in 2005, one for adequate care and one for quality of care. Both figures are based on averages from several indicators. A number of points of criticism emerged in the discussion of the individual indicators, which are summarised and generalised again below:

- The targets are averages of 'apples and pears': in other words, they are incomparable units and derive from very different types of sources (e.g. records and surveys).
- There is too great a focus on nursing home care. Only a small proportion of older people receive this care; a high proportion do however receive home care, but this not included in the present quality targets.
- The sources are not always reliable (e.g. waiting lists). In many cases there is no scientific testing of the figures.
- The figures used are not always valid. The number of institutions visited by the Dutch Client & Quality Foundation, for example, says nothing about the satisfaction of the clients of nursing and care homes.
- The time series are sometimes interrupted (e.g. professional care, waiting lists).

Some indicators were found to be usable, such as the indicators for the quality of the residential setting; however, others were not (or no longer) usable for a variety of reasons in any future Elderly Policy Monitor. The waiting list records show trend breaks; the indicator for client satisfaction is not valid (does not measure what it should measure); the indicator for professional quality is too narrow (makes a statement only about nursing home care) and exhibits a trend break. The conclusion is that the indicators for residential quality can be continued and that new indicators will have to be found for adequate care, client satisfaction and professional quality.

Which data sources are available for this? In order to monitor client satisfaction and professional quality, national data will become available in the summer of 2008 as part of the collection of annual reports on responsible care from all care institutions in the nursing and care homes sector (Stuurgroep Verantwoorde Zorg 2007).

This might suggest that the alternative indicators will be easy to find; in fact this is anything but the case. The data will become available, after which scientists will have to develop indicators on the basis of the objectives formulated by the government. Scientists and the government will then be able to formulate targets in collaboration.

The recommendations can be summarised as follows (see chart 7.1).

Chart 7.1

Proposed modification of the indicators for the quality of care for the elderly and available sources

	indicator	sources
A	**adequate care**	
	proportion of care users and clients on waiting list who receive (in)adequate professional care	scientific improvement of present waiting list records or periodic scientific population survey
B	**housing quality**	
B1	reduction in number of beds in multiple-bedded rooms (> 2 beds) in nursing homes	keep present indicator
B2	percentage of small-scale residential units for people with dementia as percentage of total capacity of psychogeriatric departments in nursing homes	keep present indicator
C	**responsible care**	
C1	client satisfaction	
	average score on Consumer Quality Index	annual report on responsible care (from 2008)
C2	professional quality	
	average extent to which nursing homes meet IGZ standards	annual report on responsible care (from 2008)

Notes

1 The concentration on nursing home care was based among other things on the negative reports on the quality of care in nursing homes by the Dutch Health Care Inspectorate and the media.
2 Definition of waiting: all clients who are not receiving all indicated functions, who receive different functions from those for which they have an indication, or who receive less than the indicated class(es) of care. (Van Rooij et al. 2007: 12).
3 The reports for 2006 and 2007 were not yet available at the time of writing.
4 Small-scale residential facilities fall within the remit of hospitals and are therefore discussed in this chapter. Combined housing and care falls under the remit of housing adaptations and is therefore discussed in chapter 5.
5 All things taken together, the average score for the three quality measurement points is 5.7. The government feels that the score must be further improved by 2010 to an average of 6.5. (Nota 64: 80).
6 This percentage has since increased again, as evidenced by a report from the Dutch Health Care Inspectorate (IGZ 2008), which appeared just before this report went to press.
7 The IGZ inspection form that each organisation has completed for the past three years is ceasing to exist. It has been integrated into the Quality Framework.
8 For the recent situation, see www.verantwoordezorg.nl.

8 Dying with dignity

Sjoerd Kooiker[1]

8.1 Dying with dignity is more than palliative care

The government memorandum on policy on the elderly against the background of population ageing (*Ouderenbeleid in het perspectief van de vergrijzing*), (TK 2004/2005), referred to throughout this Monitor as 'Memoraudum 64', begins by formulating the basic values which a civilised society must meet when dealing with the elderly people in its midst. The final basic value cited in the Memorandum is 'dying with dignity'; in a civilised country, the elderly must be able to die with dignity (p. 43). Anyone who stops to think about this for a moment will realise that being able to die with dignity is about more than just good palliative (terminal) care, and in fact encompasses all aspects of the end of life.

Before looking at how the notion of 'dying with dignity' is operationalised in policy indicators, it is important to bear in mind that end of life is a very delicate phase in human life on which many different views prevail – views are also highly culturally and historically determined. Memorandum 64 (p.81) recognises this explicitly.

> *The government believes that care is needed in dealing with the end of life, and that this must be approached in accordance with the prevailing views on this in society. Over a longer period of time, those views may be subject to change and this can lead to changes in policy.*

The government sees a modest role for itself here: 'The government would prefer to play a following rather than an agenda-setting role' (TK2004/2005: 81). In concrete terms, the government describes this in the Memorandum as facilitating opportunities and testing decisions (concerning the end of life). In making this latter point the Memorandum is in reality addressing the debate about euthanasia. It was this debate which formed the starting point in the 1990s for the intensification of the government's involvement with palliative terminal care. In 1996 there was a suspicion among politicians that the demand for euthanasia perhaps stemmed from a lack of pain management and other forms of palliative care (Onwuteaka-Philipsen et al. 2007a). Better palliative care, they felt, might lead to fewer requests for euthanasia. Political support grew for a 'palliative care incentive programme', because both supporters and opponents of euthanasia had an interest in doing something about the fact that the Netherlands lagged behind other countries in this area (Kennedy 2006). The perspective chosen in Memorandum 64 for the operationalisation of dying with dignity cannot be seen in isolation from this incentive programme

from the period 1997-2004. It focused mainly on the organisation of palliative care, and not (yet) explicitly on the quality of that care or on what the concept 'dying with dignity' means in practice.[2] By contrast, the government did subsequently make a clear choice as regards the organisation of palliative care; the government believes the terminal care should as far as possible form part of the mainstream care system and should form part of the duties of generalist care providers (Mistiaen & Francke 2004: 13). Regional networks were to be set up providing national coverage and expertise was to be promoted with specialist in-service and refresher training programmes (VWS 2001, 2002). In other words, the generalist mainstream care system had to be equipped to deliver good-quality palliative care. It was also important to prevent a shift towards institutions which led to an undermining of primary palliative care in the patient's own home, for example.

8.2 *Achievement of the targets*

Memorandum 64 was written when the incentive programme was coming to an end. It is therefore understandable that the indicators for evaluating the policy were formulated mainly in the spirit of that programme. The emphasis was on the creation of a coherent network of care providers and institutions to deliver palliative terminal care.

The targets set in the Memorandum relate to the facilitating policy measures of the Ministry of Health, Welfare and Sport (VWS) and are organisational in nature. The data for calculating whether the targets are being achieved are set out in the *Palliative Care Monitor* (*Monitor palliatieve zorg*) from the Netherlands Institute for Health Services Research (NIVEL), which was set up to monitor continuously the progress in achieving the facilitating policy. The first edition of that Monitor appeared in 2004 and contained figures on that same year (Mistiaen & Francke 2004). Subsequently, data were collected in 2005 and again in the spring of 2006 (Mistiaen et al. 2006). The Monitor was then wound up. The figures in Memorandum 64 are taken from the Monitor for the year 2004.

The targets relate to four aspects and four indicator scores. The research results from the NIVEL Monitor were translated into scores in a fairly simple way. The four aspects of palliative terminal care which carry central emphasis in Memorandum 64 are:

1 Integration of palliative terminal care in networks of palliative caregivers.
The situation in 2005 (but measured in 2004) was that 89% of palliative terminal care provisions were now incorporated in palliative care networks (Mistiaen & Francke 2004: 26). That percentage is translated in the Memorandum into a score of 8.9.
2 National coverage of palliative care consultation facilities.
In the 2004 Monitor, NIVEL reports that consultation facilities were distributed across all regions where there were Integral Cancer Centres, and thus across the whole country. Memorandum 64 concluded that national coverage had been

achieved and assigned a score of 10 (Mistiaen & Francke 2004: 33; Memorandum 64: 84; Mistiaen et al. 2005).

3 Integral Cancer Centres must have set up a palliative care department and must have in place at the apartment-specific policy and/or activity plan. The situation in 2005 was that this objective had been achieved; as a result, this also achieved a score of 10 (Mistiaen & Francke 2004: 50; Memorandum 64: 84).

4 The Integral Canter Centres had been given a new role in the VWS policy in supporting and facilitating all institutions and providers of palliative care in the region. One of the targets concerns the fulfilling of this role. In the NIVEL Monitor, the Integral Cancer Centres were asked about this. Three of them stated that they were fulfilling their new role 'completely'; one Centre said it was 'largely' fulfilling its role; four Centres were fulfilling their role reasonably and one Centre was fulfilling it to some extent (Mistiaen & Francke 2004: 50). Based on the system used in Memorandum 64, this aspect was given a score of 6.7.

