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Constantinos Phellas *Editor*

Aging in European Societies

Healthy Aging in Europe

Springer

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Overview

"Crisis, Crises of Aging"

In a couple of centuries time, historians who would like to study the cultural life of our times—end of twentieth century, beginning of the twenty-first century—might characterize it as a period of "generalized crisology." They would base their characterization on thousands of texts, documents, books, articles elaborated on daily basis in every part of our planet. Also, they would base their investigation on the work of thousands of institutions of education, research and communication, and on the production of thousands of analysts, journalists, and scholars who try to understand the nature of the current "crisis," contributing through their initiatives to the elaboration of a complex set of discourses, essays, and studies.

It is clear that future historians will have the luxury of time perspective and depth in order to analyze our times with serenity and objectivity. For us, who live the present (turbulent) events, history on-line, as we may say, it is difficult to have a precise diagnosis because the financial crisis covers the economic one; the economic crisis predetermines the social; the social feeds the cultural; the cultural leads to linguistic; the linguistic to esthetic, and so on. One has to formulate immediately the question: which is the best level, the best point of view from which the crisis could be approached in order to grasp its causalities, its forms, its trajectory?

The term *crisis* is an ancient Greek word and it has a lot of meanings. The non-Greek-speaking people use the term in its first strong meaning: that of non-functionality. That is to say, we are in front of a crisis when we observe a total change of normal flow of everyday life or a radical overturning of the dominant order of things. But what do we mean by *normal*? In which scale of time and space, do we consider the essence of normality? Which context gives us the framework and the legitimacy to name the transition from one situation to another, as a crisis?

However, the second meaning—equally strong—of the ancient Greek word *crisis*, is the precise diagnosis of problems of personal or collective life, the assessment of alternative solutions, the selection of intelligent strategies to face a multiplicity of obstacles of organized action. This meaning is not considered with the same attention by the non-Greek speakers. It is urgent both to stress the polysemic character according to Greek linguistic origins of the word *crisis*, and to point out the relative ignorance of its second meaning in order to go beyond the negative perception of the crisis. In other words, we need the second meaning of crisis to go beyond the first meaning. The crisis (second meaning) of crisis (first meaning) is the basic condition for overcoming the crisis (first and second meaning).

In a period of cultural turbulence, the fundamental aspects of social life—interactions, norms, patterns, power, production, age, gender—are the best domains in which a crisis could be detected, analyzed, and understood.

In this spirit, ageing could not be left out of the current crisography. Nevertheless, a series of questions emerge here. To which degree is it pertinent to approach aging under the threat of the crisis? To which degree the crisis does modify the analysis of aging? Or, to which degree the phenomenon of aging is really dependent on the context of crisis? To which degree the questioning on aging is the same in periods of crisis and noncrisis?

The dominant discourse on crisis in our global world is economic—financial. Is there a tendency to use the same analytical tool in the case of aging? Does a theoretical framework exist that is capable of exploring both crisis and aging? That is to say, to avoid a simplistic metaphor of crisis in the area of aging? A framework that instead allows us to be vigorous from a theoretical point of view into both crisis and aging.

If we accept the economic point of view, crises are almost normal phases, in the sense that they occur almost in periodic mode (economic history gives a full description of crises in the European continent, for example) and we expect to observe their formation and birth in a national and international horizon through a set of symptoms: poverty, misery, wars, conflicts.

The crucial question here concerns whether the rhythm of economic crisis coincides with the rhythm of aging. In other words, crisis and aging share the same determinants? This means that we have to be careful when we try to establish an interaction between crisis and aging. We may assume as a first step that in different societies, in different periods of time, different forms of crisis coexist, but it's an open question what is the mode of their interactions. Of course, if one crisis is the origin of all the others (ice periods in the Palaeolithic), the sociocultural situations are more clear from a theoretical view. In our times, however, we could observe a multiplicity of poles or sources of crises (global—local—glocal, environmental, existential. . .). The multifaceted and diffused forms of crises reflect on the multiplicity of determinants of crises and their articulation, combination, and accumulation.

In this perspective, is aging a symptom of a crisis both biological and sociocultural? Or, is it an area of social life capable to reveal a new version for the crisis? Or, is aging conceived in a new radical way by technologically advanced societies and its impact as a determinant of future cultures has nothing to do with the economic crises?

One could object the above thoughts as very general or very abstract. It would be more productive to formulate some questions on the mode of existence of the aged human beings, given the fact that all societies have developed a particular (in each case) approach for the age groups in their context. So, the questions that should be posed: What is specific for the age groups (and aging) in contemporary societies? What kind of challenges are we going to face concerning aging in our societies? Why do we observe a shifting of terms such as from third age to aging? What kind of (interdisciplinary) research is necessary on aging? What kinds of policies are necessary at different levels of governance? It is clear that the variety and the richness of the chapters of this book do not permit to create an artificial synthesis of their contents. So, I think the crisis approach could offer a unified overview (uncertain and limited by nature), and the more pragmatic and comparative questioning could permit to demonstrate the complexity of aging in the modern world. It is also evident that the authors have not been invited to answer to the above two "problématiques," it is my effort to combine their research in a common base. What is important here is their contribution to this new and promising domain of knowledge and research. Finally, each text gives us clues to answer multiple sets of questions. The issue here is not to arrive to a final and definitive answer but to create a debate in view of the crucial role of aging taking in consideration the multiplicity of its dimensions.

In order to grasp the contents of the chapters of the book, one might propose a typology based on themes and questions treated by the authors. This typology could permit to create an overview of the material of book, but, of course, it cannot cover fully the ideas, the information, and the discussions, which compose the chapters.

The first group of texts is dedicated to explore the mode of existence of the aged population in the framework of specific societies of the European level. The mode of existence is understood in different levels, symbolic, intellectual, and ideological, for example, but also in more concrete level of behaviors, practices, and networks.

The work of Fjellström and Sydner begins with the abstract issues of dependency (different forms in different societies) and individualism (the dominant cultural pattern of so-called western societies) and concentrate their attention on the (more specific) material level of food security in relation to the third age people's capacity to sustain their appetite for surviving and their appetite for life. The work of Mair on networks (family and friends) as social places for the cultivation of social ties between aging individuals and their environments give us the opportunity to understand how the individuals get imbedded in the social topologies.

Social networking, as the most accessible (and the most critical) interpersonal environment in which older Europeans have organized their living, is analyzed by Litwin and Shiovitz-Ezra, by using the current bibliography and by taking in consideration empirical data of a European Survey. Once more, the importance of social networks for the well-being in the late life is confirmed.

Paul and Ribeiro investigate how optimism or pessimism has an impact on health, that is to say how the noetico-psychological state influences health in old age, regarding the basic epidemiological parameters of morbidity and mortality.

Davidson in his endeavor to explore the life of older men in the United Kingdom, especially those who live alone, found that their sense of masculinity plays an important twofold role and twofold in the sense that masculinity enables them to achieve control on their lives and at the same time masculinity becomes an obstacle in seeking help from the others. In the same field of research, Kuyper and Fokkema investigate and try to explain the fact that the aging lesbian, gay, and bisexual adults are lonelier than their heterosexual peers. Two parameters are considered as crucial: vulnerability and experiences of social discrimination.

The question of different types of literacy (digital, health...) and numeracy becomes more and more indispensable for the functioning of "knowledge-based societies." But literacy is not distributed in a perfect way. The work of Vidovicová puts emphasis on financial literacy and innumeracy in preretirement age of Czech older workers. This work has a supplementary value as it takes in consideration the global financial crisis. Education is an important determinant in this case too.

In technologically advanced societies, people belonging to the so-called third age have lost their symbolic and professional capital, as these societies privilege the new, the young, the innovative, the rapid change, and the obsoleteness. The international crisis has contributed not only to diminish the social status of older people but also has augmented the negative factors for precocity and exclusion. The text of Ribeiro and Teixeira, having as point of departure the case of Portugal and in comparison with Europe, is focused on the evaluation of the social perception of aged populations and social groups, in view to promote social policies and changes toward a more inclusive society.

In the same scientific perspective, Torres asks some fundamental questions on the transnationalism and its implication on gerontological research. It is clear that in a multicultural social milieu or trend of contemporary societies (with all problems of past and present migration waves), it is urgent to study the dynamics of old age identity and intergenerational solidarity by taking into account the cultural difference, and to assess the capacities and mechanisms of the states to face these cultural differences.

In order to understand the present situation of the older generations, it is necessary to compare it with previous one and at the same time to establish the present situation for future comparisons. For this reason, the research of Agahi and Parker on cohort change in living conditions and lifestyle among middle-aged Swedes, and their effects on mortality, institutionalization, and late-life health, is extremely useful from methodological point of view, and also for comparative studies.

It is clear that we do not expect the above studies to give us a complete or exhaustive view of the multidimensional presence of aging in our societies. Nevertheless, we have a set of strong indications on how the aging of the population is being shaped at the beginning of our century. It is also evident that many determinants (economic, social, cultural, technological) at a national and international level contribute to the emergence of a unique phenomenon for the (present and future) aging in the history of mankind.

According to cultural patterns of our societies (e.g., the limited influence of symbolic and spiritual references on the models of life of different social groups), the question of quality of life, the well-being, and the psychological–intellectual autonomy of older population are considered as issues of high importance. In other words, what the third age has lost in institutional and ritual level (in comparison with other societies), they have gained—until recently at least in the affluent societies—in number of members of this group of the population and in care and autonomy in a material level. It is not difficult to understand why, in this book, six studies are focused on the issue of Quality of Life (QoL).

Deeg, Huisman, and Terwee present a framework to understand and to measure QoL. Phellas also provides a critical approach to the conceptualization and measurement of the notion of quality of life (QoL), which is being transformed as a large number of changes occur not only on different levels of aging (e.g., global turbulences of climate), but also on the epistemological level (high standards for the pertinence of scientific knowledge); his theoretical analysis is tested in urban and rural populations in Cyprus. Diaz-Ponce and Cahill explore more specifically the dementia and QoL. The issue is of great importance in the European context, because of the increased longevity of Europeans.

Using different surveys, studies, and experiences and especially the ABUEL survey (ABUSE among elder people of Europe), two works are presented in this book, with an aim to give insights how family and support networks aspire (around Europe) to assure the material and no-material condition for the lives of the elderly (Chiatti et al.).

The text of Ioannidi-Kapolou and Mestheneos, from the ABUEL Survey, is focused on the relationships between inequalities in the quality of life: this issue becomes more crucial as the economic crisis will create new forms of inequalities and accentuate old ones. Finally, in this field of QoL research, Kouta and Kaite present an overview of the home nursing care of the elderly. They pay more attention to the elderly people of Cyprus, who in their majority prefer to stay in their homes.

One can assume that the above mentioned works (on mode of existence of elderly, QoL, and aging) beyond their scientific interest and merit, are or will be very useful for the decision makers and the concerned populations, in order to elaborate better founded strategies that will allow them to finally face a multiplicity of challenges and constraints. Taking into consideration the growing number of obstacles faced by the modern state to exercise a coherent policy for the older populations, research findings are valuable elements and points of departures. However, in the book, three works are more oriented or more clearly dedicated to policy issues. Amitsis discusses the complicated issues of pensions, the reforms of pension systems in an aging Europe, under the threat of global economic and financial crisis; the scenarios presented demonstrate the uncertainty and frangibility of care and support of an increased number of Europeans.

Very often, the elderly people are considered as a “constraint,” as “an inevitable obstacle” for the economy. This stereotype, this oversimplification of the social status of old people, leads to a new challenge: how to transform the “handicap” to an “opportunity.” At the level of European Union and European Commission (EC), it is conceived and planned to develop a sector of innovative products and equipment to be used in order to ameliorate the life of elderly populations. The work of Wahl is dedicated to this megachallenge. In the same atmosphere, Formosa provides a critical assessment of policies in Europe concerning (the human right of) lifelong learning in relation to late-life education. His emphasis on key directives and policies has an objective to contribute to a more inclusive European social environment.

Social anthropology or anthropology could provide a large number of documents and research to demonstrate how societies have understood and faced the variables age and old age. The main lesson is very simple: variety and specificity. In the last two centuries, in the European context a certain number of institutions and patterns have established through a complex set of sociopolitical actions, conflicts, and compromises concerning the third (fourth and fifth) age. It is a common feeling that this period has finished for many reasons (e.g., demographic, ecological, political, financial) and a new sociocultural horizon, and new milestones for personal and collective life are going to appear.

The question of aging is one of the fields in which these mega- or meta-turbulences could be traced. In this spirit, this book might be read both as a symptom of this transition and as an introduction of the new cultural era under construction, with all its uncertainties and its promises.

Demosthenes Agrafiotis

Preface

Drawing from a wider range of theory, original research, and empirical sources, the authors of this book will successfully bring the reader closer into understanding the multiplicity of aging, its complexity, and the various roles which some factors play in order to enhance health and Quality of Life (QoL) in older age. The various chapters presented in this volume will be presenting concerns of pension reforms, the performance of national systems before and during the economic crisis, the role in which technology has played upon active aging, the need to establish the importance of food and food security, the positive role of family and friends, the need to impose happiness, and participation and activity in later life. The concern of dementia, disability, and chronic illnesses will also be discussed, as the importance of social support, financial stability, and the notion of inequality in older age. Additionally, this high-quality volume of chapters will provide those interested in the topic of aging a sample of research that is at the forefront of European work on the QoL of older people. Furthermore, this volume will also present examples from European societies that illustrate innovative methodological approaches that would be relevant to professional working with elderly diverse populations (e.g., ethnic monitories). As policy makers have placed aging high in their agenda, this book wishes to contribute to the policy, practice, and productive development and to stimulate further more comprehensive discussion on the implications of the most pressing health, social welfare, economic and other issues related to aging in various European societies.

Aging in European Societies would be welcomed by students across a wide range of courses in economics, sociology, psychology, gerontology, and the social sciences in general. Furthermore, students undertaking undergraduate and postgraduate courses in health studies and health promotion would benefit from reading this textbook. However, professionals will also be attracted to the book due to the dissemination of current practises in health promotion issues and practices in the field of gerontology.

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About the Authors

Neda Agahi is a postdoc at the Aging Research Center (ARC) in Stockholm, Sweden. She has a background in Public Health, and a doctoral degree in geriatric epidemiology. Her doctoral thesis concerned different aspects of leisure activities among older persons; cohort differences in participation rates, changes and continuities in leisure participation over the life course and the association between late-life leisure activities and survival. Current research concerns trends in lifestyle behaviors, associations between lifestyle factors and health/survival, and changes in these associations over time.

Demosthenes Agrafiotis is an Emeritus Professor of Sociology at the National School of Public Health in Greece. His professional activities include, among others, Engineering, Marketing, Teaching, R&D Management, Health and Illness, AIDS, Art, and Sociocultural Phenomena. He has participated and presented papers in more than 500 seminars and conferences both in Greece and abroad. He is currently a member of 20 scientific societies and committees and is also a recipient of 7 scholarships. He is currently the scientific advisor for three scientific reviews as well as acting as external evaluator for European-funded projects. He is the President of the Hellenic Society of Technology Assessment and Evaluation.

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Williams (ed.); International Poverty Law—An emerging discourse (ZED Books, London, 2006), *The European Social Inclusion Strategy* (Papazisis Publishing, Athens, 2006—in Greek), *Public Employment Agencies in the European Region* (Ministry of Labour and Social Insurance, Nicosia, 2008—in Greek) and *The Greek Social Insurance System—Reforming first and second pillars in light of the EU status quo* (Law Library Publishing, Athens, 2010—in Greek).

Suzanne Cahill is an Associate Professor in the School of Social Work and Social Policy at Trinity College, Dublin. She is also Research Director at the Dementia Services Information and Development Centre at St James's Hospital, Dublin. Suzanne has a background in Social Work practice, Social Policy, and Social Research and has worked both in Australia and in Ireland as a Social Work practitioner and researcher. She wrote her PhD while lecturing in Social Work at the University of Queensland and holds an M.Soc Science and B.Soc Science from University College Dublin. During 2011, Suzanne was chairperson of the National Dementia Advisory Committee; the latter was established to oversee an extensive research review leading to the development of Ireland's national Dementia Strategy. She is principal author of the report titled: Creating Excellence in Dementia Care: A Research Review for Ireland's National Dementia Strategy. Suzanne has published widely on aging and dementia-related topics. She currently teaches an undergraduate course on Aging and Dementia to Social Work and Social Policy students and supervises several Masters and PhD students. Her research interests include GPs and dementia, residential care policy and dementia, assistive technology, and family caregiving.

Carlos Chiatti holds a Master in Economics and a PhD in Epidemiology. He is a research fellow at the Italian National Institute of Health and Science on Aging (INRCA) and visiting fellow at the University of Newcastle upon Tyne. In addition, he teaches Health Economics at the University of Ancona. In his past professional experience, he was consultant for many public and private health institutions in projects aimed at improving services organization and the Information Systems within the Italian National Health Service. His doctoral thesis was specifically focused on social inequalities in health and health care but he has also worked on several international projects in the field of active aging. At INRCA, he worked on the project FUTURAGE, aimed at defining the roadmap for future aging research in Europe. He recently received a research grant from the Ministry of Welfare, for a large community trial (UP-TECH project) aimed at improving the provision of health and social care for patients affected by Alzheimer Disease, through a better integration of existing services and the use of new technologies.

Katrin Claßen is a psychologist and PhD student at the Department of Psychological Aging Research at the Institute of Psychology at Heidelberg University, Germany. She is writing her thesis about the relationship between psychological aspects and the evaluation of technology in middle and late adulthood. Furthermore, she is accomplishing an advanced vocational training in cognitive behavioral therapy at Heidelberg University, Germany.

Hannie Comijs is a psychologist and works as associate professor with the mental health care institute, GGZinGeest, partner of the VU University Medical Centre, Amsterdam. She graduated in 1999 on her thesis: Elder mistreatment prevalence, risk indicators, and consequences. Since her dissertation, she participates in the Longitudinal Aging Study Amsterdam, a population-based prospective interdisciplinary cohort study on the predictors and consequences of changes in autonomy and well-being in the aging population among persons aged 55 and older in the Netherlands. In LASA, she studies the course, (biological) determinants and consequences of cognitive decline, depression and ADHD in older persons in the community. To date, publications on psychosocial stress, HPA-axis, depression, anxiety, and cognitive decline are her main subjects of interest. In addition, she is involved in the Netherlands Study of Depression and Anxiety (NESDA), a 10-year prospective study that examines the long-term course of depression and anxiety in adults aged 18–65 years, in which she evaluated the screening procedure, comorbidity of psychiatric disorders, and aging effects. She also supervised a randomized controlled trial of the effectiveness of cognitive-behavioral therapy and sertraline versus a wait-list control group for anxiety disorders in older adults. Hannie Comijs is currently the principal investigator of the Netherlands Study on Depression in Older persons (http://nesdo.amstad.nl). She is currently supervising 11 PhD students, all working in the field of geriatric psychiatric disorders or cognitive decline in older persons.

Kate Davidson, PhD has a background in nursing before becoming a full-time academic, and is currently a Senior Visiting Fellow in the Department of Sociology, University of Surrey. Before retirement, she had taught as a senior lecturer in Social Research Methods, the Sociology of Later Life, and Sociological Analyses for undergraduates, and Social Policy Analyses and Managing the Research and Publication Process for postgraduates. Her particular areas of expertise are qualitative research with older people, focusing on their health and social relationships. Her original research focus compared the lives of older widows and widowers. Arising from this work, she developed a special interest in the life experiences of older men, hitherto largely ignored in sociological studies of older people. She has published numerous articles and book chapters and has coedited two books: with Sara Arber and Jay Ginn *Gender and Aging: changing roles and relationships* (2003) and with Graham Fennel *Intimacy in Later Life* (2004). She has been invited to give keynote speeches at national and international conferences, workshops and seminars. She is the codirector of the Centre for Research on Aging (CRAG) at the University of Surrey, UK, and Past President of the British Society of Gerontology.

Dorly J. H. Deeg, PhD is professor of Epidemiology of Aging in the EMGO—Institute for Health and Care Research, Department of Epidemiology and Biostatistics and Department of Psychiatry, VU University Medical Centre, Amsterdam, the Netherlands. Since 1992, she is the Scientific Director of the Longitudinal Aging Study Amsterdam, an interdisciplinary study of changes in daily functioning with aging. The LASA-team includes 45 PhD students, postdocs and senior researchers with backgrounds in— among others—Epidemiology, Internal Medicine, Psychiatry, Sociology, Psychology, Internal Medicine, and Economy. Prof. Deeg's over 300 publications cover health, disability, quality of life, utilization of health and social care services, and mortality at older ages. Her H-index is 54 (March 2012). Prof. Deeg is principal investigator of the European Project on osteoarthritis in older people, which collects standardized data in six European countries. In 2009, she won the Federal award for her research on aging from the Federation of Dutch Medical Scientific Associations. Furthermore, Prof. Deeg is founding editor-in-chief of the European Journal of Aging, serves on the editorial boards of several scientific journals, on review panels of several national funding agencies, and on the advisory board of several longitudinal studies of aging in Europe.

Ana Diaz-Ponce, M.Sc. is currently a doctoral student at Trinity College, Dublin, in the School of Social Work and Social Policy and is attached to the Living with Dementia Programme (Ireland). Ana holds an Honors degree in Social Work (University of Zaragoza, Spain) and in Sociology (University Pontificia, Madrid, Spain) and an M.Sc. in Applied Social Research in Trinity College, Dublin (Ireland). Prior to enrolling in her PhD, Ana worked as a Senior Social Worker for several years in different care settings, specializing in the care of people with dementia in Spain, and as a Researcher in Spain and in Ireland. Her research interests include dementia and dementia care, quality of life and family caregiving. Ana was awarded a scholarship in 2007 to undertake her M.Sc. by Fundacion Caja Madrid (Spain) and another scholarship from The Atlantic Philanthropies in 2008 to write her PhD study. Her PhD thesis is on the topic of quality of life and the use of antidementia drugs in people with Alzheimer's disease.

Hanneli Döhner is a sociologist, specialized on social gerontology. The title of her doctoral thesis (1982) was: "Chronically ill and disabled patients of a surgical department. Medicosocial research on identification von chronically ill and disabled and the description of their psychosocial situation." Since 1985, she is the head of the working group on social gerontology at the University Medical Center Hamburg-Eppendorf, Department of Medical Sociology and Health Economics (IMSG). Actual scientific topics are: integrated care; case and care management for older people and their families; support and relief of family carers; European comparative studies; migrant carers, reconciliation of work and care; medical care in nursing homes/violence against older women/patients with dementia in acute hospitals. She was and still is the head of several local, national, and European research and practice projects. Her main research focus in the last years was on caregivers. She was coordinator of the EU-funded project: "EUROFAMCARE—Services for Supporting Family Carers of Older People in Europe." Till today, she is involved in some projects dealing with special aspects concerning the situation on caregivers. She is engaged in different scientific societies and advisory boards and is currently a board member of the German Association of carers (wir pflegen: www.wir-pflegen.net) and member of the Executive Committee of EUROCARERS (www.eurocarers.org).

Christina Fjellström, PhD in ethnology, dietician and Professor in Meal Research at the Department of Food, Nutrition, and Dietetics, Uppsala University, Sweden. Her research includes studying food and meal habits with focus on health in modern consumer society, among different age groups and in different social environments, mostly from a cultural and social perspective but also from a historical perspective. This means using different methodology, however, foremost qualitative methods. During the last decade, she has been involved in especially research on food and older people, and food and young people. She was responsible for the Swedish part of the EU-project Food in Later Life. She has presented a wide variety of publications including topics such as food in history to managing food work among spouses to persons with Alzheimer's disease.

Marvin Formosa gives lectures on social gerontology at the European Centre of Gerontology, University of Malta, and is a visiting lecturer at the Department of Sociology and Department of Education Studies (both at the University of Malta), and the International Institute of Aging (United Nations—Malta). Dr. Formosa is in receipt of various academic/professional appointments and designations. He was appointed as an international lecturer by the International Institute on Aging (United Nations—Malta) on its missions to Thailand and Qatar. He also held the post of a Member of Scientific Committee of 19th Congress of the International Association of Gerontology and Geriatrics, as well as Visiting Scholar at Ontario Institute for Studies in Education, University of Toronto. In 2012, Dr. Formosa was also invited to join the editorial board of Research on Aging and Social Policy. His primary interests are older adult learning, social class dynamics, and social exclusion, on which he has contributed to many edited books and journals including Educational Gerontology, Mediterranean Journal of Educational Studies, Lifelong Learning Institute Review, Recerca, International Journal of Education and Aging, Journal of Transformative Education, Journal of Maltese Educational Research, Education and Aging, Aging International, and BOLD. Recently published and forthcoming books include Social Class in Later Life: Power, Identity, and Lifestyle (The Policy Press, 2013—with Paul Higgs) Lifelong Learning in Later Life: A Handbook on Older Adult Learning (Sense, 2011—with Brian Findsen), and Class Dynamics in Later Life (Lit Verlag, 2009).

Maria Gabriella Melchiorre, economist, worked from 1989 to 1997 at the University of Ancona (Italy), Department of Economic Sociology, on several national and international research projects on migrants and care policies for the family. Since 1997 till today, she has been a researcher at the Department of Gerontological Research of INRCA, working on social aspects of aging well, caregiving, elder abuse and migrant care workers, as well as on public services and social policies for older people. From November 2005 to December 2006, she had also been teaching Sociology in the Polytechnic University of Marche, Faculty of Medicine. She has been involved, among others, in the following main European projects: 1997–2000: "The role of woman in family caregiving of the elderly" (CNR); 1998–2001: COPE: Carers of Older People (FP4); 1999–2001: GATT (Geriatric Assessment Technology Training), Leonardo da Vinci Programme; 2000–2003: ACMEplus: A European project to devise a hospital Admission Case-Mix system for Elderly patients, plus a standardized method of recording hospital outcome (FP5); 2002–2004: ESAW:

Aging Well—A European Study of Adult Well-Being (FP5); 2003–2005: EUROFAMCARE: supporting family carers of older people in Europe: characteristics, coverage, and usage (FP5); 2007–2010: EURHOMAP: Mapping Professional Home Care in Europe (European Agency for Health and Consumers); 2008–2010: ABUEL: Elder Abuse: A Multinational Prevalence Study (European Agency for Health and Consumers); 2008–2011: WEDO, European Partnership for the Well-Being and Dignity of Older People (EU-funded, submitted by AGE Platform Europe); 2010–2012: T.A.M.—Helpline for abused elderly (INRCA-funded).

Martijn Huisman is an assistant professor, both with the Department of Sociology of VU University and with the Department of Epidemiology and Biostatistics at the VU University Medical Center, in Amsterdam. He is a psychologist and an epidemiologist working in the developing field of social epidemiology. His main research interests have centered around the topic of socioeconomic inequalities in health. Among other things, he has published papers about the pattern and magnitude of socioeconomic inequalities in health in older adults from a European comparative perspective. Currently, he is appointed at the Longitudinal Aging Study Amsterdam where he studies, among other things, the association of socioeconomic status with frailty, disability, and other health outcomes; the role of psychosocial factors in functioning and well-being of older adults and the meaning and associations of self-rated health.

Elizabeth Ioannidi-Kapolou has studied sociology at the City University in New York and has worked for 22 years as a senior researcher at the Department of Sociology in the National School of Public Health in Athens where she is also teaching “Research methods in Social Sciences” and has developed an optional e-learning course in English on “Cultural diversities of migrants’ health and access to care.” She is also teaching at the Kapodestrian University of Athens in the Postgraduate level “Sociology of Health” and has taught for 5 years at the Greek Open University, Department of Social Sciences “Social and Psychological dimensions of Health and Illness.” She is a founding member of SEXTANT, which started in 1991 as a multidisciplinary group of scientists, working at local, national and international levels and specializing in research, consultancy, and evaluation on the aging of the population. Since 2006, the SEXTANT group are involved in the newly formed NGO, “50?+ Hellas” (www.50plus.gr), one of whose main aims is the planning and implementation of research concerning the aging of the population and the health and social situation of older people. She has participated in many European and national research projects mainly related to social exclusion, social integration of minority groups, sociocultural diversities in migrants’ health and sexual behavior and HIV/AIDS. She was the national focal point for the European network AIDS & MOBILITY (2004–2006), and currently she is the national focal point for the COST Action ISO 603 Health and Social Care for Migrants and Ethnic Minorities in Europe (HOME) and member of the Erasmus Curriculum Development project “Health and Social Care for Migrants and Minorities.” She has a considerable number of presentations at National and International Conferences and publications in Greek and English books and scientific journals.

Charis Kaite is a PhD candidate. She holds an M.Sc. in Psychology from Middlesex University (UK) and a B.Sc. in Psychology from University of Crete. She is a member of Cyprus Psychological Association, a volunteer and a trainer of Cyprus Family Planning Association, and has been a volunteer in Witness support unit of Chingford Police Station. She worked as a Postgraduate Associate at the Cyprus University of Technology in the research program '*Evaluation of the Community Nursing Care in Cyprus in relation to the Elderly*' and as a Research Fellow of the Research Unit of Behavioral and Social Issues (RUBSI) of the University of Nicosia. Charis Kaite has been a research fellow with Research Unit of Behavioral and Social Science Unit at the University of Nicosia since 2005 in many researches concerning HIV, Diabetes, Elderly People Living with Cancer. Charis Kaite has also attended many seminars and workshops both in Cyprus and abroad concerning developments on psychological intervention and other health matters.

Christiana Kouta is an Assistant Professor at the Cyprus University of Technology in Cyprus. She holds a PhD from Middlesex University (UK) and a Masters in Health Promotion from the University of East London (UK). She has a Bachelor of Science in Nursing from the University of Indianapolis (USA) and a Diploma in Nursing from the Cyprus School of Nursing. She taught for many years at the Cyprus School of Nursing. Her research interests include: health promotion/education, community health care, sexuality, culture and gender. Christiana Kouta is currently the President of the Community Nursing Division, Cyprus Nurses and Midwifery Association (2008–2016). She is also a member of the Board of Directors of the Research Unit in Behavior and Social Issues (RUBSI) of the University of Nicosia and of the Mediterranean Institute of Gender Studies (MIGS) and a Member of the Committee of the European Transcultural Nurses Association (ETNA). Christiana Kouta was the Vice President of the Cyprus Review Ethics Committee on Clinical Trials on Medicinal Product for Human Use (Ministry of Health) from 2005–2009, a Member of the Management Committee of COST Action ISO 603: Health and Social Care for Migrants and Ethnic Minorities in Europe (HOME) (2008–2011) and a Member of the Board of Directors of the Cyprus Family Planning Association for more than a decade. Christiana has been appointed by the Minister of Education and Culture, as a member of the committee for the educational reform on the subject of Health Education (2009 till date).

Giovanni Lamura, PhD, is a social gerontologist with an international and interdisciplinary background, working at INRCA since 1992. He graduated in economics in Italy in 1990; obtained a PhD in "Life course and social policy" at Bremen University (Germany) in 1995; was visiting fellow in 2006–2007 at the University of Hamburg-Eppendorf (Germany); and research director of the pillar "health and care" of the European Centre for Social Welfare Policy and Research in Vienna (Austria) in 2010–2011. He has gained experience in international research projects mainly focused on family and long-term care of dependent older people; work-life balance; migrant care work; prevention of elder abuse and neglect; ICT-based solutions for a sustainable informal care. In 2011, he coordinated the four-country research project CARICT (Assessing the impact of ICT-based solutions for informal caregivers). In the last 5 years, he has participated, among others, in the following European projects: "EUROFAMCARE: Support services for family carers of older people"; "ABUEL: A multinational prevalence study on elder abuse"; "ASPA: Activating senior potential in an aging Europe"; "Care@work: reconciliation of employment and elder care"; "EURHOMAP: mapping home care services in Europe"; "Futurage: outlining a 'road-map' for future aging research in Europe"; and "CarICT—ICT based solutions for caregivers: Assessing their impact on the sustainability of long-term care in an aging Europe."

Howard Litwin is Professor of Social Gerontology and former Dean at the Paul Baerwald School of Social Work and Social Welfare at the Hebrew University of Jerusalem. Dr. Litwin is also the founder Director of the Israel Gerontological Data Center, the Principal Investigator of SHARE-Israel and the Coordinator of the social area for the SHARE project in Europe. His empirical research, published in 125 articles, chapters, and books, studies the correlates of well-being in later-life. In particular, his work seeks to clarify how social networks and social environment relate to perceptions, feelings, and behaviors in late life.

Christine A. Mair is an Assistant Professor of Sociology at the University of Maryland, Baltimore County (UMBC). She received her PhD in Sociology from North Carolina State University in Raleigh, North Carolina. Her general research interests include social ties, aging and the life course, and health in light of contextual considerations such as national culture, global inequality, spatial location, race/ethnicity, and gender. The unifying theme of her research is the theoretical and empirical importance of promoting well-being for diverse populations across the life course through informal (e.g., family/friend ties) and formal (e.g., national policy, local programs) processes. Her past work includes cross-national and US-based studies of social ties and well-being, inequities in social capital, and grandparenting.

Elizabeth Mestheneos, a UK-trained sociologist, began working in 1988 in Greece as an independent researcher (see www.sextant.gr), undertaking a wide range of predominantly EU-funded research projects related to aging, refugees, civil society, social inclusion, and the labor market. She was recently a research consultant on elder abuse, home care services and long-term care systems. In relation to aging, she has published on family care, older women and older workers. She is a founder member of the Greek NGO for older people "50?+ Hellas" devoted to promoting the well-being and social inclusion of all older people through information, advocacy, and research (see www.50plus.gr). In March 2008, she was elected President of AGE-Platform Europe (www.age-platform.org) representing its 160 member organizations and 28 million members in conferences and public events internationally on a diversity of topics, e.g., older workers and the labor market, aging and mental health, long-term care, new technologies and older people. She was elected in September 2008 as a Director of IFA (International Federation of Aging) and serves on the Nominating Committee.

Marti Parker is currently an Associate Professor of Social Gerontology and Head of Division Aging Research Center at the Karolinska Institute at the University of

Stockholm in Sweden. His work has concerned physical function of the elderly population, with an emphasis on the oldest old (80?+). Combining her background in sociology with a degree in physical therapy, she studies function within the social and physical context, taking into consideration socioeconomic status, social network, and the environment. A major interest is examining different ways to measure physical function, from the traditional self- or proxy-reported ADL measures, to objective tests of functioning. Function measures are often used as health indicators in population research and the differences between them are crucial for understanding health phenomenon, e.g., gender differentials or trends over time. Prof. Parker has also been involved in analyses of social policy concerning care for elderly people. Her publications can be found in journals of gerontology, social work, demography, sociology, and clinical geriatrics.

Constança Paúl is Professor of Psychology and Head of the Department of Behavior Sciences in the Institute of Biomedical Sciences Abel Salazar, at the University of Porto. She is Director of the PhD Program in Gerontology and Geriatrics and coordinates a Research Unit on Aging—UNIFAI (www.unifai.eu). Her research interests include successful aging and health determinants.

Constantinos Phellas is a Professor of Sociology and currently serving as the Vice Rector for Research and Faculty at the University of Nicosia in Cyprus. His research interests include sociology of health and illness, aging, and sexualities. Prof. Phellas holds a doctorate degree in Sociology from the University of Essex, UK. He also holds two Masters degrees from the University of Warwick (UK) and City University (UK), respectively. He has taught extensively (mainly at postgraduate level) at the University of Essex, City University, University of London, and London South Bank University. His publications focus upon the intersection of age, gender, and culture and the social and psychological aspects of public health domain. He has recently been elected as the President of the Cyprus Sociological Association for the period of 2012–2014.

Andrea Principi, sociologist, has been a researcher at INRCA since 2000, where his main tasks are national and international research coordination in the field of ageing: demographic trends, informal caregiving to older family members, health and care services for older people, aging and work, active aging, and civic engagement in older age. He has participated in several European Projects, among which: Carers@work: "Between Job and Care: Conflict or Opportunity? A Strategy for Securing Sustainable Future Care and Productivity Potentials in an Aging Society—A European Comparison," funded by the Volkswagen Foundation in 2009–2010; ASPA: Activating Senior Potential in Aging Europe, funded by the European Commission in 2008–2011; Measures to support social inclusion of the elderly, funded by the European Foundation for the Improvement of Living and Working Conditions, 2009–2010; Employment Initiatives for an Aging Workforce, funded by the European Foundation for the Improvement of Living and Working Conditions in 2005–2007; CEIL: Contributing to Equality from Independent Living, funded by the European Commission in 2003–2004; EUROFAMCARE: Services for Supporting Family

Carers of Elderly People in Europe: Characteristics, Coverage, and Usage, funded by the European Commission in 2003–2005.

Oscar Ribeiro has a Degree in Psychology (University of Minho) and a PhD in Biomedical Sciences (University of Porto). He works as an adjunct professor at the University of Aveiro (ESSUA) and as an auxiliary professor at the Higher Institute of Social Service in Porto (ISSSP). His current research interests deal with active aging, the oldest old, and centenarians' psychological resources and with the relationship between gender, health, and aging. He is a researcher at the Research and Education Unit on Aging (UniFai/ICBAS-UP Portugal).

Mirko Di Rosa graduated in International Economics at the Ancona University (Italy) in 2005. From February to July 2005, he attended an internship in Bucharest (Romania), City Hall Sector 1, European Integration Department. In 2010, he obtained his PhD degree in Economics at the Ancona University: his doctoral thesis was specifically focused on quality of public services and citizen's satisfaction. Since 2009, he collaborates at the Scientific Technological Area of INRCA, where he has gained experience in international research projects in following fields: family care of older people; reconciliation of professional and caring responsibilities; migrant care workers; prevention of elder abuse and neglect; long-term care; older workers and role of technology for improving the quality of life of older people. His other research interests are use of quantitative research methods (mainly microeconometrics, parametric and nonparametric techniques) and the evaluation of public policies, quality of public services, and students' performance.

Sara Santini achieved her Degree in Social-Political Sciences at the University of Bologna in 2000. She collaborates with INRCA "Socioeconomic Research Centre" since 2000 in many surveys and European Research projects on aging, reconciliation of care and work, caregivers' quality of life and incontinence. In her current position, she is collaborating with the Scientific Direction of the INRCA, dealing with social and health policies for the elderly and support for the caregivers. She is skilled in qualitative research and content analysis and expert in the use of the Max-Qda (Plus) Software for the management and analysis of qualitative data. She has been involved in the following European research projects on aging, reconciliation of care and work, and caregivers' quality of life: "Il ruolo della donna nell'assistenza famigliare all'anziano" (2000–2001), ESAW—Aging Well: European Study of Adult Well-Being (2001–2004), "Risk factors in postmenopausal woman caregiver" (2000–2002), Equal DIPO—Migrant women caring for older people in the Marche Region, (2002–2005), "Carers@Work: the reconciliation of work and care for an older family member" (2008–2010), Quality of life in caregivers of dependent people affected by incontinence in Europe" (2010–2011).

Laura I. Schmidt is a psychologist and PhD student in the interdisciplinary postgraduate program "Dementia" at the Network Aging Research in Heidelberg, Germany. This postgraduate program is supported by the Robert Bosch Stiftung. Since September 2010, she is working on her thesis on the performance on everyday technology tasks in old age where she is examining the effects of cognitive impairment, interface complexity, and technology experience. Furthermore, she teaches at the department of gender studies and health psychology at Heidelberg University.

Kimberly J. Stoeckel is a postdoctoral researcher at the Israel Gerontological Data Center in the Paul Baerwald School of Social Work and Social Welfare at the Hebrew University in Jerusalem. Her current research examines cross-national comparisons of well-being in later-life using the Health and Retirement Study (HRS) and the Survey of Health, Aging, and Retirement in Europe (SHARE). Previously, she has looked at housing and environment among older people.

Ylva Mattsson Sydner, Associate Professor in food, nutrition, and dietetics is a senior lecturer and head of department at the Department of Food, Nutrition, and Dietetics, Uppsala University, Sweden. Her research focus on food habits and especially vulnerable groups such as old people, disabled people, and people in need of different kinds of diets. Her research on foodservice in the public sector has especially attracted attention. As part of the Scandinavian welfare state, it is an important area that is taken for granted, but is in constant change and much associated with norms, which was shown in her dissertation on meals in the elderly care. Different kinds of methodology have been used, but foremost are qualitative methods.

Laetitia Teixeira has a Mathematic Degree, in scientific field of Applied Mathematics, in the Sciences Faculty, University of Porto, Portugal. Has a Masters Degree in Applied Statistic and Modelation and currently is student of PhD in Applied Mathematics, Sciences Faculty, Portugal, University of Porto. Currently, she is a research fellow in the Research and Education Unit on Aging (UnIFai/ICBAS-UP).

Caroline Terwee is an epidemiologist. Her research interest is in the methodology and performance of studies on measurement properties of measurement instruments. She has a special interest in (health-related) quality of life instruments. Her PhD thesis was on the development and evaluation of a disease-specific quality of life questionnaire for patients with Graves' Ophthalmopathy (2000). After her PhD, Caroline broadened her methodological research to focus especially on the methodology of assessing measurement properties of (health-related) quality of life and other measurement instruments. More recently, she developed a special interest in the methodology of systematic reviews of measurement properties. She is one of the founders of the COSMIN (Consensus-based Standards for the Selection of health Measurement Instruments) initiative (www.cosmin.nl). Caroline is coordinator of the Knowledgecenter Measurement Instruments of the VU University Medical Center (www.kmin-vumc.nl), which aims to optimize the quality of measurement and quality of measurement instruments used in medical and health science research, through consultation, education, and research. She is a board member of ISOQOL-NL (Dutch Chapter of the International Society of Quality of Life, a working group on research in health and quality of life measurement) and she is associate editor of Quality of Life Research and the Encyclopedia of Quality of Life Research.

Fleur Thomese is a psychologist and social gerontologist by training and currently is an associate professor at the Department of Sociology, Faculty of Social Sciences, VU University. She has (had) cosupervision over 5 PhD students, three of whom have graduated. She publishes mostly on, first, applying the evolutionary life history theory to contemporary developed populations. She is especially interested in how grandparental investments in child care are related to societal contexts on the one hand and evolutionarily relevant outcomes on the other hand. Second, she publishes on how neighborhoods and living environment affect social integration and social participation.

Sandra Torres is currently a Professor in the Department of Sociology at the University of Uppsala in Sweden. She has published extensively on a variety of issues having to do with aging and old age and her research has contributed to the international debates on the lack of culture relevance in gerontology, late in life migration, culturally appropriate care, and the effects of late in life migration upon elderly immigrants. Most recently, she has contributed to the study of how understandings of old age-related issues (such as autonomy, dependency, independence, and successful aging) are shaped by diminished everyday competence and home-help care recipiency. Prof. Torres is also the Associate Editor for International Journal for the Study of Aging and Later Life and is a member of the editorial boards of the following peer-review journals: Etnicity & Health, Journal of Gerontology: Social Sciences, Social Policy and Society, Socialvetenskaplig Tidskrift, and the International Journal of Qualitative Methods. Furthermore, she is the President of the Swedish Gerontological Society (SGS), a council member to the International Association of Gerontology and Geriatrics (IAGG), and leads—together with Dr. Allan Glicksman of the Philadelphia Aging Corporation—the Interest Group on International Migration and Aging of the Gerontological Society of America. At present, she also holds a Visiting Professorship at Kings College London and an Adjunct Professorship (Professor II) in Rehabilitation and Aging at Oslo University College.

Lucie Vidovićová, PhD is a sociologist and currently working in the Faculty of Social Sciences at Masaryk University, Czech Republic. Her long-term research interests include sociology of aging, environmental gerontology, age discrimination, and active aging. She is also involved in research projects in the field of family and social policy. She conducts research for national as well as European bodies and works as a consultant on a number of implementation projects such as Aging in the media and Teaching about aging. Lucie also cooperates with different governmental and NGO bodies in the field of senior advocacy. Her experience includes involvement with the European projects DIALOG (HPSE-CT-2002-00153) and ActivAge (HPSE-CT-2002-00102), and cooperation with EUROFOUND. Recent projects she has been involved in include surveys of older consumers, age discrimination (www.ageismus.cz), and aging in big cities (http://starnuti.fss.muni.cz).

Marjolein Visser is trained as a nutritionist and epidemiologist and currently is a professor of Healthy Aging at the Department of Health Sciences of the VU University Amsterdam as well as the Department of Epidemiology and Biostatistics of the VU Medical Center in Amsterdam, the Netherlands. She is head of the section of Nutrition and Health at the Department of Health Sciences. Her research interests are (lifestyle) determinants and consequences of age-related changes in body composition. Important research areas are sarcopenia, obesity, and malnutrition in old age. She is involved in (inter)national aging studies, including the Longitudinal Aging Study Amsterdam and the Health, Aging, and Body Composition study. She has authored over 150 scientific publications (H-index 53) and serves on the editorial boards of several international scientific journals.

Hans-Werner Wahl received his PhD in psychology from the Free University of Berlin in 1989. Since 2006, he is a Professor of Psychological Aging Research at the Institute of Psychology, Heidelberg University, Germany. His research activities include the understanding of the role of physical–technological environments for aging well, adaptational processes in the context of age-related chronic functional loss, processes of awareness of aging in a lifespan perspective and intervention research. He is co-editor-in-chief of the European Journal of Aging and a fellow of the Gerontological Society of America (GSA).

Chapter 1
Introduction

Constantinos Phellas

The World Health Organization once asked (2002): “As people are living longer, how can the quality of life (QoL) in old age be improved? How do we help people remain active and independent as they age? How do we strengthen health promotion and prevention policies especially those directed to older people?” (*Active Ageing: A Policy Framework*, p. 5). The increase in the number of older people proportionate to that of the population has brought much focus into the study of old age. While the ageing of the population has been evident for most of this century, it has only been taken seriously by policy makers and planners in the last two decades. If by 2025, one-third of Europe will be aged 60 and over, and by 2050 half of the population of Europe will be 50 or older, it is no wonder why policy makers have focused on this dramatic demographic change as this shift towards an ageing population will be one of the main contributors in shaping today’s and tomorrow’s economic and social developments. It is inevitably true that the demographic state of the world is changing and can be characterized by the shrinking number of young people; an increase in life expectancy and a dramatic drop in infant mortality. The consequences of such a demographic transition will have a tremendous impact on the economy, care, social development; welfare and well-being on all European member states (Agent et al. 2006). It has emerged into such an important topic of concern that it has now become a worldwide phenomenon constructing fears in how the financial sustainability of pensions and social protection systems and the shrinking number of the workforce will support that of the ageing population (Stuart-Hamilton 2011). It is a phenomenon known to be seen by governments and policy makers as a “social problem ” (MacIntyre 1997). A UN website related ageing “as a global demographic transformation [that it] has profound consequences for every aspect of individual, community, national and international life. Every facet of humanity will evolve: social, political, cultural, psychological and spiritual” (UN Programme on Ageing 2002).

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In order to prevent costly impacts on the governments and societies, special attention needs to be placed on promoting health and good QoL in older age. The questions, such as those imposed by the World Health Organization, are vitally important as they bring forward the fundamental points that need to be taken into account, such as the promotion of health and activity, as they are two very important and fundamental features that will attribute to the QoL of older people. Investing in both are also important determinants of economic growth, competitiveness, labor supply, and the decreasing likelihood of early retirement. Attention needs to be placed on the methods assessing QoL. How to improve QoL while extending its quantity, a concept, which Bowling (2009) refers to as "ageing well." There is an international interest on how to improve QoL in older age, which is recognized that having good levels of both physical and mental functioning and that of general health are related with that of well-being, and once QoL (Stuart-Hamilton 2011). There is, however, a continuous debate on whether QoL is subjective or objective and if it can be measured at all (Hunt 1997). Overall, QoL as a concept among older people is a complex and multifaceted phenomenon matter, which requires greater understanding (Fletcher et al. 1992; Testa and Nackerly 1994; Monsen 1998).

Health is also a key element of well-being and QoL. Furthermore, health status is clearly of great concern not only to older people but to governments, as older people are the main users of health services. The World Health Organization argues that countries can afford to get old if "active ageing" is promoted by governments, international organizations, and civil services. Healthy ageing can demonstrate to be a vital tool in forming a stable active ageing population as they play a substantial role on the upcoming socioeconomic problems that a country will face. It should be recognized that the ageing population has constructed to be one of the main problems that all countries are facing. The need to promote "healthy," "active," and "productive" ageing is a strong political motivator and all governments of societies in general need to ensure that the older persons remain healthy, active, financially secure, and able to live independently in their homes as long as possible (Stuart-Hamilton 2011). Therefore, it is important to understand the meanings, representations, experiences, and key factors shaping that of ageing as this will allow not only us as individuals to understand and deal with the issues it imposes, but also provide policy makers, educators, clinicians, psychologists, sociologists, and researchers ways into finding new insights into tackling this delicate but important topic. The need to bring knowledge to the nations and communities will enable today's older people, but more importantly tomorrow's older people to live a more productive healthy lifestyle.

Drawing from a wider range of theory, original research, and empirical sources, the authors of this book will successfully bring the reader closer into understanding the multiplicity of ageing, its complexity, and the various roles, which some factors play in order to enhance health and QoL in older age. The various chapters presented in this volume will be presenting concerns of pension reforms, the performance of national systems before and during the economic crisis, the role in which technology has played upon active ageing, the need to establish the importance of food and food security, the positive role of family and friends, the need to impose happiness, and participation and activity in later life. The concern of dementia, disability, and chronic illnesses will also be discussed, as the importance of social support, financial stability, and the notion of inequality in older age. In addition, this high-quality volume of chapters provide those interested in the topic of ageing a sample of research that is at the forefront of European work on the QoL of older people. This volume will also present examples from European societies that illustrate innovative methodological approaches that would be relevant to professional working with elderly diverse populations (e.g., ethnic monitories). As policy makers have placed ageing high in their agenda, this book wishes to contribute to the policy, practice, and productive development and to stimulate further more comprehensive discussion on the implications of the most pressing health, social welfare, economic, and other issues related to ageing in various European societies.

Chapter 2, by Gabriel Amitsis will discuss the development of the statutory first pillar pensions' reforms within the fragmented European Social Policy Framework. It will provide the reader with an analytical review concerning the institutional and operational status of pension reforms; discuss the performance of national systems before and during the economic crisis, as well as addressing the issues concerning the critical dilemma between adequacy and sustainability in light of the sharp financial crisis. This chapter will also present scenarios on the combined use of law and policies as means to advance effective coverage of persons outside the labor market.

In Chap. 3, Katrin Claßen, Laura Schmidt, and Hans-Werner Wahl, through collective evidence drawn from the European, Asian, and North American research communities, will check for synergies, complementarities, existing research, and implementation gaps in order to construct a more liable insight into understanding on how the role of technology may contribute to the QoL of older people. Also, drawing from their own empirical research, the authors will exemplify the potentials but also constrains that technology might have upon various groups of older people (such as those who are cognitively impaired) and also touch upon the active role media (Internet) plays on ageing well. Finally, this chapter will close with considering the kind of theoretical challenges that might arrive with the issue of ageing and technology, the kind of future research that may be acquired (from the currently based empirical state of affairs in the field), as well as exploring fresh conceptual approaches into how and in what way technology may contribute to the enhancement on the QoL for older people.

In Chap. 4, Christina Fjellström and Ylva Mattson Sydner attempt to discuss the notion of food security by analyzing loss of what they call physiological appetite but moreover discuss the loss of social appetite from a social context point of view. Dependency versus independency (particularly discussed in an ageing population), individualism and collectivism, food security, and personal abilities will also be introduced and analyzed as well as perception and informal and formal care. This chapter will end with a discussion on the welfare state and its support into the care of older people using Sweden as an example.

In Chap. 5, Christine A. Mair will arguably bring forward the importance of taking into account the differences in policy making, national culture, and economy when measuring the positive role of family and friend networks on a national macrolevel. Using historical comparative methods in combination with quantitative descriptive bivariate analyses, this chapter will go on to explore the broad macrolevel patterns of family and friend networks across 14 European nations. In particular, the expectations (if any) of the family and friends networks along the above-stated contexts will be explored by drawing upon in-depth case studies and a uniquely created multilevel dataset. Finally, a reflection upon the implications of this multilevel approach into elucidating the promotion of the well-being of older adults on a global scale.

In Chap. 6, Costança Paúl, Laetitia Teixeira, and Oscar Ribeiro will present the reader with a detailed review on optimism (happiness) and health as it has become a major concern for people who live long lives. Some issues, which appear in the literature of happiness, will be discussed with a broader view on:

- Happiness and wealth.
- Happiness across the life span.
- Happiness and its relation with health.
- The importance of social relationships in being happy.

This chapter will close with an empirical study on the happiness of old Portuguese people living among the community. Analyzing the proportion of happy people while examining the variables; age, education, and health perception, which may affect happiness. Ending with a discussion on the possibility of foster happiness in old age and stressing the importance of objective—as well as subjective variables for subjective well-being.

Chapter 7 by Ana Diaz and Suzanne Cahill argues that extended life expectancy should not be seen as a triumph but rather a reason of concern as a number of older people across Europe will be represented with dementia. This chapter will start with an overview of facts and figures about dementia and its occurrence in the United kingdom, Ireland, and the rest of Europe. The changing illustrations and formations for understanding dementia will then be discussed and through the voices of people with dementia an argument will be placed in order to form a more solid insight into understanding dementia, the personal experience of people with dementia, and particularly the effect it has upon their lives. After bringing forward the notion of QoL though various definitions, this chapter will continue with a discussion on some of the current tensions and debates arising in the literature of dementia and QoL. This chapter will close by bringing to light the new inductive approach (qualitative research) into exploring QoL in dementia and to produce a more in-depth understanding of this delicate and important topic.

In Chap. 8, Dorly J. H. Deeg, Martijn Huisman, Caroline B. Terwee, Hannie C. Comijs, Fleur G. C. F. Thomése, and Marjolein Visser focus primarily on physical functioning as disability has become one of the main indicators of health. With life expectancy increasing a questionable concern on whether the years gained will be spent in good health or in poor health. Results from the Longitudinal Ageing Study Amsterdam (LASA) specify that physical limitation is not fixed but varies with time (as one gets older) and an increase is being seen. Through the bases of these findings some suggestion for these results will be given and also some direction into future research will be explained.

Chapter 9, by Chiatti C., Melchiorre M. G., Di Rosa M., Principi A., Santini S., Döhner H., and Lamura G., offers the reader with an overview on the family's role into providing support to older people in Europe. Attention will be paid on the "epidemiology of family care," for example, the sociodemographic profile of care giving families in Europe. The link between family care and employment will be explored and a description into the increasing phenomenon of the employment of privately paid migrant care workers. This chapter will end with the fundamental need into considering the widely disregarded global risk factors such as elder abuse, neglect, and the considering factors, which may be placed in order to prevent such abominations.

Chapter 10, by Elizabeth Ioannidi-Kapolou and Liz Mesthenos, will present a detailed analysis on the main contributing factors that influence inequality on the QoL of older people. Much focus will be placed upon: age and gender, socioeconomic status, marital status, social network, and sociocultural environment. The authors place these factors as clear structures of inequality. A discussion will end this chapter on why some factors are more critical than others in influencing inequality and also briefly present the subjective factors (i.e., happiness, life satisfaction) that might influence inequality in older life.

Chapter 11, by Kate Davidson, consists of four main parts: The first part provides the reader with an overview of the shifts in both the longitudinal and marital status in the United Kingdom. The second part will discuss some of the vast literature on social network particularly relating to the experience of older people. The third part reports the findings from a major qualitative research project conducted from members of the Centre of Research on Ageing and Gender (CRAG) and finally the fourth part will reflect the ways in which social support might be sustained and nurtured through both formal and informal networks in the lives of older people, such as those in retirement, or in critical points of their lives, i.e., death (partner/family member) or that of ill health.

Chapter 12, by Howard Litwin and Kimberly J. Stoeckel, reveals the important role, which social networks might have upon the well-being of older people. By critically examining the current state of knowledge (regarding the social networks of older people in European societies), this chapter will examine issues such as:

- Whether social networks are indeed related to a good old age.
- Whether social networks diminish in size as their focal member ages and whether such diminution contributes positively or negatively to their mental and physical state.
- What seems to matter most in the realm of social network? Its composition, the social support it provides, or the perceived quality of its relationships?
- Also, the absence of social network, as reflected in perceived loneliness.

This discussion will be drawn from up-to-date literature in the field. It will also make use of data taken from the Survey of Health, Ageing Retirement in Europe.

In Chap. 13, Lucie Vidovićová reveals the current precautions in which older people are forced to take into account in order to secure their finances in retirement. The need to collect, process, and act on securing their finances has speculated an increase in the requirement for high-level literacy among preretired people. Through the authors own empirical data, three main dimensions of financial literacy will be explored: abilities (mathematical skills and financial habits), values, and information in order to see if individuals a decade or less prior to their retirement demonstrate attitudes that link financial literacy and other forms of planning for old age. All work will be done on the preretirement generation of the Czech Republic people.

In Chap. 14, Christiana Kouta and Charis Kaite will place the attention needed into understanding the current state of home care nursing in Cyprus. This chapter will be based around a 3-year study on the *evaluation of home care nursing in Cyprus* where the authors will present the findings of the study, review the international literature on home nursing, and examine the current status of home care in Cyprus.

In Chap. 15, Costantinos N. Phellas will provide a critical approach to the conceptualization and measurement of QoL in social gerontology, health, and social care research. Contemporary society demonstrates a number of fundamental changes in the various ways it perceives and responds to human ageing. Through the findings of a study conducted among elderly people in Cyprus, Phellas will hopefully strive into finding: Help to improve interventions by advising the policy makers on a national level and provide a platform where knowledge from cross-cultural research on elderly could be exchanged and shared.

In Chap. 16, Marti G. Parker and Neda Agahi will impose into embarking two fundamental questions in comparing birth cohorts at midlife with regarding to their living conditions, activity participation, and health behavior: Can we assume that the nature of these associations will be similar for all cohorts? And, if so, to what extent can we expect improvements in future cohorts of old people? These fundamental questions will be answered using nationally representative longitudinal data from 1968 to 2000. This chapter will end with examining associations (older birth cohorts) between socioeconomic and lifestyle factors with mortality and outcomes in late life.

Chapter 17, by Marvin Formosa, prevails the important role, which lifelong learning may provide as an achieving sustainable policy framework for an ageing Europe. It is suggested that it is a policy, which holds endless potentials into forming a wider insight into the understanding of the economic, social, and demographic challenges. Much argument has been placed demonstrating an unprecedented rise on older persons engaging in educational activities. Late-life learning is rarely given space in intergovernmental and nation policies on lifelong learning. This chapter will forward an action plan for later life learning incorporating six key directives: Lifting the barriers to participation, ensuring the quality of older adult learning, improving third-age guidance and rethinking higher education opportunities for older adults, bringing learning closer to homes and communities, establishing learning opportunities for housebound elders, and nursing care residents.

In Chap. 18, Sandra Torres reveals the importance of exploring the term transnationalism. Three main questions will be addressed: What does transnationalism mean? What characterizes transnationilism lifestyles and what implications do these have for gerontological research, policy, and practice ? For those who have a more limited acquaintance with transnationalism but familiar with the field of gerontology Torres's analysis on transnationalism introduces its meaning, the possibilities, and implications it may have on gerontology and its importance to social gerontology, as it has the possibility in offering a greater insight into describing some of the challenges on gerontological research.

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Chapter 2
Challenging Statutory Pensions Reforms in an Aging Europe: Adequacy Versus Sustainability

Gabriel Amitsis

Introduction

Half of the population today in EU countries is 40 years old or more. In 2060, half of the population will be aged 48 years or above. The number of elderly persons aged 65 or above already surpassed the number of children (below 15) in 2010, but their numbers are relatively close. In 2060, there would be more than twice as many elderly than children. In 2010, there were about three and a half times as many children as very-old people (above 80). In 2060, children would still outnumber very old persons, but by a small margin: The number of very old people would amount to 80 % of the number of children.

According to the projection, elderly people would account for an increasing share of the population; this is due to the sustained reductions in mortality in past and future decades. The *demographic ageing process* can be characterised as ageing from the top, as it largely results from the projected increases in longevity, moderated by the impact of positive net migration flows and some recovery in fertility.[1]

While the EU population is projected to be slightly larger in 2060 than in 2011, there are wide differences in population trends across Member States: about half of them would gain population (Belgium, Denmark, Ireland, Spain, France, Cyprus, Luxembourg, the Netherlands, Austria, Portugal, Finland, Sweden and the United Kingdom), while the population would fall in the other half (Bulgaria, the Czech Republic, Germany, Estonia, Greece, Italy, Latvia, Lithuania, Hungary, Malta, Poland, Romania, Slovenia and Slovakia).

The number of elderly people will increase very markedly; it will almost double, rising from 87 million in 2011 to 151 million in 2060 in the EU. The number of oldest old (aged 80 years and above) is projected to increase even more rapidly, almost

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[1] European Commission (2008b, 2009a).

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tripling from 23 million in 2011 to 61 million in 2060. The progressive ageing of the elderly population itself is a notable aspect of population ageing.

In this context, *pensions* correspond to the main financial source of many elderly persons in case of specific risks as labour exit and disability (Spicker 1993; Pieters 2002). Different types of pension schemes are usually grouped into two, three, four or more pillars of the pension system . There is, however, no universally agreed classification (World Bank 1994; OECD 2007). Many national pension systems distinguish between statutory, occupational and individual pension schemes, or between mandatory and voluntary pension schemes (Yermo 2002):

- *Social security statutory pensions* administered by the general government play a redistributive role over the life-cycle, insuring people against social risks and helping reduce poverty.[2]
- *Occupational pension plans* where access is linked to an employment or professional relationship between the plan member and the entity that sets up the plan (the plan sponsor). They may be established by employers or groups of employers (e.g. industry associations) or labour or professional associations, jointly or separately, or by self-employed persons. The scheme may be administered directly by the sponsor or by an independent entity (a pension fund or a financial institution acting as pension provider); in the latter case, the sponsor may still have responsibility for overseeing the operation of the scheme.
- *Individual/private pensions*where access is linked to a contractual relationship between the plan member and the entity that sets up the plan (insurance companies, investment funds and, in some cases, banks).

The recent financial and economic crisis has aggravated and amplified the impact of the severe trend on demographic ageing (Carone et al. 2005). Setbacks in economic growth, public budgets, financial stability and employment have made it more urgent to adjust retirement practices and the way people build up entitlements to pensions. The 2009 crisis has revealed that more must be done to improve the efficiency and safety of statutory pension schemes, given that they not only provide a means for a decent life in old age but also represent the reward for a lifetime of work. Relevant challenges are dominant within both the EU and national policy agendas, leading the majority of Member States on an ambitious pathway towards achieving a better balance between financial, labour market and social protection objectives in their pension systems.

Member States have attempted to protect adequacy and to respond better to changes in labour markets and gender roles. The key trends have been so far:[3]

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[2] Statutory pensions in Europe follow the traditional global approach introduced by the *ILO Convention C102/1951 concerning Minimum Standards of Social Security* (the basic international text for defining and enumerating social security risks and benefits), which codifies a 'classic' typology of social risks (medical care, sickness, unemployment, old-age, employment injuries, maintenance of children, maternity, invalidity, loss of support suffered by the widow or child as the result of the death of the breadwinner).

[3] European Commission (2007a).

- *Encouraging more people to work more and longer* so as to obtain similar entitlements as before: increases in pensionable ages; rewarding later and penalising earlier retirement; moves from benefits based on earnings in best years towards entitlement based on working career average earnings; closing or restricting early exit pathways; labour market measures to encourage and enable older workers to stay in the labour market and encouraging greater gender equality in the labour market.[4]
- *Moving from largely single to multi-tiered systems*. This is a result of the trend in most, but not all, Member States to lower the share of public pay-as-you-go (PAYG) pensions (schemes where current contributions finance current pension expenditure) in total provision while giving an enhanced role to supplementary, prefunded private schemes, which are often of a defined contribution nature.[5]
- *Introducing measures to address adequacy gaps*, e.g. through efforts to broaden coverage, support building up rights, ease access to pensions for vulnerable groups outside the labour market and increase the level of financial support for poorer pensioners.

Reforms have underpinned recent increases in effective retirement ages and opened new avenues to delivering adequate pensions in a sustainable manner. At the same time, reforms have given and will continue to give rise to greater individual responsibility for outcomes (European Opinion Research Group 2004).

Pension Arrangements in Europe

Pension arrangements are very diverse in the EU due to different institutional and policy traditions on how to provide retirement income (Clasen 2002; Pieters 2003). On the other hand, Member States are in different phases of the reform process of national pension systems (European Commission 2011). While a strong public sector involvement in the pension system through the establishment of statutory schemes is a common feature for all Member States, the importance of occupational and private pension provisions varies across countries. Statutory earnings-related old-age pension schemes (either a common scheme for all employees or several parallel

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[4] Women tend to predominate among those with atypical contracts; they tend to earn less than men and tend to take career breaks for caring responsibilities more often than men. As a consequence, their pensions tend to be lower and the risk of poverty tends to be higher among older women, also because they live longer. While periods of care are recognised in some PAYG systems, this is less straightforward in funded pension schemes, with the question of how to finance such solidarity elements.

[5] These are pension schemes where the level of contributions, and not the final benefit, is predefined: no final pension promise is made. DC schemes can be public, occupational or personal: contributions can be made by the individual, the employer and/or the state, depending on scheme rules. The pension level will depend on the performance of the chosen investment strategy and the level of contributions. The individual member therefore bears the investment risk and often makes decisions about how to mitigate this risk.

schemes in different sectors or occupational groups) constitute the core pillar of the public pension system in most countries.[6]

The public pension system often also provides a minimum-guaranteed pension to those who do not qualify for the earnings-related scheme or have accrued only a small earnings-related pension (Van Vugt and Peet 2000). Minimum-guaranteed pensions are usually means tested and are provided either by a specific minimum pension scheme or through a general social assistance scheme. In a few Member States, notably in Denmark, the Netherlands, Ireland and the United Kingdom, the public pension system provides in the first instance a flat-rate pension, which can be supplemented by earnings-related private occupational pension schemes. In these countries, the occupational pension provision is broadly equivalent to the earnings-related public pension schemes in most of the EU countries.

A number of Member States, including Sweden and some new Member States such as Bulgaria, Estonia, Latvia, Lithuania, Hungary, Poland and Slovakia, have switched part of their public pension schemes into *private-funded schemes*.[7] Typically, this provision is statutory but the insurance policy is made between the individual and the pension fund. Participation in a funded scheme is conditional on participation in the public pension scheme and is mandatory for new entrants to the labour market (in Sweden for all employees), while it is voluntary for older workers.[8]

The type of benefits provided by the public pension systems diverges across countries. Most pension schemes provide not only old-age pensions but also early retirement, disability and survivors' pensions. Some countries, however, have specific schemes for some of these benefit types; in particular, some do not consider disability benefits as pensions (despite the fact that they are granted for long periods) and in some cases they are covered by the sickness insurance scheme.

The financing method of the pension systems also differs across countries. Most public pension schemes are financed on a PAYG basis, whereby contribution revenues are used for the payments of current pensions. In addition, there is a considerable variation between countries regarding the extent to which contribution revenues cover all pension expenditure. In most countries, minimum-guaranteed pensions are covered by general taxes. Earnings-related schemes are often subsidised to varying degrees from general government funds. Some specific schemes, notably public

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[6] European Commission (2008a).

[7] These are pension schemes whose benefit promises are backed by a fund of assets set aside and invested for the purpose of meeting the scheme's liability for benefit payments as they arise.

[8] According to the decision of *EUROSTAT* (The Statistical Office of the European Commission), these schemes are to be included in the private sector in national accounts because the transactions are between the individual and the pension fund. Thus, they are not recorded as government revenues or expenditure, and consequently, they do not have an impact on the government surplus or deficit. In addition, the insured persons have the ownership of the assets of the fund and, thus, they bear the risks and enjoy the rewards regarding the value of the assets. Furthermore, the EUROSTAT decision specifies that a possible government guarantee for such a fund is not an adequate condition to classify such schemes as social security (public) schemes, because such a guarantee is a contingent liability and these are not considered as economic transactions until they materialise.

sector employees' pensions sometimes do not constitute a well-identified pension scheme but, instead, disbursements for pensions appear directly as expenditure in the government budget. On the other hand, some predominantly PAYG pension schemes have statutory requirements for partial pre-funding and, in view of the increasing pension expenditure, many governments have started to collect reserve funds for their public pension schemes.

While occupational and private pension schemes are usually funded, the degree of their funding relative to the pension promises may differ, due to the fact that future pension benefits can be related either to the salary and career length (defined-benefit system) or to paid contributions (defined-contribution system).

Statutory Pensions Before the Economic Crisis

At the EU level, not all Member States were in the same situation when hit by the 2009 crisis. In particular, the size and structure of social protection varied greatly. Generally, richer countries spend a larger share of their GDP on social protection, and periods of economic growth had allowed many governments in the EU to devote more resources to social policy intervention (i.e. Nordic countries). The structure of social protection expenditure shows that old-age pensions and sickness and health care benefits represent the bulk of spending in all EU Member States, and have also been the areas where most reforms have taken place (European Commission 2009d).

Large increases in the at-risk-of-poverty rate of the elderly[9] have been observed in a number of Member States, especially in those that have experienced strong economic growth, accompanied by a strong increase in wages in the years before the crisis. However, there are specific indications that where pensions were indexed to prices and not to wages, at-risk-of-poverty rates for the elderly have increased dramatically. In some Member States, however, part of the impacts of reforms to improve minimum-income pensions and reduce poverty rates may have been dampened by faster increases in the income of the working-age population (e.g. CY, FI and United Kingdom). In some cases, an improvement of the relative income situation of the elderly may have resulted from a strengthening of pension benefits (e.g. IE). This illustrates that the type of indexation of benefits can significantly influence the evolution of the relative income position of the elderly over time compared with the working-age population. This applies specifically to minimum-income pensions which play an important role in averting poverty in old age.

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[9] At-risk-of-poverty rates are defined in the EU context as the share of persons with an equivalised disposable income below an at-risk-of-poverty threshold. Equivalised disposable income is defined as the household's total disposable income divided by its 'equivalent size' to take account of its size and composition. The at-risk-of-poverty threshold is set at 50 and 60 % of the national median equivalised disposable income. It must be noted that income generated from owner-occupied housing or housing beneath market rents—i.e., imputed rent—is not included in the definition of income. Inclusion of this element of income could make significant difference in the measurement of risk-of-poverty rates.

Currently, pension systems have significantly reduced poverty among older people, though the risk of poverty is higher for older people than for the general population.[10] However, single elderly women still face a much higher risk of poverty than single men.

Adequacy Versus Sustainability Challenges

The *current adequacy of pension systems* should be defined and monitored according to the two main objectives of pensions (Disney and Johnson 2001; Holzmann and Hinz 2005):

- Pension systems aim to provide all individuals income security due to retirement. As some people may be poor over a lifetime and unable to save enough during working life to ensure decent resources in old age, one of the key objectives of public pension systems is precisely to *relieve absolute or even relative poverty*. This is exactly the policy background for establishing programmes that reduce the risk of poverty in old age and prevent *social exclusion* (Amitsis 2001) by providing minimum adequate levels of pension income.
- From a methodological point of view, elderly poverty is basically measured relative to that of the working-age population. The main indicators used within the EU context are at-risk-of-poverty rate and the relative income of the elderly. These together may provide a clear picture of the efficiency of minimum-income pensions in providing adequate income security for the elderly.
- Pensions are also a mechanism for *consumption smoothing*. During their retired lives people have to consume real goods and services, just as during their working years. Thus, 'adequate' pension income allows for smoothing the consumption path over time, through the productive middle years and then the retired years. This also implies that 'adequacy' has to take into account the need to retain the value of income over time (i.e. indexation) so as to keep constant the real value of a person's pension.

In order to account for this second dimension in the definition of adequacy, current traditional indicators look at measures of replacement income, i.e. the extent to which pension systems enable workers to preserve their previous living standards when moving from employment to retirement and the relative income of the elderly.[11]

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[10] On average, people aged 65+ have an income which is around 83 % of the income for younger people, ranging from 54 % in Latvia to more than 100 % in Hungary (2009).

[11] The main indicator is the aggregate replacement ratio. However, this only looks at pensions currently in payment. But given the long-term implications of pension reforms, theoretical replacement rates are useful as an additional analysis tool. This gives us the possibility to look at the adequacy of the replacement income provided by pension systems for theoretical cases. It also allows us to stress-test this adequacy by assuming macroeconomic shocks such as the change in rate of returns for funded pensions or by assuming career-breaks for individuals, for example in the case of unemployment.

On the other hand, the *current sustainability of pensions* can be viewed in terms of their impact on broader policy and economic objectives. All pension schemes, regardless of the financing mechanism they use (funding or PAYG) transfer a share of the current output of the real economy from the active to the retired. A less-favourable balance between the active and the retired will therefore represent a major challenge to any pension system.

From a methodological point of view, pensions' sustainability objectives within the EU context include:

- Raising overall employment and prolonging working lives so as to improve the balance between the active and the retired.
- Safeguarding sound public finances.
- Ensuring that adjustments to benefit and contribution levels are equitable.
- Enhancing the quality of funded pension schemes, which in many countries, will play an increasingly important role in providing adequate pensions (European Commission 2003).

The *future adequacy and sustainability of pensions* could be assessed using theoretical replacement rates,[12] given that they may show how changes in pension rules can affect pension levels in the future. A look at the link between theoretical replacement rates and the evolution of pension expenditure shows that developments in pension promises can involve a heavy future cost in the light of a society with low fertility rates,[13] if labour market patterns remain constant. In other words, a country with an ageing population which aims to maintain the same replacement rate will inevitably need to devote more resources to pensions. The burden of this sensitive process could be dampened by increasing the size of available resources, either by increasing employment and/or capital or minimising administration costs/pension amounts.

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[12] They refer to an indicator showing the level of pension income after retirement as a percentage of individual earnings at the moment of take-up of pensions or of average earnings. Replacement rates measure the extent to which pension systems enable typical workers to preserve their previous living standard when moving from employment to retirement.

[13] Only a modest recovery in the total fertility rate, which is the average number of births per woman over her lifetime, is assumed for the EU, from 1.52 births per woman in 2008 to 1.57 by 2030 and 1.64 by 2060. In the euro area, a similar increase is assumed, from 1.55 in 2008 to 1.66 in 2060. In all countries, the fertility rate would remain below the natural replacement rate of 2.1 births per woman that is needed in order for each generation to replace itself. This will result in slow growth and in most cases actual declines in the population of working age. The fertility rate is projected to increase in all Member States, except in the few where total fertility rates are currently above 1.8, namely France, Ireland, Sweden, Denmark, the United Kingdom and Finland, where it is assumed to decrease but remain above 1.85, or remain stable. The largest increases in fertility rates are assumed to take place in Slovakia, Poland and Lithuania, which had the lowest rates in the EU in 2008; here, the increase would occur gradually, approaching the current EU average rates only in 2060. See European Commission (2009b).

Future levels of pensions in relation to earnings (income replacement levels) will depend on different factors, notably the pace of accrual of pension entitlements[14] (which is strongly linked to the developments in regional labour markets), the maturation of pension schemes and the effect of institutional reforms. However, most Member States are in a situation where reforms of statutory schemes will lead to a decrease of replacement rates at given retirement ages. This most probably reflects of reforms that have lowered future benefit levels at a fixed retirement age in order to cope with increasing longevity and the expenditure this would otherwise entail (Amitsis 2011). As a result, many Member States have also increased incentives to work longer. Measures include increasing retirement age, flexible retirement options, increasing contributory periods needed for a full pension, and designing work incentives into pension schemes. These offer ways and means to bring effective retirement age into line with expected increases in life expectancy.

However, as the work histories required for a full pension are being extended, it is important to protect vulnerable groups and cater for career breaks which should not be unduly penalised in the pension system. While the most vulnerable groups are often protected by minimum-income provision, persisting labour market differences between men and women translate into income inequalities in old age. Member States have transposed into their national legal order EU-binding instruments to equalise pension eligibility ages for men and women to help ensure that women can have a decent retirement income. Furthermore, care burdens, which still mainly fall on women, and the way they result in lower pensions, are being monitored, and an increasing number of countries are beginning to give pension entitlements for care-related absences from the labour market (European Commission 2006).

- One of the ways to ensure both the sustainability of pension systems and an adequate level of income for pensioners is to extend working lives in line with the expected rise of life expectancy rates.[15] The EU's target under the *Growth and Jobs Strategy*[16] was to reach a 50 % employment rate for older workers by 2010.

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[14] This corresponds to a rate at which future pension benefits are built up. It is used in defined benefit schemes and based on the formula linked to the scheme.

[15] Life expectancy has been rising steadily, with an increase of two and a half years per decade in the countries holding the record of highest life expectancy. If the pace of future progress in the reduction of mortality remains the same as it has been over past decades, most people in the EU will live very long lives. For the EU as a whole, life expectancy at birth for men would increase by 8.5 years over the projection period, from 76 years in 2008 to 84.5 in 2060. For women, life expectancy at birth would increase by 6.9 years, from 82.1 in 2008 to 89 in 2060, implying a narrowing gap in life expectancy between men and women. The largest increases in life expectancy at birth would take place in the most recent EU Member States, according to the assumptions. Life expectancy for men in 2008 is lowest in Estonia, Latvia, Lithuania, Hungary, Slovakia, Poland, Bulgaria and Romania, where it ranges between 66 and 71 years. It is assumed that some catching up will take place, with increases in life expectancy of more than 10 years over the projection period—a bigger increase than in the rest of the EU. Overall however, life expectancy at birth is projected to remain below the EU average in all new Member States—except in Cyprus—throughout the projection period, especially for men.

[16] European Commission (2005a).

In 2007, the employment rate for older workers in the EU-27 was 45 % compared with 37 % in 2001.