In Memorandum 64, the total score for the aspect 'being able to die with dignity' is given a score of 8.9 in 2005. This is the average of the four scores (8.9 + 10 + 10 + 6.7 / 4 = 8.9).

The targets are related to the facilitating policy pursued by VWS in respect of palliative care. For two aspects, the target had already been reached in 2005 (aspects 2 and 3) and had therefore already achieved a score of 10. It is unlikely that a new score would be lower, unless the definition of the target is changed. Aspects where improvement is still possible are 1. the integration of palliative terminal provisions in networks; and 4. the fulfilment of their new role by the Integral Cancer Centres. The targets for these aspects could be derived from the last version of the NIVEL Monitor from the spring of 2006. This states that 91% of the palliative terminal care provisions were incorporated in palliative care networks (Mistiaen et al. 2006: 13). In terms of Memorandum 64, this would mean a score of 9.1. As regards the fulfilment of their new role by the Integral Cancer Centres, comparison with the Monitors from 2004 and 2006 produces the picture as shown in table 8.1.

Table 8.1

Role fulfilment by the nine Integral Cancer Centres on behalf of palliative care institutions and providers in the region

role fulfilment	2004	2006
completely	3	3
largely	1	6
reasonably	4	
to some extent	1	
total	9	9

Source: Mistiaen & Francke (2004: 50); Mistiaen et al. (2006: 74)

All the integral Cancer Centres are fulfilling their role largely or completely, and Memorandum 64 could now award a score of 10 for this target.[3]

8.3 Social developments, trends and policy accents

Today, in 2008, the start-up phase is essentially past and it is therefore important to select new indicators. The associated targets have also been achieved, or appear in view of their high scores to offer little scope for further improvement. In any event, we may assume that monitoring indicators on dying with dignity should comprise more than the organisational characteristics measured to date. The new indicators must match the current status of palliative care, and the present policy accents. Those accents are the result of social developments over the last ten years (see box on the following page).

The last NIVEL Monitor from 2006 reported growth in the number of terminal provisions of 40% in two years (2004, 2005 and the measurement in the spring of 2006). As the NIVEL Monitor no longer exists, Agora, the expertise centre for palliative care, keeps a record of the number of palliative care provisions in the Netherlands. The most recent list of provisions registered with Agora is shown in table 8.2.

Table 8.2
Terminal care provisions as at 1 April 2008

type of provision	number	number of places
hospice (own nursing staff, high care)	41	258
home from home (mainly volunteers, low care)	49	167
hospice facility in/near nursing home (unit, separate places)	88	332
hospice facility in/near care home (unit, separate places)	47	108
children's hospice (often respite care)	5	50
facility in/near hospital (palliative care with admission)	11	38
palliative day centre – daycare	3	
palliative day centre – outpatient clinic	2	
palliative day centre – psychosocial care	7	
consultation team (professionals)	52	
team information and advice to patients	5	
voluntary organisation	153	
other palliative care	15	12
home care with specific palliative care provision	60	

Source: Agora (2008) at www.palliatief.nl (consulted at 20 May 2008)

Table 8.2 shows that there is a very wide variety of facilities, which moreover not only focus on the elderly. On the one hand palliative terminal care has acquired a specific place within mainstream care provision, for example in nursing and care homes. On the other hand, more and more independent palliative terminal care facilities are being set up in the form of hospices and 'homes from home', where volunteers play a big part in the care delivery.[4]

Social developments

In his speech at the first Dutch National Palliative Care conference, James Kennedy (2006) painted a picture of palliative care up to the 1990s as a marginal element of the Dutch health care system. There was 'a handful' of hospices, but a genuine hospice tradition did not exist in the Netherlands. Thanks to the government incentive programme, the advocates of palliative care suddenly had the wind in their sails. Kennedy noted that this theme was rapidly embraced by everyone, in typical Dutch fashion. This was connected to the fact that both proponents and opponents of euthanasia welcomed the encouragement of palliative care. The government incentive led to strong growth in the number of facilities, the number of networks, the consultation function of the Integral Cancer Centres, the furthering of the expertise of professionals, and the promotion of support for volunteers. Kennedy placed a number of question marks alongside the rapid growth and expressed the suspicion that it had taken place too quickly. He explained that the institutions which had been active in the initial phase and for which palliative care was their 'core business', were small and were not able to make a major impact on the design of that care within the established institutions. Moreover, the established institutions acquire funds in close consultation with the state. In Kennedy's view, government policy was focused primarily on established institutions and not on ensuring that all citizens have access to the palliative care they need as patients. He also argued that the care was not delivered in the place where the inspiration 'at the coal face' was the greatest, but rather where it best suited management.

In addition to the formal care delivery, volunteers have a major role to play in the delivery of palliative terminal care, both in the various facilities and in the home setting. It is estimated that almost 7,000 volunteers (6,817 in 2005, see: Bart et al. 2007: 17) are employed in the terminal care sector. Their number has more than doubled since 1998. The majority of them are female (86%), with an average age of 55 years. Most of the volunteers are active in home care (52%), followed by work in the homes from home (35%) and high-care hospices (13%). In recent years there has been a reduction in the support offered by volunteers at home in the final phase of life. This development was also raised in the discussion with the researchers from NIVEL. Anneke Francke recounted that there were signs from the field that it is becoming increasingly difficult to enthuse volunteers to provide care at home to terminal patients. Most volunteers prefer to work in a hospice or home from home, where it is much easier to build up a good atmosphere.

Palliative care networks have also sprung up everywhere in the Netherlands thanks to subsidies and coordinators have been appointed, first via the CVTM scheme,[5] and since 1 January 2008 via a new subsidy scheme (VWS 2007c). Independent hospices and homes from home also have a place in this network; the percentage of them that are represented in the administration networks grew from 40% in 2004 to 54% in 2006 (CVTM scheme Monitor, Baecke & Cazemier 2007: 9). The CVTM Monitor states that in 2006 the build-up phase of the palliative care networks was complete, and that 'attention has shifted from the development of a network to the realisation of goals by the network' (Baecke & Cazemier 2007: 21). Elsewhere, the Monitor states that networks are becoming ever better at meeting the conditions for effectiveness, and that the situation had stabilised in 2006. They were also increasingly evaluating their own functioning; the number doing so increased from 31 in 2003 to 75 in 2006. (Baecke & Cazemier 2007: 11). This is not to say that there are no gaps in the organisation of palliative care. For example, the Monitor concludes that the match in the regions between care supply and demand is limited.

The consultation function of the Integral Cancer Centres is another important part of the incentive programme. This function means that primary health care professionals (mostly GPs) receive professional, patient-specific support from the Integral Cancer Centres. The number of consultations increased from 406 in 1999-2000 to 5,289 in 2004. In 2006 there were more than 6,000 consultation requests, but the number of requests received by the palliative care consultation teams is now falling. A study is planned into the reasons for this.[6]

Professionalisation and quality systems

Palliative terminal care is a fairly new form of care and its professionalisation is still in full swing. Professionalisation means that practitioners of a (new) profession need to define their knowledge and skills, to draft standards for professional conduct and that there is a need to give accreditation to those who meet those standards. This process is currently ongoing in palliative care. For 'high-care hospices' (i.e. hospices which employ a doctor and nursing staff) a quality mark has now been developed based on the quality system developed by the Association of Independent High-care Hospices (Associatie van zelfstandige high-carehospices). The Dutch Palliative Care Network (NPTN) awards the Palliative Care Quality Mark to institutions for which it has been determined via an independent inspection that the quality system is applied in day-to-day practice in the correct manner. In 2007 the NPTN took the initiative of developing a quality system for palliative care units in hospitals as well. This system is based in part on the existing system for high-care hospices (see www.nptn.nl). Units which meet the standard can then also obtain a quality mark.

Via the Netherlands Organisation for Health Research and Development (ZonMw), the government is working to develop an overarching quality framework for palliative care with a linked basic set of measurable quality indicators. (ZonMw 2006: 17). A number of quality indicators have been developed which relate mainly to the care process (Pasman et al. 2007), but as yet there are few indicators for mea-

suring the outcome of that process. The quality framework for responsible care for the nursing, care and home care sector currently has no palliative care module, for example (Stuurgroep Verantwoorde Zorg 2007).

The growth and professionalisation of care is also leading to an increased desire to research, measure and weigh, and a registration system is being developed. An example is the Hospice Palliative Care Register (REPAL), which has been developed by the Oost Integral Canter Centre and which provides an insight into the characteristics of hospice users and the care programmes they undergo (Groot 2007). Another example is the Liverpool Care for the Dying Pathway, which is being used in the Rotterdam region under the name 'Zorgpad Stervensfase' (Van Zuylen et al. 2007). It is a protocol with forms on which all caregivers make notes in the end of life phase about the patient and the care provided. In this way, all available information is entered into one file.