- Given the current economic downturn and increasing unemployment in the European region, protecting the pension entitlements of future pensioners during periods of unemployment is also an emerging feature in most pension systems across the EU. The risk of unemployment is well covered by public pension schemes in many Member States. Nevertheless, it is definitely less true for funded pensions and the preservation of pension entitlements during unemployment is typically less generous than for periods of child care. However, it is important to monitor such protection of pension entitlements together with the effects on work incentives in order to prevent becoming a new dependency trap.

In the Joint 2009 Ageing Report (European Commission 2009b), Member States provided some major assessments of their success in achieving sustainable and adequate pensions. From scenarios based on trajectories for present and coming reforms to pension systems and assumptions about continued growth and increasing employment rates, it seems that sustainability (in terms of the public budget impact of ageing-induced extra pension costs) has markedly improved over the last decade. In fact, a challenge in some national systems in terms of pension policy (i.e. notwithstanding the need to eventually implement a fiscal exit strategy and reduce the high budget deficits currently prevailing in a large majority of at-risk countries) would be to secure sufficient future adequacy.

The compelling factor behind most pension reforms has been *the need to ensure sustainable finances in pension systems in the long run as the population ages*. Changes in the old-age dependency ratio would result in public pension expenditure in the EU-27 to increase from 10.1 % of GDP in 2007 to 18.8 % in 2060. However, Member States have implemented reforms that address this increase to a large extent. As a result of these reforms and a projected increase in employment rates among the population aged 15–64 from 65.5 % in 2007 to 69.9 % in 2060, public pension expenditure is forecast to reach only 12.5 % of GDP in 2060.

In response to the longevity challenge, due to many pension reforms, the relative level of annual pensions will decrease over the next 40 years, given a 40-year career. That said, in many cases policymakers have tightened eligibility rules for full pensions and extended pensionable ages to encourage longer working lives as people live longer. There has also been a move towards greater pre-funding of pensions as a method for moving some of the payment burden forwards to current working generations, but also as a method of reaping eventual gains from growing financial markets, which traditional PAYG systems do not do (European Commission 2007b).

Pension policy responses by Member States to the ageing challenge have combined three broad types of reform measures: (1) encouraging/enabling more people to work more and longer, (2) greater pre-funding of pensions and (3) decline in the accrual of annual pension rights, all else being equal.

General policies fostering economic growth and jobs together with societal changes (such as structural changes in the skill, gender and sectoral composition of older workers) have clearly formed the backdrop to much of recent progress particularly in terms of more people working more. But pension reforms have certainly underpinned developments through changes in design and incentives embedded in pension schemes. These include:

- Increasing pensionable ages—i.e. the ages at which retirement benefits can be accessed, or accessed without any actuarial reductions (for instance in the United Kingdom, DE, DK before 2030, HU, MT, SI and AT for women).
- Abolishing or restricting early retirement options (for instance, in BE, DK, ES, LV, LT, PL) and examining critically other routes out of work prior to formal retirement, such as disability and incapacity schemes.
- Improving flexible retirement options, allowing and encouraging people to continue working, perhaps in a reduced capacity, and supplementing to pensions for people who choose to defer taking them.
- Increasing the link[17] between actual contributions (number of contributions, period they are made over and their level) and eventual pension income.
- Linking pension benefit calculation and/or indexation of benefits to changes in longevity or dependency ratios.[18]
- Outlawing and reducing age discrimination in work places and labour markets at both EU and national levels.

One may consider that strengthening the link between contributions and the accrual of benefit rights means that the same contributions as in the past will give people less annual pension. But, given increasing longevity, this annual reduction does not necessarily imply a lower overall transfer paid out over the retirement period. Moreover, the drop in the value of annual pension will be reduced as more people will be getting pensions in the future (e.g. more women).

Given the projected reduction in working-age population, the same level of contributions cannot continue to fund these increased pensions. This led Member States to seek other ways to rebalance their systems. Reducing the replacement rates at a given age of retirement is one way to return to a more sustainable balance between contributions and total pension paid over (longer average) retirements. Another way is to continue to pay the same annual pension but to increase the age at which it is first payable in line with longevity increases.

The overall decline in the relative level of pension benefits at a given retirement age emerging from reforms has given rise to serious critical questions (raised particularly by trade unions and pensioners' associations) whether the *key improvements in the overall financial sustainability of statutory pension schemes have been obtained*

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[17] Due to their nature, funded pensions—both defined-benefit (DB) and defined-contribution (DC)—tend to have such links and notional defined-contribution (NDC) schemes (as in SE, IT, PL, LV) are also designed in this way. But increasingly other public pension designs (e.g. AT, DE, ES, FR, PT) also have features where longer working lives feed into higher pensions.

[18] Many pension reforms (e.g. SE, IT, PL, DE, FI, FR, AT) have already introduced such mechanisms. While these measures may have little impact on retirement decisions, they can (if allowed to operate as intended) reduce pension benefits in relation to earnings and contribute to better alignment of expenditures with revenue.

at the cost of adequacy. While this issue calls for further investigation (European Commission 2010c), as adequacy is a multi-level, contextual concept, it would be reasonable to argue that greater sustainability has been secured by introducing a greater element of conditionality into future pension provision. Obtaining replacement rates similar to those of the recent past will require people to work substantially more and longer and in many cases people will also have to increase their contributions to voluntary pension savings schemes.

Statutory Pensions During the Economic Crisis

Social protection systems can respond in different ways to the downturn in the economic cycle. On the one hand, anti-cyclical behaviour in public spending, especially on social expenditure, is an important part of bringing an economy out of recession, since social protection expenditure constitutes a large part of total expenditure. The role of social protection expenditure as an automatic stabiliser is to attenuate the consequences of economic shocks on the level of activity (i.e. by maintaining consumer incomes and thereby promoting demand). In that sense, given that pension spending forms the biggest item of social protection expenditure, it is evident that it can play a crucial role as an anti-cyclical automatic stabiliser to sustain and re-boost the economy. The strength of the automatic stabiliser depends on the marginal propensity to consume off the group to which the benefit goes.

Pensioners, a priori, should tend to consume their income as they have less incentive to save. On the other hand, at a time of crisis, as GDP contracts, government budget balances are often strained, and cutbacks in pensions or indexation due to growing budget deficits are also observed. Both types of pension policies have been introduced in the current crisis. Some countries have held back the indexation of pensions (e.g. EE), postponed planned pension payments (e.g. HU) or cut pension benefits (e.g. LT, EL) to cope with their fiscal consolidation concerns. Other countries have increased pension benefits, typically by increasing minimum pensions (e.g. ES, FR, FI, BG) or by increasing the indexation of pension payments beyond the normally applied rules (e.g. PT, FI).

Current pensioners have so far been among those least affected by the crisis, given that they overwhelmingly draw their pensions from public (pre-reform) PAYG systems and established most of their pension rights before cost-reducing reforms began to take effect. Notwithstanding the trend towards a larger role for funded schemes, benefits from such schemes still generally play only a marginal role in pensioner income. In the few countries where this type of income is already important, benefits furthermore tend to be of the defined-benefit type where the investment risk is borne by the scheme. Thus, current pensioner income is not so sensitive to the short-term ups and downs of financial markets. Moreover, even though reductions in contribution revenues immediately weaken public pension scheme finances in most countries, it would still take a longer weakening of overall public finances before pensioners could conceivably be affected through lower indexing of benefits. Current pensioners are therefore also not particularly affected by the impact of the crisis on the labour market.

PAYG schemes also have not been immune to the crisis. The effect of the crisis on different cohorts of pensioners varies depending on how much future pension systems will differ from the current arrangements. In most Member States, most retired cohorts today obtain their pensions under pre-reform rules providing for guaranteed pension levels. Younger cohorts in reformed schemes may be affected to some extent depending on the design of the scheme.

It is the economic crisis, rather than the financial crisis that precipitated it, that is affecting PAYG pensions. The sustainability of PAYG pensions ultimately depends on the strength of the underlying economy, so fewer people working and paying social security contributions, lower economic growth and higher levels of national debt all weigh down on PAYG schemes. At least over the short term the effects are very limited. Where they occur, impacts may take the form of lower indexation (e.g. EE, LV), higher contributions (e.g. CY, LV, RO) or delayed reforms.

The strength of PAYG pensions is that they are resilient to shocks in the short term, and these impacts can be smoothed and shared over long periods. The majority of Member States have preferred to accept increased deficits in their social security schemes, so that automatic stabilisers can play their role. Anti-cyclical behaviour in social spending is an important part of supporting an economy in recession. This is one of the factors contributing to ballooning general government deficits and a dramatic increase in the level of gross general government debt in the EU, from 58.7 % of GDP in 2007 to 83.7 % of GDP in 2011 (European Commission 2010b). In order to limit the increase in public debt some countries have decided to deplete their reserve funds (e.g. IE, LV)[19] whereas in others this is being considered (e.g. PL).

The responsiveness of pension systems to the business cycle is determined by the current capacity of public budgets to protect people. In that sense, Member States are in very different positions to face the crisis. Countries with more balanced budgets can afford to apply a higher degree of counter-cyclicality at a time of crisis as compared with countries where the consolidation of fiscal budgets is the major concern. Countries with mature pension systems and balanced budgets will thus have more budgetary room for manoeuvre at the onset of a recession and will be in a better position to protect the most vulnerable and those most affected by a downturn.[20]

In contrast, countries faced with major public finance imbalances are left with little room for manoeuvre to address the social consequences of the crisis. Funded pension schemes have been more immediately and directly impacted by the financial crisis. Falls in the value of investments feed through into deficits in *defined-benefit*

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[19] While in LV the reserve fund partially covers the deficit of the social security system, the reserve fund in IE was used as a means to help solve the effects of the crisis in the banking sector. Although this can be considered an effective use of resources in times of constraint, it is important to consider the long-term demographic pressures on the pension system. The use of funds earmarked for pensions can also lead to a loss of social confidence and acceptance for the pension system.

[20] European Commission (2010b).

pension schemes[21] and into lower individual pension fund accounts. How these then impact on actual pension incomes for individuals depends on how quickly and to what extent investments recover and what mechanisms are in place to mitigate and share investment risk.

PAYG pensions are also impacted. Ultimately, the economy determines what is affordable for PAYG pensions. Lower growth, fewer people in work to pay for those already retired and increases in national debt all weigh down on PAYG pension systems. The impact on individual pension income depends on how quickly countries return to growth and higher employment rates, what adjustment mechanisms are in place and what further reform measures are necessary to ensure PAYG schemes are sustainable in the long term.

The demographic challenge remains the key and the crisis has added to this challenge. Indeed, the financial crisis may have put into sharper focus underlying structural issues regarding the sustainability of pension systems. These issues may previously have been masked by expectations of returns on funded pension schemes or anticipated levels of economic growth and employment rates which may now seem over-optimistic.

Adequacy Versus Sustainability Challenges

There is a marked uncertainty regarding economic growth over the medium and long term. The recession could have implications for the growth potential of the EU economy. On the demand side, deteriorating labour market conditions could constrain consumption in the medium term, while the supply side of the economy could be also affected. Trend growth in the next few years (2012–2020) could be lower than projected in the pre-crisis scenarios. This would have serious implications for the future adequacy and sustainability of pensions.

The long-term nature of pensions gives them a specific resilience to economic shocks, as there is usually time for the systems to recover. Long transitional periods in pension reforms also tend to protect the pensions of those in or close to retirement today. However, the length of the shock and the financial situation of the system when the crisis hits crucially affect how the system can handle the payment burden in the short and long term. Pension reforms have been based on certain assumptions of growth and returns on paid contributions. If pension systems are unable to handle the effects of lower than expected returns or a narrower contribution base due to unemployment, this could ultimately affect the adequacy of benefits.

However, a system that cannot pay out adequate pensions is not sustainable in the long run, as its social or even political credibility will decrease.

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[21] These are pension schemes where the benefits accrued are linked to earnings and the employment career (the future pension benefit is pre-defined and promised to the member). It is normally the scheme sponsor who bears the investment risk and often also the longevity risk: if assumptions about rates of return or life expectancy are not met, the sponsor must increase its contributions to pay the promised pension.

Member States have let pension systems play the role of automatic stabilisers in the current crisis. However, anti-cyclicality should be maintained when recovery sets in, so that social protection systems are sustainable in the long run. This often implies politically difficult decisions. Meanwhile, automatic adjustment mechanisms in pension schemes may tend to be activated in a pro-cyclical rather than anti-cyclical manner, which needs to be monitored or adjusted.

In the event of protracted low growth, the majority of EU Member States will be faced with the difficult task of adjusting social security expenditure to levels that reflect the trend growth rate of the economy and are affordable in the long run. Over the coming decades the sensitivity of pensioner incomes to the economic situation will change significantly. The share of funded pensions in the income packages of future pensioners is expected to increase markedly. At the same time, the bulk of funded schemes will be of the defined-contribution type where investment risks are moved to pension savers. In addition, the reduced pensions from public PAYG schemes will increasingly be calculated on life-time earnings-related contributions. On present trends, only those with very long careers and largely unbroken contributory records will obtain rights to a full (maximum) pension.

Adequacy will therefore not just depend on the ability of workers to respond positively to the new work incentives within national pension systems. It will also be contingent on the ability of labour markets to deliver sufficient opportunities for prolonging average careers.

The effects of the crisis on pensions being paid from statutory PAYG systems are often indirect. The EU labour market is contracting and an unemployment rate of over 12 % is projected for the EU in 2012 and 2013. The effect of high unemployment on pensions is twofold:

- Higher unemployment, along with slower productivity and wage growth, affects both the tax and contributory base of pension systems, reducing the revenues that pension systems rely on.
- Long-term unemployment can negatively affect the accruals of pension entitlements, having an adverse affect on individual pensions.

It is thus vital to monitor the length of the period of unemployment and actively promote a reasonable return to the labour market. Past crises have often resulted in older workers, a relatively vulnerable group on the labour market in the best of times, being prematurely pushed out of the labour market. Given the demographic challenges that PAYG systems are yet to face, it is important that Member States reduce the risk of older workers being forced into early exit pathways from the labour market, including early retirement, unemployment and disability schemes.[22]

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[22] In *Latvia,* the government intends to increase the retirement age from 62 to 65 by 2021. In *Hungary*, the retirement age will be gradually raised from 62 to 65 by 2022. In the *Netherlands*, the government has proposed that the pensionable age should rise to 66 years in 2020 and to 67 years in 2025, while there would be special provision for people who began their careers very young and those who worked in physically demanding jobs. In *Slovenia,* the government has disclosed a plan to increase the retirement age from the current 61 for women and 63 for men to 65 for both by 2020 (early pensions would be accessible from the age of 60 instead of 58). In *Romania,* the government

The crisis can be used as an opportunity to carry out necessary reforms and to give an impetus to politically difficult decisions at EU and national level. If increases in retirement age are to be successful, they need to be coupled with other measures that give older workers the opportunity to return to the labour market, e.g. offering flexible retirement options, monitoring whether wage differentials between younger and older workers do not push out older workers from the labour market, changing the habits of employers or outlawing discrimination on the grounds of age. The longer term challenge of ageing is no longer such a distant scenario. Over the next decade, the working-age population will begin to shrink. Indeed, the setbacks from the crisis and the likelihood of lower growth have thrown this into sharper focus.

On the other hand, *the balance between adequacy and sustainability is under pressure from the financial and economic crisis* (Borella and Fornero 2009). Increases achieved in employment rates for older workers must now be defended against rising unemployment. Recovery packages have secured the ground for a thriving economy to supply the income that can pay for pensions. But they have also reduced the hard-won public finance improvements intended to provide room for extra expenditure to address ageing and this lost ground will have to be regained.

The Role of EU in Promoting Adequacy/Sustainability of National Pension Systems

Ensuring adequate retirement income is the main purpose of national pension systems, strongly related to the guarantee of fundamental social security rights through Constitutional norms, ratified International Conventions and statutory acts. However, the lack of explicit EU competencies for the regulation of statutory pensions (still a national responsibility) explains why the political debate has focused predominantly on problems associated with the long-term financial sustainability of national pension systems. Given that poverty rates among pensioners will be increased during the financial crisis and public pension replacement rates in most cases will decline, EU activities will be needed to address adequacy gaps without distorting sustainability.

The Impact of EU Binding Law on National Pension Schemes

There are four basic institutional 'models of interaction' between the EU and national levels relevant to statutory pensions: the regulatory co-ordination by the EU of national social security systems in respect of migrant workers; the relatively rare phenomenon of EU-level harmonised regulatory social security norms; the promotion of harmonisation or convergence through soft law norms and financial support;

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is considering an increase in the retirement age from 58 to 60 for women and from 63 to 65 for men by 2014.

and modified deregulation in the context of the EU's law of the internal resonance and meaning within the culture of citizenship, which is specific to democratic Europe (Armstrong 2000).

The key EU competencies focus on the *coordination of national social security schemes* and their *harmonisation in gender issues* (equality of treatment between men and women), strongly related to the main objective of Community Law, as an instrument to strengthen the development of the 'internal market' (an area in which free movement of goods, persons, services, and capital is ensured) and ensure that competition within that internal market is not distorted.

(a) EU law in the social security field provides for the coordination but not the harmonisation of social security schemes. This means that each Member State is free to determine the details of its own social security system, including which benefits are to be provided, the conditions of eligibility, how these benefits are calculated and what level of contributions should be paid.

EU law provisions, in particular *Regulations No. 883/2004*[23] and *No. 987/2009*[24] (replacing Regulations No. 1408/71[25] and No. 574/72[26] since 1 May 2010), establish common rules and principles, which must be observed by all national authorities when applying national law. These rules ensure that the application of the different national legislations respects the basic principles of equality of treatment and non-discrimination and persons exercising their right to free movement within the EU are not adversely affected by the application of different national legislations.

With regard to pensions, the EU Coordination Regulations cover old-age pensions, survivors' pensions and invalidity pensions. In general, only statutory schemes are coordinated. The EU Coordination rules lay down for the following principles:

- Aggregation: periods of insurance or residence completed under the legislation of another Member State are taken into account if necessary for entitlement to a benefit.
- Waiving of residence clauses: entitlement to a pension does not depend on residence in the Member State granting the pension.
- Each Member State where a person was insured for at least 1 year pays a pension; there is no "transfer" of pension rights to the pension system of another Member State.

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[23] Regulation (EC) No. 883/2004 of the European Parliament and of the Council of 29 April 2004 on the coordination of social security systems (Text with relevance for the EEA and for Switzerland), OJ L 166, 30 April 2004, pp. 1–123.

[24] Regulation (EC) No. 987/2009 of the European Parliament and of the Council of 16 September 2009 laying down the procedure for implementing Regulation (EC) No. 883/2004 on the coordination of social security systems.

[25] Regulation (EEC) No. 1408/71 of the Council of 14 June 1971 on the application of social security schemes to employed persons and their families moving within the Community.

[26] Council Regulation (EEC) No. 574/72 of 21 March 1972 fixing the procedure for implementing Regulation (EEC) No. 1408/71 on the application of social security schemes to employed persons and their families moving within the Community.

(b) Within the gender agenda, *Directive 79/7/EEC*[27] implements the principle of equal treatment between men and women in matters of social security and notably covers statutory pensions. It, however, contains a number of exceptions to the principle of equal treatment. Member States are, for example, allowed to maintain different retirement ages for men and women. At the same time, even if there is no obligation flowing from EU gender equality law to equalise pensionable ages for men and women in the field of social security, gender equalisation is often a first step in reforms aimed at increasing the retirement age in general to preserve the adequacy and sustainability of pensions.

The Open Method of Coordination

The *Open Method of Coordination* (OMC) is a policy process without binding effect that promotes convergence trends in the social protection framework of Member States through the application of four interrelated techniques: Fixing guidelines for the Union, combined with specific timetables for achieving the goals, which they set in the short, medium and long terms; establishing, where appropriate, quantitative and qualitative indicators and benchmarks against the best in the world and tailored to the needs of different member states and sectors, as a means of comparing best practice; translating these European guidelines into national and regional policies by setting specific targets and adopting measures, taking into account national and regional differences; periodic monitoring, evaluation and peer review, organised as mutual learning processes (De la Porte and Pochet 2002).

In 2001, Member States agreed to a set of objectives for their pension systems which have since guided reform efforts and their assessment at EU level. Member States and the Commission since 2006 assess progress towards the common objectives within the streamlined OMC on Social Protection and Social Inclusion. The Social OMC works through common setting of objectives by the Commission and the Council, developing common indicators that measure progress towards objectives, reporting by the Member States on the basis of those objectives, and summarising of the findings by the Commission in an annual report subsequently endorsed by the Council (Joint Report).

The OMC provides a framework for regular monitoring of the pension systems and reforms throughout Europe (European Commission 2003). The most common form of monitoring takes place in the form of National Reports sent in by Member States, and annually produced joint analyses and assessments by the European Commission and the Council. The Joint Reports assess progress made in the implementation of the OMC, set the key priorities and identify good practice and innovative approaches of

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[27] Council Directive 79/7/EEC of 19 December 1978 on the progressive implementation of the principle of equal treatment for men and women in matters of social security, OJ L 6, 10 January 1979.

common interest to the Member States. They also identify areas for further in-depth study and discussion.

The common objectives on pensions were confirmed in 2006 (European Commission 2007a). Member States are committed to providing adequate and sustainable pensions by ensuring:

- *Adequate* retirement incomes for all and access to pensions which allow people to maintain, to a reasonable degree, their living standard after retirement, in the spirit of solidarity and fairness between and within generations.
- The financial *sustainability* of public and private pension schemes, bearing in mind pressures on public finances and the ageing of populations, and in the context of the strategy for tackling the budgetary implications of ageing, notably by supporting longer working lives and active ageing; by balancing contributions and benefits in an appropriate and socially fair manner; and by promoting the affordability and the security of funded and private schemes.
- That pension systems are *transparent*, *well adapted* to the needs and aspirations of women and men and the requirements of modern societies, demographic ageing and structural change; that people receive the information they need to plan their retirement and that reforms are conducted on the basis of the broadest possible consensus.

New Policy Initiatives

Recent initiatives in the broader pension field highlight the interest of EU bodies in advancing the importance of adequate and sustainable pensions for strengthening social cohesion. They include the *Green Paper "Towards adequate sustainable and safe European pension systems"*[28] and the *European Year for Active Ageing and Solidarity between Generations (2012).*

(a) The Green Paper was published in July 2010 as a fundamental policy initiative by the European Commission[29] to promote links and synergies between pensions and the overall *Europe 2020 Strategy for smart, sustainable and inclusive growth* (European Commission 2009c). It has adopted a broader overview on pensions compared with the 1997 Commissions' *Green Paper on Supplementary Pensions*,[30] given that it focuses on all pension pillars (social security pensions, occupational pensions, life assurance). On the other hand, it indicates a cross-policy, holistic approach within the EU context, which has arguably been missing from previous initiatives.

The key issues of this process were discussed through a pan European consultation (opened on 7 July 2010 and lasted until 15 November 2010) that received almost 1,700 responses, including more than 350 from Member State Governments, National Parliaments, business and trade union organisations, academia, civil society and

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[28] A '*White Paper on Pensions*' is scheduled for the third quarter of 2011; it will identify the most important measures to be taken forward.

[29] European Commission (2010c).

[30] European Commission (1997).

representatives of the pension industry. The responses from the key stakeholders provide a rich texture of well-presented positions on the European framework on pensions and pension issues in general, which help to shape the various policy options for consideration.

According to the Consultation Report (European Commission 2011), the bulk of Member States want efforts to concentrate on improving or deepening the existing European policy framework on pensions rather than extending it. Yet, most of them at the same time welcome reinforced economic policy coordination.

Responses to the Green Paper suggest that *improvements to the existing EU pension's framework* could be beneficial in ensuring the sustainability of public finances. Some respondents consider that the EU level could contribute with harmonised measures of pension indicators, facilitating an informed and straightforward discussion on relevant pension policy issues, and challenges at the EU level. Many underline that such additions should be developed within existing frameworks, which in general are deemed to be appropriate. The Social OMC is seen as the right instrument to support national efforts to strengthen adequacy of pensions.

A higher *effective retirement age*is widely recognised as necessary. While, according to some respondents, it should be determined by national policies with involvement of the social partners, others suggest that the pensionable age should evolve in line with life-expectancy and a few suggest taking into account the life (or healthy-life) expectancies of different professions. The European Parliament recommends that priority be given to ensuring that employees work until the pensionable age. Numerous respondents underline that pension reforms should be coupled with active labour market policies, lifelong learning opportunities, effective social security and health care systems and improvement of working conditions.

(b) The European Council agreed in June 2011, subject to the vote of the European Parliament, to designate 2012 as the *European Year for Active Ageing and Solidarity between Generations*. The promotion of active ageing involves creating better opportunities and working conditions to enable women and men who are in their late 50s and above to play their part in the labour market, combating social exclusion by fostering active participation in society and encouraging healthy ageing. The purpose is to enable local authorities, social partners and civil society organisations, which have a role to play in promoting active ageing, to plan campaigns and activities around this theme.

The objectives of the Year are to:

- Raise awareness of the value of active ageing by highlighting the contribution that older people can make to society and to the economy by mobilising more their potential.
- Exchange ideas and good practice on how best to promote active ageing policies.
- Offer a framework for action to enable member states and stakeholders to develop policies and specific activities to encourage active ageing and solidarity between generations.

The types of activities envisaged include conferences, educational campaigns, awareness raising, dissemination of good practice and research work. Almost all Member

States have already appointed a national coordinator to organise activities at national level and to coordinate with his counterparts of other member states and with the Commission.

At EU level, the year 2012 will be used to identify, discuss and agree what is needed to mainstream active ageing and intergenerational solidarity in the most relevant EU policy processes and instruments and to deliver positive change. At national and regional level, the Year will be used to organise a variety of events targeting a wide range of stakeholders: children, youth, women, family and older people's organisations, social service providers, local authorities, etc. The purpose of these activities could be to raise awareness among the media and the public of the need to adopt a new approach to ageing and relations between generations, to create opportunities for different age groups to get to know each other better and to promote a better image of both youth and older people, to run awareness campaigns or workshops on specific themes, to enable citizens' groups and policymakers to develop innovative solutions together and to learn more about what they can do with the support of the EU to help local actors meet their demographic challenge in a way that is sustainable and fair of all.

Conclusions

The current financial crisis and the economic downturn within the European region have outlined the need for ensuring the resilience of reformed systems in terms of ensuring sustainable financing and providing adequate pensions, both in the short and long term. Financial losses in pre-funded schemes can affect the solvency of these schemes and thus their ability to pay out pensions. The inherent risk of lower returns for future pensions in defined-contribution schemes has also been brought into sharper focus. In PAYG schemes, where the contribution base provided by the working population is the key, the damage caused by long-term unemployment to the sustainability of these systems has been highlighted. At the same time, as eligibility rules are tightened in reforms, the effect of long career breaks on future pensions also becomes significant.

Adjustments to all kinds of pension schemes may therefore be necessary to ensure their long-term health. But one of the few positives that can be taken from the crisis is that it may give national governments and stakeholders the necessary impetus for further reforms, in particular to encourage and enable more people to work more and longer.

The National Context

Comprehensive assessment of national pension systems and policies at EU level has demonstrated the determination of Member States to ensure that pension systems will continue to deliver adequate benefits in a financially sustainable way (European Commission 2010a). Although existing statistical tools for monitoring the current situation are unsatisfactory and projections of the future situation with regard to adequacy have yet to be developed, most Member States are confident that they will be able to provide good and possibly improved protection against poverty and ample opportunities for most workers to maintain their living standards during old age.

However, it remains to be seen in the near future whether reform strategies can make serious inroads into reducing poverty risks in old age. Whereas the shift to more private pension provision might, by itself, weaken internal solidarity in pension systems, it should be pointed out that many Member States maintain strong elements of solidarity in statutory schemes and may even encourage solidarity in occupational schemes.

On the other hand, financial sustainability of public pension systems is crucial for maintaining sound public finances and no Member State envisages financing future pensions through borrowing (*with the certain exception of Greece!*).[31] By contrast, most Member States plan to use the time before ageing starts to accelerate to bring their public budgets in order, either by reducing debts or by setting up dedicated reserve funds to meet future increases in pensions' expenditure.

Through determined efforts to raise employment and consolidate public finances, Member States expect to be able to maintain both adequate benefit levels in public schemes and reasonable contribution levels. However, some increase in contribution times and/or downward adjustments in benefit levels are inevitable in many Member States. In some systems, they will take place automatically as an effect of lower accrual rates or in response notably to increasing life expectancy, in others they will be the result of new policy decisions after general parliamentary elections.

The reform and modernisation of pension systems must be based on sound information and a large political consensus between beneficiaries and stakeholders. In particular, the importance of proper information to individuals about their pension situation is widely recognised. Regular statements about the build-up of pension rights may raise awareness of pension matters at an individual and collective level and become driver of serious change in pension systems.

Moreover, even for those Member States who consider that they have adopted a right strategy so far, one may highlight a set of risk factors that will determine the success of these strategies. Regarding financial sustainability, the risks stem from insufficient employment growth, insufficient consolidation of public deficits and insufficient contribution income to meet benefit commitments. In view of the fact that ageing will accelerate rapidly within the next 10–15 years, every year of sluggish growth represents a major setback. Countries that rely on funded provision face the

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[31] Pension spending has consistently been documented to pose a very significant risk to the long-term sustainability of public finances in Greece. On current trends, the projected spending on pensions in 2060 is expected to exceed 24 % of GDP and the estimated deficit of the social security system is estimated at over 15 % of GDP. In this respect, the Socialist government (in power since October 2009) decided to address the issue of pension spending through two kinds of measures during the implementation of the *Financial Stabilisation Mechanism* of the Greek Economy since May 2010: (1) policies that rationalise expenditure and increase the revenue base and (2) a radical institutional reform of the pension system.

risk of low returns on financial assets, which may lead to pressure for increased public expenditure.

Another major risk is that coverage rates and levels of private provision remain low, resulting in a challenge to adequacy—and, through means-tested provision, to public finances. Finally, countries where major reform measures are still required or where pension reform is conducted incrementally always face the risk of political blockages. These may be particularly serious in countries with highly fragmented pension systems influenced by powerful lobby groups and may result in high levels of expenditure with poor effectiveness in terms of reduced poverty risks in old age.

The EU Context

Ensuring that public policies cater for sustainable, accessible and adequate retirement incomes remains a priority for economic policies in the EU. While Member States share similar fundamental challenges, the situation differs considerably across the Union, both in terms of demographic prospects, growth potential (catching up effects), design of pension arrangements and in terms of constraints on account of the fiscal situation and external competitiveness. For several countries where the pension reforms process has not been set in motion, the pre-crisis message firmly remains; there is a need to align the ‘pension promise’ with what the rest of the economy can be expected to support. For other countries, additional reforms might be needed to ensure the lasting success of already implemented pension reforms.

There has been considerable progress in the last decade in analysing and assessing the challenges to pension policy posed in particular by population ageing. Several Member States now pay due consideration in their medium-term budgetary planning to the long-term sustainability and viability of public spending programmes and to the future fiscal positions overall. The EU Fiscal Framework (strengthened with the 2005 reform of the *Stability and Growth Pact*) explicitly addresses the link between medium-term budgetary policies and long-term trends that can affect fiscal positions. In particular, the structural budgetary targets (*Medium-Term Budgetary Objectives*) that Member States have set take account of the future pressures on public budgets that arise from demographic transition to an older population. In this respect, structural policies, including modern social protection systems and their contribution to employment, productivity and economic growth is at the heart of EU policy making.

During this global sharp economic crisis, European political leaders and policymakers have a historical opportunity to preserve the *social impact of pensions*, developing a new paradigm for the next generations that will address current dilemmas about the guarantee of *sustainable and adequate retirement incomes for older people.* This long-term process involves all aspects of pension policy:

- Reaffirming the institutional status of public pensions as an entitlement of beneficiaries and not charity for elderly poor.
- Striking the right balance between the role of public, occupational and private pillars.

- Introducing new eligibility criteria (prolonging working lives, adjusting the retirement age) for the provision of benefits.
- Adjusting pension system parameters before and after retirement (accumulation and valorisation of pension rights, indexation of pension benefits after retirement).
- Adapting the amount of benefits on current living standards and needs.

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Chapter 3
Technology and Ageing: Potential for European Societies

Katrin Claßen, Laura I. Schmidt and Hans-Werner Wahl

Technology and Ageing Well: An Oxymoron?

Could it be that ageing well has a substantial relationship with technology or may in the future increasingly require the use of technology? In many children, but certainly in adolescents and young adults, we already see a close connection between the use of technology and "living well" all over Europe. But what about ageing? There is a lot of talk about the European societies as "greying societies", but this well-known demographic dynamic interacts with the ongoing and, as some say, accelerating shift of European societies towards "information societies". Could it even be that the interaction between the trend towards ageing of our societies and the increasing use of technology in all major arrays of our everyday world is among today's intriguing scientific challenges, because it links two, if not "the" megatrends of modernity? There can in any case be no doubt that general trends such as the "total" communication and information trend via the Internet, for example, on personal computers and mobile phones, the "automatisation" we see in many everyday instances (e.g. automatic teller machines, ticket machines, computer voice menus, car technology) and sensor-based or global positioning system (GPS)-based "helpers" now widely available to support out-of-home behaviour or security and comfort in the home environment increasingly touch upon the sphere of older adults. The observation reported by Rogers et al. (2001) that "Nearly every minute of every day, we encounter, interact with, and rely on technology" (p. 187) now also applies to today's older adults.

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Indeed, a full new and rapidly growing "silver market" has emerged with technology products designed for older adults, particularly for older adults with some kind of competence loss in terms of physical, cognitive or social functioning. Robots accompany frail older adults while strolling around or using the bathroom, personal computers provide cognitive or physical training programmes, smart home environments reveal as highly adaptive for those with sensory, mobility or cognitive decline and robot animals play a significant role in demented older adults' social and emotional life. In addition, we see a new cohort of older adults at the horizon eager to make full use of such a range of technology products in the interest of "staying connected" in old and very old age and ageing well even in the situation of accumulated loss experiences. If it is true that the "Mängelwesen Mensch" (human being with deficiency as inherent in the human condition), as German anthropologist Arnold Gehlen has put it, finds its radicalisation in old and very old age, technology may be among the major means to efficiently counteract such chronic deficiency of human existence across the lifespan into very old age (Baltes and Smith 1999). It is likely that we currently see only the very first beginnings of a possible future success story in terms of a productive liaison between old age and technology—and the frequently maintained oxymoron between the both no longer does exist. Going further, the now 27 member states of the European Union may provide ageing and technology research with a unique "natural laboratory" able to study processes of an increasing liaison between older age and technology including its variations driven by economic, social, demographic, health-related and cultural differences between the European countries.

In this chapter, we examine the issue of ageing and technology in the following steps: We start with a short overview of the development and ambitions of what is now frequently coined *gerontechnology*. The emerging research and practice area can in itself be regarded, as we will show, as a strongly European-driven momentum of the development of ageing research, which now informs and nurtures the international ageing research. We then compile some of the fundamental insights regarding technology and ageing. We also summarize a selection of empirical research on technology use of various groups of older adults including those with cognitive impairments, before we end with some reflections on future developments.

Technology and Ageing as a Research Topic

The term gerontechnology appeared in the 1990s to describe an interdisciplinary endeavour that seeks to develop new and adapt existing technology to the needs and ambitions of ageing and aged people. Gerontechnology is concerned with research informing the development, dispersal and distribution of technologically based products. The composite term gerontechnology builds on the foundations of the sciences underlying technology (e.g. computer science and electronics) and the scientific study of ageing, frequently coined gerontology.

Although early work in the United States has nurtured much the research array of ageing and technology (see, for example, the handbook chapter of Charness and Bosman 1990), European initiatives were highly important for the field's development. In particular, an initiative of the European Commission titled COSTA5 became instrumental in the early 1990s and stimulated a first programme of respective European research. Some of the outcomes can be found in a reader published in 1992 titled *Gerontechnology*, which was edited by two Dutch scholars, Herman Bouma and Jan Graafmans, both significant promoters of the then new research field. In the year 1996, the "International Society for Gerontechnology" (ISG) was founded in Helsinki and this was followed by a series of successful conferences held in Munich, Miami Beach, Nagoya, Pisa and Vancouver. After the turn of the century, substantial funding initiatives of the European Commission targeting ageing and technology continued and were later channelled under the umbrella of "Ambient Assisted Living" (AAL). AAL is a major initiative to address demographic ageing including its challenges and potentials for citizens, healthcare and social systems as well as for industry and the European market. The programme is implemented in 23 states and aims at enhancing the quality of life by supporting the development of technology. Projects funded by the initiative cover issues such as smart homes, health at home, care, monitoring, leisure, active retirement, communication and networking. The programme started in 2008 and will last until 2013 with about 25 projects funded each year. Besides, North America continues to contribute to the technology and ageing area, for example, via its structure of *Roybal Research Centres* also investing into the translation and implementation of technology research findings to applications in the "real world" of older adults (Rogers and Fisk 2010). In addition, Asian researchers are putting much emphasis on technology and ageing research, especially robot technology, and it seems that the Asian world is particularly eager to use technology as a means to support and stimulate ageing well including older adults with dementia-related disorders (Kohlbacher and Hang 2011).

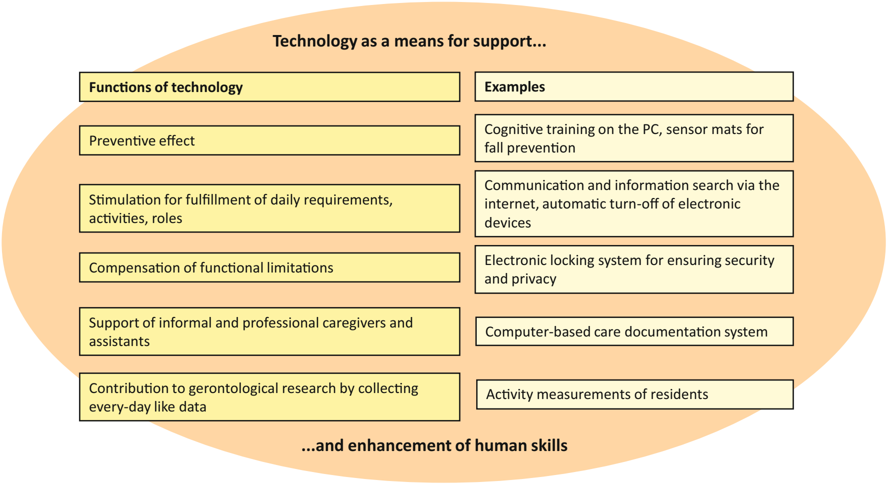
What has gerontechnology to offer? Mollenkopf (2000) proposed five categories of technologies able to support ageing well (Fig. 3.1).