The final phase of life: wish and reality

The place where someone dies plays an important role in discussions about (the quality of) palliative care. When asked, where do people themselves say they would like to die? In 2004 the IVA research bureau sent a questionnaire on this to 2,000 respondents from the Centerdata panel (Van den Akker et al. 2005). The result was first that most people would like to die at home (73%) and secondly that the people above all do not wish to die in a care home or nursing home. A fuller summary of the responses can be seen in table 8.3.

Table 8.3

First preference for the most ideal place to die for people who are incurably ill, 2004 (in percentages, n = 1,804)

	35-64 years	≥ 65 years	total
at home	75	65	73
care home	1	1	1
home from home	17	21	18
hospice	6	8	6
nursing home	0	1	0
hospital	2	5	2
other institution	0	0	0

Source: Van den Akker et al. (2005)

NIVEL recently studied the locations of non-acute mortality; table 8.4 is based on the study report (Van der Velden et al. 2007). If we compare the preferences of the population with the reality of dying from non-acute diseases and causes of death, it is striking that far more people die in hospital or nursing home than the public would like.

Table 8.4

Place of death of people dying from a chronic disease, 2006 (in percentages)

number of deaths in 2006	135,372	percentage (rounded off)
of which due to non-acute causes	73,000	54
of which:		
died at home		32
died in hospital		27
died in a nursing home		25
died in a care home		10
died elsewhere or unknown		5

Source: Van der Velden et al. (2007)

Providing terminal care and support at home requires a fair amount of coordination and stands or falls on the adequate availability of informal carers. Providing informal care for an elderly person dying at home is often more intense than other forms of informal care (Vissers 2006: 39). A good interplay between informal and formal care can prevent an unwanted hospital admission. Elderly people who receive only informal care are three times as likely to die in hospital than their counterparts who receive a combination of formal and informal care (Vissers 2006: 29).

Changing view of the government

The view of central government on the terminal phase of life and on dying with dignity has undergone a shift in emphasis of the last ten years. The starting point for the government's involvement with palliative care was the debate on the most appropriate medical approach to end of life and the law on euthanasia. In response to the Euthanasia Act, palliative sedation was put forward as a good alternative (Crul 2004); neighbouring Belgium was surprised that the Netherlands had regulated euthanasia by law but lagged behind in palliative care (Vissers 2006). Finally convinced of the need to make up the lost ground, the Dutch government set to work energetically with an incentive programme. The fact that medical decisions around the end of life were seen as a reference point here can also be seen in Memorandum 64 in relation to the role that the government sees for itself.

Now, ten years later, the State Secretary for Health, Welfare and Sport (VWS) has observed that the phase of the hospice pioneers is past (VWS 2007c). The accompanying model, with an abrupt transition from the curative to the palliative phase (lasting approximately three months) must make way for a much more gradual transition, in which curative and palliative care operate alongside each other, with the curative element gradually being replaced by palliative care. The letter from the State Secretary states that 'the palliative phase must be identified earlier than is currently often the case and primary carers must play a crucial role in this, partly in view of the wish of people to die at home'.[7] She accordingly wishes to set about strengthen-

ing primary palliative care during the present government term and to ensure that it is provided close to people in the home setting, at neighbourhood and district level. The plan for this was tabled in Parliament on 15 April 2008 (VWS 2008); it sets out four objectives:

1 improving networking;
2 early deployment of palliative care;
3 strengthening good initiatives from the field;
4 raising, measuring and testing the quality of care.

To achieve these objectives, a total of € 10 million per year in additional funding has been made available for palliative care.

8.4 *Dying with dignity*

Palliative care is intended to allow people in the final phase of their lives to 'die with dignity'. Memorandum 64 refers to the basic values of a civilised society, and cites being able to die with dignity as one of them. In the spirit of Memorandum 64, dying with dignity should be the starting point for palliative care, as well as the yardstick by which it is gauged. It is of course not easy to define what constitutes dying with dignity, partly because of the role played by all manner of personal and cultural influences. However, everyone realises that the dying process is a very particular phase of life and that palliative care should be designed in such a way that it reflects and respects the delicacy of this phase of life. 'There is a clear distinction between the normal, hectic everyday world and the special world in which people find themselves when they receive palliative care' (Van den Dungen et al. 2006).

Dying with dignity thus entails a distancing from a number of the shortcomings of the present day and from the vagaries of modern society. In caring for and supporting a dying person we must as far as possible shield them from the pressures of modern life and the enormous drive for efficiency that dominates it. There may well be such a thing as efficiently organised palliative care, but there is no such thing as dying efficiently. Dying demands calm and an atmosphere of security. We wish to offer the dying person the certainty that everything around him or her has been well taking care of; that they need have no worries about the organisational aspects; that there is the time and space necessary for them to come to terms and be at peace with their lives and with their loved ones, thus affording them the prospect of a good death.

A good death has been defined as one which is 'free from avoidable distress and suffering for patients, families, and caregivers; in general accord with patients' families' wishes; and reasonably consistent with clinical, cultural, and ethical standards' (US Institute of Medicine, quoted in Chochinov 2006: 103). A good death means allaying any fears on the part of the dying person about losing control, and allowing them to retain their personal sense of dignity and identity, reinforcing the relationships with loved ones and where possible resolving conflicts. Research into aspects of a

good death shows that 'being able to say goodbye to loved ones', 'dying with dignity', 'being able to take end of life decisions' and 'dying without pain' are considered very important (Rietjens et al. 2006). In research carried out in other countries, dying 'in your sleep', 'suddenly' or 'peacefully' were all cited as forms of a good death (Payne et al. 1996). A striking view of what constitutes a good death emerge when GPs in a refresher training programme on end of life were asked to make a drawing of their own deathbed. They drew their death on a chair or in bed surrounded by their loved ones, pets and house plants, but notably with a complete absence of any technical instruments, tubes, doctors or nurses (Wanrooij & Koelewijn 2007: 98). Palliative care is designed to make a good death possible, with attention for the physical, psychological, social and spiritual needs of the dying person and his or her loved ones.

Scientific research has only recently begun devoting attention to the notion of a good death or dying with dignity as a measurable concept. This is of course because dignity and dying with dignity are concepts that are difficult to operationalise and measure. The best-known researcher in this field, the Canadian Chochinov, discusses a number of motions in relation to a good death from a variety of sources, and also indicates what palliative care should take into account in order to make dying with dignity possible (Chochinov 2006). In his 'dignity model', Chochinov distinguishes between three aspects:

1 Disease-related aspects such as mental and physical independence and the burden of both physical and psychological symptoms;
2 Dignity as an experience (personal pride) and as the retention of roles and autonomy;
3 Social dignity, which relates mainly to privacy and social support (and thus to the question of whether or not someone has the feeling of being a burden to others).

This model has been used in the Netherlands to investigate the meaning of the concept 'dignity in the final phase of life' among volunteers in palliative care and among doctors who provide support and consultation on euthanasia issues ('SCEN' doctors) (Onwuteaka-Philipsen et al. 2007b). There is a good deal of correspondence between these two groups; important aspects for (loss of) dignity are: 'not being able to look after oneself physically', 'feeling that one has no control over one's life', 'not being capable of thinking clearly' and 'feeling a burden to others'.

If we as a society wish to allow terminal patients to die with dignity, then the aim must be that society ensures that people in the final phase of life are genuinely able to determine where they wish to die. It also means that we must organise the care in such a way that we are able to offer the dying the peace and security they need for a good death.

8.5 *Conclusion*

This chapter is ultimately about the question of what the government should measure in order to obtain an insight into whether or not its citizens are able to die with

dignity, and how it can chart positive or negative trends in relation to dying with dignity. This is not the same as measuring the quality of palliative care. Although quality measurements are important, they are in the first place an internal matter for the institutions and health professionals and form part of the professionalisation of palliative care. We are much more concerned here with what Luc Deliens described in his inaugural lecture as the public-health objective in end of life care (Deliens 2006). He listed a number of domains, and closer examination shows that these also embrace dying with dignity:

1 Physical comfort of the patient (managing pain and symptoms);
2 Well-being of the patient, their family and loved ones (psychological and spiritual);
3 Understandable information and control of the treatment options and the planning of care;
4 Continuity of care;
5 Quality of the mourning process for those left behind.

In order to translate these domains into measurable indicators, Deliens formulated 12 questions. Answering these questions enables the 'quality of the end of life' to be mapped out (see appendix F at www.scp.nl). For many people, answering these questions could offer an extensive overview of palliative care and dying with dignity in the Netherlands. However, an extensive data gathering exercise would need to be set up for this, and quite apart from the desirability of such an exercise, the question of feasibility also immediately raises its head. Deliens therefore advocates examination of existing (administrative) databases in the light of these questions, before considering new data gathering exercises. He sees possibilities in making the mortality statistics compiled by Statistics Netherlands (CBS) suitable for measuring the quality of the end of life.[8] If dying with dignity means that the dying person is able to retain his or her autonomy, for example concerning the place of death, but also in relation to pain management and remaining conscious in the final phase, then information will have to be gathered in some way about individual dying persons; the mortality statistics are such an information source, which Deliens argues should be expanded.[9]

It is likely that a good deal of choice information concerning palliative care will become available in the near future, including satisfaction surveys in relation to palliative care institutions (e.g. among next of kin), information on waiting lists, and so on (e.g. via www.kiesbeter.nl). A selection should then be made from this information for the compilation of periodic reports and for the definition of targets for organisations which provide palliative care.