These functions include: (1) technology for prevention and deceleration of age-correlated declines in strength, flexibility and persistence in the physiological, cognitive or social domain; (2) technology able to enhance and strengthen specific areas or even new roles older people may play; (3) technology for compensation of decreasing skills related to higher age; (4) technology for supporting caregivers and (5) technologies for enhancing gerontological research. An example for the latter is the detailed recording of daily activity of residents (or community dwelling older adults), which could be done via GPS-based technology or other devices able to record in- or outdoor movements (e.g. accelerometer). So, some of these functions and examples we will refer again later in the empirical research section.

Some Fundamental Insights Regarding Technology and Ageing

What "Good" Gerontechnology Requires

There is an intensive research going on regarding the requirements technological solutions should fulfil. For example, the concept of *universal design* has been sug-



Technology as a means for support...

Functions of technology	Examples
Preventive effect	Cognitive training on the PC, sensor mats for fall prevention
Stimulation for fulfillment of daily requirements, activities, roles	Communication and information search via the internet, automatic turn-off of electronic devices
Compensation of functional limitations	Electronic locking system for ensuring security and privacy
Support of informal and professional caregivers and assistants	Computer-based care documentation system
Contribution to gerontological research by collecting every-day like data	Activity measurements of residents

...and enhancement of human skills

Fig. 3.1 Functions of technology

gested as an orientation for design, construction and manufacturing (Connell et al. 1997; Preiser 2001). Seven principles related to the concept of universal design offer guidance to account in the most efficient way for features that meet the needs of a wide range of users of technology: (1) equitable use, (2) flexibility in use, (3) simple and intuitive use, (4) perceptible information, (5) tolerance for error, (6) low physical effort and (7) size and space for approach and use. With focus on applied research studies on human factors and user needs, the *usability* of products and environments and the impact of universal design are evaluated. A clear strength of the universal design approach is its focus on all kinds of users, thereby avoiding any stigmatisation of older adults.

According to Fozard (2002), applications of ergonomics and universal design that compensate for age-associated limitations in physical and cognitive functioning will become more complex and probably shorter lived. Therefore, beyond ergonomics and universal design, the potential of gerontechnology is seen in emphasizing technological developments that support lifestyle and environmental interventions able to enrich the course of ageing (see also Rowe and Kahn's 1998 distinction between "usual" and "optimal" ageing).

Rogers and Fisk (2010) have recently compiled what psychology has to offer to the design of advanced technology for older adults. By matching psychological needs with design characteristics, they focus on defining and identifying people's capabilities and limitations that influence technology interactions. In this regard, they refer to the concept of environmental press presented in Lawton and Nahemow's (1973) model, according to which successful performance is depending on the demands imposed by the environment in relation to the capabilities of the individual. Rogers and Fisk (2010) describe successful examples with impacts on practice and implementation, stressing that although plenty of guidance for design is provided in the literature, the transactional dynamic of fitting user needs with technology requirement remains a major challenge (Fisk et al. 2009). Furthermore, Rogers and Fisk (2010) provide an overview of advanced technology systems and their potential for the older end-user (e.g. robotics and ambient technologies). A major conclusion is that practically relevant research can only enhance the well-being, health or safety, if older users are involved in the development and design process as early as possible. Similarly, Topo (2009) argues that the majority of technology studies have addressed formal and informal caregivers, whereas little research has explicitly included the view of older persons themselves.

In their conceptual framework based on a lifespan development view (Baltes 1997), Lindenberger et al. (2008) propose guidelines for the design of assistive technologies driven by three fundamental principles: (1) net resource release, or marginal resource benefit; (2) person specificity and (3) proximal versus distal frames of evaluation considering constraints as well as capabilities of ageing individuals.

The first principle of *net resource release* states that the use of technology is only adaptive if the operation costs (resource investments) are lower than the pay-offs regarding the cognitive resources that are released. For example, using a complex video-phone system initially requires substantial resource investments to understand the instructions, resulting in a low resource balance regarding this device. When developing and evaluating assistive technology, objective and subjective assessments of the resource balance should be taken into account. Improvements in the resource balance caused by using the technological device should be of significant amount—at least in the long run. To enable such benefits, it is essential that technological and psychological knowledge is integrated.

The second principle of *person specificity* points to the need of adaptation to the specific habits, abilities and preferences of the potential users. Besides the general importance of taking the pronounced heterogeneity of the older population serious, it seems crucial to introduce the potentially helpful role of technology early in the disablement process, in particular before the onset of severe cognitive impairment. By this means, the older user may be able to adapt easier to the technology in the longer run, even if cognitive decline happens at a later point in time, and there still remains room for precise adjustment on the part of the device concerning the user's specific competences or preferences.

The third principle of *proximal versus distal frames of evaluation* focuses on long-term benefits, considers risks regarding the entire lifespan and takes into account possible historical changes. Depending on the observation period, the evaluation may provoke different results. Nehmer et al. (2010) state, for instance, that the use of mobile navigation systems in automobiles can help people to reach their destination more efficiently and with less mental effort, allowing them to use their freed-up cognitive resources to have a conversation while driving. However, they also propose that the constant use of a navigation system leads to chronic disuse of navigational and spatial orientation skills that may be followed by possible decline in those abilities.

Following the three principles of Lindenberger et al.'s (2008) framework, the relation between support and challenge of technology can be improved with positive implications for everyday performance, participation and well-being. It is obvious that to use this opportunity in its full potential, close interdisciplinary collaboration between psychologists, engineers, computer scientists and geriatricians is needed.

Factors Influencing the Use and Acceptance of Technology

Attitudes Towards Technology Contrary to the widely spread opinion, older adults' attitude towards technology is relatively positive in general (Burdick and Kwon 2004; Czaja et al. 2001a; Mitzner et al. 2010). This is also the case for people with cognitive impairments (Hanson et al. 2007). Compared with younger ages, however, older adults reveal more problems and errors in learning a new technology and need more time to get used to new technologies (Czaja et al. 2006). Furthermore, they reported anxiety and frustration using technology more often (Rogers and Fisk 2010). Many of such problems of older adults can be overcome with adequate design and trainings though. The training should account for decreasing abilities and compensate them. As mentioned above, it is advisable for the acceptance and use of technology to introduce it as early as possible and to offer sufficient training. There is a variety of factors influencing the older adults' acceptance and use of technology. Some of these factors will be addressed in the following.

Experience with Technology Observing today's adolescents and even children dealing with technology shows that their technology handling seems to be "native" and the technology seems to be a natural part of their everyday life. In comparison, older adults' use of technology sometimes seems to be kind of burdensome. Such observation supports the notion that every generation was and will be influenced by a particular technological socialisation during their life course suggesting the usefulness of the concept of *technology generation* (Goor and Becker 2000; Sackmann and Weymann 1994). Only since the cohorts of those being born at the beginning of the 1960s, a "computer socialisation" has been a natural part of early-life development and education. Furthermore, factors such as the use of technology at the workspace have significant influence on the opportunity to gain experience with technology.

Costs and Benefits One of the key factors influencing the use or non-use of technology is the perceived benefit (Melenhorst and Bouwhuis 2004; Melenhorst et al. 2006). The benefits are opposed to the costs (e.g. need for training) and a decision to adopt a technology requires that the perceived advantages outrun the perceived disadvantages. In this context, Courtney (2008) was able to show that privacy issues can be a barrier to adopt technology. In the study, participants in residential care facilities were asked to discuss the adoption of smart home information technologies. They indicated privacy concerns about identity, information recipients, physical space and boundaries as well as shared information content. On the other hand, older adults seem to accept privacy limitations in some areas, if independence in their home could be maintained through the use of technology (Rogers and Fisk 2006; Rogers and Fisk

2010). As has also been found, technology will not be used by older adults, if no immediate positive consequences on quality of life are perceived (Day et al. 2001).

Design Assistive technological devices for older adults have been developed mainly in the area of rehabilitation. Using such technology may result in stigmatisation and discrimination and hence may lead to negative effects in technology use and acceptance. Therefore, an essential factor is the unobtrusiveness of a technological device, which plays a significant role in (negative) technology evaluations (Courtney 2008; Courtney et al. 2007; Davis and Venkatesh, 1996; Demiris et al. 2008). Going further, modern technological devices are equipped with small buttons and are operated via touch displays. Such features require an unfamiliar operation mode for many older adults and may thus become a barrier to use the technology. That is, good design for older adults should meet their needs and skills on the one hand and avoid stigmatisation at the other hand. To fulfil these requirements, and to repeat, the older end-user should be integrated in the processes of development and design from its very beginning (Blaschke et al. 2009; Rogers and Fisk 2010).

Person-Related Variables Numerous studies showed that the evaluation of technology is related to attitudes, needs, wishes, abilities and competencies of the user (Kearns et al. 2007; Mollenkopf and Kaspar 2004; Raappana et al. 2007; Sävenstedt et al. 2006; Sixsmith et al. 2007). For example, Scherer (2005) illustrated that the components of successful, effective and satisfied technology use resulted from a good match of device and support features, user goals and preferences and environmental resources. Furthermore, technology experience is positively related with a more favourable technology evaluation (Czaja and Sharit 1998; Melenhorst and Bouwhuis 2004). With respect to the acceptance of technology, Marcellini et al. (2000) also mentioned socio-demographic variables such as gender, education, health and social circumstances influencing the pre-disposition for technology. They examined the use and acceptance of ticket machines, automatic teller machines and telephone cards by older adults in four European regions and found that age was the most important explanatory factor for the three technologies, i.e. the users were mostly the "young-old". Furthermore, education was a more important variable than gender.

A Closer Look at Empirical Research on Ageing and Technology

A Glance on Research in Germany

The Sentha Project Historically, the interdisciplinary research project sentha (German title: "Seniorengerechte Technik im häuslichen Alltag") starting in the second half of the 1990s has been important for the development of technology and ageing research in Germany (e.g. Hampel et al. 1991; Mollenkopf 2002; Mollenkopf and Kaspar 2004; Mollenkopf et al. 2000). The project generally aimed at identifying technology difficulties and necessities of older adults in their everyday lives. For example, in a sub-project more than 1,400 persons aged 55 and older were assessed in a representative survey with regard to the role of technology enhancing quality of life. Concerning technology equipment, age was negatively correlated with possessing items such as a personal computer or a dishwasher. Most wishes referring to better usability were related to communication and information technologies. (e.g. Hampel et al. 1991; Mollenkopf et al. 2000).

The BETAGT Project The BETAGT project (German title: "Bewertung neuer Technologien durch Bewohner und Personal im Altenzentrum Grafenau der Paul Wilhelm von Keppler-Stiftung und Prüfung des Transfers ins häusliche Wohnen") funded by the Robert Bosch Foundation aimed at identifying the psycho-social consequences of the implementation and use of new technologies on residents and staff in an institutional care setting. In particular, the perception and use of a personal computer designed for older people as well as a computer-based care documentation system for staff were taken into account. The focus was on positive (well-being, quality of life, information) as well as negative (insecurity, handling problems) outcomes. To obtain a rather comprehensive picture of the effects of new technology, a mixed-methods approach (environmental setting analyses, external observational protocols, situational post-actional evaluations, classical questionnaires and in-depth interviews with technology stakeholders) was followed. Besides residents and staff, the assessment also addressed family members in order to get a more differentiated insight into the role of technology particularly among cognitively impaired residents. As expected, the results underlined that current cohort residents' life-long experience with technology was limited. Nevertheless, a positive attitude towards technology dominated the picture. Systematic observations revealed that the personal computer designed for older people was not used by residents in an unassisted way. However, engageing with the computer together with an occupational therapist seemed to give pleasure to the residents. The computer-based care documentation system was primarily used for data documentation. Compared with the traditional manual documentation procedure the computer-based care documentation system was rated to take less time and allowed for more efficacy. Findings generally supported the potential and limits of new technology in long-term care settings (Claßen et al. 2010).

The SenTra Project One of the more common behavioural manifestations of dementia-related disorders are severe problems with out-of-home mobility. It is not uncommon for people with dementia to get lost, or to be found seriously injured or dead. Various efforts have been made to attain a better understanding of mobility behaviour in case of dementia, but most studies are based on institutionalised persons. The interdiscinplinary project SenTra (abbreviation for "Senior Tracking") addresses the assessment of mobility in Alzheimer's disease, mild cognitive impairment and cognitively unimpaired participants by taking advantage of advanced GPS-based tracking technologies. The project is conducted in Germany as well as in Israel. Emerging findings support the assumption that dementia coincides with a narrower spatial activity pattern, whereas this seems not to be the case regarding mildly cognitive impaired and unimpaired older adults (Oswald et al. 2010). As was also found, tracking technology was rather well accepted by caregivers of demented older adults, while professionals raised more concerns (Landau et al. 2009).

A Glance on Other European and International Research

The MOBILATE Project The MOBILATE Project (Mollenkopf et al. 2004), conducted in five European countries (Germany, Finland, Hungary, Italy and the Netherlands) dealt with the purpose to enhance outdoor mobility in later life. It aimed at better understanding the interplay between personal competencies and coping efforts as well as aspects of the technological and social environment. To achieve these objectives, different data sources (urban vs. non-urban regions) and data-collection strategies (questionnaires and diaries, cross-sectional and follow-up, cross-country datasets) were combined. The results indicated that satisfaction with out-of-home mobility in older adults depends on a combination of personal and environmental (inclduing technology) aspects. Furthermore, the pre-conditions for mobility differed substantially between countries, age (particularly in very old age), gender, healthy and disabled persons, as well as urban and rural areas. The project's findings underscore the importance of integrating transport policy and urban as well as social planning.

The Project ElderGames Within the European project ElderGames, conducted in Spain, Norway and the United Kingdom, it was hypothesised that similar to children elderly people may profit by the effects of play. Motivating environments such as a special comfortable play table were developed targeting on the enhancement of cognitive, functional and social abilities of older people (Gamberini et al. 2006). The project aimed at promoting the digital inclusion of elderly people by means of the play activity with special focus on cognitive abilities. Furthermore, the various enhanced abilities were said to have positive effects on the quality of life. Another objective was to facilitate the communication between the older adults and their family members as well as to use the innovative play application to monitor quality-of-life-related variables and to transfer them to experts in elderly care and supervision. Thus, the application may be a tool for early diagnosis of cognitive disease or social unease. After several modifications, the developed play table and the online game were evaluated positively. Intergenerational game sessions were set up and yielded interesting applications. Moreover, the monitoring software led to satisfactory results.

North American Research The Center for Research and Education on Aging and Technology Enhancement (CREATE) was founded in 1999 as a consortium of the University of Miami, Florida State University and the Georgia Institute of Technology with funding provided by the National Institute on Aging. The center's major aim is to advance the existing knowledge and research in the field of ageing and technology and to disseminate established evidence into various contexts such as communities, industry and health services (Czaja et al. 2001a). Studies include the performance of older people in real-world settings with computers (Czaja and Sharit 1998; Czaja et al. 2001b), automatic teller machines (Rogers et al. 1997) or navigation tasks (Pak et al. 2008). Other projects provided guidance for the development of training programmes for older adults including telecommunications, home healthcare technologies, interactive databases and more (Mayhorn et al. 2004; Rogers et al. 2001;

Rogers et al. 2007). Furthermore, usability and design issues were systematically tested (Fisk et al. 2009; Mead et al. 2002; Nichols et al. 2006).

Asian Research The research group of Shibata at the National Institute of Advanced Industrial Science and Technology (AIST) in Japan has created the interactive robotic seal PARO. It is equipped with five kinds of sensors, which enables it to register tactile or auditory cues, for instance. Since 2003, the robotic seal is adopted primarily in institutional settings in Japan as well as in Europe. Studies indicate that the residents' interaction with the robotic pet leads to improved positive emotions and less depression (Shibata et al. 2004; Wada et al. 2005). As was also found, PARO strengthened social networking and reduced the residents' level of stress (Wada and Shibata 2006). In addition, the Japanese Bio-Mimetic Control Research Centre has developed the humanoid robot RI-MAN (derived from "Robot Interacting with Human"), which is aimed for use in nursing care. Similarly, RIBA ("Robot for Interactive Body Assistance") was developed by Tokai Rubbers Industries with the aim to assist personnel and patients at care facilities. This robot is capable of safely lifting and moving persons from bed to a wheelchair and back.

Outlook: Potential and Challenges of Technology for European Societies

European societies are particularly challenged by the coincidence of pronounced demographic change and a strong trend towards technological innovation also touching increasingly upon the older generation. Besides the post-retirement phase, which is normally addressed with the term "old age", the ageing and technology interactive dynamic and, hopefully, the cross-fertilisation of both trends can be expected to also play a key role in European's ageing labour force. The background is that a lot of concern has been raised in terms of losing innovative potential and competition power, if European's labour markets are growing older. On the other hand, technology may play an important role in the future towards compensating age-related functional loss and at the same time allow unfolding resources, which are particularly pronounced in older employees. For example, intelligent assistance systems may compensate for some of the age-related decline in information-processing capacity and working-memory function, which already happens between the age of 50 and 65. The *net resource release* (Lindenberger et al. 2008) of using such technology may be that older employees are able to invest more into "social mentoring", for example, advising younger employees in strategies of conflict resolution and planning a career pathway. Such optimistic views, nevertheless, require a lot of investment in focused education and training to further the older employees' capability to use technology in an efficient manner. To take this argument even further, European societies are challenged at large to invest into training opportunities in order to prevent what has been called "digital divide". That is, all efforts must be exerted to *include* Europe's older population into our societies' trends towards technology innovation. In addition, digital divide may also happen within the older population and there is a risk that the older "haves", i.e. those highly educated and well-equipped with other socio-structural resources, are increasingly divided from the "have-nots", i.e. those who have been disadvantaged because of low education, long phases of unemployment due to economic crises or migration background. It is clear that such dynamics also are shaped by the diversity of the 27 European member states, for example, in terms of economic wealth but also different cultural understanding what "good ageing" means.

After what has been said in the body of this chapter, it seems clear to us that technology has much to offer for European's future older adults. An important point in this regard also is that the emphasis of gerontechnology on the role of compensation, being of critical importance without any doubt for older adults and all kinds of rehabilitative efforts, increasingly moves towards stimulating, educative and emotional enhancing roles of technology products. The robot seal PARO is only one prototypical example of this trend with a focus on older adults with dementia and it seems that European societies can learn a lot in this regard from Asian societies, letting aside all the cultural differences, which are obviously there. Going further, technology such as the Internet has been empirically found to become a new resource for exerting agency such as health information seeking, learning and educational purposes, and cognitive and physical training activities (Charness and Boot 2009). In addition, new forms of attachment and emotional interchange between older adults (grandparents) with grandchildren seem to be linked with the new communication media (Quadrello et al. 2005). Research in this area underlining the potential of technology to elicit personal growth and not so much "only" compensation seems an important need of Europe's future gerontechnology research.

The limits of technology use and the ethical challenges coming with technology and ageing, nevertheless, deserve intensive discourse and future research efforts. For example, there has always been the temptation in technology history to overestimate the potential of technology. Translated to ageing, such temptation may support views that ageing is no longer among the key challenges of human existence, particularly in times of inflation of very old individuals. Furthermore, technology use with older adults comes with ethical dilemmas, for instance, in terms of privacy (sensor and tracking technology) and the balance between autonomy, dependence and manipulation (e.g. Who decides that a demented older adult uses a specific technology?). In many cases, technology is associated with conflicting means–ends relations. For example, the use of tracking technology in demented older adults may help family caregivers ("peace of mind"), but may also reduce some of the still available autonomy of the target person as well as may question standards of care in professionals (Landau et al. 2009).

Finally, there is reason to assume that the area of technology and ageing brings a substantial impetus to the growing *silver market* within Europe. That is, gerontechnology may in the longer run not only serve the quality of life of older adults as well as further European's ageing societies including the ageing workforce at large, but may become an important economic factor in itself (Kohlbacher and Hang 2011).

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Chapter 4
Dependence and Individualism: The Influence of Modern Ideologies on Older People's Food Security

Christina Fjellström and Ylva Mattsson Sydner

Introduction

The Healthy Older Person

Food is one of the most fundamental human needs. However, in modern consumer society, where food availability appears to be infinite, perceptions of food have come to focus on other values than sheer survival. If struggling to avoid starvation were the reality for most people in earlier times, overconsumption is the concern in modern times and also the wish to express one's identity through food and meals, which entails the possibility of making one's own choices. Not surprisingly, different generations attach different meanings to food, as is shown in a study on attitudes influencing food choices in the European Union (Lennernäs et al. 1997). However, the notion that food is important for people's health is seen among people of all ages, young as well as old, and thus has become a dominant discourse of today's consumer society (Lupton 1996; Sykes et al. 2004; Ristovski-Slijepcevic et al. 2008). Using a social constructionist perspective, Deborah Lupton (1996) discusses how the meaning and knowledge of food and health are formed by formal and informal education as well as by sensual embodied experiences and emotional states. Thus, the knowledge about a foodstuff, entailing whether it is healthy or unhealthy, she says, will influence the way people feel after they eat it (p. 85). People today are well aware of which foodstuffs fall under the categorization of healthy or unhealthy, and this is true also regarding the older generation.

In a study where 560 European senior citizens, aged 65–98, were interviewed about food and meals in everyday life, the wish to eat healthily was a prominent

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finding (Lundkvist et al. 2010). The phenomenon was presented in the narratives as a fear of causing illness by not eating healthily enough, thus a concern for oneself, but it was also narrated as a responsibility not to cause illness. Reading between the lines, this latter concern could be interpreted as not wishing to be a burden to society. In the discourse analyses of the European Commission's Health Promotion Programme 1996–2000, the authors conclude that there has been a shift in blame in "recent health policy" from the individual to the collective (Sykes et al. 2004). In the interview study with 560 senior citizens in Europe this discourse was not seen; they rather conveyed that the blame for becoming sick lies with the individual and thus said, such as this woman from Germany, for example: "But then I say, if I take too much fat or live too unhealthily, like eat too much, it could lead to complications like a stroke or something like that, then I'd have a guilty conscience" (Lundkvist et al. 2010). The discourse on health thus involves consumers' taking individual responsibility for this issue (Turner 1996).

Individualism and Collectivism

Warde (1997) discusses how the development of informalization in society increases self-regulation, self-discipline, and self-control of the body to maintain health. Trying to be responsible for one's health and body could therefore be seen as a heightened degree of individualization. The concept of individualism and collectivism has engaged scholars for many years, and one of the more influential researchers in this area is Hofstede (1980, 1991). Individualism, according to Hofstede, stands for a society where everyone is expected to look after oneself, while collectivism stands for a society in which people from newborn onward are integrated into strong cohesive ingroups. Triandis et al. (1990) widened the concepts and also discussed their consequences. They point out that cultures that shifts toward becoming more individualistic tend to be characterized by affluence, cultural complexity, migration, and urbanism, and the consequences of this will be socialization for self-reliance and independency, but also loneliness as a result of loss of social networks. Collectivism is associated with ingroups—which they define as "a group which shares a common fate," and these are socialized for obedience and duty, social support, and interdependency.

Individualism is thus highly associated with independency and expects the individuals to be responsible for his or her own fate, body, and health, while collectivism stands for groups of people, mostly only one ingroup sharing the same fate, and where the group defines social norms and where dependency is a more dominant feature than in individualistic cultures. Triandis et al. (1988) argue that this is to present an oversimplified picture and that individualism and collectivism should be seen as multidimensional constructs and more as a continuum rather than a dichotomy. Despite a broader view of the concepts, it is clear that modern consumer society is influenced by an ideology where individualism goes hand in hand with independency and collectivism with dependency, respectively.

Dependency Versus Independency: A Theoretical Introduction

The notion of independency versus dependency is particularly discussed in relation to an aging population. The current demographic trend in the western world with increasing number of older people living longer than before has developed into a problem that is being addressed in many different arenas, the main issue of which is not only if the aging population can manage everyday life by themselves, but also if they want to manage by themselves. An illustration of this, particularly in relation to food in everyday life, was the name given to the EU project mentioned above: "Food in later life. Choosing foods, eating meals: sustaining independency and quality of life." This was also the key issue addressed by the senior population in Europe; they expressed a strong desire to manage by themselves (Lundkvist et al. 2010).

The concept of being dependent versus independent is central to research on aging, older people, life course perspectives (Stabell et al. 2004; Baltes 1996; Hareven 1995; Featherstone and Wernick 1995; Hockey and James 1993; Munnics and vanden Heuvel 1976) and has attracted the attention of researchers in different disciplines, such as medicine, sociology, psychiatry, and anthropology (Baltes 1996). According to historians such as Thane, the desire to maintain one's independence and manage in everyday life for oneself has been the ultimate goal for old people as far back in history as this can be traced (Thane 2000). Even though people of all ages are more or less dependent on each other and there is a chance that at any time during the life course a person can become totally dependent on others, the expression particularly is associated with aging (Hockey and James 1993). One explanation is that the aging in fact involves physiological changes, and at one time or another, this implies for the vast majority of aging people at one stage or another, limitations in physical functions, perhaps even mental functions will occur. This means that other people may need to take over various activities of daily living for the aging person; for example, food work (see definition by Bove et al. 2003: planning menus, shopping for food, and prepare meals). To rely on others because of chronic diseases is by Nettleton (2006 p. 71) being described as being in a biophysical situation which at the same time has significant social consequences. Thus it is the old person's biophysical situation of frailness and sickness related to the aging that force her or him to become more or less dependent.

To consider dependency as an inevitable part of aging, however, is questioned by many researchers as deterministic, emphasizing the social construction of old age rather than shortcomings in society that limit old people to be independent (Baltes 1996). She also argues that when older people become aware of restrictions in their own capacity, and they realize that the environment will limit their possibilities in everyday life, automatically both the selection and compensation of behaviors and activities will take place. Baltes also believes that this phenomenon makes older people experience dependency differently compared to those that are not restricted in everyday life. This was also noted among older people in Europe, who declared that continuous development of adaptations and new strategies in everyday life made the feeling of dependency decline (Sydner et al. 2007). It should be mentioned that the persons who participated in this study were relatively healthy and able to manage their food and meals on a daily basis without any major setback from previous routines and habits. However, when a person needs to take on a totally new role associated with food work problems will arise, as in a study among spouses to patients diagnosed with Alzheimer's disease (Fjellström et al. 2010). The wives of the men who were sick were still able to be good food providers, considering the new situation, yet all men but one whose spouses were sick expressed great concern. These men were inexperienced cooks and expressed in their narratives how taking on the new role as food provider had caused them great anxiety. It even could be interpreted in their stories that their spouse was at risk of not having optimal food intake because of their lack of knowledge. They wanted to give their spouses the food they liked, but they did not know how to achieve that, so the men's own food preferences ruled. The men also complained how little help they had got from the health care system.

Food Security and Personal Abilities

As long as free-living ageing persons manage without problems to perform everyday food work, their nutritional status is likely to be better than among those with disabilities or other issues that limit them. In a study by Gustafsson et al. (2002, 2003 i.e publications by Gustafsson et al. is from 2002 and 2003) it was shown how embedded ideals of the importance of cooking from scratch resulted in deficient energy or nutrient intake. The reason for these women to push their limits and try to cope themselves—when support was actually needed—was that they did not want to be dependent on others. It could thus be said that the construct of the older housewife and cook, who should and must care for herself, can create a problem related to nutrition and health. Both these women and the women with dementia (Fjellström et al. 2010) could be regarded as not having food security. The concept of food security is useful to describe and discuss how any kind of dependency concerning food affects an individual in relation to support and care. The concept and the definitions of food security vary, as do ideas regarding how it can be used in studies (Pinstrup-Andersen 2009). FAO (1996) declare that food security implies economic and physical access to nutritious and safe food that meets people's dietary needs and preferences and promotes an active and healthy life. An even more holistic definition of food security is used by Germov and Williams (2004) who defines food security as "the availability of affordable, nutritious and culturally acceptable food." For someone who is dependent in everyday life, food security needs to be the responsibility of someone else. This someone else could be a significant others in civil life, the market, and/or the welfare state.

Warde (1997) writes that ". . . changes in the organization of food provisioning in households have encouraged individualizations" (p. 181) and relates this to full-time gainful employment among women, which has made people in a household cook for themselves more today than before. People are thus more likely to make personal and individualized choices today as opposed to joint family decisions. The joint family decision between the man and the woman on what food to prepare and eat was one of the things particularly missed by the wives of the men diagnosed with dementia from before they became sick (Fjellström et al. 2010). The women usually knew what their husband liked because they had always been responsible for the food and meals, yet they had tried to do it as joint social activity. The lack of a joint family decision in the household where the women were diagnosed with dementia had become more of a food security issue among the women diagnosed with dementia because the men taking on the new role as food provider did not know what the women liked or preferred. Thus food security can be difficult to achieve if a person is dependent on someone else and if that person is unaware of the food chosen is culturally accepted by the person that is dependent. According to Pinstrup-Andersen (2009), this should be understood and referred to as an individual's or a household's preferences of commonly used everyday food, not exceptional or extravagant food. Yet, food security and independency must be seen in the light of what is achievable in a society, considering both the individual's rights and the responsibilities of the collective as in the welfare state. Despite the fact that most people would like to have control of their own lives, the society is obliged to care for its citizens. Ultimately it becomes a question of autonomy versus security. How much independence should and is possible to give a person, which in fact needs assistance and support without compromising the security of her/his life? The question posed here has been shown to cause a dilemma among persons with intellectual disabilities and food in everyday life (Adolfsson et al. 2010). They are encouraged to be independent, yet their freedom to choose foods and meals—and not having enough insights in food and health issues—endanger their health. This dilemma can have undesirable effects on health and quality of life in these people's daily life.

Perceptions on Informal and Formal Care

In an Australian study where older men and women with home-help service reflected on the meaning of being independent, certain key issues were put forward (Plath 2008). Being independent entailed managing to do things yourself and to decide by yourself what you want to do. Furthermore, it assumed that you still retained your physical and mental capacity and have sufficient resources to do what you want to do, and that you have social status and self-confidence (Plath 2008). Also in interviews comparing older Thais and Australians, physical capacity was one of the most important issues when discussing old age as a symbol of maintaining your independence (Fox 2005). The informants in Fox's study kept coming back to differences between formal and informal care. For the Australian older person, the formal elderly care organization was particularly associated with becoming dependent, although there were some that were grateful for the help they received in the nursing homes. In old age, Thai people mostly live with their children, who are expected to take care of their old parents. Many of the senior citizens expressed delight that they no longer worry about everyday life—they had left their lives in the hands of someone else. In this informal care setting, however, losing your freedom and ability to decide for yourself was also discussed, as for example the old man whose son and daughter-in-law took all the food he had bought for himself, without asking him.

It is evident that the perceptions of old age and dependence may vary in different cultures, but in contemporary studies, it often appears that older people want to care for themselves as long as possible, but also fear the day when they have to let go and let someone else take over. According to psychologists, the fear of becoming dependent on others when you get old is based on the perception that one's needs in life have not or will not be fulfilled (Garner 2008). This is an issue that must be addressed in both informal and formal elderly care. In Sweden, the formal elderly care has been on the agenda for many decades.

Support and the Welfare State: The Swedish Example

The Welfare State

The concept of a welfare state is usually equated with some sort of security for its citizen when in need of help. How this help should be given is valued differently in different cultures, for example as formal (public) or informal (family) help. In Esping-Andersen's (1990) model, three 'regimes' are used to discuss how welfare production is allocated between state, market, and household in various European countries, and although his model has been criticized, it is still used (Sipilä 1997; Warburton and Grassman 2011). Of the three regimes—the liberal welfare regime, the conservative welfare regime, the sociodemocratic welfare regime—the last one is representative of Sweden. The majority of health care and social services such as elderly care in the sociodemocratic welfare regime are organized and financed by public taxation (Larsson and Bäck 2008, p. 15 and 259; Hofstede 1996). This regime also has, among other things, been characterized by, a high degree of "de-familisation," which means that an adult (an old person) can uphold a socially acceptable standard of living without having to involve the relationship of the family by making use of established security provisions (Warburton et al. 2011; Bambra 2007). According to Bambra's cluster analyses of welfare regimes in 21 countries, Sweden was part of a social democrat welfare regime, and together with Norway, constituted the very core ideology of a welfare regime associated with de-familisation. In other words, Swedish citizens are supported by income protection when specific needs arise, and these grants are designed as social rights. Concerning elderly care, the Swedish Parliament and Government set up laws and regulations, by which different ministries, agencies, and boards supervise and control the organisation. However, the actual supervision is preformed at the local level, i.e. the municipalities, in relation to those laws and regulations (Mattsson Sydner and Fjellström 2007). In Sweden, as in other countries, old people in need of care and support represent a heterogeneous group in terms of problems and needs. Regarding food provision, the need for help ranges from minor actions or arrangements in a person's everyday life to very significant interventions, help, and support. Examples of minor actions might be to arrange common meals in formal elderly care settings to break the isolation of eating in one's own room or by the bed. It could also be delivery of food to those that still are free living but can no longer manage food work on their own. Efforts such as these could thus be of great significance to maintain health and prevent illness among old people in need of support.

Extensive efforts, however, are needed for those individuals that, for example, cannot eat by themselves because they are physically or mentally disabled. The actions that are needed in these situations vary depending on whether they are intended to support relatively good health, slow down a worsening condition, or "merely" serve as an important aspect of a person's quality of life. In all Swedish municipalities we see a higher proportion of older people in the population, and accordingly the responsibility for elderly with an extensive need of care has also increased, which calls for multifaceted strategies. Trydegård and Thorslund (2001) argue that there is no single typical "Swedish welfare model" for the elderly, neither in terms of home care nor related to institutional-based care. They consider that it is more accurate to describe the situation with the term 'welfare municipalities' than to speak of a unified welfare state. Therefore it is important to point out that even if the responsibility for care of old dependent people lies with different decision levels such as a central, regional, and local, the municipalities (the local level) are the ones that are in charge of the daily care such as providing food and meals (Mattsson Sydner and Fjellström 2007). The ways the municipalities organize this vary, as do the resources they use for this purpose (National Food Administration and National Institute of Public Health 2005).

Shifts in Welfare Ideologies

Gustavsson (1996, p. 47) stresses that the structure and organization of the elderly care in the public sector in different countries is at any given time a complex result of many different factors. Historical traditions in the broadest sense, economic development and growth, political structure and mobilization, dominant ideologies, and the degree of cultural and political homogeneity/heterogeneity are therefore all important factors in the development of the social construction of elderly care in the public sector as part of the welfare state. Yet, the welfare state is represented foremost by its administrative organization and structure, which is why it is important to recognize this "body" of the state as a social construction, including the organization and administration of elderly care. During the last few decades, the Swedish welfare state has gone from representing expansive and largely centrally controlled welfare programs with a strong reliance on rational solutions in the 1960s to being replaced by a notion that decentralization is the solution of upholding the welfare state. According to Nygren et al. (1997) we can see a clear ideological and political change in the public sector from the 1970s and thereafter, including welfare targets such as care for children and care for elderly persons. From that point on, the focus of actions within these areas aimed at developing social services instead of focusing primarily on care and treatment. Furthermore, as part of these ideological changes, a new phraseology was introduced, which meant for example that words like "patient" and "client" were changed to "customer." Reasons for this shift could be explained by financial problems in the welfare state, for example (Government Official Reports 1996:163 S. 251ff), yet it was a significant reorientation toward belief in the market and the individual's own choice. Thus it can be argued that the Swedish welfare state included the notion of the modern consumer society that the individual's choice of lifestyle constructs his or her identity and gives meaning to everyday life, and thus promoted the ideology of individualism.

We can also conclude that the implication of this process from a more collectivistic to an individualistic discourse has been a shift from state governmental management, and thus everyday control, of each and every local government to a structure in which the state controls its local organizations by a framework in which the instruments constitute general principles, guidelines, and objectives.

The Capable Older Customer: A New Rhetoric

The rhetoric and language have changed accordingly, with the development of new discourses and constructs of meanings attached to food and meals. Szebehely (2000, S. 172) discusses how language within the public sector has become market-influenced. She relates language change to the elderly and writes that "frail older persons have come to be regarded as customers in the market for caring", where social care services instead have been transformed into a product as in "attendance" or "hygiene." The process of a market-oriented language in caring is furthermore pointed out by Wærness (1996, p. 214), who explains the phenomenon by a growing demand for efficiency and user influence. Also Lindqvist and Borell (1998) argue that the decentralization that occurred in the public meal sector is associated with the wish for "customization," which entailed that decision-making should be closer to the citizen. This development in the public meal sector could be seen as an attempt to reconcile the language and ideologies that were dominant in the earlier centralized and collectively formed public meal sector with the "new ideology" that focuses on the individual (Mattsson Sydner 2002). Thus a new construct of the public meal sector was emerging, mixing collectivism and individualism.

Strategies to Handle Meals in the Welfare State Characterized by De-Familisation

The social transformation that occurred during the development of the welfare state has meant that a significant proportion of the population's diet have been transferred from the home's private sphere to public institutions. Meals in the public sector, as nursing homes, schools, and hospitals, are in contrast with both the commercial meal in the restaurant industry and the private dinner at home. Menell et al. (1992, S. 112) points out that the meal at home can be seen as a sphere characterized by a personal, private, and intimate aspects and that various forms of institutions somehow needs to be a replacement for those aspects. Thus the reorientation of elderly care during the 1990s, from hospitals and institution to special housings, entailed a focus on a home-like environment (Government Bill 1990/1991:14, Government Bill 1997/1998).

However, food and meals in the public sector, in Sweden and elsewhere in western society have largely been characterized by rational efficiency associated with industrial production, more than a meal associated with the intimacy of a home. The quest for efficiency, as in developing methods to measure and calculate all areas, and to foresee and systematically organize the work, has greatly influenced the public meal —and particularly a great faith in medical science (nutrition and health) has been stressed when talking about food and the public meal (Hirdman 1983; Lupton 1996; Beardsworth and Keil 1997). In relation to the public meal, there has been an ideological shift toward a "marketization", which follows the ideological and political change in the welfare state described by Nygren et al. (1997).

Documents developed to support meals in the public sector were mainly focused on the nutritional content of the food (Stockholm County Council in 1987; National Food Administration in 1991; Karlstrom et al. 1998). The guidelines that have been applied in the elderly care context have largely been based on research related to nutritional status, while other aspects of food and meals are based on experiential knowledge. According to Ekström (1993), the emphasis on nutritional recommendations in the public meals sector is a form of meal ideology regarding what is perceived as the proper values regarding food and meals. As we have discussed earlier in this chapter, this would thus be a construction of what food should prevail; it focuses on nutrients rather than social or gastronomic aspects, for example. Ekström argues that in Sweden there are norms for what food policy, food groups, and composition of food and nutrients to apply in the public meal sector. These standards are foremost associated with beliefs among experts on diet and nutrition, i.e. those who work with information in this area in the welfare state. Ekström points out that to some extent this ideology on food and nutrition is in contrast to the food culture developed by people in their everyday lives. As pointed out earlier, to neglect people's food culture could affect food security, especially for those in need of help and support. In a recent official government document (National Board of Health and Welfare 2007), it was emphasized that authorities were directed to develop the quality of food and nutrition issues in elderly care. This work resulted in official guidelines from both the National Food Administration and the National Board of Health and Welfare, who now stressed the importance of social and cultural aspects of food and meals, not only nutritional values.