Briefly summarised, monitoring dying with dignity means on the one hand defining a minimal data set on the individual dying process, and on the other making a choice from the quality information that becomes available as part of the professionalisation of palliative care.

Notes

1 Dying with dignity, palliative care and all it entails, is a relatively new subject for SCP. The author consequently felt the need to discuss the topic with experienced researchers. On 19 September 2007 a meeting took place with Dr Anneke Francke (nurse and nursing and care programme leader at NIVEL in Utrecht), Dr. Patriek Mistiaen (also a nurse and a palliative care researcher at NIVEL) and Prof. Luc Deliens (medical sociologist and head of end of life studies at VU Amsterdam and Vrije Universiteit Brussel). To gain an insight into the practice of terminal care, two meetings were held with Inge Jansen, director of the Demeter university hospice in De Bilt (5 and 6 February 2008). The author would like to thank all concerned warmly for their cooperation.

2 Several parties were involved in organising this incentive programme. A start was made by the later ZonMw, which carried out a research and development programme on palliative care in three phases (Hackenitz & Van Ginkel 2004). The first phase consisted of an inventory of existing practices, current developments and projects in the field of palliative care (Francke et al. 1997). In the second phase (1998), four future scenarios were outlined (Francke & Willems 2000). The third phase consisted of a number of projects aimed at the structural embedding of the existing initiatives and care provision and integrating them into mainstream care. There were also a number of other government incentive programmes for palliative care which had the same aim: the programme for the founding of six academic Palliative Care Development Centres (COPZ) and the Hospice Care Integration programme (PIH). In 2002, at the behest of the Minister of VWS, the Agora palliative care expertise centre was founded.

3 Memorandum 64 draws a distinction between two categories for the fulfilling of their role by the Integral Cancer Centres, 'completely or largely' on the one hand and 'reasonably or to some extent' on the other. Since all Centres fell into the category 'completely or largely' in 2006, it is plausible that, following the system used in the Memorandum, a score of 10 should be awarded.

4 There are also striking differences in the funding of the provisions. Nursing and care homes receive € 90 per day per place for their hospice facilities. The care provided in hospices is funded under the Exceptional Medical Expenses Act (AWBZ). To cover the costs of coordinating volunteers, a new subsidy scheme was launched by the Ministry of VWS on 1 January 2008 (VWS 2007c). The Ministry recognises that the accommodation costs of the homes from home and the high-care hospices constitute a structural problem and, in order to resolve this problem, has proposed making available an annual subsidy of up to € 2 million (VWS 2008: 8). In granting the subsidy, the Ministry adopts the principle that voluntary palliative terminal care provisions have deliberately opted for an independent position, for which complete funding is therefore not appropriate. In practice, hospices charge patients a contribution for the non-care-related costs. They also receive gifts and donations from private individuals and companies.

5 CVTM = Coordination of Voluntary Homecare and Informal Care. The scheme was abolished on 1 January 2007 with the introduction of the Social Support Act (Wmo).

6 This was said by Cilia Galesloot from the palliative care department of the Oost Integral Cancer Centre during a symposium of the NAPC (Netherlands Association of Palliative Doctors/Consultants) in Bunnik in mid-November 2007.

7 This new view incorporates many elements from the inaugural lecture by Professor Kris Vissers, professor of Palliative Care at Radboud University (Vissers 2006).

8 In the interview with the author on 19 September 2007, he said the following about this: 'I always say, we need a more detailed [death] certificate; the process prior to death should also be recorded. At present, the law stipulates that you have to establish the cause of death. A doctor has to do that, that is completely regulated by law. But the law says absolutely nothing about how the patient died. Whereas if we had that information, that wouldn't be a sample, but a complete record. It would then be possible to evaluate everything at national level. You could then evaluate at the level of the disease, the level of the place of death, the setting, in other words, age, sex, and so on. You could derive an unbelievable number of analyses from it. But how something like that should be implemented socially, that's something which we all need to reflect on.'

9 If such an expansion is realistic, it is very likely to be limited to, say, the last 24 hours prior to death. If dying with dignity also means that the dying person feels safe and knows that everything is being done to ensure that their last journey passes off as well as possible (including literally), then we must focus indicators on this. An example might include minimising unwanted admission to hospital and nursing homes in the final days prior to death. It is worth remembering that 80% of patients who die in hospital were still at home a week before their death (Abarshi et al. 2007).

9 Conclusion: the benefits of population ageing

Cretien van Campen

When the media talk about 'population ageing', the discussions are usually accompanied by a doomsday scenario of high costs for society. The increase in both the number and proportion of elderly people, it is argued, will push up the costs of health care and make the state retirement pension unaffordable, because these costs have to be borne by an ever shrinking labour force. Several authors have shown that these predictions are exaggerated. Older people in the future will be healthier and fitter than ever and will make a considerable contribution to society in the form of voluntary work and informal care (Timmermans 2007; Knook 2008; Schnabel 2006). The increase in the costs of health care will be due mainly to new medical technology, care delivery and epidemiological developments, and where they are caused by age, it is primarily the final year of life that demands a great deal of care (Polder 2008).

Not only do the costs of population ageing deserve more considered thought, but there are in fact also benefits. Each of the chapters in this report has shown that the benefits of population ageing are increasing in various domains of life, such as health, work and housing: more older people live independently and more older people make a contribution to society in the form of paid and unpaid work than in the past. The benefits of population ageing are related to the two central values set out in Memorandum 64, the government policy document on policy on the elderly against the background of an ageing population (*Ouderenbeleid in het perspectief van de vergrijzing*), namely sovereignty and solidarity (TK 2004/2005). Today's elderly have more opportunities for living independently and playing a full part in society than ten years or so ago. Their contribution to society means they are not only receivers but also givers in a society based on solidarity.

Elderly policy is driven by a desire to support and strengthen their sovereignty in the fields of health, social participation, purchasing power, housing, mobility, care dependency and end of life. A key example of this policy was the introduction of the Social Support Act (Wmo) in 2007, which seeks to support and where possible strengthen the independence and full participation in society of the elderly and other groups in society (see www.invoeringwmo.nl).

Memorandum 64 translated the core value of sovereignty in each of the above policy domains into derived objectives (see table 1.1 in chapter 1). The government proposed to monitor the results of the policy in broad outline. To achieve this, the objectives were in turn translated into numerical targets for those objectives. The government already realised at that time that establishing good indicators was a process there was still under development and which would therefore be a key policy

challenge for the near future (Memorandum 64: 48). The Netherlands Institute for Social Research | SCP was asked to compile a trial edition of the Elderly Policy Monitor. The question was twofold: 1) Have the targets that the government formulated in 2005 been achieved? and 2) Are the proposed indicators usable for future monitoring or do they require improvement?

During our study of these questions it quickly became apparent that it was very difficult in most cases to determine empirically whether the targets are being achieved. The reasons for this include the unclear formulation and operationalisation of indicators, the lack of data for time series, and changing policy objectives during the period studied. For this reason, we sought contact with the responsible ministries for each policy domain and adapted the indicators where necessary in consultation with them. If the targets have been adapted since their inception, we have taken the values most recently submitted to Parliament as a basis.

We were then faced with having to deal with data from different years. Broadly speaking, the remit was to monitor changes between 2005 and 2007. In practice, the figures for 2007 were often not available by early 2008 and the figures in Memorandum 64 which purport to be for the year 2005 often actually date from 2003 and 2004. We resolved this problem by analysing the most recent two-year period for which figures were available (sometimes a three-year period, depending on the frequency of the data collection) and – something that in retrospect proved more important – by placing the recent figures in a long-term trend, enabling us to assess whether a recent change was an outlier or in line with that trend.

Bearing these qualifying comments in mind, we will now present as factual an answer as possible to the question of whether the targets set out in Memorandum 64 have been achieved. Later we will look at possible improvements to the Monitor as a whole.

9.1 *Achievement of the targets*

The basic values sovereignty and solidarity are translated in Memorandum 64 into policy objectives and targets in seven social domains: participation in (paid and unpaid) work; adequate income; suitable housing; mobility; staying healthy; being assured of care; and dying with dignity. The number of targets for each social value varies from two to six.