From Collective Feeding to Market Oriented Food Provision: A Dilemma of Shifting Ideologies

Meal provision in the public sector in Sweden has thus changed during the last few decades from collective feeding to a situation where meals are a matter of individual choice, preferably in a restaurant-like environment. If the restaurant environment has not been realistic to achieve, a “home-like environment” in care settings for the elderly and disabled has been highlighted as desirable (Government Bill 1997/1998:113, p. 49). However, in practice, there is no restaurant environment that offers free choices from a menu to school children, preschool children, or older persons in elderly care. The present discourse advocates a consumer driven by free choices rather than being fed food as part of a collective, including the norms of the group, which could be equality for all—the same food for all.

The shift in ideology described shows a dilemma in which ambivalence related to what social construction the welfare society should symbolize—the individual or a collective identity. Eliasson (1996) highlights the importance of being able to see people both as a “subject” and as “objects,” i.e. people should be seen both as individuals and part of a collective, and both are dependent on others. She argues that seeing persons as either “subjects” or “objects” is to express a “half of humanity” ideology. Eliasson discusses how traditional institutional care has been criticized for its perception focusing on people as objects, meaning the staff/professionals within the institutions were experts and guardians in relation to those who received care. She also argues that to consider humans as only subjects, i.e. people are individuals with the freedom of choice to do whatever they like, is also to express a “half of humanity” ideology, meaning we do not have to be responsible for taking care of others. A strong emphasis on individualization and autonomy can thus lead to a kind of abdication of responsibility for others, even within the social care framework—which is based on the structure of collectivism.

Contemporary society, where older people seem to pursue the wish to be independent, perhaps has to do with the development of the individualistic consumer society where everyone is expected to make his/her own conscious choices. On the other hand, people are also encouraged by the consumer society, the collective, to be responsible citizens and take good care of their bodies, protect their own health in order to not to burden the society, which nevertheless can lead to feelings of guilt (Lundkvist et al 2010; Warde 1997). A part of the organizational change in Sweden has resulted in a shift from a focus on home-help service for social and domestic duties to home healthcare, with a focus on medical care. The effect has been that a large proportion of the elderly population do not have any form of support at all from municipal elderly care, a fact underlined in the Elderly Mission Final Report, which indicates that many municipalities now have restrictive distribution of home care (National Board of Health and Welfare 2000). We argue that also this situation will affect the old person’s food security. Szebehely (2000) stated as early as 2000 that we were witnessing a period that was characterized by public rhetoric that emphasizes the individual’s own responsibility. She stressed that older people are encouraged to cope on their own as long as possible, and when they cannot manage any longer, they are forced to take the initiative themselves to get help. Thus individualization with a focus on freedom of choice is discussed by Svedberg Nilsson (2000: 235 ff) who believes that the phenomenon is based on economic ideals that have grown strong since the 1980s.

In this social construction of how people in modern society should perceive themselves—as an individual, independent consumer who is free to chose whatever food they want—stands in sharp contrast to how society has collectively solved issues regarding food and meals. However, this social construction is influencing society as a whole, not least the official authorities, who, as we have shown earlier in this chapter, now have included in their guidelines the importance of individual solutions and seeing old persons as a subject and not only as an object. The work with food and meals for care-dependent individuals has been shown in different studies to be problematic regarding food, meals, and nutritional quality (Mattsson Sydner 2002; Saletti 2007). Today national guidelines are published by the National Food Administration and the National Board of Health and Welfare, and there is political interest in the subject. However, little is known about the effect food and meals have on the everyday life for old people who are dependent, but sometimes media reports about lunch boxes delivered by the municipalities' kitchens that no one will eat or that old people are charged extra if they want jam with their breakfast porridge. Harnett (2010) uses the concept of a "policy-practice gap" that is applicable also here. It is difficult to turn policies into practice. The benevolence of the authorities is clear. However, is it realistic to achieve? The real challenge is to reach an elderly-care organization for food service that can bring together collectivistic solutions with individualistic wishes and incorporate both a physiological appetite (physiological needs related to food and meals) with a social appetite (social and cultural needs related to food and meals) without jeopardizing the food security of older people.

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Chapter 5
European Older Adults' Social Activity Networks in National Context: A Cross-National Exploration of National Cultural, Policy, and Economic Characteristics

Christine A. Mair

Previous sociological and gerontological research documents the benefit of social ties for older adults. By integrating literature on linked lives, activity theory, and social networks, I suggest the concept of a "social activity network" (SAN), which is a broad network, composed of activity-related ties and family network ties. Studies of older adults' social activity networks cross-nationally reveal regional and national differences. Scholars suggest that variation in older adults' ties may reflect cultural, economic, and policy differences between nations. Few studies, however, have specifically examined the potential contextualizing role of national culture and economy/policy using empirical cross-national measures. In this chapter, I combine data from six sources including the Survey of Health, Ageing, and Retirement in Europe (SHARE), World Values Survey (WVS), European Values Study (EVS), Organization for Economic Cooperation and Development (OECD), World Bank (WB), and United Nations (UN). Utilizing this unique combination of data, I empirically document cross-national patterns in social activity networks in Europe and discuss the implications of national measures for the study of older adults' social lives.

Linked Lives

Linked Lives and Activity

Older adults' social lives are an important component of healthy aging. The life course perspective's principle of "linked lives" emphasizes the importance of family, friends, acquaintances, and other relationships across the life span (Elder 1985). Family network ties, such as spouses or adult children, can serve as an important system of emotional, functional, and financial support (Hareven 2001). Historically, the family network represents the primary source of elder care. Although not all family

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ties are supportive (Wellman 1981), lacking a family network may be a social and health risk factor for older adults.

Family network ties, however, are not the only social linkage of importance for older adults. Although a majority of studies on linked lives tend to focus on family, the life course perspective's conceptualization of linked lives is explicitly inclusive and, by definition, includes a range of tie types. Friend ties, for example, may provide resources such as social support or social integration. A broad approach to social ties is particularly useful for the study of older adults' social relationships, as mounting empirical evidence suggests that networks with multiple tie types are linked to older adults' well-being (Litwin 2001, 2007). Gerontological literature explores the role of nonfamily ties through activity theory, which posits that participation in groups, events, and organizations is advantageous to well-being (Havighurst 1957; Maddox 1963). Empirical tests of the theory find that activity is most beneficial when it occurs with high quality informal, friend ties (Lemon et al. 1972; Litwin and Shiovitz-Ezra 2006; Longino and Kart 1982). Thus, I conceptualize activity participation as yielding the potential for social ties. Jointly, activity-related ties and family network ties compose a "social activity network" (SAN).

The Social Activity Network: Activity-Related Ties and Family Network Tie Availability

The basic unit of SAN is a social tie, which is embedded in a larger set of social relationships that can include family, friends, neighbors, acquaintances, or other affiliations formed through informal and formal interactions across the life course. Therefore, a SAN is composed of two types of ties: (1) activity-related ties (which capture ties formed through informal and formal participation in groups, events, organizations, etc., which may also include activities with kin) and (2) family-network ties (which are kin-based ties such as partners/spouses, children, etc.). The concept of a SAN is similar to a general social network, yet it does not focus on work-based ties and directly incorporates a consideration of activity participation. Further, although a SAN may yield beneficial social resources such as emotional support, this is not an inherent quality of the SAN (e.g., unlike the "convoy model" based on confidant relationships, Kahn and Antonucci 1980). Finally, a SAN does not exemplify an explicit network composition typology, as such configurations are thoroughly explored elsewhere (e.g., Litwin and Shiovitz-Ezra 2006). Rather, a social activity network is a wide-ranging, fluid, social opportunity structure with the *potential* to facilitate social engagement, integration, and support across the life course from multiple kin and non-kin-based sources. This broad conceptualization of a SAN is an intentional decision that acts as a starting point for an exploratory study of the extent to which activity engagement and family support availability vary within a range of cultural and economic contexts in Europe.

Social Activity Networks Cross-Nationally

Few studies examine SAN-like ties cross-nationally and those that do find regional distinctions. For example, studies report distinct north–south differences across Europe. Individuals in Southern/Mediterranean Europe place a higher value on family network ties (Alber and Kohler 2004; Kalmijn and Saraceno 2008). Older adults in Mediterranean nations have more frequent interaction with children, live closer to children (Litwin 2010), and provide more family support (Lowenstein and Daatland 2006). Older adults in non-Mediterranean, Northern nations participate in more activities (Hank and Stuck 2008; Litwin 2010), such as volunteering (Erlinghagen and Hank 2006). The general north–south divide noted by these scholars is observed in other studies of European older adults (e.g., Albertini et al. 2007; Attias-Donfut et al. 2005; Hank 2007; Ploubidis and Grundy 2009).

Despite sharing a continent, the nations of Europe experienced different historical trajectories, which have led to path-dependent divergent development. Previous studies of SAN-like ties with the Survey of Health, Ageing, and Retirement in Europe suggest cultural differences between the family-oriented South and the non-family-oriented North (e.g., Litwin 2010; Hank 2007). Macro-level examinations of the state and the family in the lives of older adults point to the role of economic/policy differences across regions, such as welfare state type and global development (Bengtson et al. 2000; Bengtson and Lowenstein 2003; Blome et al. 2009).

Although these authors note cultural and economic differences between nations, very few studies empirically test the extent to which nation-level measures account for this variation. A focus on the north–south divide illustrates general patterns, yet it is a crude characterization of key differences in historical, cultural, economic, and political national contexts in Europe. There are many nations that do not fit neatly into region-based comparison. Ireland, for example, is classified by the United Nations as a Northern European nation, yet shares many similarities with Western Europe. Ireland also experienced a tumultuous relationship with the United Kingdom, which led to a trajectory of periodic political turmoil and slowed economic growth for nearly all of the 20th century, unlike many nations in Western and Northern Europe (Murphy 2000). There are similar examples of regional outliers in Southern Europe. For example, although Spain and Italy are both Southern European nations with a cultural emphasis on familism, Italy has a stronger public pension system, which may influence older adults' choices about their social ties in later life. Very few studies, however, have empirically explored beyond region to examine the role of specific national characteristics in shaping patterns of activity-related ties and family network ties cross-nationally (for family-based studies, see Katz et al. 2003; Leira 1999). I address this gap in the literature by documenting the historical context behind these differences, hypothesizing patterns, and exploring in-depth descriptive and bivariate patterns cross-nationally. To do so, I take advantage of the extensive availability of cross-national nation-level data, in combination with cross-national individual-level data from sources such as SHARE, to create a unique dataset that assesses cross-national variation in older adults' SAN ties.

Historical Time and Place

Although cultural, policy, and economic differences existed throughout Europe historically, the World wars and the Cold War of the last century played a recent and direct role in the modern manifestations of Europe. I draw upon the life course's emphasis on historical time and place, which encourages scholars to consider individuals' life course trajectories as inseparably embedded within geographic locations and time periods (Elder 1995; Elder et al. 2003; George 2003). Historical events (e.g., World wars) and spatial conditions (e.g., proximity to other nations) contextualize culture, policy, economics, and individuals' social lives (Berkman et al. 2000; Uhlenberg and Mueller 2003).

Older adults surveyed in SHARE were born between 1905 and 1956 and thus their lives are conditioned by a tumultuous period in European history. Following the two World wars, distinctions emerged in Europe along regional lines, resulting in a war-torn Western Europe, a Communist Eastern Europe, economic disadvantage in Southern Europe, and continued neutrality in the North (Bradshaw and Wallace 1996; Chirot 1977). These regional distinctions, however, mask important cross-national variation, as each country played a different role in the conflicts and outcome of the wars (Chirot 1977). Modern-day Germany, Austria, Czech Republic, and parts of Poland were economically disadvantaged after WWI and WWII. This created more permanent divisions across Europe and within nations as communist rule persisted in East Germany, Czech Republic, and Poland until the 1980s. Thus, Eastern Europe is shaped by its communist history and the economic disadvantage resulting from isolation from the capitalist economic development occurring elsewhere in Europe. On the other hand, much of Western and Northern Europe prospered after WWII. West Germany, France, Austria, Belgium, and Denmark emerged relatively economically sound. Neutral Switzerland and Sweden remained stable and were able to develop well-funded social safety nets. Southern Europe and Ireland, however, experienced decades of within-nation post-WWII conflict and thus were also isolated from the booming prosperity of Western and Northern Europe for many decades.

National Culture and Policy/Economics

Traditional Familism and Secular Individualism

Europeans are embedded within cultural traditions that stem from historic religious and political differences (Beugelsdijk et al. 2006; Inglehart and Baker 2000). Using historical and cross-national data on a range of cultural values, global development scholars identify enduring global "cultural zones" (Inglehart and Baker 2000; Inglehart and Welzel 2005), such as Catholic Orthodox, Ex-Communist, and Protestant Europe. Inglehart and Baker (2000) postulate that individuals in traditionally Catholic nations (Southern Europe) and Post-Communist Europe (Eastern Europe) demonstrate stronger support for traditional, survival-oriented values that emphasize religiosity, national pride, respect for authority, conservative family views, and a deemphasis on independence (Inglehart and Welzel 2005). Familism, or a cultural emphasis on the precedence of the family over individuals, is an aspect of traditional culture. Although the family was historically the primary support system for older adults across multiple continents (Bengtson et al. 2000), contemporary studies suggest that familism is most common in Southern Europe (Katz et al. 2003). Focusing on regional trends, however, ignores variation within regions. Greece, for example, despite a Catholic history and strong familistic values, is ranked similar to Switzerland in terms of nontraditional values (Inglehart and Welzel 2005). Similarly, the Czech Republic shares a family-based orientation with Poland yet nontraditional views more similar to Germany.

At the other end of the cultural spectrum are nations that emphasize secular and self-expressive values (Inglehart and Baker 2000; Inglehart and Welzel 2005). Secular values place a lower emphasis on religiosity, national pride, and traditional family views while self-expressive values endorse individual liberty and choice, willingness to sign political petitions, and other similar values (Inglehart and Welzel 2005). These nations are also more likely to emphasize the importance of non-family ties, such as friends. Inglehart and Baker (2000) find that more secular, individualistic cultural values are common in the "Protestant Europe" cultural zone. This cultural zone includes Western and Northern European nations such as Germany, the Netherlands, Switzerland, Sweden, and Denmark. Yet, the existence of secular, individualistic values is not purely due to Protestant heritage. They identify a wide-scale, global cultural shift toward these values, which they attribute to economic development. Yet again, regional characterizations mask within-region diversity. Although the North is considered the least familistic, Ireland's Catholic traditions yield conservative views on the family (Inglehart and Welzel 2005). Germany shares a secular Protestant orientation with Western Europe, yet has the lowest self-expressive values in the region and shares survival-oriented values comparable to Greece and the Czech Republic.

Welfare State Generosity and Development

Cultural differences are intertwined with material considerations such as welfare state policies and economic development. These factors are important for study of older adults' social activity networks because they are associated with standard of living and support resources. Both welfare state provisions and economic development establish a minimum standard of living for older adults, which is particularly important if an individual lacks financial support or family network tie availability. Esping-Andersen's (1990) typology of welfare states attempts to capture development-based divergence, classifying nations into three "Worlds": Liberal (e.g., Switzerland), Conservative (e.g., Austria, Belgium, Germany, France, and Italy), and Social Democratic (e.g., Denmark, Netherlands, and Sweden). Northern and Western Europe's postwar economic advantage permitted the establishment of strong policies to protect against poor health and poverty. Wealthier nations, however, do not always spend more on state-based supports. For example, a number of wealthy European nations recently transitioned towards privatized pension systems (e.g., Denmark; Anderson 2004) yet still maintain strong public health systems.

Esping-Andersen (1990) did not classify Southern and Eastern European nations in his welfare state typology because of their unique features (with the exception of Italy; see also Ahlquist and Breunig 2009). Postwar disadvantage in these nations inhibited state development. Welfare state generosity relies on strong state-based funding fueled by a productive labor force, both of which are more common in highly developed nations. Southern Europe still maintains strong public pensions but has weaker public health systems. Whereas some Northern and Western nations privatize their systems to offset costs to the state (e.g., Denmark), this is a privilege of national wealth that Southern and Eastern Europe (e.g., Greece and Poland) do not necessarily possess. Therefore, I also consider national wealth and economic development. Although all European Union nations are "fully developed" by global standards, their divergent histories led to economic and policy-based diversity that likely shapes activity opportunities and support availability.

Research Questions and Hypotheses

Considering cross-national variation in social activity networks, I ask the following questions: To what extent do older adults' SAN ties vary across Europe? Do national culture and policy/economic characteristics offer insight into SAN variation in Europe? What are the implications of these findings for future empirical cross-national studies of older adults' social lives? Because of the divergent cultural and policy/economic-based diversity across Europe, however, I anticipate that cross-national differences in older adults' SAN ties are partially explained by national characteristics. More traditional cultures, for example, place stronger emphasis on the family. Therefore, my first hypothesis is that there is an association between traditional, familistic values and higher utilization of family network ties. Second, I also hypothesize an association between secular, self-expressive values and a stronger emphasis on affiliations of choice, such as activity-related ties. Financial support is also an important consideration as individuals age. State-based provisions, such as welfare generosity, may offer additional support to older adults, making individuals less likely to provide or receive care from their SAN ties. Thus, my third hypothesis is that welfare state generosity is associated with a lower proportion of older adults caring for a sick/disabled adult or with proximal children. Welfare state generosity, however, is intricately linked to the state's capacity to provide funds. More economically developed nations have more resources (public or private) and more opportunities for activity participation. Therefore, my fourth hypothesis is that there is a relationship between economic development and higher utilization of activity-related ties, but lower utilization of family network ties. The hypotheses presented here are intentionally broad and association-based, which I explore through descriptive and bivariate patterns.

Method

I begin by documenting SAN variation cross-nationally through descriptive data of SAN ties by nation using SHARE data (Table 5.1). Next, I utilize five sources of national empirical data (Table 5.2) and explore bivariate correlations between national characteristics and key SAN ties (Table 5.3). I present scatter plots to illustrate the relationships between aggregated SAN participation and nation-level culture (Fig. 5.1) and policy/economics (Fig. 5.2). Finally, I explore the overlap between national measures with correlations of national variables (Fig. 5.3). This analytical approach takes advantage of this unique combination of data by noting broad, cross-national patterns and providing a first step to understanding contextualized SAN ties.

Measures

Social Activity Networks: Survey of Health, Ageing, and Retirement in Europe (SHARE)

To examine the SAN ties cross-nationally, I draw on individual-level data from the SHARE.[1] SHARE is a longitudinal dataset of older adults in the European Union, which began in 2004. Wave 1 sampled older adults in 11 nations, including Southern Europe (Spain, Italy, and Greece), Western Europe (Germany, France, Austria, Belgium, Netherlands, and Switzerland), and Northern Europe (Sweden, Denmark). Wave 2 (2006/2007) added Eastern Europe (Poland, Czech Republic) and Ireland. I analyze data from Wave 2, as this sample includes Eastern Europe.

SAN ties include activity-related ties and family network ties. I examine the extent to which respondents participate in social activities by drawing on an item in SHARE that asks whether or not an individual participated in any of the following activities over the last month (1 = yes; 0 = no): (1) voluntary/charity work, (2) cared for a sick/disabled adult, (3) help to friends/neighbors, (4) education/training event, (5) sports/social/other club, (6) religious organization activities, and (7) political/community organization. I also create a scale of activity-related ties by summing an individual's total number of activity types. To assess family network ties, I ex-

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[1] This paper uses data from SHARELIFE release 1, as of November 24, 2010 or SHARE release 2.3.1, as of July 29, 2010. The SHARE data collection has been primarily funded by the European Commission through the 5th framework program (project QLK6-CT-2001–00360 in the thematic programme Quality of Life), through the 6th framework programme (projects SHARE-I3, RII-CT- 2006–062193, COMPARE, CIT5-CT-2005–028857, and SHARELIFE, CIT4-CT-2006–028812), and through the 7th framework programme (SHARE-PREP, 211909 and SHARE-LEAP, 227822). Additional funding from the US National Institute on Aging (U01 AG09740–13S2, P01 AG005842, P01 AG08291, P30 AG12815, Y1-AG-4553–01 and OGHA 04–064, IAG BSR06–11, R21 AG025169) as well as from various national sources is gratefully acknowledged (see www.share-project.org/t3/share/index.php for a full list of funding institutions).

plore family network tie *availability*. Because a majority of respondents are married (76 %) and have children (91 %), I focus on respondents with lower family network availability and thus potentially greater family need. Specifically, I examine respondents without children (biological, fostered, adopted, or step; 1 = no children; 0 = has children) or proximal children (i.e., children living within 5 km, including coresident children; 1 = no proximal children; 0 = proximal children). I also examine the availability of a partner/spouse (i.e., married/partnered, divorced, widowed, and never married). Table 5.1 displays descriptive statistics by nation for respondents with full data on all measures ($N = 30{,}040$). I include example measures of age, gender, education, nativity, location, and health to show the basic sample composition, but do not discuss these measures directly.

National Culture: World Values Survey (WVS) and European Values Study (EVS)

To measure culture, I draw primarily from the WVS (1999–2001) and the EVS (1999–2001). Inglehart and Welzel (2005) utilize a range of items from these two datasets across 95 nations to create two axes of cultural values: (1) secular-rational versus traditional values and (2) self-expressive versus survival values (for general information on these scales, see Inglehart 1997). Known as the Inglehart-Welzel scale, each subscale ranges from − 2.5 to 2.5 and higher values indicate more secular, self-expressive values. These measures are validated in multiple studies of global development (Pryor 2008; Inglehart and Welzel 2005, 2010) and endorsed by the WVS. In addition, I examine two specific measures of national values related to family and friends. Because items assessing the role of family care in the EVS and WVS are not available for all 14 nations, I utilize an example from the SHARE data aggregated to the nation-level.[2] Specifically, I draw on three questions from SHARE take-home survey that ask respondents to rate the extent to which the family (vs. the State) should bear responsibility for older persons': (a) financial support, (b) help with household chores, and (c) personal care. I collapse response categories into three options: (0) "mainly state/totally state"; (1) "both equally"; and (2) "mainly family/totally family" and create a summation score of these items, yielding a scale of older adults' family-based preference ranging from 0 to 6. I also include a measure of value placed on friends from the WVS (average of available years, 1981–1999), which asks respondents to rate how important friends are in life. I take the average proportion of individuals reporting friends as "very important" (most extreme response), and create aggregate measures for each nation.

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[2] The World Values Survey provides a measure of family importance ("How important is family in life?"), but there is very little cross-national variation in this measure—approximately 90 % of individuals in Europe describe family as "very important." Thus, it is unlikely that this item captures the observed regional differences in familism in Europe.

National Policy/Economics: World Bank (WB), Organization for Economic Cooperation and Development (OECD), and United Nations (UN)

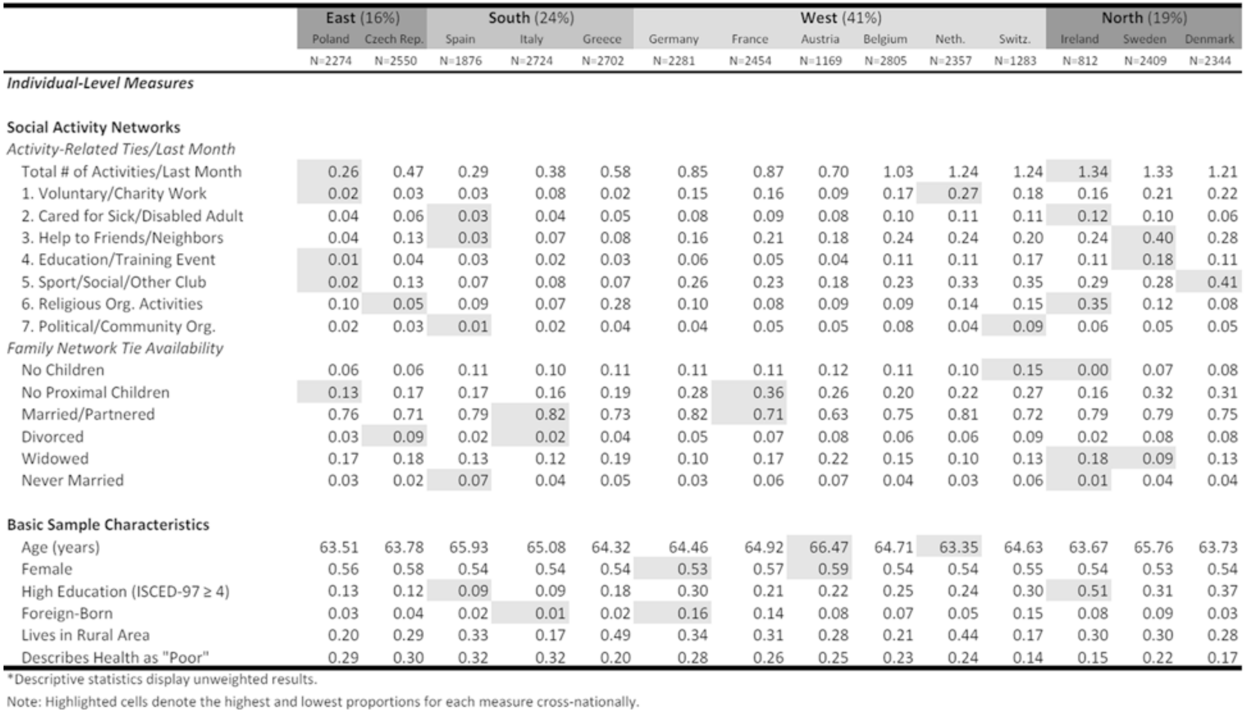
To measure policy/economic characteristics, I examine welfare state generosity and economic development using data from the WB, OECD, and UN. I measure welfare state generosity as the percent of GDP spent on public pensions (average from available years 1990–2005, OECD) and percent of GDP spent on public health (average from available years, 2003–2005 from the WB World Development Indicators). I assess economic development first through gross domestic product, purchasing power parity (GDP, PPP, constant 2005; WB, averaged from available years 1990–2005). This measure is designed to account for the final value of all goods/services produced in a nation, adjusted for exchange rate, and is considered a reputable measure of standard of living. Second, I examine each nation's score on the inequality-adjusted Human Development Index (HDI), an internationally recognized measurement of economic development provided by the UN that takes into account factors commonly associated with development such as health (life expectancy at birth), education (mean years of schooling and expected years of schooling per nation), and living standards (gross national income per capita). Although there is little variation within Europe for the non-inequality-adjusted HDI measure, the inequality-adjusted version of this index has more variation. Therefore, I use the inequality-adjusted HDI measure for the only year it is publicly available (2010) as a proxy for the general development climate for the time SHARE data were collected (2006–2007).

Results

SAN ties differ cross-nationally in Europe. Older adults in Eastern and Southern Europe participate in fewer activities than in Western and Northern Europe (Table 5.1). Across Eastern and Southern Europe, the percentage of individuals that participate in any given activity is between 1 and 5 %, compared to Northern Europe where participation peaks at 30 or 40 % for certain activities (e.g., helping friends/neighbors, sports/social/other clubs). There is less variation cross-nationally in family network tie availability as a majority of respondents are married/partnered with children. The proportion of respondents without proximal children ranges from 13 to 19 % in the East and South, to 16 to 36 % in the West and North. These statistics echo the findings of other SHARE studies, which describe a north–south divide.

What accounts for cross-national differences in social activity networks? In Table 5.2, I explore the empirical measures of national culture and policy/economics. Culture measures reveal a continuum from traditional, survival-oriented familistic values to more secular, self-expressive cultures that place a higher value on friends. Traditional values are most pronounced in Ireland and Poland, while secular values peak in Sweden and Germany. Older adults' preferences for family-based care follow

Table 5.1 Social activity network measures and sample characteristics by nation. (SHARE 2006/2007; $N = 30.040$)

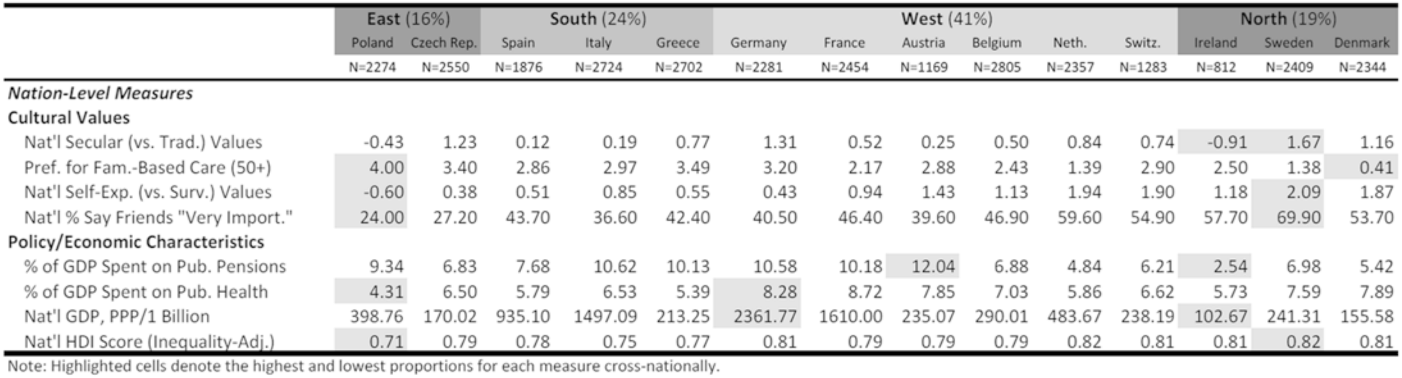


	East (16%)		South (24%)			West (41%)						North (19%)		
	Poland	Czech Rep.	Spain	Italy	Greece	Germany	France	Austria	Belgium	Neth.	Switz.	Ireland	Sweden	Denmark
	N=2274	N=2550	N=1876	N=2724	N=2702	N=2281	N=2454	N=1169	N=2805	N=2357	N=1283	N=812	N=2409	N=2344
Individual-Level Measures														
Social Activity Networks														
Activity-Related Ties/Last Month														
Total # of Activities/Last Month	0.26	0.47	0.29	0.38	0.58	0.85	0.87	0.70	1.03	1.24	1.24	1.34	1.33	1.21
1. Voluntary/Charity Work	0.02	0.03	0.03	0.08	0.02	0.15	0.16	0.09	0.17	0.27	0.18	0.16	0.21	0.22
2. Cared for Sick/Disabled Adult	0.04	0.06	0.03	0.04	0.05	0.08	0.09	0.08	0.10	0.11	0.11	0.12	0.10	0.06
3. Help to Friends/Neighbors	0.04	0.13	0.03	0.07	0.08	0.16	0.21	0.18	0.24	0.24	0.20	0.24	0.40	0.28
4. Education/Training Event	0.01	0.04	0.03	0.02	0.03	0.06	0.05	0.04	0.11	0.11	0.17	0.11	0.18	0.11
5. Sport/Social/Other Club	0.02	0.13	0.07	0.08	0.07	0.26	0.23	0.18	0.23	0.33	0.35	0.29	0.28	0.41
6. Religious Org. Activities	0.10	0.05	0.09	0.07	0.28	0.10	0.08	0.09	0.09	0.14	0.15	0.35	0.12	0.08
7. Political/Community Org.	0.02	0.03	0.01	0.02	0.04	0.04	0.05	0.05	0.08	0.04	0.09	0.06	0.05	0.05
Family Network Tie Availability														
No Children	0.06	0.06	0.11	0.10	0.11	0.11	0.11	0.12	0.11	0.10	0.15	0.00	0.07	0.08
No Proximal Children	0.13	0.17	0.17	0.16	0.19	0.28	0.36	0.26	0.20	0.22	0.27	0.16	0.32	0.31
Married/Partnered	0.76	0.71	0.79	0.82	0.73	0.82	0.71	0.63	0.75	0.81	0.72	0.79	0.79	0.75
Divorced	0.03	0.09	0.02	0.02	0.04	0.05	0.07	0.08	0.06	0.06	0.09	0.02	0.08	0.08
Widowed	0.17	0.18	0.13	0.12	0.19	0.10	0.17	0.22	0.15	0.10	0.13	0.18	0.09	0.13
Never Married	0.03	0.02	0.07	0.04	0.05	0.03	0.06	0.07	0.04	0.03	0.06	0.01	0.04	0.04
Basic Sample Characteristics														
Age (years)	63.51	63.78	65.93	65.08	64.32	64.46	64.92	66.47	64.71	63.35	64.63	63.67	65.76	63.73
Female	0.56	0.58	0.54	0.54	0.54	0.53	0.57	0.59	0.54	0.54	0.55	0.54	0.53	0.54
High Education (ISCED-97 ≥ 4)	0.13	0.12	0.09	0.09	0.18	0.30	0.21	0.22	0.25	0.24	0.30	0.51	0.31	0.37
Foreign-Born	0.03	0.04	0.02	0.01	0.02	0.16	0.14	0.08	0.07	0.05	0.15	0.08	0.09	0.03
Lives in Rural Area	0.20	0.29	0.33	0.17	0.49	0.34	0.31	0.28	0.21	0.44	0.17	0.30	0.30	0.28
Describes Health as "Poor"	0.29	0.30	0.32	0.32	0.20	0.28	0.26	0.25	0.23	0.24	0.14	0.15	0.22	0.17

*Descriptive statistics display unweighted results.

Note: Highlighted cells denote the highest and lowest proportions for each measure cross-nationally.

Table 5.2 National cultural values and policy/economic characteristics by nation. (SHARE 2006/2007, WVS and EVS 2004, WVS 1981–1999, WB 1990–2005, OECD 1990–2005, UN 2010; $N = 14$ nations)



	East (16%)		**South** (24%)			**West** (41%)						**North** (19%)		
	Poland	Czech Rep.	Spain	Italy	Greece	Germany	France	Austria	Belgium	Neth.	Switz.	Ireland	Sweden	Denmark
	N=2274	N=2550	N=1876	N=2724	N=2702	N=2281	N=2454	N=1169	N=2805	N=2357	N=1283	N=812	N=2409	N=2344
Nation-Level Measures														
Cultural Values														
Nat'l Secular (vs. Trad.) Values	-0.43	1.23	0.12	0.19	0.77	1.31	0.52	0.25	0.50	0.84	0.74	-0.91	1.67	1.16
Pref. for Fam.-Based Care (50+)	4.00	3.40	2.86	2.97	3.49	3.20	2.17	2.88	2.43	1.39	2.90	2.50	1.38	0.41
Nat'l Self-Exp. (vs. Surv.) Values	-0.60	0.38	0.51	0.85	0.55	0.43	0.94	1.43	1.13	1.94	1.90	1.18	2.09	1.87
Nat'l % Say Friends "Very Import."	24.00	27.20	43.70	36.60	42.40	40.50	46.40	39.60	46.90	59.60	54.90	57.70	69.90	53.70
Policy/Economic Characteristics														
% of GDP Spent on Pub. Pensions	9.34	6.83	7.68	10.62	10.13	10.58	10.18	12.04	6.88	4.84	6.21	2.54	6.98	5.42
% of GDP Spent on Pub. Health	4.31	6.50	5.79	6.53	5.39	8.28	8.72	7.85	7.03	5.86	6.62	5.73	7.59	7.89
Nat'l GDP, PPP/1 Billion	398.76	170.02	935.10	1497.09	213.25	2361.77	1610.00	235.07	290.01	483.67	238.19	102.67	241.31	155.58
Nat'l HDI Score (Inequality-Adj.)	0.71	0.79	0.78	0.75	0.77	0.81	0.79	0.79	0.79	0.82	0.81	0.81	0.82	0.81

Note: Highlighted cells denote the highest and lowest proportions for each measure cross-nationally.

a more consistent trend from East and South to West and North. The highest rates of preferences for family-based care are in Poland and Greece and the lowest in Denmark and Sweden. Self-expressive values, an indicator of individualism, are highest in Sweden and Denmark and lowest in Poland and the Czech Republic. Finally, the proportion reporting friends “very important” peaks in Sweden and the Netherlands and is lowest in Poland and the Czech Republic.

Table 5.3 displays correlations between SAN aggregated at the nation-level and national characteristics. Hypothesized relationships are indicated by a box and notably high correlations (those ≥ 0.70) are indicated by shaded cells. Nations with more traditional values (lower secular values) and higher familism have moderately higher proportions of family network tie availability. For example, older adults’ family-based preferences are moderately correlated with the national proportion without proximal children ($r = -0.63$, $p < 0.001$). For an illustration, I refer to Fig. 5.1a which indicates that as familism increases, the proportion of individuals without proximal children decreases. High familism is strongly correlated with lower proportion of the population that provided help to a friend/neighbor ($r = -0.79$, $p < 0.001$) and fewer activities overall ($r = -0.77$, $p < 0.001$). Familistic nations display a pattern of heightened family network tie availability, yet familism is also linked to fewer ties with friends/neighbors. Nations with less traditional, more self-expressive cultural values are highly correlated with activity ties. I illustrate examples of these relationships in Fig. 5.1c, d. Nations reporting more activities also endorse self-expressive values ($r = 0.85$, $p < 0.001$; Fig. 5.1c) and place a higher value on friends ($r = 0.87$, $p < 0.001$). This trend holds most notably for providing help to a friend/neighbor (Table 5.3). These correlations reveal potential explanations for cross-national SAN variation.

Next, I examine associations between policy/economics and SAN ties (Table 5.3; Fig. 5.2). Public pension expenditures are moderately negatively correlated with the proportion of respondents who provided help to a sick/disabled adult ($r = -0.42$, $p < 0.001$; Table 5.3; Fig. 5.2a). Yet, the association is weak and further clouded by the fact that public health spending shows the opposite association. The strongest correlation, however, is between public health expenditures and the proportion of older adults without proximal children ($r = 0.86$, $p < 0.001$; Table 5.3; Fig. 5.2b). As public health spending increases, so does the proportion of older adults without children staying nearby. Thus, higher welfare state generosity may be linked to lower family tie availability or dependence. However, considering the opposite associations of pensions and public health with caring for a sick/disabled adult, welfare state generosity may capture something broader, such as economic development. Economic development measured through GDP PPP has low correlations with all SAN ties. Figure 5.2c illustrates the weak association between GDP PPP and activities. Inequality-adjusted HDI, however, is positively and strongly correlated with activities ($r = 0.83$, $p < 0.001$). The scatter plot reveals a tight association, despite low variation in HDI for the 14 nations in the sample. These correlations provide preliminary insight into macro-level patterns of national culture and development as they relate to SAN ties.