– Paid work

The policy objective of active social participation by older people is translated into targets in relation to paid and unpaid work. The target of a labour market participation rate of 50% among people aged 55-64 by 2010 will be achieved if the increase in the rate continues at its present pace. In 2003, 43.3 % of 55-64 year-olds were working for a least one hour per week; this had risen by more than three percentage points in 2006, to 46.7%. Analyses over a longer period show that the activity rates of men and women in this age group have developed differently. The turnaround in the

labour market participation rate of working men aged 55-64 years began to change in around 1993/94, when the Dutch economy began to climb out of the economic decline. The activity rate of older women has by contrast shown a rising trend since the middle of the 1980s, though the starting level was very low.

– *Unpaid work*
In addition to participation in paid work, participation in unpaid work in the form of voluntary work is one of the policy objectives. The aim of keeping the proportion of volunteers among the over-65s constant in recent years has not been achieved. An analysis of the long-term trend shows that following an increase in the proportion of volunteers in the early 21st century, it began falling again after 2002. The fall in 2004-2006 appears to have taken place mainly among older people who were not members of a religious community.

– *Income*
The policy objective that older people should have sufficient income to be able to lead an independent life is translated into a target for the purchasing power of single elderly people living only on state pension. The objective of maintaining the earlier improvement in their purchasing power relative to that of a single person on social assistance benefit below the age of 65 (ratio 106 : 100) has been achieved. Up to and including 1994 the amounts for social assistance benefit and state old-age pension were exactly the same. The older person's tax credit was introduced in 1995 and raised substantially in 1999. Today, into their data, the net old-age pension amounts to approximately 111% of social assistance benefit.

– *Housing*
Older people must have access to adequate housing, geared to their individual needs and supported by customised care provision. This policy objective is operationalised in the form of targets for sufficient stairless homes (in which the living quarters are accessible without having to climb stairs) and homes with on-call care in the locality. The question of whether the target for adequate homes for older occupants has been achieved can only be partially answered; a change in the definition means it is not possible to determine the increase in the number of stairless homes.

The number of homes for older occupants with care on call (care-supported homes) rose from approximately 101,000 to 129,000 between 2002 and 2006. This increase of just over 7,000 homes per year is well below the target of 14,000 a year. The rise in care-supported homes is mainly visible in the homes with the youngest and oldest elderly and in households where one occupant has a moderate or severe physical disability.

– *Health*
The policy objective of encouraging elderly people to remain fit and healthy for as long as possible is operationalised in a target for the number of over-65s to engage

in enough exercise and sport, and a target for the number of fall incidents among the over-65s. The percentage of older people taking exercise increased between 2000 and 2005.[1] The target of 45% of the over-65s complying with the standard was achieved in 2004, i.e. before the target year of 2005, and the objective of 50% for 2010 was achieved in 2005. It is only among people aged over 65 who perceive their health s poor that the percentage is much lower, with only 21% meeting the exercise standard.

After correction for the population profile, a declining trend can be observed in the number of fall incidents in the period 2002-2006. This downward trend is in line with the target of approximately 6%. Older people living in institutions form an exception, with a sharp increase of 17% in the number of fall incidents in 2002-2006.

– Care

Older people who become vulnerable as a result of health problems must be assured of adequate care of good quality. This policy objective is translated into the largest number of targets: one for adequate care (waiting list reduction for nursing and care and for home care), and four targets for quality, especially of nursing home care.

It is unknown whether the target for waiting list reduction has been achieved due to changing definitions and recording of waiting list and data.

At least two of the targets for quality of care have been achieved; one has not and in one case this cannot be established. Client satisfaction was measured through client testing. The target of 100% testing will be achieved in 2007. In 2005, client satisfaction was tested in 87% of care and nursing homes, well above the derived target of 71%.

The first target for housing and care quality – eliminating all rooms containing more than two beds in nursing homes by 2006 – has not been achieved. This had been achieved for 16,200 multiple-bedded rooms in 2006, or 74%.

With regard to the second target for housing and care quality, namely small-scale residential facilities for people with dementia, the government's aim is that this form of residential setting should account for 20% of the total psychogeriatric care capacity by 2010. Forecasts suggest that this target will be achieved. As a proportion of the demand for places for people with dimension, small-scale living will increase from 10% in 2005 to 25% in 2010.

The target for the quality of care delivery relates to the number of nursing homes which meet the standards for professional quality set by the Dutch Health Care Inspectorate (IGZ). In 2006 and 2007 the IGZ and the field developed new standards, as a result of which it is not possible to determine whether the target and has been achieved.

– Dying with dignity

The policy objective of dying with dignity is translated into four targets concerning the facilitation and organisation of palliative care: 1) integration of palliative terminal care facilities into networks of palliative care providers; 2) national coverage

of palliative care consultation facilities; 3) setting up palliative care departments in Integral Cancer Centres; and 4) the fulfilling of a new role by the Integral Cancer Centres. The targets had already been practically achieved when Memorandum 64 was formulated. Aspects 2 and 3 had already achieved a maximum score in 2005; aspect 1 achieved a score of 91% in 2006, and in 2006 Integral Cancer Centres were fulfilling their new role largely or completely. Consequently, the fourfold target for palliative care has been achieved.

A special case: mobility

The policy objective that older people must be able to move around their residential setting freely and in safety is translated into targets relating to the accessibility of transport. In consultation with the Ministry of Transport, Public Works and Water Management (V&W), this Monitor does not devote a separate chapter to mobility. We will therefore deal with this topic briefly here.

Instead of the indicators used in Memorandum 64, V&W has developed a new set of indicators for the accessibility of urban and district transport and rail transport. The objective is to improve the accessibility of public transport for people with physical disabilities. This policy is not exclusively focused on the elderly, though they do form the largest group of people with physical disabilities. National targets for 2010 and 2030, respectively, have been formulated for bus and railway transport. The term for the realisation of targets in relation to accessible tram transport, for which the various public transport authorities are responsible, varies from region to region (TK 2007/2008e, TK 2006/2007b). At the time of writing, national figures were available for the achievement of the targets for accessible bus transport. The first target means that by 2010 all buses must be accessible for people with disabilities by means of a low floor and/or kneeling system. The second target means that by 2005 50% of bus stops must have been adapted to accessibility standards in relation to height, width and platform markings.[2] Table 9.1 summarises the accessibility of bus transport based on an inventory of 19 public transport authorities in the autumn of 2007.

Table 9.1
Accessibility of bus transport, 2004-2007 (percentages)

	2004	2005	2007
percentage of accessible buses	55		75
percentage of accessible bus stops		2	8

Source: TK (2007/2008e)

Summary: achievement of targets

Table 9.2 summarises the current status with regard to the achievement of the targets for the seven social values set out in Memorandum 64. We have been able to make statements on 10 of the 14 targets. Seven of those 10 have been achieved and

in all seven cases the change was confirmed within two years by the trend in the long(er) term. Three targets have not been achieved, though they were all close to being achieved and it is likely that with an additional effort they could be achieved in the coming period. Finally, there are groups that form exceptions for four of the targets as a result of which they have not been achieved.

Table 9.2
Summary of the achievement of targets, long-term and exceptions

policy domain	indicator	target achieved?	long(er) term trend	exceptions
paid work	proportion in work > 1 hour/week	yes	rising	women, ethnic minorities, low-educated
unpaid work	proportion doing voluntary work > 1 hour/week	no	falling	
income	ratio state pension : social assistance benefit for single person	yes	rising	ethnic minorities, people with incomplete state pension and/or supplementary pension
mobility	accessibility of public transport	not known	rising	
housing	housing in stairless homes	not known	not known	
	housing in care-supported homes	no	rising	
health	proportion meeting exercise standard	yes	rising	people with health problems
	number of fall incidents	yes	falling	residents of institutions
care	size of waiting list for nursing and care	not known	not known	
	client satisfaction	yes	rising	
	reduction of multiple-bedded rooms in nursing homes	no	rising	
	small-scale residential units for patients with dementia	yes	rising	
	quality of nursing home care	not known	not known	
dying with dignity	facilitation and organisation of palliative care (four components)	yes	rising	

At first sight, this appears to be a fairly pleasing result. However, the picture clouds when the targets are examined more closely. In some cases it was almost impossible for the targets not to be achieved or they are substantively so vague that achieving them means little. Some of the indicators would however be usable for monitoring with a few minor adjustments. For the substantive discussion of this, reference is made to the individual themed chapters. Here we concentrate on recurring criticisms and weak points in the structure of the Monitor as a whole and make suggestions for improvements.

9.2 Considerations and suggestions

The first thing that becomes apparent when the targets from Memorandum 64 are laid out next to each other is the dissimilarity of the figures. In the field of housing, the targets are concerned with the supply of provisions (homes for old occupants); for care they are sometimes concerned with the need for provisions (waiting lists) and sometimes with evaluation of provisions (client satisfaction with care for the elderly); and in the area of health they are concerned with the behaviour of people (exercise). There is a lack of unity of measurement in the Monitor in this respect. When looking at the data sources from which the targets were derived, we encountered a range of different data types: surveys, records, forecasts and estimates. Each of these data sources has its own advantages and disadvantages, but in essence they say different things. If these figures are 'hammered flat' to produce scores, this nuance disappears. Suggestion: translate the values 'sovereignty' and 'solidarity' into the same type of measurement units for the different policy domains. For example, consistently opt for the perspective of the elderly (use of provisions, choice of healthy lifestyles, choice for quality), and use appropriate data sources. Our experience was that the targets that were based on population surveys lend themselves better to analysis, because we were able to distinguish subgroups and analyse trends.