Finally, I examine correlations between national variables. Examples are displayed in Fig. 5.3. For example, self-expressive values are negatively correlated with

Table 5.3 Correlation between aggregated SAN measures and national characteristics. (SHARE 2006/2007, WVS and EVS 1999–2001, WVS 1981–1999, WB 1990–2005, OECD 1990–2005, UN 2010; $N = 14$ nations)

Aggregated Sample Measures of Social Activity Networks	Total # of Activities	Help to Friends/Neighb.	Cared for Sick/Disab. Adult	No Proximal Children	Not Married/Part.
Nation-Level Measures					
Cultural Values					
Nat'l Secular (vs. Trad.) Values	0.46 ***	0.56 ***	0.26 ***	0.57 ***	0.00
Pref. for Fam.-Based Care (50+)	-0.77 ***	-0.79 ***	-0.42 ***	-0.63 ***	0.16 ***
Nat'l Self-Expressive (vs. Surv.) Values	0.85 ***	0.81 ***	0.62 ***	0.59 ***	-0.06 ***
Nat'l % Say Friends "Very Import."	0.87 ***	0.82 ***	0.65 ***	0.60 ***	-0.25 ***
Policy/Economic Characteristics					
% of GDP Spent on Public Pensions	-0.61 ***	-0.51 ***	-0.42 ***	0.00	0.18 ***
% of GDP Spent on Public Health	0.47 ***	0.57 ***	0.41 ***	0.86 ***	0.16 ***
Nat'l GDP, PPP/1 Billion	-0.22 ***	-0.25 ***	-0.07	0.25 ***	-0.40 ***
Nat'l HDI Score (Inequality-Adj.)	0.83 ***	0.78 ***	0.70 ***	0.67 ***	-0.06 ***

Note: Boxed cells indicate hypothesized relationships. Highlighted cells emphasize measures with "high" correlations (≥ 0.70)

*p≥0.05, **p≥ 0.01, ***p≥ 0.001

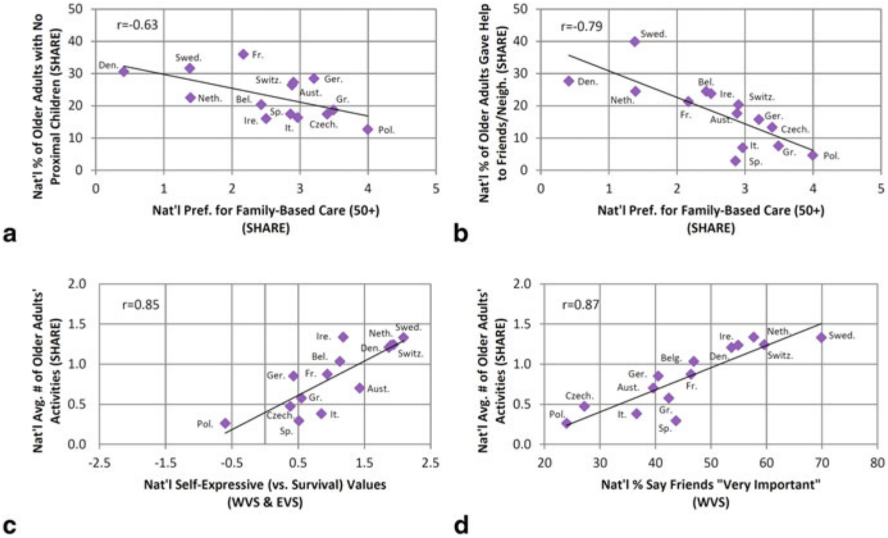


Fig. 5.1 Social activity network examples by national cultural values. (SHARE 2006/2007, WVS and EVS 1999–2001, WVS 1981–1999; $N = 14$ nations)

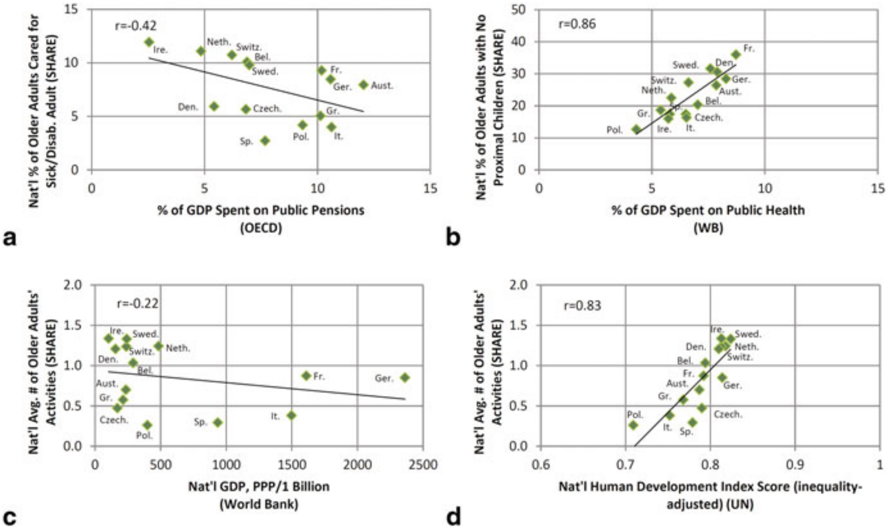


Fig. 5.2 Social activity network examples by national policy/economic characteristics. (SHARE 2006/2007, OECD 1990–2005, WB 1990–2005, United Nations 2010; $N = 14$ nations)

preference for family-based care ($r = -0.85$, $p \leq 0.001$; Fig. 5.3a) and positively correlated with the proportion who report friends are very important ($r = 0.89$, $p \leq 0.001$; Fig. 5.3b). Public pension and health expenditures, however, are not highly correlated ($r = -0.13$; $p \leq 0.001$; Fig. 5.3c). HDI is highly positively correlated with

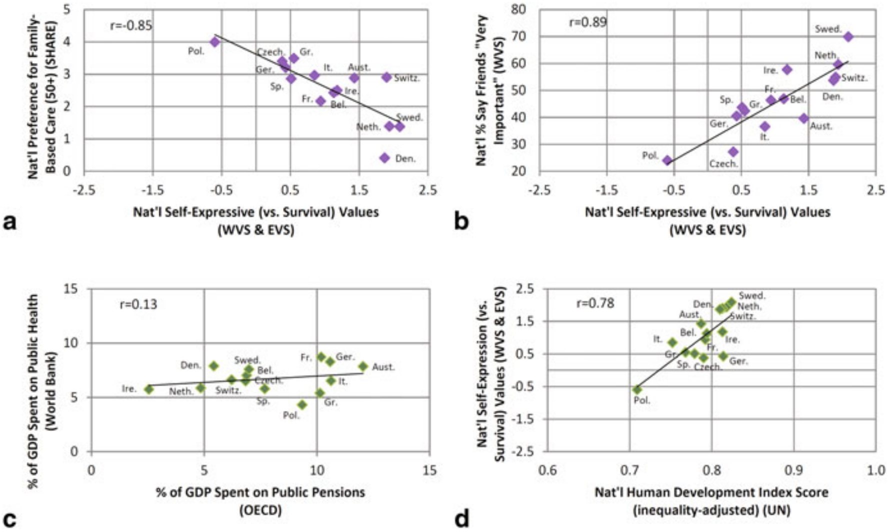


Fig. 5.3 Correlations between key national measures. (SHARE 2006/2007, WVS and EVS 1999–2001, WVS 1981–1999, OECD 1990–2005, WB 1990–2005, UN 2010; $N = 14$ nations)

self-expression values ($r = 0.78$, $p \leq 0.001$; Fig. 5.3d). I explore the meaning of these findings below.

Discussion

Traditional Cultures and a Lack of Social Activity Network Ties

Traditional cultural values, such as support for family-based care, are only moderately associated with family network tie availability cross-nationally but are strongly associated with fewer activity-related ties. Specifically, traditional values and familism are moderately associated with a lower proportion of the older population without proximal children, yet are strongly correlated with a lower proportion of older adults who have provided help to a friend/neighbor or participated in a multiple activity types (Fig. 5.1b, c). Therefore, the results offer only partial support for my first hypothesis. Traditional and familistic values are not strongly linked to higher family network availability but are more directly linked to a lack of activity. There are a number of possible explanations for this finding. First, the measures I chose to represent family network tie availability may not adequately capture older adults' interactions with their family networks. For example, traditional and familistic values have a slightly stronger association with the proportion of older adults who have cared for a sick/disabled adult ($r = 0.62$, $r = 0.65$, $p \leq 0.001$; Table 5.3). Due to the ambiguous wording of the survey item, this "activity" may involve kin. Second, it may be that despite strong emphasis on traditional familism, older adults in familistic nations do not possess equally strong family networks. Therefore, what are the challenges faced by older adults in familistic nations with a lack of social activity network ties?

The endurance of traditional cultural values highlights the importance of considering those left vulnerable by a national cultural emphasis on familism. What conditions are faced by older adults with strong family expectations yet low family network support (Fig. 5.1a)? Despite familistic preferences in Southern and Eastern Europe, as well as Ireland, urbanization and intergenerational mobility are increasing in Europe while marriage and fertility rates are declining. Although Ireland emerged from delayed economic development at the end of the 20th century (Murphy 2000), Poland, Czech Republic, and Greece's economic isolation in the post-war era left these nations struggling to establish the types of formal supports found in Northern Europe. Therefore, older adults' lower likelihood of participating in activities in many familistic nations may be due not only to a lack of cultural proclivity towards activity-related ties but also because of a lack of *availability* of those ties. With empirical data on the prevalence of national traditional, familistic national cultural values and individuals' family network tie availability, scholars can explore ways to improve the conditions of older adults through a consideration of cultural expectations and SAN tie availability.

Individualistic Cultures and Prominent Activity-Related Ties

In contrast to the weaker association between traditional, familistic cultural values and family network ties, self-expressive (individualistic) values and an emphasis on the importance of friends are both strongly associated with activity-related ties (e.g., help to a friend/neighbor or number of activity types; Table 5.3). These results support my second hypothesis and highlight the role of activity-related ties in nontraditional nations. For example, more traditional, familistic nations such as Poland, Czech Republic, and Italy have lower emphases on activity-related ties (Fig. 5.1b) and lower endorsement of friends as "very important" (Fig. 5.3). In contrast, individualistic nations that value friends such as Sweden and the Netherlands utilize more activity-related ties (Fig. 5.1d). Thus, although aging scholars express concerns over declines in family support for older adults, activity theory may provide insight into a new dimension of support. Older adults in nations with low familism do not lack ties, but rather, may simply seek different types of social ties—activity-related ties, which are also more likely to be nonkin.

What do these empirical measures of culture tell us about cross-national variation and how are they connected to activity-related ties? The values examined here reflect a cultural continuum that may condition interest in and access to activities. The strong correlation between an emphasis on friends and self-expressive cultural values (Fig. 5.3b) suggests that these national characteristics may represent a broader set of "modernized" values (Inglehart and Baker 2000). Indeed, these "modernized" values appear to directly contrast traditional, familistic values as represented by the strong, negative correlation between familism and self-expressive values (Fig. 5.3a).

Thus, European nations vary along a continuum between traditional/family-oriented values and self-expressive/friend-oriented values. Both extremes are strongly linked to activity-related ties, except in opposite directions. Therefore, the cultural continuum may reflect older adults' interest in activity-related ties. Whereas "activity" is emphasized as universally beneficial for older adults' health, activity-related ties that are broad and non-kin-based are not only uncommon in traditional, familistic nations but may also be less desired. Therefore, gerontologists' emphasis on general activity holds primarily in self-expressive, friend-oriented nations.

(Seeming) Weak Role of Welfare State Generosity

To explore influences beyond culture, I turn to the role of policy and economics. Welfare state generosity, measured as public health expenditures, is strongly correlated with a lack of proximal children. Public health expenditures, however, are not strongly associated with a lower proportion of older adults who cared for a sick/disabled adult and have no strong associations with SAN ties. Therefore, the results offer only partial support for my second hypothesis and raise questions about the use of public expenditures as measures of welfare state generosity. For example, nations with the strongest public pension systems are not always the ones with the highest public health spending or other state provisions. In fact, these measures of welfare state generosity are only weakly correlated (Fig. 5.3c). Therefore, although it is possible that older adults in nations with strong public health systems are less reliant upon adult children living nearby (Fig. 5.2b), there may be other important policy factors to consider. For example, focusing on welfare state generosity does not account for Northern and Western Europe's growing reliance on private pensions. Reliable data on private pension funding, however, are not currently available for all nations in the sample yet the seeming lack of effect of welfare state generosity may reflect not only opposite patterns of public pensions and public health cross-nationally in Europe but also the ever-increasing role of privately funded support for older adults. These factors should continue to be explored in cross-national research as more data become available.

Dominating "Development"

Finally, I hypothesized that economic development would be associated with more activity-related ties and lower family network tie availability. The results indicate that although GDP PPP is not associated with SAN ties (Fig. 5.2c), nations' HDI scores are strongly associated with more activity-related ties (Fig. 5.2d). In addition, HDI is moderately associated with a higher proportion of older adults without proximal children. Thus, the results offer partial support for my final hypothesis and also emphasize the role of economic development measured as HDI, rather than GDP PPP. Although GDP PPP and HDI are commonly used measures of development, the very concept of "development" acts as a panacea for cross-national research by explaining a variety of trends such as wealth, health, education, and infrastructure. But what is "development" and how does it contextualize SAN ties? For example, one measure of "development" is strongly correlated with SAN variation (HDI; Fig. 5.2d) while the other is not (GDP PPP; Fig. 5.2c). Common measures of economic development can be problematic in cross-national research, as they tend to explain a large proportion of statistical variation without pinpointing which aspects of development are most important. Although HDI is a broad measure, it includes specific components: health, education, and wealth. One could argue that these components are primarily *outcomes* of "development" and not causes. Yet, these three components of HDI offer tangible traits of development that appear to be highly predictive of SAN tie variation in the expected directions (e.g., development is associated with more activity-based ties and fewer traditional family network ties such as proximal children; Table 5.3; Fig. 5.2).

Therefore, the final piece of the puzzle linking all of the cross-national patterns observed may be the broad meaning of "development." "Development" as measured by HDI (health, education, and wealth) is strongly correlated with "modernized" value sets (self-expressive/friend-oriented cultural values; e.g., Fig. 5.3d). Thus, the social participation encouraged by activity theory is not only biased against familistic cultures but may also represent an economically privileged status. Older adults, who are healthier, educated, wealthier, and with more self-expressive values likely have more opportunity and desire to participate in social groups unrelated to the family. In fact, many of the activity-related ties examined are intuitively linked to characteristics of economic development and individualism. For example, participation in sports events likely requires a minimum level of health, educational/training events may require previous experience or financial resources, volunteer/charity events likely require financial or time-based resources, and help to a friend/neighbor reflects interest in cultivating nonfamily ties. In this way, individuals in developed nations are "selected" into activity-related ties due to their higher likelihood of being capable of and interested in participation. Individuals in more traditional, familistic nations that are less "developed" may not only be culturally predisposed to family network ties but also may simply lack opportunity for the types of activity-related ties captured by SHARE measures. Therefore, empirical national measures of culture and economics offer a more nuanced, contextualized view of variation in European older adults' social activity networks cross-nationally by revealing the potential selection effect of "modernized" development.

Conclusion

In conclusion, older adults' social lives are diverse and consist of activity-based ties and family network ties, both of which compose a SAN. Cross-nationally, there is notable variation in SAN ties. Yet, few studies have attempted to explore this variation using empirical national measures. Therefore, I address this gap in the literature by constructing a dataset of SAN ties and national characteristics drawn from six publicly available sources. Using this uniquely created dataset, I find that cross-national variation in SAN ties is partially explained by variation in traditional/family-oriented values, self-expressive/friend-oriented values, and economic development. Although an emphasis on national measures is limited in that there is certainly within-nation variation in culture (e.g., ethnic and political divisions) and economic/policy characteristics (e.g., local housing and labor markets; Blome et al. 2009), an empirical examination of nation-level variables offers a preliminary step to extrapolating explanations for cross-national SAN variation. The results of this study reveal that individuals in traditional/family-oriented nations may be vulnerable to a lack of overall SAN ties, that the benefits of general activity theory are biased in favor of self-expressive/friend-oriented nations, and that ability to participate in social activities may be a privilege of economic development. With these factors in mind, future studies should continue to examine empirical measures of national characteristics through multivariate and multilevel analyses in order to gain a clearer understanding of the explanations for and implications of SAN variation cross-nationally. In this chapter, bivariate correlational analyses, in combination with historical, cultural, political, and economic contexts, provide a broad foundation for more advanced studies of the role of social activity networks in the lives of European older adults.

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Chapter 6
What About Happiness in Later Life?

Constança Paúl, Laetitia Teixeira and Oscar Ribeiro

Along with the remarkable rise of life expectancy, happiness has become a major issue for people who live a longer life. The aging process encompasses some declines that challenge the well-being of people. In this chapter, we briefly review some major issues appearing on the happiness literature beginning with a broader view on happiness and wealth, followed by happiness across the life span, its relation with health, and the importance of social relationships in being happy. We finish with an empirical study on happiness of old Portuguese people living in the community analyzing the proportion of happy people, and looking at the predictors of happiness (age, education, and health perception). We discuss the possibility of foster happiness in old age stressing the importance of objective as well as subjective variables for subjective well-being.

Introduction

Happiness is defined by Veenhoven (1984) as the positive self-assessment of life as-a-whole. Often the term "happiness" is used interchangeably with subjective well-being (SWB) and life satisfaction (Böhnke 2005), although there seems to be a consensus in considering SWB a broader concept that includes happiness as the affective part and life satisfaction as the cognitive counterpart (e.g., Diener et al. 2003). In a broad sense, happiness is feeling good about the self and the personal life, it is a

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relevant aspect of "good life" and particularly among older individuals, and it may be considered as a component of successful aging (e.g., Palmore 1979). However, there is no agreement on what are the determinants of happiness.

Presently, there is a huge amount of international and cross-cultural literature on happiness, associating it with wealth and analyzing its correlates for the general population (e.g., Delhey 2004). Nevertheless, extensive studies on happiness, namely the cross-cultural ones resulting from World Values Survey, Gallup International, or European Social Survey, study the general population 15 years old and over, and so, specific questions about happiness in old age remain mostly unanswered. We will direct our attention to happiness in later life, as we know that personal, objective and subjective variables (e.g., SES, health status, social relations) change with age, and probably also its impact on happiness in later years.

General Happiness and Its Relation with Wealth

We begin by looking at the literature associating happiness and wealth in the whole population to have an overview of the prevalence of happiness and its correlates in different countries and comparing Portugal to the other European countries with similar geographical and social context.

The curve of happiness by GDP per capita in each country shows a direct association between richer countries and higher means of happiness. A similar association can be observed between happiness and the human development index rank. In the work of Delhey (2004) "Life satisfaction in an enlarged Europe," the life satisfaction in Europe rises with the country GDP per capita. However, when Ireland, Greece, Portugal, and Spain joined the European Community in 1985, life satisfaction increased for a short period of time and then stabilized at the respective country set point, although living conditions improved greatly during the following years. Apparently, this indicates that the wealth conditions are not directly related with life satisfaction.

The domains influencing happiness in EU15 are family life, standard of living, and social life, although the order of factors varies across countries (EF/04/105/EN 2004). In all the indicators of SWB and life satisfaction studied, authors show a worst performance of southern European countries, including Portugal, when comparing with the other countries of EU15. In the European Social Survey (Vala et al. 2010), the level of reported happiness all over Europe diminishes in 2008 when compared to the first wave of studies carried out in 2002, and Portugal follows the trend but is always below the mean (6.6 vs. 6.8 out of 10). On the contrary, Inglehart (2010), taking data from the World Values Survey (http://www.worldvaluesurvey.org), shows that happiness increased in 40 of 52 countries between 1981 and 2007, corresponding not only to economic development but also to transition to democracy of dozens of countries. The other variables that explain SWB are religion, social tolerance, and the level of democracy. Considering the distinction we have made above of life satisfaction and happiness, the author shows that economic conditions influence more life satisfaction, while religion and democratization influences happiness. In this chapter, the author makes it clear that there are two routes to happiness, one linked with modernization (economic growth and freedom) and the other with faith (religion). This second route was observed in poor countries of Latin America (e.g., Colombia, Mexico, El Salvador, Guatemala, and Brazil) that showed similar levels of happiness to rich Nordic countries (e.g., Iceland, Denmark, and Sweden). The first group of countries score high in religiosity and happiness, contrary to the second group that scores low in religiosity and high in happiness. It seems that through religion they reduce unhappiness by lowering one's expectation and accepting the dignity of suffering. The relationship between GDP and the happiness is by no means complex. Graham et al. (2010) discuss the Easterlin paradox that relates income with happiness both within and across countries by showing that there is a great deal of variance among countries, depending on the method selected, the pool of countries, the rate of change to mention just a few, and many mediating variables leading to divergent conclusions.

The SWB range in Europe is 70–80 % or, after including non-Western countries, 60–80 % (Cummins 1995, 1998). Still at a country level across Europe, the abstract idea of what constitutes life satisfaction does not differ all that much. Gundelach and Kreiner (2004) showed that country characteristics together with the sense of control of life are the most important predictors of life satisfaction, while happiness is mostly related with social relations, which they call social capital, reinforcing the idea of happiness as the affective evaluation of life as a whole. The prevailing concerns in all countries are, according to Delhey (2004), making a living (income), family life, and health, but again the order of priorities differs from country to country.

At an individual level, the relationship between money and happiness is even more complex, as happiness refers to an affective judgment rather than cognition about objective life conditions. Corroborating this idea in Thai culture, a recent study reported that happiness seems to be associated with the feeling of contentment with what one has, more than with the objective wealth (Gray et al. 2008). Controlling for demographic and all external factors, the respondents who did not feel poor showed the highest level of happiness compared to those who felt as poor as or poorer than their neighbors.

According to Lyubomirsky et al. (2005), the level of individual happiness depends on three main factors: a genetically determined set point; happiness-relevant circumstantial factors; and happiness-relevant activities and practices. The set-point-of-happiness model (Lykkens and Tellegen 1996) holds that external events may change the level of life satisfaction of individuals during a short period of time, but then satisfaction returns to the original set point. Individuals get used to certain patterns of wealth and the routine becomes unconscious, losing the potential to raise happiness, probably also due to hedonic adaptation. In brief, external conditions influence happiness but just to a certain level, and a pool of internal variables are the counterparts of wealth as determinants of happiness.

None of these studies focus specifically on old people but the relation between money and happiness seems to be particularly relevant to old people due to the probably diminished wealth during retirement, mostly for old women, with no or short contributive careers. Probably old people, namely in Portugal, adapt to their financial condition because their expectations are low, their resignation is high, and maybe they follow the second route to attain happiness, using strategies of religiosity to reduce unhappiness as Inglehart (2010) proposed. Otherwise, we are expected to find lower levels of happiness than frequently described in literature, as we will see in the next sessions.

Happiness Across the Life Span

The variation of happiness across the life span is very important particularly when our focus is happiness in old age, but evidence is controversial. According to Ferring and Boll (2010), there are two competing hypotheses about the development of SWB in old age: (1) the presence of a marked change, with a decrease of SWB in old age when compared to other age groups, evidencing some decline of positive affect in the oldest old groups (e.g., Easterlin 2006) and (2) little/no change of SWB in old age when compared to other age groups. On this last hypothesis, several meta-analyses (e.g., Pinquart and Sorensen 2009) suggest that despite losses there is no pronounced decline in global life satisfaction.

The curve of happiness, at least in the United States, rises slightly, on average, from ages 18 to midlife and declines slowly thereafter due to the satisfaction people get from various life domains: their financial situation, family life, health, and work (Easterlin 2006). The slight rise in happiness through midlife is due chiefly to growing satisfaction with one's family life and work. Beyond midlife, happiness has a continuing decline due to dissatisfaction with health and a probable negative trend with financial situation. According to Cooper et al. (2010), happiness increases with age, except in those with dementia-related diseases. In the Heidelberg Centenarian Study, Jopp and Rott (2006) found high levels of happiness in centenarians. Basic resources (i.e., job training, cognition, health, social network, and extraversion) explained a substantial proportion of variance in happiness.

By comparing cognitive decline and happiness in representative surveys of old residents in India, China, and Latin America, Cooper et al. (2010) showed that 82.3 % participants were very or fairly happy and that happiness increased with age. Better cognition was associated with greater happiness, after controlling for sociodemographic characteristics and physical disability. Contrarily to evidence from several studies, it seems that both younger and older people believed that happiness declines with age despite the fact that self-reports confirmed increasing happiness with age (Lacey et al. 2006).

Happiness and Health

There is a huge amount of research associating happiness and health, be it morbidity, survival, or longevity. In fact, we may consider health as one of the most important variables of SWB (e.g., Diener and Seligman 2004). According to Koopmans et al.

(2010), happiness was inversely associated with mortality in a 15 years prospective population-based study of elderly in Arnhem. However, when they control for physical activity and prevalent morbidity, the association is no longer significant, suggesting that there is no direct association between happiness and mortality and that the relationship may be mediated by physical activity and lower mortality. Nevertheless, the relation between health and happiness is considered to be very important for old people, principally if health problems disrupt daily functioning, and Angner et al. (2009) emphasized the importance of subjective health measures to predict happiness over objective ones.

According to Veenhoven (2008), happiness does not predict longevity in a sick population but it does predict longevity among those in a healthy population. Happiness may be considered a buffer against becoming ill. Although satisfaction tended to be lower in disabled groups, Marinié and Brkljacie (2008) reported that regardless of presenting some disability, people expressed happiness and moderate life satisfaction. For this particular group, satisfaction with economic status did not seem to be an important happiness predictor as for the general population. However, satisfaction with health, relationships, and achievements contributes to happiness in persons with or without physical disability, while physical safety and acceptance by the community predicts happiness in people with disability. The concept of "disability paradox" (Albrecht and Devlieger 1999) shows the apparent contradiction between existing high levels of disability and high levels of life satisfaction in old and disabled people.

The findings are not consensual. It seems that there is an expected level of disability that is compatible with maintenance of happiness, but once this limit is passed, happiness decreases in step with increasing difficulties (Paúl et al. 2007). Perhaps there are objective/subjective limits beyond which SWB is not sustainable. This seems to be true for health and probably also for wage and education that beyond a certain low boundary are negatively associated with satisfaction, while above a certain limit don't seem to predict happiness anymore.

Happiness and Social Relations

Supporting social networks seems very important in maintaining happiness. In all European countries, social relations, mainly family life, predicts happiness, although in different proportion and priority order from country to country (Delhey 2004). Social relations are intimately related to happiness, reinforcing each other. There is no happiness if you cannot share it with other people, particularly with close ones (Diener and Biswas-Diener 2008). Social relations appear to be a cause, a consequence, or a mediator of happiness. Lonely people are probably less happy than those with large and active social network, whatever the relation between loneliness and happiness may be. North et al. (2008) examined the role of family income and social support and showed that family social support was more strongly associated with happiness when family income was low than when family income was high.

In addition, change in family social support was positively related to change in happiness, whereas change in family income was unrelated to change in happiness.

Waldinger and Schulz (2010) examined the links between perceived health and happiness and concluded that for both men and women, the daily links between time spent with one's partner and happiness were strongly moderated by marital satisfaction, and that marital satisfaction buffered day-to-day links between poorer perceived health and a decline in happiness. The role of marital satisfaction is protecting older adults' happiness from daily fluctuations in perceived physical health and for the influence of social connections in promoting happiness in the lives of older adults. Menec (2003) shows that in general, social and productive activities were positively related to happiness, function, and mortality, whereas more solitary activities (e.g., handwork hobbies) were related only to happiness.

Predictors of Happiness: An Empirical Study in Old Portuguese Dwellers

The following study analyzes the proportion of happy old Portuguese people by age group, and determines the predictors of happiness. The results presented here are part of an extensive project on active aging (DIA Project) that includes a cross-sectional survey of adults aged 55 + years living in the community. For this study, subjects were recruited randomly through announcements in local newspapers, local agencies (e.g., seniors' clubs), and NGOs, and using the snowball method by which participants indicate other persons with similar conditions. The study ran in different Portuguese regions, including the Madeira and Azores Islands. The survey was conducted by trained interviewers, using a structured questionnaire format that entailed demographic, psychological, and social questions. A full description of the assessment protocol (P3A) can be found in Paúl et al. (2008) and at http://www.projectodia.com. The interviews took place in local community facilities (e.g., parish hall) or in the participants' homes. Informed consents were obtained from all the participants.

The sample comprises 1,322 persons aged 55–101 years old. The average age was 70.4 years (SD 8.7 years) and females comprised 71.1 % (939) of the sample. The majority of participants were married/partnered 729 (55.7 %), 400 (30.6 %) were widowed, 114 (8.7 %) were single, and 65 (5.0 %) were divorced. As for the social network, 24.7 % of the participants lived alone. Primary school education was reported by 55.3 % of the respondents, 19.1 % had never attended school, 17.8 % had completed high school, and 7.7 % had higher education (trade qualification or university degree). The majority (49.6 %) had a monthly income equal or less than € 386 (by reference to the Portuguese Minimum National Wage in 2006).

Along with sociodemographic characteristics, we analyzed cognitive functioning measured with the Portuguese version of the Mini-Mental State Examination (MMSE) adapted to illiterate people and people with very few years of education (Folstein et al. 1975; Guerreiro et al. 1994), social network assessed with the Lubben Social Network Scale (LSNS), which comprises four subscales—family, friends, confidants, and helping others (Lubben 1988) using a cut-off score of 20 to qualify elderly people at greater risk of extremely limited social network. Subjective indicators of health condition were determined by a standard health-rating item: "In general, how would you rate your health?" (Response options were very good, good, regular, poor, and very poor) and by considering the sum of self-reported health problems.

Descriptive statistics were firstly used to report data distribution and their association with happiness, followed by a logistic regression model to determine which variables better explained happiness. Happiness measure was dichotomized for statistical purposes with 1 "Happy" including very happy and happy and 0 "Unhappy" including unhappy and very unhappy. Other potential explanatory variables entering in the model were age (1. <65 years, as the reference category; 2. 65–74 years, 3. ≥ 75 years); gender (0. Female, 1. Male, as the reference category); marital status (1. Married, as the reference category, 2. Widow(er), 3. Single, 4. Divorced); educational level (1. Illiterate, 2. 4 years, 3. 5–8 years, 4. 9–12 years, 5. High education, as the reference category); income (1. One minimum wage, 2. Between 1 and 2 minimum wage, 3. Between 2 and 3 minimum wage, 4. More than 3 minimum wage, as the reference category); the cognitive functioning was measured with the Portuguese version of the MMSE and organized in tertiles (0. MMSE <29 [Tertiles 1 and 2], 1. MMSE ≥ 29 [Tertile 3], as the reference category); problems interfering with daily living (0. No, as the reference category, 1. Yes); subjective indicators of health condition were determined by a standard health-rating item: "In general, how would you rate your health?" (Response options were very good, good, regular; Self-perception of health: 1. Very good or Good, as the reference category, 2. Reasonable, 3. Poor or Very poor); number of diagnoses, self-reported of the number of diagnosis people have from the current list of diseases (0. No diagnosis, as the references category, 1. 1 and 2 diagnosis, 2. 3 or more diagnosis); Lubben Social Network Scale using a cut-off score of 20 was used to qualify elderly at greater risk of extremely limited social network as follows (0. Short social network [<20], as the reference category, 1. Large social network [≥20]).

The results show a prevalence of happiness of 68.3 % (n =903). The proportion of people feeling happy decreased with age: 75.2 % in the group aged 55–64 years, 71.0 % in the age group 65–74 years, and 62.8 % in people 75 years old and more. The distribution of percentages of happiness by potential explanatory variables can be seen in Table 6.1.

Happiness varied by gender with more men feeling happy (75.4 %) than women (66.9 %), and varied with education level with more people with high education (79.0 %) and more people affording more than three minimum wages of the income (82.2 %) reporting happiness. Happiness is more frequent in married (74.3 %) and single (64.6 %) and in people not isolated (72.3 %). Old people that perceived their health as good or very good had the highest percentage of happiness (88.5 %) followed by those that perceived their health as regular (69.8 %) or very poor and poor (45.5 %). People having problems interfering with daily living had lowest percentage of happiness (58.3 %) than people without problems interfering with daily life (77.6 %). People without cognitive deficit presented a higher percentage of happiness

Table 6.1 Association of explanatory variables with happiness

	n	Cases of happiness	Unadjusted			Adjusted		
			OR	CI 95 %	*p*	OR	CI 95 %	*p*
Age					0.001			0.049
<65 years	327	246 (75.2)	1	–	–	1	–	–
65–74 years	556	395 (71.0)	0.81	0.59–1.1	0.178	1.7	1.1–2.6	0.016
≥75 years	417	262 (62.8)	0.56	0.40–0.77	<0.001	1.4	0.86–2.3	0.181
Gender								
Male	378	285 (75.4)	1	–	–	1	–	–
Female	924	618 (66.9)	0.66	0.50–0.86	0.003	1.0	0.70–1.5	0.880
Marital status								0.078
Married	723	537 (74.3)	1	–	<0.001	1	–	–
Widow(er)	390	246 (63.1)	0.59	0.45–0.77	<0.001	0.72	0.50–1.1	0.089
Single	113	73 (64.6)	0.63	0.42–0.96	0.032	0.73	0.42–1.3	0.262
Divorced	64	40 (62.5)	0.58	0.34–0.98	0.043	0.42	0.20–0.92	0.029
Education					<0.001			0.005
High education	100	79 (79.0)	1	–	–	1	–	–
Illiterate	246	131 (53.3)	0.30	0.18–0.52	<0.001	0.91	0.35–2.3	0.838
4 years education	711	506 (71.2)	0.66	0.40–1.1	0.104	1.8	0.74–4.3	0.196
5–8 years education	79	61 (77.2)	0.90	0.44–1.8	0.774	0.99	0.36–2.7	0.978
9–12 years education	151	118 (78.1)	0.95	0.51–1.8	0.872	1.2	0.53–2.8	0.660
Income					<0.001			0.190
More than 3 minimum wage	169	139 (82.2)	1	–	–	1	–	–
One minimum wage	623	396 (63.6)	0.38	0.25–0.58	<0.001	0.77	0.37–1.6	0.485
Between 1 and 2 minimum wage	316	219 (69.3)	0.49	0.31–0.77	0.002	0.67	0.32–1.4	0.276
Between 2 and 3 minimum wage	149	117 (78.5)	0.79	0.45–1.4	0.403	1.3	0.64–2.8	0.435
MMSE								
Tertile 3	336	262 (78.0)	1	–	–	1	–	–
Tertiles 1 and 2	934	618 (66.2)	0.55	0.41–0.74	<0.001	0.75	0.49–1.2	0.206
Social network								
Large (≥20)	1021	738 (72.3)	1	–	–	1	–	–
Short (<20)	60	34 (56.7)	0.50	0.30–0.85	0.011	0.86	0.47–1.6	0.641
Number of diagnostics					<0.001			0.331
0	204	163 (79.9)	1	–	–	1	–	–
1 and 2	596	433 (72.7)	0.67	0.45–0.98	0.041	0.69	0.41–1.2	0.154
3 or more	502	307 (61.2)	0.40	0.27–0.58	<0.001	0.68	0.40–1.2	0.161
Problems interfering with daily life								
No	727	564 (77.6)	1	–	–	1	–	–
Yes	530	309 (58.3)	0.40	0.32–0.52	<0.001	0.85	0.62–1.2	0.325
Self-perception of health					<0.001			< 0.001
Very good/good	382	338 (88.5)	1	–	–	1	–	–
Reasonable	596	416 (69.8)	0.11	0.074–0.16	<0.001	0.12	0.070–0.21	< 0.001
Poor/very poor	312	142 (45.5)	0.30	0.21–0.43	<0.001	0.28	0.17–0.44	< 0.001

(78.0 %) than people with cognitive deficit (66.2 %). Looking at happiness as a dependent variable, the unadjusted odds ratio for happiness showed that all explanatory variables are associated with happiness. When adjusting for all the variables present in the model, only self-perception of health, education, and age remained associated with happiness. The model explained 20.5 % of variance in happiness.

In brief, all the associations between studied variables and happiness follow the expected trend that means being men, married, more educated and wealthy, with a larger social network and cognitively intact, with a better self-perceived health and less number of diagnosis, and without health problems interfering with daily life, rises happiness. When we control for all the variables in the model, only age, education, and health perception remain significant predictors of happiness.

The percentage of happy and very happy people in our sample is slightly below (68.3 %) the range observed in EU15 (70–80 %; Cummins 1995, 1998). When comparing the mean of happiness in Portugal with the mean of EU15, 6.8 versus 7.6 out of 10, we notice that Portugal had a clearly lower mean (Böhnke 2005). This conclusion appears repeatedly in other studies such as the European Social Survey with four waves up to now (Vala et al. 2010) probably showing the welfare inequalities between countries and in trend with a direct relationship with a country's level of prosperity and welfare. Our results are in the range of the expected for the country and we must notice that our sample just included people 55 years old and over. Contrary to some authors (e.g., Cooper et al. 2010), the percentage of happy people is lower in older cohorts in our sample. Age, particularly very old age, predicts less happiness probably showing a more helplessness cohort. Our results may have a historical explanation considering that those old people are one of the last generations of Portuguese people that lived the majority of their productive life under a dictatorship political regimen, living very difficult lives, and being resigned with their fate. Another explanation may be that the sense of finitude, the accumulation of losses, and several declines associated with age, decrease the sense of happiness, corroborating the findings of Easterlin (2006) that explain the continuing decline of happiness beyond midlife, by the dissatisfaction with health and a probable negative trend with financial situations. Portuguese population is the least happy among the EU15 and authors agreed with the idea that old people face a slightly higher risk of having poor subjective quality of life.

In the unadjusted model of happiness, gender is associated with health but this was no longer significant in the adjusted model. Our data seem to corroborate Inglehart (2002) that after stating that previous research has consistently found that men and women have similar levels of happiness, life satisfaction, and other global measures of subjective well-being, demonstrates that significant gender-related differences in subjective well-being exist, but tend to be concealed by an interaction effect between age, gender, and well-being. The author explained these results with the devaluation of old women in modern developed societies. Along with this possible explanation, we may think about the higher morbidity rate generally observed in women that based their self-perceptions of poor health closely related in our study with less happiness.

Although the percentage of happiness rises in direct association with income, when controlling for all the other variables in the adjusted regression model, income loses its potential to explain happiness, reinforcing the idea that there is no direct relation between wealth and happiness.

The percentage of happy people is higher in married people and about 10 points lower in all the other categories, suggesting that companionship is important for happiness although marital status did not explain happiness in the adjusted model. The same happens with social network. We must notice that the great majority of people in our sample have an extensive social network as it is common in southern European countries (Walker and Maltby 1997).

More people with large social networks are happy but social network is no longer significant in the adjusted model of happiness. Data from the European study of life satisfaction (Delhey 2004) show that in Portugal, the three most important self-reported factors contributing to quality of life are health, family, and income. Through a regression approach to life satisfaction, results show that the domains of satisfaction for Portugal are family, health, and social life. Family and social life are areas of general satisfaction in the Portuguese population to which people are adapted and probably do not promote happiness, as the set-point-of-happiness model previews (Lykkens and Tellegen 1996).

The education level, which for these cohorts is very low, keeps predicting happiness when controlling for all the other variables in the model. In this sample, the effect emerged mostly from illiteracy that still is a major problem among old cohorts, introducing a slightly different problem that is not the number of years of education but the absence versus presence of education. The absence or a very low level of education probably acts by isolating and withdrawing people from information, preventing a more active participation in society, promoting lower self-esteem, and making it difficult for them to have control over their lives.

Cognitive performance is associated with happiness, with more people with better scores being happy (78 %) than people with scores in the two worse tertiles (66.2 %). This findings is in line with Cooper et al's (2010). However, this variable is not significant in the adjusted model contrary to what happened with education.

Health perception, besides "real health" (number of diagnosis), seems to be a very important factor explaining happiness in old people as Angner et al. (2009) also showed. Although the majority of old people reported being happy or very happy (68.3 %), those perceiving their health as poor or very poor reduce in 72 % the probability of being happy, independently of their real health condition. By these means, self-perception of health shows up as a very good predictor of the happiness outcome.

Portuguese Older People: Between *Fado* and *Saudade?*

Evidence shows that most old people feel happy and that happiness varies with self-perception of health, stressing the importance of subjective variables in pursuing contentment. Nevertheless, Portuguese people, namely old people, are not as happy as expected considering the European Community context where it belongs since

1986, and this is visible when Portugal appears as an outlier in most of the cross-cultural studies (e.g., Inglehart 2010; Vala et al. 2010). These findings are puzzling and correspond to a mixture of negative thinking and resignation that may explain the negative correlation found by Inglehart (2010) between SWB and religiosity in Portugal. Probably religion attracts the unhappiest people as a final attempt to reduce unhappiness, and looking for reassurance and social support. Therefore, it is possible that the Portuguese culture is an expression of this persistent unhappiness. On this issue, there is a well-known Portuguese song called *fado*, which means fate or destiny, that is traditionally a poem about misfortune, death, and broken hearts; and, complementarily, the widely spread feeling of *saudade* (a feeling of mourning for people, places, or even trivial things) that always accompanied Portuguese people, or even love as a "contentment discontent" referred by the major poet Camões (sixteenth century). These are examples that stand for a peculiar and fatalistic attitude towards life. Although this may not be exactly unhappiness, it strongly deals with sadness and inhibits people to be happy and satisfied with their lives. More important than the answer to this philosophical question is to know if it would be possible to foster happiness particularly in old age.

Intervening on self-perceptions of health of old people by stimulating health comparisons with others, and cognitive reappraisal of health problems may seem effective in promoting a more positive perception of life as a whole (Araújo and Ribeiro 2011). Education should always be of concern, although it is very difficult to improve it significantly in later life, particularly for those who never attended school. We should research further the effect of education on happiness. We may question if the kind of association between education and happiness is direct or if education is a moderator between adaptive behaviors and happiness.

Boosting Happiness in Old Age

Relevant activities and practices are one of the factors associated with happiness and interventions promoting happiness may be based on behaviors that get people involved in intentional activities (Lyubomirsky et al. 2005). Those activities require some degree of effort to enact, namely in the field of gratitude and forgiveness, and must be concordant with the self. Although the authors only present examples of successful intervention with students, they may be used with old people. In line with these authors' suggestions, three main strategies are to be considered: (1) beginning with choosing a particular happiness-boosting activity fitting goal-person, usually involving belongingness, self-efficacy, and autonomy, (2) then initiate it, using self-regulatory effort, self-discipline, and will-power, and (3) finally maintain it through self-reinforcing. Activities like "*spend more time socializing*," "*became present oriented*", and "get *better organized and plan things out*" are types of strategies that probably will increase happiness in old people, as well as in younger ones, although we miss empirical evidence. Volunteering is a common example of a suggested activity that benefits volunteers—recipients as well as volunteers by, among other things, increasing the sense of worth and happiness.

Bearing in mind old people, one major theory to base upon interventions to foster happiness is Carstensen et al.'s (1999) socioemotional selectivity theory that considers that old people tend to maximize positive emotions by reformulating and selecting goals that best fit their actual capabilities and interests or reformulating old ones, adapting them to the time of their remaining life, as well as adapting to the challenges of getting old. By using the dual model of coping, Rothermund and Brandtstadter (2003) show how old people lower the expectancies in certain domains of behavior, according to their actual levels of performance in order to buffer the negative effects of deficits in subjective well-being. This corresponds to an accommodative and compensatory kind of coping allowing a successful adaptation and maintenance of happiness during the process of aging. Helping people to reformulate their goals and then engage in its achievement will be an efficient way of getting them involved in cognitive and volition activities that will increase happiness. By pursuing the objective of healthy aging, investing in old people toward their happiness is empowering them to cope with the challenges of the aging process and having more quality of life and SWB.

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Chapter 7
Dementia and Quality-of-Life Issues in Older People

Ana Diaz-Ponce and Suzanne Cahill

Background: The Facts and Figures About Dementia

> Worldwide, there is a new case of dementia every 7 seconds. (The Lancet, Ferri et al. 2005)

The increase in life expectancy as witnessed in today's Western World is a very positive feature of the twenty-first century. However, population ageing, and the particular increase in numbers of people across the world belonging to the middle-old and old-old age cohorts (75 and over) will inevitably result in an increase in disability, and a very significant increase in the incidence of age-related health problems including Alzheimer disease and the related dementias.

Dementia is an umbrella term used to describe a group of illnesses with common symptoms but with difference causes (Smith and Buckwalter 2005). It has been defined as "a group of diseases characterised by progressive and in the majority of cases, irreversible decline in mental functioning" (O'Shea 2007). Different diseases cause dementia of which Alzheimer's disease is by far the most common, accounting for approximately two-thirds of all cases (Jalbert et al. 2008). Other common dementias include vascular dementia sometimes known as multi-infarct dementia and lewy body dementia. Whilst dementia is predominantly an age-related illness, a very small percentage of people develop an early-onset dementia. In Ireland today, of the circa 42,000 people known to have dementia about 3,500 are men and women aged less than 65.

To date, little is known about the exact causes of dementia and despite much clinical and pharmacological research, dementia remains by and large a progressive and non-curable illness. In the case of AD, drug treatments may slow down the progression of the illness for some people; but these drugs do not tackle the underlying problem causing the dementia and as such fail to produce a cure. Clinical symptoms

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of dementia vary considerably depending on the dementia sub-type, the area of the brain affected, other co-morbidities and the course of the illness.

Typically, initial symptoms of dementia include short-term memory problems, language difficulties, disorientation problems along with mood and sometimes personality changes. Some people living with dementia (PLwD) are also likely to present with behavioral and psychological problems (sometimes known as challenging behaviours) such as aggression, agitation, depression, apathy, anxiety, delusions and hallucinations. As the disease progresses to the intermediate stage, usually the ability to perform basic activities of daily living (ADLS) becomes greatly impaired. In severe dementia, verbal communication and short- and long-term memory are very impaired or completely lost and people with severe dementia usually become totally dependent on others for almost all ADLs. Nevertheless, as O'Shea (2007, p. 6) rightly demonstrates, considerable variation in symptoms can occur during the course of the illness, "which means that not everybody with the disease will necessarily progress neatly from one stage to the next. The uniqueness of the disease must, therefore be acknowledged, in that no two individuals with dementia are likely to be affected in precisely the same way".

Although dementia is no longer considered a normal part of ageing, incidence and prevalence studies have consistently shown an almost exponential increase in dementia with advancing age. In patients aged more than 65, crude prevalence rates for dementia varied between 5.9 and 9.4 % (Berr et al. 2005) and the prevalence of dementia is said to double almost every 5 years. The magnitude of dementia therefore particularly in the light of world population ageing is huge. For example, at the beginning of the century it was estimated that worldwide there were between 24.3 and 27.7 million PLwD (Ferri et al. 2005; Wimo et al. 2006) and that by 2040 this figure would rise to 81.1 million (Ferri et al. 2005). Recently, European estimates (EU-27), suggest that some 7,300,000 Europeans are living with dementia (Alzheimer Europe 2009). In Ireland, last available estimates suggest that some 41,740 Irish people have a dementia (Cahill et al. 2012).

> In summary, as the risk of dementia increases exponentially with age, an inevitable consequence of population ageing will be the growth in numbers of older people presenting with a dementia. At a global level, today, there are probably around 24–35 million people living with dementia of whom more that 7 million are Europeans.

Perspectives on Dementia: Towards a New Understanding of Dementia

> (...) The doctor turned to me and asked me a question about myself. Someone outside my family and friends was interested in me, not my condition, not the disease, not what it felt like to have Alzheimer's disease. He asked a question about me! (Taylor 2007a)

It is argued that traditional approaches to understanding dementia are limiting since in strictly adhering to the bio-medical model (Bond 1999) this approach has failed to consider the subjective experiences of the illness. Stated simply, the bio-medical model is nihilistic and restrictive; it is said to reduce the individual with dementia to a diseased or atrophied brain and in so doing "squeeze the individual out" (Stokes 2000). The approach tends to view everything about that person's behaviour as being related to the dementia.

Despite such criticism, the bio-medical model has been hugely influential in shaping attitudes and approaches to dementia care over the years and in determining the direction of service interventions and research. Regrettably, this model has placed the spot-light on the illness, rather than on the person and on the limitations of the disease (Bond 1999), thus subjugating individuals to passive roles as "diseased victims" or "patients". Indeed, in this old culture of care, dementia was sometimes referred to as the "never ending funeral" and family caregivers regarded as the "hidden victims". The illness was seldom openly talked about and people with advanced dementia were often relegated to psychiatric settings where they were heavily medicated and offered little to no psycho-social stimulation.

Those who subscribed to this model considered dementia to be a condition beyond help and without hope (Gilliard et al. 2005). A nihilistic view prevailed—nothing could be done for these patients or sufferers and quality of life issues were seldom, if ever, considered. For a long time, health service professionals, subscribed to this bio-medical model of dementia, thereby neglecting social factors involved in the definition and interpretation of this disease and in the experience of dementia. In the words of Lyman, this led to a "legitimation of medical control over persons with dementia illnesses". (Lyman 1989, p. 603).

In the last few decades, several voices (see amongst others the work of Kitwood; Sabat; Oliver; Marshall; Downs; Bond; and Bartlett and O'Connor) have critiqued the dominance of the bio-medical model and have advocated for a new approach to dementia (i.e. psycho-social or humanistic model, social model and citizenship model). These writers have challenged the way dementia is understood.

The humanistic or psychosocial framework emerged in the early 90s and introduced the concept of "personhood" in dementia care. It was spawned by amongst others, the work of several psychologists including the late Tom Kitwood who have challenged the more traditional perspectives, arguing that PLwD are first and foremost people who are unique and continue to have value. They have brought attention back to the person; thereby "reinstating the person as a valued human and social being with moral worth and entitlement to human rights" (Downs 2010, p. 238). Kitwood defined personhood as "an status that is bestowed upon one human being by others in the context of a particular social relationship and institutional arrangements". The work of Kitwood stressed the importance of the interpersonal relations in understanding the experience of dementia and in dementia care. From this perspective, how the individual with dementia is treated and perceived has a great influence in his/her performance, behaviour and QoL (Bartlett and O'Connor 2010)

The social model of dementia, which adopts the social model of disability is a relatively new way of thinking about dementia (and was advocated notably by Marshall). From this approach dementia is regarded as a disability and PLwD as citizens, and focusses on rights and social inclusion rather than on impairment. The social model differentiates between the impairment that PLwD may have and their disability, implying that the difficulties faced by the person are a product of society rather than just due to individual's deficits. They argue for a better understanding of the subjective experiences of living with dementia, the impact and significance of the social context has to be incorporated.

Proponents of this new culture of dementia care would argue that individual's perspectives and experiences are unique and worthy of being listened to. The social model suggests that those diagnosed and living with dementia are the experts and should be carefully listened. In this way, agency moves from the medical staff to the individual living with dementia.

The individual's response to dementia and its consequences are central to the social model. Proponents of this perspective would argue that an understanding of dementia needs to take account of the life story of PLwD and their carers, their material circumstances, the meaning dementia has for the individual and the struggles they experience to be included in society as citizens. This new way of viewing dementia and the emerging new culture of care reflects the view that much can be done to improve the QoL of PLwD whilst we continue to await the "magic bullets of biomedical advances" (Bond 2001). This re-casting of what having a dementia really means, has placed much greater emphasis on QoL issues and on the social context of dementia and the way in which this illness is experienced.

The Emergence of a QoL Interest in Dementia Care This change in the conceptualisation of dementia as reflected in the shift away from bio-medical approach —diagnosis and treatment, to a social or bio-psycho-social approach—more holistic, together with an interest in gaining insights into how PLwD experience the illness, including an improved understanding of positive states and of personhood, has resulted in a burgeoning body of literature on the topic of QoL and dementia. To illustrate this point, a recent literature search, using the keywords "quality of life" and "dementia" on various engines (CINAHL, PsychInfo, Pubmed and Medline), yielded a total of 387 citations for the period 1980–1999; this same search for the period 2000–2009 yielded a total of 2,240 citations, reflecting the vast growth in interest in this topic.

A key contributor to this debate on QoL and dementia is the late Powel Lawton—an American Psychologist whose writing pre-empted Kitwoods but whose work remains seminal. Lawton originally defined QoL to mean "the good life". Whilst his work (dating back to the 1980s) is still considered by some as the most systematic attempt to conceptualise QoL in older adults and PLwD (Ready and Ott 2003; Ettema et al. 2005; Jonker et al. 2004). Most of the subsequently developed models and measurement instruments refer to his work (Ettema et al. 2005).

Lawton's conceptual framework was envisaged as a meta-construct and presumed to account for all areas of life, for every aspect of behaviour, the environment and experience (Ettema et al. 2005). He argued that the concept of quality of life was multidimensional and thus, quality of life, must be assessed both objectively and subjectively. In his own words, "quality of life is the evaluation, by subjective and social—normative criteria, of the behavioural and environmental situation of the person" (Lawton 1994, p. 138). Lawton identified four overarching dimensions in QoL : (1) psychological well-being, (2) behavioural competence, (3) perceived QoL and (4) objective environment (Lawton 1994). He proposed that the assessment of *behavioural competence* may include activities of daily living (external–normative evaluation), cognitive performance (neuropsychological testing) and social behaviour (using scales of pathological behaviour). The *environment* might be assessed either by physical means (amount of space in the bedroom, presence of amenities, physical safety, privacy, etc.) or by experts' ratings of the "homelike quality of a care area". Finally, the two subjective dimensions (psychological *well-being and perceived QoL*) refer to the person's own subjective evaluation of the many facets of his or her environment and mental health. (Lawton 1994, pp. 138–139). Lawnton's model presents "psychological well-being" as the subjective individual evaluation of the person's overall QOL and is consequently proposed as the ultimate outcome of the model.

In the case of PLwD, Lawton (1994) proposed that QoL measurements should in addition include, the following domains: (1) competent cognitive functioning, (2) the ability to perform activities of daily living (ADL), (3) positive behaviour in external engagement (time use and social behaviour) and (4) a favourable balance between positive emotion and absence of negative emotion. He concluded that the major components of the usual assessment batteries (cognitive function, ADL and pathological behaviour) "shall be considered legitimate indicators of quality of life" (Lawton 1994, p. 149). However, he understood that positive QoL must also be included in assessment, i.e. the use of time, social interactions and affective domains. Although Lawton did not develop a particular scale, most of the disease-specific scales in dementia have been based on his work (Ettema et al. 2005)

> In summary, interest in dementia and in quality of life issues has grown enormously in recent years as new insights into Alzheimer's disease and the other related dementias have emerged and as new ways of thinking about creative ways for providing person-centred care have developed. A shift in paradigms has also occurred; from dementia being traditionally seen only as a medical–biological health issue, to nowadays it being seen as a disability characterised by memory and cognitive impairment and helped or hindered by prevailing social attitudes and by positive or negative care practices. This paradigm shift has brought the individual with dementia back to the centre stage. It has placed a much greater focus on quality of life issues. Whilst recognising that dementia is an incurable disease, much it is argued can still be done for the individuals living with this condition. Consequently, how to promote and maintain optimal well being and quality of life has become a main concern in care and research (Ettema et al. 2005). Nowadays, any type of intervention should primarily aim at improving or maintaining QoL.

Main Challenges in the Definition of QoL in the Context of Elderly People and Dementia

> Quality of life is defined in so many ways by so many people and, regrettably, often is not defined. (Lawton 1997)

Since the time of Powel Lawton's writings, many systematic attempts have been made to develop an acceptable definition of the concept of QoL, particularly as it relates to old people and to PLwD (Lawton 1997; Bond 1999; Ettema et al. 2005). Although a number of unresolved issues still exist, some level of concordance on what the term should embrace has recently been achieved, reflecting the fact that the construct should be multi-dimensional, holistic and that it should include, when possible, the subjective perceptions of the individual (see amongst others Selai and Trimble 1999; Brod et al. 1999; Ready et al. 2002). The section to follow will address some of the main unresolved challenges that this area still faces.

What Do We Mean by QoL and Why Is it Important? Despite Lawton's earlier and in-depth contribution to this body of literature and the more recent burgeoning interest in "quality-of-life " issues, curiously, little agreement exists in theory and in practice as to what the term "QoL" actually means and today one of the major challenges confronting people working in this area is how best to conceptualise and define it. As Taillefer et al. (2003) pointed out, a lot of confusion exists about the concept as many researchers fail to define what they mean by QoL in their investigations. It is suggested that a clear-cut definition of QoL is needed as Feinstein's description (1987), till date QoL has been used as an "umbrella" concept where almost everything could be considered to be part of QoL. As an example, over the last decades, the term quality-of-life has been used in many different ways, being used several times as a proxy for health, ability to function or psychological well-being. This means that the concept of Qol often can "mask differences in conceptualisation and in what is being measured" (Bowling 2001).

Despite this lack of consensus on definition, nonetheless, agreement does exist that QoL is a very important issue in the context of research in dementia and dementia care. It is important for several reasons not least the fact that global ageing means that in the absence of a cure for dementia, prevalence rates will continue to rise and increasingly the interest will be in finding out how people live and cope with this illness. In addition, with no curative treatments imminent, researchers will continue to need outcome variables, which may help to demonstrate the effectiveness of certain approaches to care including pharmacological and non-pharmacological interventions. Indeed, it has been argued that from a health economics perspective, QoL assessment can be considered as the best way of appraising outcomes of treatments and should inform "health economic decisions and debate about the allocation of scarce resources" (Selai and Trimble 1999, p. 101). QoL issues are also important in the context of dementia care, as if we are successful in detecting those most at risk, i.e. those with a poor or reduced QoL, we can identify where resources can be best channelled.

A further issue concerning QoL definitions, which still remains unresolved, is the distinction between QoL itself and the main factors influencing QoL (Taillefer et al. 2003). In the area of dementia, for instance, much debate exists about the role that "cognition" and other "disease-orientated issues" may play in determining QoL. Some experts, for example, have used "memory" as part of their QoL definition and measurement in dementia whereas others have seen it not intrinsically as part of Qol, but rather as an indicator or potential predictor of QoL.

Health-Related Versus Environmental-Based QoL Another key distinction in defining the construct QoL is between health-related QoL (HRQoL) and non-health- or environment-based QoL (Power 2003). Spilker and Revicki (1996) state that HRQoL, “represents those parts of quality of life that directly relate to an individual’s health. This includes domains such as physical, psychological, social, spiritual, and role functioning, as well as general well being”. As HRQoL refers to aspects of QoL that are directly affected by changes in health, it is expected to improve with an appropriate medical treatment. In contrast, non-health-related QoL domains include the environment (e.g. financial resources, housing, access to entertainment, etc.) and personal resources (e.g. friendships, appreciation of nature or aesthetics, spiritual and religious life, etc.). These are factors that do not easily change/improve with medical care.

One of the main dilemmas when applying the HRQoL construct to elderly population is that inevitably HRQoL declines with age and in the case of dementia, as the disease progresses, the health status of the person will inevitably deteriorate. Also, although the World Health Organisation (WHO) definition of health draws attention to a comprehensive understanding of health, including one’s bio, psycho and social well-being, as Jonker et al. have argued, focussing on HRQoL has often led researchers to examine aspects of QoL affected predominantly by disease, addressing issues mostly relating to limitations and handicaps (Jonker et al. 2004). In contrast, environmental factors (non-health-related) are not influenced by decline and can remain high regardless of age or even improve with greater age.

Normative Versus Subjective Approaches to QoL Another dilemma in attempting to define QoL is whether the concept is a normative, i.e. objective or subjective. Normative approaches to QoL are basically embedded in positivist functionalist social science (Bond 1999). Here, QoL is assessed externally and any measurements developed are built from the researcher rather than a lay perspective (Bond 1999). The domains included are based on what the researcher feels is important. The approach taken implies that it is possible to measure QoL objectively and consequently, the person has little to say about how he/she feels about his or her own QoL. An example of this can be found in the bio-medical model of QoL that places most emphasis on functional capacity. Implicit within this viewpoint is that all people aspire to an optimal level of functioning and consequently those who are impaired or have a disability have inherently a worse QoL. From this perspective, PLwD are irrevocably “fated” to a poor QoL as their illness advances.

However, in the 1970s the notion that QoL could be a subjective concept gained relevance, as it was argued that QoL is entirely a subjective concept to which every individual attaches different meaning. From this perspective, the definition and particularly the measurement of QoL is a greater challenge, especially in the area of dementia. It suggests that only the individual is able to determine what really matters in his/her life and then he/she is the one to establish what is optimal.

The disability paradox is a good illustration of this. It has been consistently reported how people with serious illness, disabilities, and as well those living with dementia, report that they experience a good or excellent QoL and this does not concur with an objective external evaluation of QoL. From this perspective, measurements will try to reflect what people consider relevant for their lives and their own evaluation of the different domains. In the area of dementia research, Carson argued that although this approach does include the perspectives of PLwD, “their subjective accounts are limited to self-reports on response items within domains that may or may not be personally relevant” (Carson 2008, p. 1). And, consequently, subjectivity does not refer to the individual evaluation of what matters in life. It is therefore “the researcher and not the individual who determines which domains are to be assessed” (Ettema el al. 2005, p. 363). A “truly subjective” approach is the one proposed by phenomenology. This approach recognises the personal nature of QoL and takes as its starting point, the individual and the perspective of the person identifying important domains to their life and their QoL. Thus, QoL is defined as what the individual determines it to be. (Bond 1999)

One example of the difference between the approaches explained above can be seen when measuring QoL. A PLwD can be assessed “objectively” about his memory (e.g. using a mini-mental state examination [MMSE] test) or can be asked how does he/she feels the memory is at the moment or how much does he/she worry about his/her memory, or can just be asked what is important to him/her without anticipating “memory” has to be relevant to him/her.

Finally, some scholars have proposed a mixed definition of QoL. For instance, Lawton’s conceptual framework developed in the 1980s to define QoL proposes that QoL needs a “multidimensional evaluation, by both intrapersonal and social normative criteria, of the person environment system of the individual” (Lawton 1991 as cited by Ettema et al. 2005, p. 356). His framework reflects the view that QoL comprises both objective components (behavioral competence and environmental quality) as well as subjective components (perceived QoL and psychological well-being).

QoL as a Dynamic Construct Finally, another critical aspect of QoL is that it is a dynamic concept that changes not only amongst people but also over time, according to changing circumstances or life stages. Carr et al. (2001) have argued that QoL is closely related to individual expectations (discrepancy between expectations and experience) and have pointed out how people’s expectations may change over time (accommodation/adaptation to change) and thus the evaluation of QoL will change over time. The fact that QoL is a construct under constant review (Allison et al. 1997) constitutes another challenge to its definition and measurement.

In the dementia research, this is very relevant as some research has shown that PLwD and their family caregivers may adapt (response shift) to the limitations of the disease in their daily life and that this may help to explain their positive evaluation of QoL. For instance, Byrne-Davis et al. (2006) advocate that change in QoL of PLwD as a result of a change in health (e.g. the diagnosis of dementia or the limitations produced by the disease) may be transient or may even never happen, as QoL is the result of both external and internal processes. They propose that PLwD may still report a very good QoL without any external intervention that “repairs” their limitations because they can “adjust” to anything using internal processes alone. They regard "response shift" (adaptation to change) as the "essence" and not a measurement anomaly of QoL in dementia.

In longitudinal studies on QoL in dementia, findings show that in most cases QoL (1–2 years follow-up) changes very little over time (up to 2 years follow up) or does not change at all. Lyketsos et al. (2003) in the United States conducted a 2 year longitudinal study and found a small decline in QoL, the only predictor they could associate was low QoL at baseline. Karlawish et al. (2004) in a 12 months follow-up study, found that functional deterioration was more strongly associated with decline in QoL than decline in cognition. More recently, European studies (Hoe et al. 2005; Selwood et al. 2005; Missotten et al. 2007) found no change in QoL over time.

> To summarise, QoL is a complex concept that poses several challenges by way of definition and measurement. It can be defined as "a multidimensional collection of objective and subjective areas of life, the parts of which can affect each other as well as the sum. It is also a dynamic concept, reflecting values as they change with life experiences and the process of ageing". (Bowling and Gabriel 2004)

How and by Whom Should QoL Be Measured in the Context of Dementia?

> If you really must know about the quality of my life, just ask me! My answers to your questions won't be reliable, and won't be valid. But they will be true for me. (Taylor 2007b)

How Should QoL Be Measured in Dementia?

Generic Versus Dementia-Specific Tools Generic QoL instruments have been devised to assess QoL across a wide range of populations and interventions. On the other hand, disease-specific measurements are designed to be relevant to particular interventions, certain sub-populations or patient groups that are disease-specific (cancer patients or PLwD).

Disease-specific QoL measurements include domains that are important for the particular disease under investigation and thus they facilitate an understanding of the impact that this disease may have in the person's QoL. Whilst this makes it more difficult to generalise results (comparison of results across different diseases or with general population), these disease-specific scales are more responsive than the generic ones to any change due to the course of the illness or in response to treatments (Schölzel-Dorenbos et al. 2010)

In dementia research, whilst generic QoL instruments such as Euroqol (EQ-5D), or Duke Health profile, or SF-36, etc.) have sometimes been used to assess QoL, a consensus exists that disease-specific instruments are more suitable (Smith et al. 2005; Ettema et al. 2005). It has been argued that most generic measures are not well designed to enable PLwD to complete (Smith et al. 2005). A recent German study conducted by Schiffczyk et al. (2010) confirmed this; their findings showed that the Euroqol failed to capture the effect of dementia on patients' daily lives. The authors concluded that "rating of the QoL with Euroqol is a useless measure in dementia research" (Schiffczyk et al. 2010, p. 55)

There is a growing number of disease-specific scales available in dementia. In 2005, Ettema et al. identified 6 dementia-specific scales to asses QoL, Ready and Ott reported 9 in 2003 and Schölzel-Dorenbos in 2010 listed a total of 16 different scales. Some of the most widely referenced disease-specific scales in dementia are: ADR QL (Rabins et al. 1999), QOLAS (Selai and Trimble 1999); DCM (Kitwood); DEMQOL (Smith et al. 2005); DQOL (Brod et al. 1999); QoL-AD (Logsdon et al. 2002); QUALID (Weiner et al. 2000), Qualidem (Ettema et al. 2007) and BASQUID (Trigg et al. 2007b). However, the relevant domains included in these scales vary considerably (Schölzel-Dorenbos et al. 2007); confirming the lack of agreement about what domains best represent QoL in dementia (Bond 1999). In almost all dementia-specific QoL measurements, "affect" has been found to be an essential domain (Ettema et al. 2005; Schölzel-Dorenbos et al. 2007). In addition, most scales contain at least one of the following domains: (1) self-esteem, (2) activities, (3) enjoyment and (4) social interaction (Ettema et al. 2005).

Overall, no single instrument on QoL can claim superiority or has a gold standard rating and no one particular instrument adequately captures the broad canvas of QoL (Sloan et al. 2005). Likewise, none of these instruments can be used to evaluate the effect of every intervention in every care settings and stages of dementia. Schölzel-Dorenbos et al. (2007) suggested that different factors such as severity of dementia, care-type/setting, and the specific QoL domains, an intervention focuses on, are the key factors that may help to decide which instrument should be used. Recently, the INTERDEM group led a literature review (Moniz-Cook et al. 2008) looking at different instruments for measuring the outcomes of psychological interventions and in the case of QoL they concluded that overall the QoL AD (Logsdon et al. 2002) seems to be "the measure of choice" as it is short and easy to complete, has been used widely and translated to several different languages. Although initially Logsdon et al. (2002) only involved people in mild stages, later work in the United Kingdom reported that the scale could be used with people whose MMSE score was as low as 3—severe cognitive impairment (Hoe et al. 2005; Thorgrimsen et al. 2003).

Whose Views Should be Sought when Doing Research About QoL and Dementia?

Gathering reliable and valid data from PLwD has been regarded by some as one of the major challenges of research on QoL in this population. The individuals' capacity to reliably report on their QoL has been questioned due to their obvious cognitive deficits. In particular, issues around cognitive decline; difficulties in communication and attention; loss or denial of insight; anosognosia (unawareness of deficits) and neuropsychiatric symptoms (agitation, delusions, anxiety, etc.) have been identified as the main barriers to self-reported QoL (Selai and Trimble 1999; Thorgrimsen et al. 2003, etc.). In addition, it has been noted that although people in mild stages of dementia can answer questions, these patients are likely to give overly optimistic ratings (Selai 2001).

However, in recent years there is growing evidence to suggest that PLwD can respond accurately to questions asked about their QoL (Brod et al. 1999; Logsdon et al. 2002; Ready et al. 2002; Trigg et al. 2007a; Cahill and Diaz-Ponce 2011, etc.). Research has confirmed that mild to moderate cognitively impaired individuals "can articulate feelings, concerns and preferences and provide evaluations of their health and quality of life" (Cahill and Diaz-Ponce2011; Trigg et al. 2007a, p. 2). Short, straightforward, face-to-face interviews have been deemed appropriate for this population.

Whilst there is a general consensus about the reliability and ease with which those with a mild cognitive impairment can respond to QoL questions, views differ in relation to those with a moderate-stage dementia, and generally in the cases of people with severe dementia, a proxy report is recommended (Kane 2003). Brod et al. (1999, p. 33) concluded that in the context of dementia, the validity of the responses in relation to questions asked is reliant on two factors: "(1) the respondent's ability to comprehend the question being asked and (2) the respondent's awareness of his/her internal subjective status".

QoL's instruments have followed different approaches, some such as the QoL-AD have incorporated both self- and proxy-reported information (either in a joint interview or separately) to provide a more comprehensive and accurate measure of QoL (Ready and Ott 2008; Smith et al. 2005), others advocate to exclusively collect the PLwD's point of view (Brod et al. 1999).

When comparing both sources (self versus proxy), patient-proxy agreement in QoL in dementia has been shown to be moderate at most (Smith et al. 2005). Moreover, it seems that PLwD mostly report their experiences "here and now", whereas relatives respond on the basis of both the past and current situation (Smith et al. 2005). Also, proxies have been found to frequently underestimate clients' or relatives' QoL (Thorgrimsen et al. 2003; Ettema et al. 2005). Proxy ratings may be biased by the proxy's own expectations and belief system, their prior or current relationship and the burden of care (Weyerer and Schaufele 2003). Objective and concrete questions have been reported as providing a higher level of agreement between the proxy and the PLwD (Weyerer and Schaufele 2003; Ettema et al. 2005).

Observational methods have also been considered as a third approach to evaluate QoL in dementia. Observational methods include the researcher or a trained staff member as a proxy. This method has been mainly developed for institutional care. Using the Dementia Care Mapping, Kitwood and Bredin were amongst the first to employ this method in dementia care. However, limitations of this approach include: (1) uncertainty about whether what is being observed is what the individual considers important and corresponds with how the person perceives his/her QoL; (2) direct observation may also be biased and (3) observational techniques require extensive training and are time consuming (Thorgrimsen et al. 2003; Weyerer and Schaufele 2003).

What Do We Know About QoL in Dementia? A Summary of the Main Findings Using Quantitative and Qualitative Approaches

> QoL is a subjective concept, yet most measures of QoL are based primarily or partly on 'expert' opinions. (Bowling and Stenner 2011)

Over the last decades, several studies, using one or more of the validated scales, have been carried out and have yielded diverse and sometimes contradictory results in relation to QoL and dementia. A key finding is that PLwD have reported better QoL than expected, and have more positive assessments of their own QoL compared with proxy informants.

Although a number of factors and predictors have been studied in QoL in dementia, overall the only factor known to affect QoL is mood (depression and anxiety) . Other variables including age, gender or level of education have been shown not to be associated with QoL (Banerjee et al. 2009). Atypically, Banerjee (2006) reported worst QoL in younger PLwD and they believed this could be associated with lower expectations as the person grows older. However, overall there is no evidence to suggest a clear association between QoL and demographic factors.

Findings about the effects of cognition and activity levels on QoL in dementia are also incongruent. Staff members and family caregivers often identify poor physical functioning and impaired cognition as a detriment to patient QoL, whereas when self-reporting is used most evidence suggests that there is no association between cognition or function and QoL. This same pattern has been observed in the relationship between QoL and neuropsychiatry symptoms and challenging behaviour (irritability, apathy). A clear and consistent pattern has been noted with much poorer QoL ratings being reported by staff or relatives, a finding inconsistent with the ratings on QoL by PLwD themselves (Banerjee et al. 2009). It has been argued that anosognosia could play an important role in this as PLwD may not be aware of their limitations and this may explain the lack of association between those factors and QoL.

Studies investigating insight and anosognosia have yielded discordant findings. Whilst some studies suggest no clear relationship (Vogel et al. 2006), more recent studies suggest that impairment of insight is associated with better HRQoL in people with moderate dementia (Hurt et al. 2010) were in accordance with the latter work where they showed that lower awareness of memory function may be associated with better QoL.

Finally, most of the literature suggests that the place where the person lives may have an important impact on QoL. It is assumed that PLwD living in the community (at home) enjoy a better QoL than those living in a long-term care. Curiously, this view has been questioned by a recent research conducted in Belgium where people with MMSE scores from 4 to 18 (indicating severe to moderate CI) living in an institution presented better QoL than people living at home (Missotten et al. 2009).

Finally, there is a growing interest in investigating the potential benefits in terms of quality of life of both pharmacological (anti-dementia medication) and non-pharmacological (psychosocial) interventions in relation to quality of life. Research conducted in the United Kingdom (Orell 2011; Banerjee 2011) seems to indicate that both types of interventions have a small but similar effect improving QoL of PLwD.

As stated so far, most of the work in the area of QoL and dementia has used quantitative approaches (using validated scales) and has provided controversial but very useful information. However, given the complexity of the area, recently a growing body of literature suggests that qualitative approaches in dementia research can widen and complement current knowledge and thinking. By eliciting PLwD's voices and experiences, qualitative approaches can help to generate new ideas and concepts (Gibson et al. 2004) and may produce a better and deeper understanding of QoL in dementia. Over the last decade, a number of studies using exclusively qualitative methods and interviewing PLwD and their caregivers have been conducted exploring what matters most to them and the factors that mostly contribute to their QoL.

Some examples of such work include studies undertaken by Brod et al. (1999), Smith et al. (2005) and Byrne-Davis et al. (2006). The latter in using qualitative approaches and by including PLwD in the development of their frameworks have added new and relevant information to the conceptualisation of the term. For instance, Brod et al. (1999) were one of the first researchers who incorporated the voice of PLwD to help to guide and conceptualise QoL in dementia. Brod's work used three focus groups consisting of caregivers, health care providers and people with a mild to moderate dementia to help develop the Quality-of-Life Scale (Thorgrimsen et al. 2003). Although this involvement was limited (only six PLwD participated), it was a novel way at the time of working as up until then the only evidence was based on literature; on the perceptions of nursing staff (e.g. Deletter et al. 1995), or family caregivers and experts in the area of dementia (e.g. Rabins et al. 1999). From this qualitative investigation, Brod et al. (1999) concluded that traditional domains included in QoL were relevant to PLwD (i.e. physical functioning, activities, mobility, social interaction and bodily well-being). Also, they found two new relevant domains to PLwD: aesthetics ("experience of appreciation and pleasure obtained from sensory awareness") and interaction capacity ("communication difficulties as well as difficulties in social interactions"; Brod et al. 1999, p. 29).

Another example of involving people in research affected by the condition can be seen in the work of Smith et al. who developed the DEMQoL (2005). To complement their conceptual framework, they carried out 19 individual interviews with community dwelling PLwD (including people with mild, moderate and severe cognitive impairment) and 20 interviews with family caregivers. Their framework includes five conceptual domains, namely: (1) daily activities, (2) health and well-being, (3) cognitive functioning, (4) social relationships and (5) self-concept. Whilst most of their findings concurred with generic models of HRQoL, they advocate that some of the domains that emerged in their work (i.e. domain "Self-concept" and the Subdomain "embarrassment") are unique to dementia and are not well represented in generic models of HRQoL. Interestingly, they eliminated two initial components mentioned by PLwD, that is: (1) keeping busy and (2) fearfulness as the evidence supporting these was insufficient. Conversely, they included other components such as going to the toilet, using a knife and a fork, etc. which although not mentioned by PLwD, were supported by the literature, or by experts or caregivers. Their work also confirmed that reports about QoL from PLwD and caregivers may differ and that to rely exclusively on proxy reports may be questionable. Their research shed new light on the idea that some aspects of HRQoL are specific to dementia and then specific frameworks and scales have to be used for its understanding and measurement.

Building on earlier works, Byrne-Davis et al. (2006) made the point that PLwD had been rarely involved in the exploration of the construct of QoL. To address this, their conceptual model primarily relied exclusively on the reports of PLwD. They carried out nine focus groups including a total of 25 PLwD all living at home. They found a total of 22 issues that contributed to QoL and in contrast with previous work, their work revealed that almost all of the reported issues were non-dementia-specific. For example, only 2 out of the 25 participants mentioned that their memory problem or the disease affected their QoL. In this way, their conceptual model challenges the belief that cognitive domains have in most QoL scales in dementia. Their model proposes that QoL is the "outcome of a process of evaluation of (personal) issues that are important to us" (Byrne-Davis et al. 2006, p. 861). This consists of evaluating where relevant issues are according as the person would like them to be and whether the person is able to cope with the potential discrepancy. They argue that in dementia "social comparison" and "evaluation of own happiness" are key components that contribute to overall QoL. They also suggest that people almost always tend towards homeostasis (adaptation). In their model, "coping theories" and "response shift" have a central position for understanding QoL in dementia.

In recent years, many research studies have been conducted using qualitative approaches exclusively (Jonas-Simpson and Mitchell 2005; Train et al. 2005; Dröes et al. 2006; Cahill and Diaz-Ponce 2011). These studies have explored in depth what matters most to PLwD and the factors that mostly contribute to their QoL. Overall, this body of qualitative research reveals that PLwD associate their QoL with: (1) a general feeling of happiness and contentment; (2) their relationships with others, particularly their family; (3) attachment and feelings of belonging; (4) health; (5) being given freedom and choice; (6) having access to privacy, security and feeling treated with dignity and respect, (7) self-esteem, feelings of worthiness, being useful, meaningfulness (8) enjoyment of activities and having something to do and look forward to (9) spirituality and (10) finances (Dröes et al. 2006; Jonas-Simpson and Mitchell 2005; Moyle et al. 2007; Train et al. 2005; Byrne-Davis et al. 2006). Conversely, feelings of loss are very common with this population of older people and the latter have been reported as having a detrimental effect on their QoL.