The targets also use different time horizons. For housing and transport the horizon is far in the future, because building and developing these provisions takes many years. By contrast, when it comes to the healthy behaviour of older people, even seasonal influences within a year can be detected. Suggestion: choose targets which can reveal changes in the medium term of between two and five years.

Different age thresholds have been used in the formulation of the targets: 55+ (paid work, housing), 65+ (unpaid work, income, health), or no age threshold (transport, care, dying with dignity). Three groups of older people consistently emerged from the analyses in the different chapters. Broadly speaking these are the working elderly (aged up to 65 years), retired and fit elderly who are active in voluntary work (65 to approx. 75 years), and elderly people who have become care-dependent due to long-term illnesses and disabilities (from age 75 upwards the chance of this increases rapidly). This shows that old age is not a single phase of life but comprises two or three phases (cf. Knipscheer 2005). Suggestion: take the lowest threshold of 55 years for all targets and make a distinction between three phases, which can be accommodated by a division into three age categories: 55-64 years, 65-74 years and 75 years and older. Additionally, it makes a difference for the oldest group of over-75s in particular whether they live alone or with a partner; if older people become dependent on help due to health problems, the presence of a partner is of crucial importance for care and provisions (De Boer 2007).

To what extent should a Monitor describe developments and to what extent should it seek to explain them? When carrying out the assignment the authors of the chapters felt the tension between these two different tasks. On the one hand a description

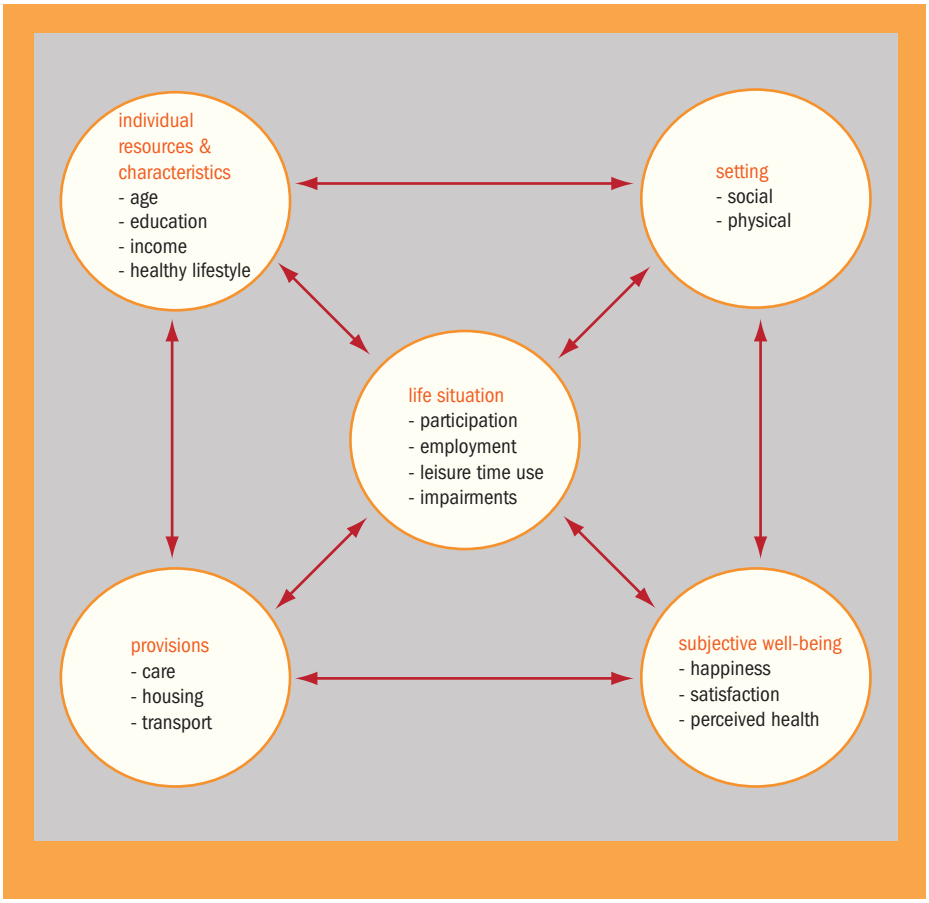
of the achievement of the targets in a given policy domain for the entire elderly population provides little in the way of new information; on the other hand, there is too little scope to explain the identified developments. Where the data permitted this, we opted for a middle way by specifying the changes for subgroups and placing them in a longer temporal perspective. Among other things this shed more light on vulnerable groups. Suggestion: refine the monitoring of targets to include subgroups and compare the changes found against trends in the long(er) term.

Finally, there is a lack of cohesion between the targets. While it is clear that health, work, housing, transport and care for the elderly are closely interrelated in their lives, that interrelationship is not reflected in the set of targets. Suggestion: use a model which indicates which domains could be monitored and what the relationship between the targets is.

To increase the cohesion between the indicators for the different policy domains, SCP uses the life situation model for policy-related trend studies, for example (Roes et al. 2003, 2005; Bijl et al. 2007). This model distinguishes individual resources and characteristics (e.g. age, education, income, healthy lifestyle), provisions (care, housing, transport), the setting (physical and social), the life situation (participation in paid and unpaid work, leisure time use, cultural participation, being active with/without physical or psychological disabilities) and subjective well-being (satisfaction, happiness, perceived health). The life situation model offers opportunities for an analytical framework for the Monitor. Figure 9.1 shows a slightly adapted version for this Monitor.

Incorporating the themes used in the model also makes clear which themes are missing in the Monitor: as regards individual resources, for example, education; for life situation, the participation in non-work-related domains such as leisure time use; with regard to setting, indicators for the social setting (e.g. social exclusion or loneliness). The domain subjective well-being (happiness, satisfaction) is entirely absent from the Monitor. The government does however pursue policy in these domains, including for the elderly. Suggestion: the Monitor would be improved if it were expanded to include these indicators.

Figure 9.1
Life situation model



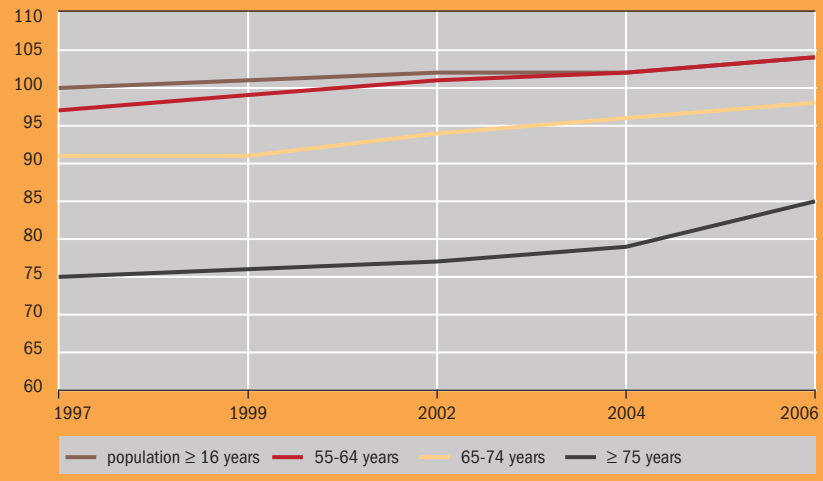
The present Monitor also lacks an 'alerting function'. A good deal of attention is devoted to the results in specific policy domains, but there is no broad perspective on how the elderly in the Netherlands are doing. The life situation model includes two indicators which present a picture of this: the life situation index and the happiness scale (Boelhouwer 2007). The first indicator summarises people's material and physical living conditions, while the second summarises their subjective well-being. The added value of these indicators is that they summarise the degree to which older people function independently and fully in society (in short, the sovereignty that is a core value in Memorandum 64) in a figure and can therefore reveal trends for groups and subgroups. By way of illustration of the two indicators, we show a few time series for the over-55s.

The life situation index is a composite measure of eight policy-relevant indicators of quality of life: physical disabilities, housing, social participation, participation in sport, ownership of consumer durables, mobility, leisure time activities, and

holidays (Boelhouwer 2001; Boelhouwer & Stoop 2004).[3] The index rose for all people aged 55 and over in the year 2004-2006, broadly the period covered by this Monitor (see table G.1 in the appendix, available at www.scp.nl). The increase among the over-75s, in particular, is stronger than the national average, and among the over-75s it is above all the proportion of people in excellent health that has risen (table 6.1). Figure 9.2 shows that the score of older people on the life situation index has risen faster over the last then years than that for the population as a whole, though it must be borne in mind that the scores for older people are still lower on average. In the period 1997-2060 the average score on the index for the population aged 16 years and older rose by four points; the score for 55-64 year-olds rose by seven points and that of the over-75s by nine points.

Figure 9.2

Scores on the life situation index of 55-64 year-olds, 65-74 year-olds, the over-75s and the population aged 16 years and older[a]



a Non-institutionalised population.

Source: CBS (POLS-SLI'97-'06) SCP treatment; SCP (CV'04-'06)

The life situation index mainly incorporates aspects of people's material quality of life. In order to shed light on the more subjective aspects as well, we show trends here in the happiness of older people, as an indicator for the domain 'subjective well-being'. Happiness is sometimes confused with euphoria or 'that Swiss Life feeling' (see chapter 1). Modern happiness researchers are more inclined to define perceived happiness as the development of activities which offer enjoyment, meaning and involvement. This definition shows that happiness is a social rather than a personal phenomenon, which is focused on objectives and which goes beyond personal enjoyment or temporary euphoria (cf. Seligman 2002; Huppert et al. 2005; Lyubomir-

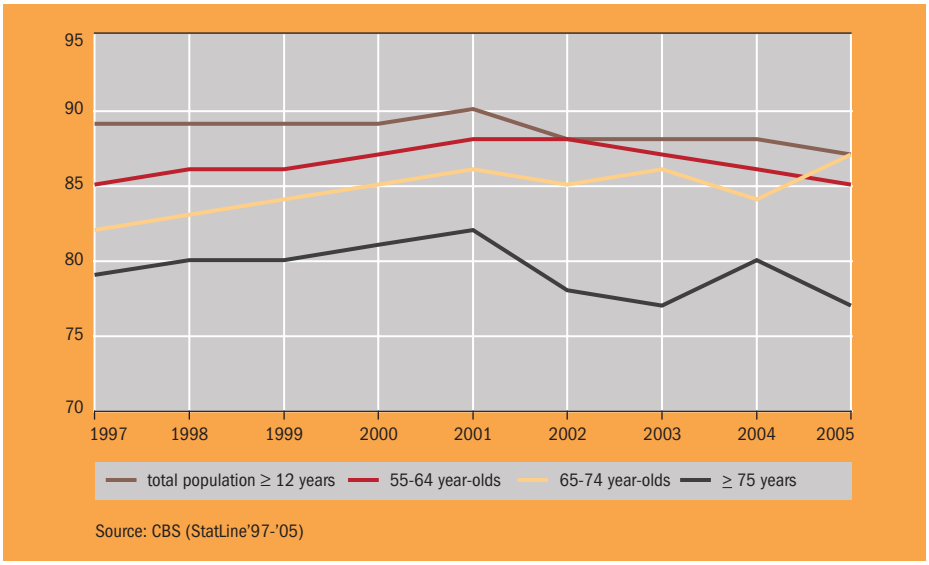
sky 2008). The topics dealt with in the Monitor such as paid/unpaid work, health and mobility, contribute directly to happiness, which is therefore a relevant outcome measure for policy (Layard 2005; Veenhoven 2002). In this sense, measuring happiness serves as an indicator for the sovereign functioning and full citizenship of the elderly.

Humanitas, an organisation which is successfully pursuing a new approach to care for the elderly, takes the happiness of the residents of nursing and care homes as a guideline for its policy (Becker 2003). Local senior citizens' organisations such as Meierode in the Province of Brabant (www.meierode.nl) place the central emphasis on happiness when helping people who are growing old(er) to give structure to their lives (Van Kreij 2008). Subjective well-being is an important theme for senior citizens' associations. Not only do they protect the interests of the elderly, but they also give practical tips and support in creating an meaningful life for people who have passed the age of 65 (see their websites: Samenwerkende Ouderenorganisatie (Senior Citizens' Federation), www.ouderenorganisatie.nl; KBO (Union of Catholic Senior Citizens' Associations), www.uniekbo.nl; and PCOB Protestant Christian Senior Citizens' Association, www.pcob.nl.).

The proportion of happy older people did not change significantly between 2003 and 2005.[4] There are however differences between the three age groups, between people with good and less good health, and between men and women (see table G.2 in the appendix). By contrast, changes can be observed in the long-term trend. Figure 9.3 shows the proportion of happy people in the period 1997-2005 for the three age groups and the total population aged 12 years and older.

Figure 9.3

Proportion of (very) happy people among 55-64 year-olds, 65-74 year-olds, the over-75s and the population aged 12 years and older, 1997-2005 (in percentages)



Source: CBS (StatLine'97-'05)

Figure 9.3 shows a steady increase for the three groups of older people in the second half of the 1990s. This rising trend ended in around 2001 and 2002, after which it began falling.[5] This downturn is clearly visible for 55-64 year-olds and the over-75s. Among 65-74 year-olds, the proportion appears to stabilise, with some fluctuation. There has also been a decline in happiness in the total population since 2001, the year of the assault on the Twin Towers in New York. The trends in the life situation and happiness of older people suggests that their material quality of life has improved over the last ten years, but that there has been a reversal in their perceptions since 2001.

9.3 *What information does a monitor offer?*

The monitors and target group reports published by SCP generally describe trends in social developments in broad outline with the aim of identifying new developments that are relevant for policy, but also in order to make them broadly transparent and measurable (cf. Vrooman et al. 2007; Andriessen et al. 2007; Portegijs et al. 2006; De Boer 2006). The researchers start from policy objectives and select appropriate indicators and data sources to describe and analyse the developments. In the assignment for this Monitor, the indicators had already been established in Memorandum 64 and we had little freedom in selecting indicators.

In Memorandum 64 the government expressed the intention of tracking the results of its policy in a monitor. To this end, the government selected indicators which sometimes relate to the broad lines of policy (paid and unpaid work, adequate care), sometimes to specific components of policy (healthy exercise standard, small-scale housing for people with dementia, palliative care). Clearly, the closer the indicator and target are to the specific policy, the more information they provide (e.g. the healthy exercise standard), but the broad lines of that policy (staying healthy) are then lost from view. Some indicators measure only the extent to which a policy measure has been implemented (e.g. in how many institutions the client satisfaction survey has been carried out), and not what the result is (how many residents are satisfied). With general indicators, the relationship with specific policy measures is generally weak (e.g. labour market participation), but such an indicator has the advantage that it shows trends in society. Participation in employment is not only the result of policy, but also of the economic cycle and of the behavioural choices of older people.

It is better if specific policy measures are the subject of separate evaluation research. Excellent and detailed monitors are available for a number of policy domains, such as a Housing Monitor, a Health Monitor, a Housing & Care Monitor, an Employment Monitor and a Palliative Care Monitor. The ministries concerned have access to data from these monitors and are therefore apprised of how older people are doing in these areas more quickly than could be achieved with an Elderly Policy Monitor.

Monitoring the main lines of policy could more appropriately offer the type of information that SCP incorporated in earlier Reports on the Elderly. These offered a view of the different policy domains from the perspective of the elderly and gave an impression of the cohesion of the policy on the elderly pursued by the various ministries involved.

The answer to the question 'What information does an Elderly Policy Monitor offer?' naturally depends on what the party commissioning the Monitor wishes to know. That commissioning party could make two specific choices for the future Monitor:

1 About which elderly people should the Monitor provide information? All over-55s or only the group of care-dependent, vulnerable over-75s?
2 Does the Monitor offer information on the achievement of policy and/or does it identify trends in the behaviour and perceptions of the elderly?

Any number of scenarios can be constructed for future Monitors. At the two extremes of the spectrum are a Monitor which resembles chapter 7 in this report on care, with a set of indicators that stick close to the implementation of policy, do not have age thresholds and provide information on the degree to which the policy has been implemented; at the other extreme is a sort of Report on the Elderly, with a set of indicators on the broad outline of policy, with age thresholds and providing information on trends in the life situation of the elderly.

It is up to the party commissioning the future Monitor to make this choice. In the next section we put forward suggestions for substantive indicators.

9.4 *Designs for a Monitor*

In this section we present a framework of possible indicators that could be used to monitor the achievement of policy objectives in relation to the life situation and well-being of the elderly in the future. We divide the life domains into resources, provisions, setting, life situation and participation, and subjective well-being.

– *Resources*

The most important resources for the elderly are health, income and education.

Health has many different facets that influence the independent functioning of older people. Monitoring the theme of 'staying healthy', in addition to the existing monitoring of healthy lifestyle (proportion of older people who meet the combinorm for exercise), and a relevant outcome measure (proportion of older people falling in the year), could also incorporate a generic health measure, which summarises a large number of the health aspects that are relevant for independent functioning. The SF-12 (Ware 2001; Botterweck et al. 2001) incorporates such a measure for physical and psychosocial functioning. These two measures show in general terms how the physical and psychosocial functioning of older people develops over time

(see § 6.4). Adding the SF-12 would offer an insight into the development of the general health of the elderly, in addition to the specific policy-related information.

For monitoring *income*, the present indicator for purchasing power, which applies only for a small group of single older persons living only on state retirement pension, could (as suggested in chapter 3) be exchanged for two indicators for the entire elderly population:

1 The proportion of over-65s living below the poverty line; and
2 The proportion who have a lower standardised income than the average standardised income of those aged under 65.

Education was not investigated in this study, but can certainly not be left out as a key determinant of health, participation and use of provisions. The existing indicators from SCP Reports on the Elderly could be used for this: education level and/or participation in education such as the Open University and higher education for the elderly (HOVO) (Herweijer 2006).

– Provisions

We include under the heading 'provisions' the themes 'adequate care of good quality', 'dying with dignity', 'housing provisions' and 'mobility'. It would of course be possible to think of many more topics in relation to provisions for the elderly in their local neighbourhood, but care, housing and mobility are essential for living independently.

A reasonable picture of whether older people in the Netherlands receive adequate care can be derived from the waiting list records for home care services, care homes and nursing homes (the nursing, care and home care sector). The quality of care is assessed from two perspectives: that of health professionals and that of the users. An indicator is included for both perspectives which can be derived from the annual reports on responsible care which institutions will be publishing from 2008: 1) the proportion of institutions in the sector complying with the standards for professional care; and 2) the proportion of institutions in the sector whose users are satisfied with the quality of care. The first indicator could be based on the standards formulated by the Dutch Health Care Inspectorate (IGZ) and the second on the standards contained in the Consumer Quality Index (CQ-index) developed by NIVEL (Wiegers et al. 2007; VWS 2007a). New indicators are being developed for monitoring dying with dignity in the palliative care programme of ZonMw (2006).

For *housing*, the proposal is that the existing indicators – stairless homes and care-supported housing, both for older people living independently – should be merged to form a set of housing and care indicators with the quality indicators for single-person rooms in nursing homes and small-scale residential units for people with dementia, so that a profile of four indicators is created for the residential setting of the elderly, both the large group who live independently and the small group who live in institutions.

A new indicator needs to be developed for *mobility*. The present indicators for the accessibility of public transport for people with disabilities only deal with the supply side and say nothing about the usage. Moreover, older people also make (a great deal of) use of (their own) cars and collective on-demand transport. Harms (2008) observes a sharp decline in the use of public transport and growing car use by older people between 1985 and 2005. Not all older people have mobility impairments. The new indicator would need to show how many older people are able to travel from A to B using different modes of transport (cf. De Klerk & Schellingerhout 2006).

– Setting

The social setting often determines how long older people are able to continue living independently. Loneliness is one of their greatest complaints (Van Tilburg & De Jong Gierveld 2007). The widely used loneliness scale would be a useful tool for measurements in the social setting domain (De Jong Gierveld & Van Tilburg 2008).[6]

– Life situation and participation

Participation or 'taking part' has come to occupy a central place in present policy on the elderly. The Social Support Act (Wmo) was introduced partly in order to support participation and independence. In the present Monitor, participation is followed in relation to paid work and voluntary work. Adding an indicator for informal caregiving to the existing indicator for participation in voluntary work would enable the total participation in unpaid work to be largely charted.

However, participation in society entails more than paid or unpaid work. Culture and leisure time use fill part of the days of older people. In order to make the picture of their participation more complete, an indicator could be added for participation in cultural activities (cf. Duimel 2007).

The life situation index, which is situated at some distance from policy measures, could serve as a generic indicator for the sovereignty of the elderly. The proportion of older people with a low score on this index – this is the group with a disadvantage in material and physical quality of life compared with the rest of the population – could then be monitored.

– Subjective well-being

People attach great value to their subjective well-being and undertake and invest in activities to maintain their happiness in old age (Van Kreij 2008; Becker 2003). In addition to the foregoing largely behavioural and material indicators, an indicator for subjective well-being, such as the proportion of older people who feel happy, could be easily added to the Monitor, and would enable trends in the satisfaction of older people to be monitored.

Table 9.3 summarises the proposals. All indicators referred to could be measured at least once every two years and using the same unit, namely the proportion of people who take part in an activity, use a provision and/or assess it positively.

Table 9.3

Preferred indicators for a future Elderly Policy Monitor

domain	indicator[a]
resources	
health	% exercise as per combinorm
	% with fall incidents
	% with low physical and mental score on SF-12[b]
income	% below poverty line
	% with purchasing power below average under 65
education	(new indicator needed)
provisions	
care	% satisfied users of nursing, care and home care
	% nursing, care and home care organisations meeting IGZ standards
	% waiting for care for the elderly
dying with dignity	(new indicator needed)
transport	(new indicator needed)
housing	% in stairless homes
	% in care-supported homes
	% in single-bedded rooms in nursing homes
	% in small-scale residential units for people with dementia
setting	
loneliness	% lonely people
life situation and participation	
participation in paid work	% with work > 1 hour per week
participation in unpaid work	% providing informal care > 1 hour per week
cultural participation/leisure time use	(new indicator needed)
social position	% with low score on life situation index[b]
subjective well-being	
satisfaction and happiness	% happy people[b]

a For an explanation of the specific indicators, please refer to the themed chapters.

b Generic indicators.

9.5 Conclusion

The main conclusion that can be drawn from this report is that it is possible to monitor the achievement of policy objectives (and targets) using an Elderly Policy Monitor, provided a number of conditions are met. In the first place, the targets

must be empirically based on periodic research. Secondly, definitions and question formulations must not change during the period being monitored.

We have made a number of suggestions which would increase the power of the Monitor. The first is to develop a conceptual model that makes clear the relationship between the targets in the Monitor. The second suggestion is to use a combination of targets close to the policy as well as indicators of social trends in relation to the broad outline of policy, so that both a detailed and an overall picture is created of the sovereignty of older people in the Netherlands. The success of policy initiatives can be derived from the achievement or non-achievement of the targets, while the indicators of social developments in broad outline indicate how the elderly are doing in a general sense. Finally, it is recommended that the term 'policy on the elderly' be replaced by a different term. There are several reasons for this: the over-55s are not (yet) elderly; the age category from 55 years onwards incorporates several different generations (third and fourth age); the policy for the over-55s in fact begins at an earlier age (e.g. education and pension provision). An alternative would be to restrict the policy on the elderly to the group of care-dependent vulnerable people, most of whom are aged 75 years and older.

This trial edition of the Elderly Policy Monitor replaces the periodic Reports on the Elderly from SCP. When researching and compiling this trial edition, it became clear that there are important differences of nuance between an Elderly Policy Monitor and a Report on the Elderly. Since there is no integral policy on the elderly, as Parliament recently established (TK 2007/2008b), translating policy in a number of domains into targets that can be empirically monitored results in a fragmented picture of diverse indicators of different types. By contrast, the Report on the Elderly devoted attention precisely to the cohesiveness of policy from the perspective of the older citizen and identified in new developments and problem areas.

Consideration could be given to creating an Elderly Monitor which monitors the general objectives of the policy on the elderly, the trend in the life situation and well-being of the over-55s (and the various subgroups) over time on the basis of a number of interrelated policy-relevant indicators. This trial edition of the Monitor shows that a proportion of these indicators are already present and can be monitored over time. For some others we have made specific suggestions. These would enable empirically based statements to be made about the degree to which policy objectives are being achieved, both for the entire population aged over 55 and for subgroups within that population, such as the over-75s, ethnic minorities, men and women, people with and without health problems. However, this information will only be of genuine use if it is embedded in a model which expresses the interrelationship between the indicators. Sufficient information about the elderly is gathered in the Netherlands; the trick is to bring it together and make it transparent.

Notes

1 The norm for adults (aged over 18) is half an hour of moderately intensive physical activity on at least five days per week.
2 With a national network of an average of 50% accessible bus stops, approximately 70% of passengers from the target group would have an 'accessible bus journey', in which both the entry and exit bus stop are accessible (TK 2007/2008e).
3 The index is the result of a combination of indicators for eight aspects of life situation: health, housing, (social) participation, participation in sport, ownership of consumer durables, mobility, leisure activities, and holidays. A limited number of indicators has been chosen for each of these aspects, such as the degree to which someone is hindered due to an illness or disability, housing type, whether or not they perform voluntary work, degree of social isolation, the extent to which they participate in sport, and whether or not they visit the cinema, museums or the opera. The indicators are then combined statistically.
4 CBS periodically collects data on the happiness of the Dutch. The most recent figures from the trend series of the POLS survey are available up to and including 2005 for the question 'To what extent do you consider yourself to be a happy person?'.
5 This increase is in fact not significant for the over-75s because of the relatively small number of people in the sample.
6 An alternative would be to measure social exclusion which relates to several domains of life situation. The indicator comprises four components: material deprivation (income and debts); inadequate access to provisions; inadequate social participation; inadequate normative integration (lack of involvement, rejection of norms and values) (Jehoel-Gijsbers 2007).

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