An Irish study carried out in Dublin by the authors of this chapter and investigating QoL in people with different levels of CI living in a long-term institution, reported very similar results (Cahill and Diaz-Ponce 2011). In this research, four main themes emerged, which appeared to be associated with QoL. These were: (1) relationships, (2) attachment, (3) affect and (4) activities. Similar to other studies, the family in general and social relationships in particular emerged as the main priority and source of happiness for most of these elderly men and women. For this group "attachment" to the environment where they now lived was very relevant. Several of these people interviewed reflected back to their former homes and neighbourhoods where they used to live. For some, particularly those with a mild to moderate CI, the NH felt now like home, whereas others could not feel in this way and some still craved for home. In addition, in this same study, the QoL of residents with mild, moderate and severe dementia were compared, and the main conclusion reached was that people with mild CI seemed to report a better QoL and felt more at home in the NH. The most striking differences in QoL was found in the narratives of those with a mild versus severe cognitive impairment.

Overall, it seems that this inclusive way of looking at QoL in dementia may help gain a better understanding adding new and relevant information to the area. Firstly, it acknowledges that self-ratings on QoL provided by the PLwD are valid, reliable and useful. Using qualitative approaches also enables those with different levels of impairment including those with very severe dementia to be involved. This qualitative approach is more in keeping with the current understandings and perspectives on dementia where the individual is valued and put back to the centre, and where the person and his or her understanding and evaluation of QoL is the best Gold Standard to measure and conceptualise QoL.

> To summarise, although research using validated scales has yielded very relevant findings, recently it has been argued that to achieve a better and richer understanding of QoL, PLwD's own views must be taken into account. Including PLwD subjective views in research has proved effective to further our understanding and obtain a better conceptual models for QoL in dementia. QoL scales do not encompass all issues that are important to this people, and although PLwD and caregivers' subjective views seems to be quite similar, "they differ in their thinking about the concrete aspects that affect the quality of life in dementia". (Dröes et al. 2006)

Conclusions

- QoL is a complex term and difficult to measure. Attempting to measure QoL in PLwD adds new challenges to its definition and measurement.
- QoL can be defined as a multi-dimensional concept; it is made up of both subjective and objective factors.
- When defining and measuring QoL in dementia, disease-specific approaches seem to work better than generic instruments.
- In addition, QoL has to be regarded as a dynamic construct, and some research may suggest that it may be very difficult to generate a single instrument that applies to all stages of dementia. In the area of dementia, adaptation to illness and response shift may add some challenge to measuring QoL over time.
- Evidence suggests that PLwD can provide reliable information about their QoL, Proxy informants tend to underestimate PLwD QoL and because of this proxy information does not accurately reflect PLwD priorities and evaluation of their QoL.
- Research conducted with proxy informants tends to associate QoL in dementia with neuropsychiatric symptoms, worst cognition and activity limitation but this does not concur with the reports of PLwD.

- One of the main challenges in research in this area is measuring QoL in people with a severe dementia as these are very vulnerable people that have been largely ignored when looking at QoL.
- Measuring QoL in people with a mild to moderate dementia is achievable but capturing the subjective perspectives about well-being and QoL from those with a severe impairment is a lot more challenging.
- A growing number of validated scales have been developed to measure QoL in dementia and research using these scales has yielded very useful information. Cognition and function appear not to be directly related to QoL in dementia. Although a number of other variables have been investigated, till date, the only factor emerging as being consistently associated with QoL in dementia is mood.
- Recently, it has been suggested that by involving PLwD themselves in qualitative research a richer and more in-depth understanding of their priorities and of the factors associated with QoL in dementia.

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Chapter 8
Changes in Functional Ability with Ageing and Over Time

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Introduction

The steady increase in life expectancy in most European countries implies that a growing number of citizens reaches higher ages increasingly. For decades now, this development has been a cause for concern to policy makers and the general public because of the expected increase in costs of health and social care. This concern has given rise to the need for population-based data to monitor health and daily functioning of older persons, and to obtain insight into trajectories leading to the utilisation of care services. For projections of health and social care costs, it is furthermore of interest to monitor trends in the prevalence of ill-health and disability at the population level to see how this changes over time.

The concept of disability, in this chapter, is defined as a consequence of ill-health or illness, generally chronic diseases. Disability is established as a powerful indicator of health status at older age (Guralnik et al. 1996). Some theoretical models have been developed with the aim of conceptually linking ill-health to disability, including the model adopted by the World Health Organisation (WHO 2002), which defines functional ability as encompassing all body functions, tasks, or actions, and disability as including impairment, limited capacity or restricted performance of activities. Measurement of disability usually entails self-reports of difficulty or need of help in performing everyday tasks needed for independent living. The term disability is often used to include mobility impairment, which is considered to precede disability in

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activities of daily living (Verbrugge and Jette 1994). In a growing number of studies, performance-based tests are used to capture early stages of disability (Guralnik et al. 1994).

If prevalences of ill-health and disability rise or fall, factors responsible for these changes need to be traced. Thus, determinants of the onset and course of disability, as well as consequences of disability, need to be studied using longitudinal data. This chapter reviews empirical data on trends in the prevalence of disability, on changes in functional ability and on determinants and consequences of such changes.

Availability of Data

Comparison of morbidity and disability across European countries is difficult, because each country shapes its health policy using its own concepts and measurement of health indicators. The first international studies started in the 1960s and 1970s in a few European countries, but were limited in scope or included only a selection of the older population (Appels et al. 1996; Jylhä et al. 1998; Knoops et al. 2004).

Since the 1980s, epidemiological studies of health and functioning in older age have boomed. Although the initial focus of epidemiological studies was mainly on ageing-related chronic diseases, their focus shifted to independence in daily functioning as this was increasingly considered to be an essential aspect of healthy ageing. Several of these studies, moreover, were interdisciplinary in scope, because there was an understanding that with ageing, physical, mental and social aspects of functioning are closely related. Most were confined to smaller geographic areas such as one city or county.

Only in the 1990s, a number of cross-national surveys became available that used common instruments and sampling methods. The best known is the European Community Household Panel survey, conducted in the non-institutionalised population in 13 countries. For the assessment of health in older age, however, this survey is less suitable, because in many countries a sizeable proportion of older persons live in institutions.

In the early 1990s, in various countries across Europe, longitudinal studies on ageing were started that were in part or fully funded by national governments. A decade later, the European Union started to fund consortia that performed cross-national longitudinal studies, either making use of existing cohort studies, or setting up identical data collection in a number of countries (e.g. Minicuci et al. 2003; Börsch-Supan et al. 2005). In the Netherlands, the Ministry of Welfare, Health and Culture in 1991 initiated a nation-wide, interdisciplinary, longitudinal study to monitor changes in daily functioning in the older Dutch population, the Longitudinal Aging Study Amsterdam (LASA), with data collection cycles every 3 years. It includes more than 4,000 participants aged 55–102 years (Huisman et al. 2011). This study now spans almost 20 years and is one of the longest running nationally representative studies in Europe. This chapter will draw predominantly on findings from this study.

Daily Functioning: Morbidity and Disability

Daily functioning in ageing in the first place is dependent on the presence of chronic diseases, also termed morbidity. Although their prevalences vary across European countries, there is a fair agreement in the top five of chronic conditions. First in rank are musculoskeletal diseases, including arthritis and osteo-porosis, with a prevalence ranging from 40 % to 70 %, depending on the country. Heart diseases, including myocardial infarction, angina pectoris, heart failure and peripheral artery disease, rank second. Respiratory diseases, including chronic bronchitis, emphysema and asthma, rank next. Diabetes ranks fourth, and stroke and cancer share the fifth rank with prevalences from 5 % to 11 % (Minicuci et al. 2003).

Although morbidity itself may not profoundly affect daily functioning, it may have consequences in terms of functional ability and ultimately, disability (WHO 2002). Severity levels of disability are distinguished, depending on the tasks of daily living in which difficulty is present. More complex activities such as shopping, preparing a meal and doing housework are termed instrumental activities of daily living (IADLs), and disability in IADLs is considered mild disability. More basic, and at the same time more obligatory activities, such as bathing, dressing and toileting, are termed activities of daily living (ADLs), and disability in ADLs is considered severe disability. The latter are less likely to be affected by socio-cultural factors than the former. Nevertheless, a surprising variety is observed in prevalence of ADL disability across European countries, ranging from 6 to 35 %. ADL disability turns out to have highest prevalence in Italy and Spain, and lowest in Finland, suggesting a north-south gradient (Pluijm et al. 2005; Van den Brink et al. 2003).

Trends in the Prevalence of Morbidity and Disability

In all western countries, there is ample evidence of an increase in the age-specific prevalence of chronic diseases in the past 20 years (Freedman and Martin 2000; Fleming et al. 2005). This increase may partly be explained by earlier diagnosis and improved medical treatment. As a result, persons with a chronic disease may live longer with their disease, thus raising the prevalence of chronic diseases.

For the Netherlands, based on data from LASA, Fig. 8.1 shows changes in the prevalence of several common chronic diseases among 65–85-year olds during the period 1992–2009. In general, a rise in the prevalence of diseases is observed. Detailed calculations show that these increases are greater than 10 % for heart diseases, diabetes, cancer and joint disorders. Thus, also for the Dutch older population, a substantial increase in the prevalence of chronic diseases is seen.

The prevalence of disability may also change over time as it is linked to chronic diseases, but the trend in disability prevalence may not correspond to the trend in chronic disease prevalence. Indeed, according to the dynamic equilibrium theory (Manton 1982), morbidity or mild disability may show a trend that is different from severe disability. Following the course of a chronic disease, we will first encounter

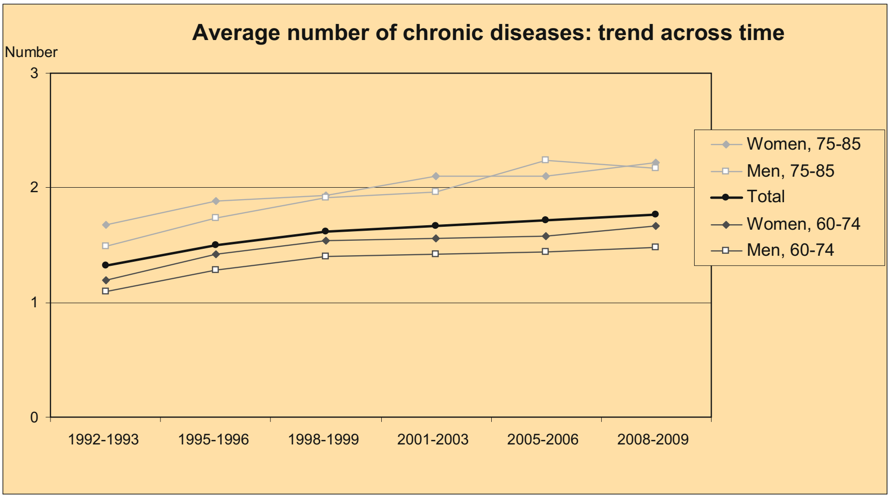

Fig. 8.1 Time trend of average number of diseases by age and gender. (Longitudinal Aging Study Amsterdam, 1992–2009)

mild disability, and later on, severe disability. This would mean that the prevalence of disability rises parallel to the development of the disease. Of course, improvements in the treatment of chronic diseases can delay the onset of disability, but so far no cure exists for the major chronic conditions. Thus, unless improvement in the treatment of diseases can delay the onset of disability enough to compensate for the increase in disease prevalence, it is likely that the prevalence of disability increases along with the growing prevalence of chronic diseases. However, persons with a chronic disease may have fewer disabilities because their disease is diagnosed at an earlier stage or because improved medical care and increased use of assistive devices have reduced its deleterious effects (Wolf et al. 2005). Several studies, including European ones, showed that specific chronic diseases have become less disabling during the last decades of the twentieth century (Deeg et al. 1994; Puts et al. 2008; Robine et al. 1998). However, in the most recent decade, the association between chronic diseases and disability did not show significant changes (Hoeymans et al. 2012).

There is a host of recent evidence on population trends in disability showing different results across countries and periods (Robine and Michel 2004). Most studies show a decline in the prevalence of disability since the 1980s (Freedman et al. 2004), the majority of which have been conducted in the United States. In European countries, reported trends include both decreases and increases in disability (Parker et al. 2005; Sagardui-Villamor et al. 2005). In a recent report or the Organisation for Economic Cooperation and Development (OECD), in many western countries an increase in the prevalence of severe disability was observed, but equally in many western countries a decline in this prevalence was seen (Lafortune et al. 2007).

Notably, disability trends may differ across gender and socio-economic status. Although women have been found to have more disability than men in several

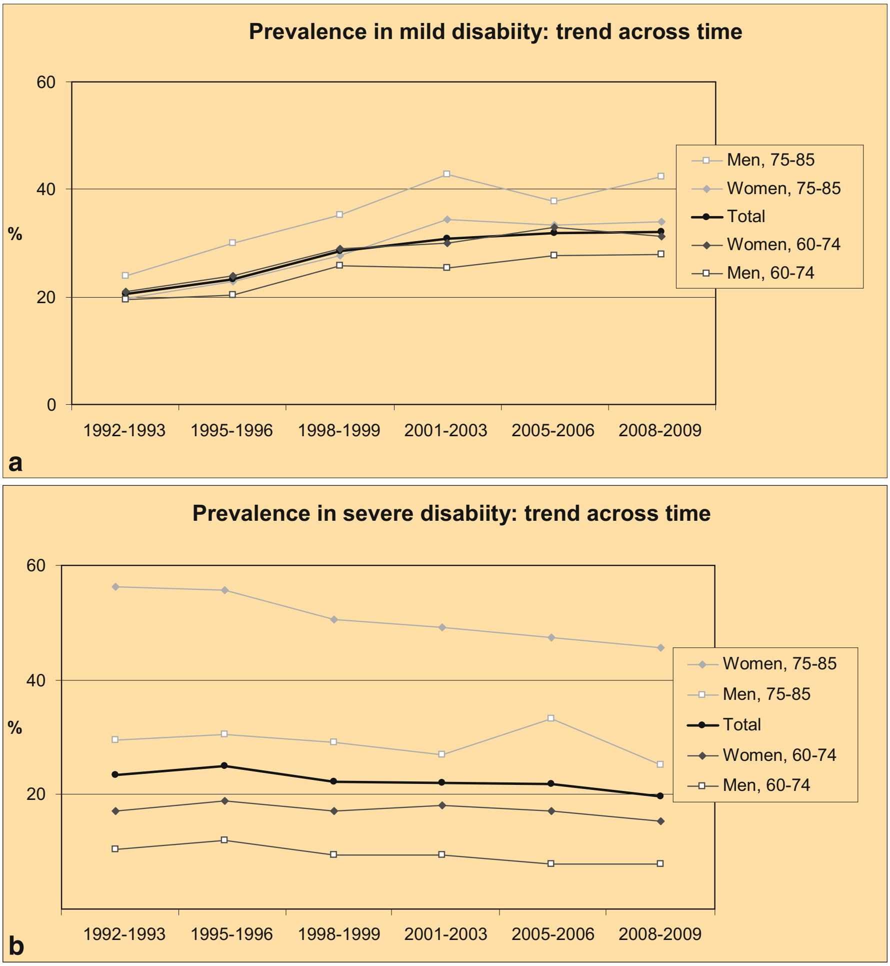

Fig. 8.2 Time trend of mild disability (**a**) and severe disability (**b**) by age and gender. (Longitudinal Aging Study Amsterdam, 1992–2009)

countries, the trend in disability in women was not different from that in men (Fors et al. 2008). In contrast, disability in population groups with higher education is higher than in groups with lower education, but prevalence of disability in the higher educated tends to be declining, whereas this is not always the case in population groups with lower education (Crimmins and Saito 2001).

Several reports based on LASA data show that the prevalence of self-reported disability in the Netherlands has increased since 1992. This increase is seen in older ages (65 and over; Portrait et al. 2010; Sonnenberg et al. 2008) as well as in late midlife (ages 55–64; Hoogendijk et al. 2008). The increase in the prevalence of disability is observed only in mild, but not in severe disability (Fig. 8.2a, b). Whereas in the age group of 65–84 years the prevalence of mild disability rose from 21 % in 1992 to 32 % in 2009, the prevalence of severe disability showed a slight decline of 3 % points (Deeg and Broese van Groenou 2007; Galenkamp et al. in press). Also, in the Netherlands, trends differ across sub-groups of the older population. A more unfavourable trend is seen in women as compared with men, and in those with a low education level as compared with the higher educated.

The increase in the prevalence of mild disability may be partly attributed to the increase in the prevalence of chronic diseases, as described, but also to a worsening of lifestyle factors such as physical activity, nutrition and alcohol use (Visser et al. 2005), and to psychosocial factors such as a lower sense of mastery (Deeg and Huisman 2010). These are individual characteristics, which are essentially amenable for intervention. These are discussed in detail in the paragraph on longitudinal change. Other factors responsible for changes in the prevalence of disability are less easily influenced. These may be demographic factors related to changes in the composition of the population, such as the relatively fast increase in the proportion of the oldest-old (Robine and Michel 2004).

Changes in prevalence may also stem from societal developments that are occurring in the period monitored (period factors), or from characteristics of the particular generations or cohorts that constitute the older population, which can be traced to factors that influenced how they grew up (cohort factors). Portrait et al. (2010) examined a large number of period and cohort factors, such as the business cycle during the childhood of current older generations (an example of a cohort factor) or changes in the availability of care during the study period (an example of a period factor). The authors found no explanatory value for cohort factors, but did find one clear period factor: the decrease in the number of hospital days was associated with the increase in the prevalence of disability. During the study period 1992–1999, the hospital length of stay had fallen steadily for a number of reasons such as greater efficiency. It appears that policy-driven changes in care may affect daily functioning of older people.

Longitudinal Change in Functional Ability

For a better understanding of factors influencing trends in the prevalence of disability, we now turn to factors determining the onset and course of disability in individuals as they age. When following the group of older people who have no difficulty in any of six daily activities at baseline, we can examine which percentage develops disability (i.e. incidence of disability). In the course of 6 years, this incidence amounted to 45 % for a cohort aged 58–88 years (Broese van Groenou et al. 2006). Of course, the incidence rose with age, and amounted to 68 % in the age group of 75–88 years. The incidence showed differences across gender (men: 40 %, women: 52 %) and even more so across levels of education (high: 31 %, low: 56 %).

Recovery from disability was observed as well, but to a much lesser extent. Among older people with disability at baseline, 20 % did not report disability at 6 years follow-up. This percentage decreased with age and was only 10 % in the age group of 75–88 years. Recovery did not show significant differences across gender and level of education.

The reported incidence should be regarded with caution, as it may not be very relevant when an older person develops difficulty with only one activity. Hence, it may be more important to examine a change in functional ability that can be defined as relevant, regardless of the level of disability at baseline. This was done by Puts et al. (2005), who reported a relevant function loss in self-reported and performance-based physical functioning of 25 and 23 %, respectively, across 3 years. Again, in women and in the lower educated a greater functional loss was observed than in men and in the higher educated. Moreover, regardless of age or gender, older people living alone showed more functional loss than older people living with their partner: 30 and 20 %, respectively (Puts et al. 2005).

Predictors of Change in Functional Ability

Chronically ill older people were found to have a 3.5 times larger risk of onset of disability than older people without chronic diseases. This risk rate was found to rise to even 4.6 when chronically ill older people were diagnosed with an additional disease (Broese van Groenou et al. 2006). Multi-morbidity, the co-occurrence of two or more chronic diseases, is present in as many as two-thirds in the age group of 65 and over (Schram et al. 2008). In a detailed study of pairs of co-occurring diseases, an additional disease was shown to have an extra effect on function loss only when it affects a body system that is different than the one affected by the first disease (Kriegsman et al. 2004). An example is the onset of osteo-arthritis (affecting the musculoskeletal system) in an individual who already is suffering from heart disease (affecting the cardiovascular system). Cognitive decline is also an important cause of function loss and disability onset in older adults. It was found that older persons declining in cognitive function had a twofold increased risk of function loss (Comijs et al. 2005). Thus, regardless of somatic morbidity, cognitive impairment contributes to complexity of health problems and ensuing need of care.

Frailty is a concept increasingly used by geriatricians and gerontologists, and is defined as the multi-system decline as a consequence of ageing-related changes in the neuromuscular, endocrine and immune systems (Fried et al. 2001). Frailty can be conceived as a measure of taxability and recovery potential. Fried defined it using five indicators: weight loss, weakness, slowness, lack of energy and inactivity. There is, however, a debate whether the concept of frailty should be narrowly defined to include only physiological aspects, or if it should be broader defined to include psychological aspects as well (Morley et al. 2002). In a series of studies based on data from LASA, we adopted the broad concept and included nine indicators: low weight, poor lung function (as a measure of weakness), physical inactivity, cognitive impairment, poor vision, poor hearing, incontinence, depressive symptoms (including lack of energy and slowness) and a poor sense of mastery. Subjects were defined as frail when they scored poorly on three of the nine indicators. Puts et al. (2005) showed that frail subjects ran a more than twofold risk of function loss more than 3 years, as compared with non-frail subjects. This increased risk proved independent of age, sex, education and especially of the presence of chronic diseases. Moreover, it concerned both self-reported and performance-based functional decline.

The predictive ability of frailty for function loss emphasises that maintenance or decline in functional ability depends on multiple factors. Some of these factors may be causal, such as a decreased lung function or the onset of a chronic disease, whereas other factors may accelerate or slow down the rate of function loss. Van Gool et al. (2005) reported that depressive symptoms—one of the frailty indicators commonly used—are an example of the latter: older people with depressive symptoms showed accelerated functional decline. Geerlings et al. (2001) demonstrated that the influence of depression was especially strong for decline in functioning in daily activities, and less strong for decline in mobility, which generally precedes onset of disability. It is conceivable that depression is a causal factor in functional decline through its underlying pathology of diminished interest and motivation.

In addition to chronic diseases, causal factors for functional decline are usually sought in physiological parameters. Various so-called biomarkers are independent determinants of decline in functional ability. Markers of inflammation (interleukin-6, C-reactive protein, and alpha1-antichymotrypsin) were shown to be predictive of function loss (Schaap et al. 2006). As these markers are implicated in the pathogenesis of a number of chronic diseases, they are indicative of sub-clinical disease. Raised levels of inflammation furthermore decrease the level of serum albumin and total cholesterol, which biomarkers can be easily determined in general practice. Serum albumin is involved in the transport of various substances through the bloodstream, and cholesterol has a role in the production of hormones and in cell membrane permeability. Low levels of both markers proved predictive of functional decline, especially in combination with each other (Schalk et al. 2004). Both albumin and total cholesterol are synthesised in the liver, and it is suggested that an overall deterioration in the liver function might be associated with a poor health status, and might therefore contribute to functional decline. With proper nutrition, adequate levels of albumin and cholesterol can be maintained. Other nutrition-related biomarkers such as vitamin D are more difficult and thus more expensive to assess, but also were found to predict decline in functioning (Wicherts et al. 2007). Vitamin D deficiency is common among older people and can cause bone loss and muscle weakness. Genetic make-up was found to be of additional importance: the e4 variant of the apolipoprotein-E gene (ApoE), well-known for its predictive ability for cognitive decline and dementia, was also found to be predictive of physical decline, regardless of cognitive functioning (Henderson et al. 1995; Melzer et al. 2005). ApoE has a role in the clearance of lipoproteins such as cholesterol. The predictive ability of biomarkers appears to be stronger for objective, performance-based mobility impairment than for disability in daily activities, i.e. for the earlier stages of disability.

From the social factors that have been examined in relation to functional decline, socio-economic status plays an important role. Both a low educational level and a low income increase the risk of incident disability in 3 years time (Broese van Groenou et al. 2003; Huisman et al. 2005). The chance of recovery, however, proved not to be influenced by socio-economic status. In searching for explanations for socio-economic differences in functional decline, Koster et al. (2006) found different explanatory factors in subjects younger and older than 70 years. In the younger age group, lifestyle proved to be of predominant importance, whereas in the older age group lifestyle appeared to have no explanatory value. In contrast, psychosocial factors such as a low sense of mastery and lack of social engagement proved to contribute to the explanation of socio-economic differences in physical function loss in the older age group. In particular in men, a low sense of self-efficacy was shown to be associated with functional decline (Cooper et al. 2011).

Of lifestyle factors, especially physical inactivity and poor nutrition resulting in obesity were important predictors of function loss. Smoking and excessive alcohol use did not play a significant role. It was noted that physical inactivity was an equally important predictor of functional decline in chronically ill and in healthy older adults (Visser et al. 2002). Moreover, not only current intensity of physical activity, but also physical activity intensity during young adulthood proved to be predictive of functional decline in later life (Pluijm et al. 2007). A similar life course effect was found for body weight: obesity at middle age was equally predictive of functional decline in later life as obesity in late life itself.

In addition to the physical and psychosocial factors already discussed, one LASA-based study showed that lack of social support was predictive of function loss (Bisschop et al. 2003). Social support was detailed as partner support and support by other relatives and by non-kin. If present, the partner is generally the most important source of support, so that partner support would be expected to protect against function loss. However, partner support appeared to be protective only in those older people who did not yet have a chronic disease at baseline, i.e. in the case of first-onset disease and disability. In contrast, those who already had chronic diseases at baseline benefited from contacts with daughters and non-kin in terms of better maintenance of functioning.

Consequences of Changes in Functional Ability

Decline in functional ability may have a range of adverse consequences. It means having more difficulty moving about, moving more slowly and being less able to compensate in unexpected circumstances. The risk of fall accidents is therefore strongly increased in the presence of function loss (Stel et al. 2004; Pluijm et al. 2006). In addition, function loss may lead to decreased self-rated health, more psychological distress and loneliness (Dykstra et al. 2005; Jonker et al. 2008; van de Kamp et al. 2008). Moreover, in spouses one partner's function loss increases the feelings of loneliness in the other partner (Korporaal et al. 2008). Longitudinal analyses showed that physical function loss increases the probability of chronic depression (Beekman et al. 2002; Geerlings et al. 2000). Depressive symptoms proved to decrease, however, when older people who had experienced function loss were admitted to a care institution (Thomése and Broese van Groenou 2006). Physical function loss also affects social functioning: social networks become smaller, disabled older adults receive more instrumental support but provide less support to others and participation in social activities decreases (Van Tilburg and Broese van Groenou 2002; Aartsen et al. 2004; Broese van Groenou and Deeg 2006). Especially, sport activities were reported to decline in the face of function loss.

Considering the effects of function loss on the utilisation of health and social services, a distinction can be made between acute care, i.e. out-patient care and hospital admission, and long-term care, i.e. informal or formal care in the home and institutionalised care. Although function loss is associated with the use of acute care (Pot et al. 2009), this association is temporary in many cases as the aim of hospital care is to treat the health condition, and recovery is mostly achieved. However, the use of long-term care is often permanent, so that when people start using some type of long-term care, we can speak of a 'transition' to this type of care.

In older people who in a 3-year period experienced a first onset of function loss, 17 % made a transition to informal care, 5 % to subsidised professional home care, 9 % contracted home help paid for out-of-the-pocket and 2 % were admitted to a care institution (Geerlings et al. 2004, 2005). It was thus demonstrated that at first onset of function loss, older people generally look for care in their own informal network or pay for help out of their pockets, and only a small minority look for government-provided care. A different picture arises for older people who have experienced function loss for a longer period of time. Among them, 25 % made a transition to informal care, 15 % to subsidised professional home care, 11 % contracted home help paid for out-of-the-pocket and 6 % were admitted to a care institution. At this stage, informal care is still the type of care used most often. However, subsidised professional home care takes a second place, while the transition to a care institution is more often made than among those with a recent onset of function loss.

An ultimate consequence of decline in functional ability is mortality. Disability, in particular performance-based functional impairment, is a powerful predictor of mortality (Smits et al. 1999; Deeg and Kriegsman 2003). However, not all older people experience a similar decline in functioning prior to death (Deeg 2005). Klinkenberg (2004) showed that in the last phase of life of older persons, four different trajectories can be distinguished. Nineteen per cent died without experiencing any disability and 26 % experienced disability only in the last week before death. A gradual, protracted decline was experienced by another 24 %. The largest group, 31 %, experienced disability at the severest level measured already more than 3 months before death. This group was on average older, had a larger share of women, and was more often institutionalised than the other groups. Moreover, this group relatively often had suffered a stroke or had osteo-arthritis, and more often was cognitively impaired. Thus, this high-cost group with severe, long-standing disability was characterised by notoriously disabling chronic conditions.

Conclusions

In this overview of findings concerning changes in functional ability in the older population over time and in individuals as they age, functional ability was shown to be influenced by and to have influence on many factors, from the micro to the macro level. From the data on trends in the prevalence of disability, it can be concluded that the extent of disability in the older population is not a fixed fact, but changes over time. Similar to several other studies in Europe, the LASA study indicates that the prevalence of mild disability increases over time, whereas the prevalence of severe disability stays the same or slightly decreases. These trends are not observed in all European countries, as recent data show that, for example, in Norway, mild disability decreased in prevalence, and in France, severe but not mild disability showed increasing prevalences (Moe and Hagen 2011; Cambois et al. 2008). Moreover, in Sweden a reversal from a positive to a negative trend in the prevalence of mobility disability was seen in the late 1990s (Parker et al. 2008). To explain such discrepancies, cross-national research is needed with exactly the same measures of disability as well as of potential explanatory factors. Although such studies now exist, they are relatively recent and cannot yet address time trends over a period of sufficient length.

From the longitudinal findings, it can be concluded that a sizeable proportion of the older population experiences function loss, especially at higher ages. Several factors, such as a decreased lung function, may be considered as causal factors. Other factors, such as depressive symptoms or a low level of education, may be regarded as factors accelerating function loss. This accelerating effect may be due to an unhealthy lifestyle, for example, malnutrition or non-compliance with treatment regimens, such as intake of medications that are prescribed to counteract the consequences of a disease. Regarding depression, it is, nevertheless, conceivable that this is a causal factor in functional decline through underlying pathology. In either case, the findings emphasise that depressed older adults and older adults with a low level of education are risk groups with increased probability of function loss.

In light of the absolute and relative increase of older people in the populations of European countries, it is paramount to prevent onset and further decline of function loss, or at least to postpone these to older ages than the ages at which they now occur. To this end, causal factors such as lifestyle, chronic diseases or biomarkers can be targeted. Sufficient physical activity is a likely candidate to postpone function loss, especially in chronically ill older people. Also, better disease management is highly likely to postpone functional decline. Several biomarkers found to predict function loss are indicative of undernutrition. Thus, the nutritional status of older people needs due attention. However, it is at least as productive to identify groups of older people with increased risk of function loss. Improvement of the recognition of depression in older people is an example. Finally, helping older people to improve their sense of mastery or to maintain a social network of sufficient diversity are other interventions highly likely to have a beneficial effect on their level of daily functioning.

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Chapter 9

Family Networks and Supports in Older Age

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Introduction

This chapter aims at providing a comprehensive overview of the family's role in providing support to older people in Europe. To this purpose, after an introduction on relevant concepts and trends, attention is paid to the "epidemiology of family care", i.e. the socio-demographic profile of caregiving families in Europe. In the fourth paragraph, the intersections between family care and employment are explored, in order to identify the strategies that European families adopt to reconcile work and care duties. We then pass on to describe the increasing phenomenon of the employment of privately paid migrant care workers, which is becoming one of the most common solutions to prevent family care burden in many European countries, also as a mean to reconcile employment and family care. Before drawing some final considerations, a widely neglected global risk is analysed, i.e. the phenomenon of elder abuse, which

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is increasingly reported when family and other support networks fail to meet older people's needs for care.

The proposed analysis, mainly empirical and evidence-based, draws substantially on survey data collected by three large European studies—EUROFAMCARE (EFC), "Carers@work" and ABUEL[1]—and on information stemming from EU-representative sources such as SHARE and Eurobarometer, as well as on the ongoing theoretical debate in this field.

Basic Concepts and Trends

The family is a fundamental institution in human society. Family lineages represent one of the major factors influencing individuals' opportunities and risks along the life course, and can be considered a key source of social inequality (Ferraro et al. 2009). Indeed, not only are individuals at birth embedded in their own family environment but, regardless of any genetic, economic, social and ecological background, their resilience to adverse conditions is highly influenced by their family's capacity to mobilise resources in form of e.g. financial, material or psychological supports (Walsh 2003).

The importance of family networks is not likely to decrease in older age when, especially with the onset of frailty and disability, they represent a key factor influencing quality of life and well-being. Family care has traditionally been regarded as the "natural" source of care for older frail people, and the role of family support in older age has become increasingly evident as a consequence of the demographic transition (Laslett 1989).

Comparative social policy traditionally stressed the differences between long-term care (LTC) solutions in countries characterised either by the "statist" or the "familistic" paradigm (Doyle and Timonen 2009; Jenson and Jacobzone 2000). According to the former, the state has an extensive role in terms of financing, providing and organising care: this paradigm is typical of Nordic countries, where a high degree of regulated care work is provided by the formal care market to support older dependent persons. In the familistic paradigm, families and individuals are the main actors for organising, financing and providing care services. In such contexts, typically represented by the Mediterranean area but in recent times also by Eastern European countries, few benefits of care provision or financial assistance are provided by

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[1] The EU-funded research project EUROFAMCARE (EFC) was carried out in 2004–2005 in six European countries (Germany, Greece, Italy, Poland, Sweden and the United Kingdom) with the aim to evaluate the situation of family carers of older people in relation to the availability, use and acceptability of supporting services (for more details, refer to http://www.uke.uni-hamburg.de/eurofamcare). The project Carers@work (acronym for "The Reconciliation of Employment and Eldercare", funded by the Volkswagen Foundation) aimed at analysing existing policies for and reconciliation strategies of working carers of older people care in Germany, Italy, Poland and the United Kingdom (http://www.carersatwork.tu-dortmund.de/en/). The ABUEL study, financed by the European Agency for Public Health, aimed at estimating the prevalence and risk factors of elder abuse and neglect in the community in seven countries: Germany, Greece, Italy, Lithuania, Portugal, Spain and Sweden (for more information, please refer to: http://www.abuel.org/).

the State. Between the two "extreme" models, different intermediate patterns can be found across the European countries, where the balance of family-state responsibility in elder care varies considerably.

Despite this heterogeneity, empirical data show that everywhere in Europe family members and other informal carers are those who provide the bulk of care to dependent older relatives. As postulated by the "hierarchical compensatory" model (Cantor and Little 1985), formal care services and more distant help are activated only when family carers fail or are unable to meet the older person's needs.[2]

Research findings show the existence of stronger family ties in Southern Europe, and of relatively "weaker" family relationships in Northern Europe (de Jong Gierveld 2009)—i.e. more support exchange within the household are found in the Mediterranean countries, whereas non-Mediterranean individuals report frequent exchanges outside the household. According to some scholars, however, this doesn't mean that the latter have less family-based social networks, rather, that they have family arrangements whose network exchanges extend over greater distances (Litwin 2010).

Recent socio-demographic trends have modified the concept of "family" in most of European countries. These entail inter alia phenomena such as population ageing, de-institutionalisation and family disruption (Saraceno et al. 2006; Glaser et al. 2009)—as a consequence of the increase in divorce rates, decline in marriage and childbearing and fertility changes—as well as the increased participation of women into the labour market. These changes are likely to impact in terms of the availability of family members to continue to provide emotional, financial and instrumental support to their older relatives, this leading in turn to a redefinition of family's roles, responsibilities, obligations and relationships (Grundtvig 2010).

Scholars comparing Europeans views on normative family solidarity have been debating whether this solidarity has been "lost" or "changed" (Daatland and Herlofson 2003). Nevertheless, according to the second European Quality of Life Survey (EQLS), 3 % of Europeans state they care for an older or disabled relative several times a week, 4 % once or twice a week and 8 % less than once a week. On the whole, circa 20 % of the population is involved in caring tasks—i.e. about 125 million carers in Europe (Anderson et al. 2009)—so that more than 80 % of care is provided by family carers, primarily children and partners (Huber et al. 2010). Indeed, family solidarity is a still robust concept in Europe (Lowenstein 2007), and three out of ten Europeans themselves believe that the best option for older parents is to live with one of their children (Special Eurobarometer 2007).

Epidemiology of Family Care in an Ageing Europe

Europe is today characterised by relatively small-sized households, mainly composed by single persons living alone, often aged 65 years and over. Two "ideal types" of

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[2] This model is the one informing the so-called "subsidiarity principle", according to which Welfare States have a residual function and have to be activated only in case of family "failure".

living arrangements can be found among older people in the EU: in Scandinavia and Continental Europe (e.g. Germany and France) older people predominantly live with a spouse/partner or alone, while in the Southern and Eastern European countries, it is frequent for them (although to a lesser extent, when compared with the past) to live also with people other than a partner, e.g. in multi-generational households with other relatives (Eurostat-European Commission 2010).

Although ageing per se does not necessarily imply to suffer from disability or illness, chronological age is the strongest risk factor for dependency. In this regard, older European functional status is comparable with other Western countries: according to official sources, severely disabled older Europeans in 2009 were 14.7 % of people aged 65–74 years, 25.0 % in the group of 75–84 and 37.6 % in the group of 85+ (Eurostat 2011).

As far as the number of family caregivers and of older people in need for care is concerned, data availability and reliability remains limited. In this regard, the EUROFAMCARE (EFC) study represents a groundbreaking and useful source.[3] According to it, the vast majority of older people receiving family care resides in their own home (93 %), while the remaining minority (7 %), mainly concentrated in Sweden, Germany and the United Kingdom, lives partly in care homes and partly in sheltered housing. More than two-thirds of all cared-for older people live with someone else, and this is especially true for the Polish and Italian contexts. More than half of care recipients are widowed (56 %) and almost two-thirds of the households are single-person households, the proportion of one-person households reaching the largest share in Sweden. Approximately, three quarters of older people in the Italian, Swedish and German EFC samples suffer from a high degree of impairments: in 46 % of cases, family carers report that the older person has memory problems, and 34 % suffer from behavioural problems. Their need for support relates mainly to the sphere of domestic tasks (92 %), emotional/psychological/social support (89 %), mobility (82 %), financial management (80 %) and physical/personal care (66 %).

Regarding the profile of European family carers, they are mostly middle-aged people, as indicates the mean family carers' age in the EFC sample, which is approximately 55-year old. However, the role of older people themselves in caring after dependent persons in their same age group has not to be neglected, since in Italy, for instance, up to 10 % of care is provided by more than 80-year-old caregivers. In almost half of cases, family carers are represented by children of the cared-for, though in Sweden a high proportion of spouse carers can be found.

The caregiving relation traditionally has been seen as a dyad. However, Van Dussen and Morgan (2009) found that older people of 75–84 years are more likely to rely on multiple caregivers and extended support networks, e.g. on more sources of support, if their spouses are dead or ill and therefore not available to provide them the required support.

Another crucial aspect to consider with regard to elder care is that this is a primarily "woman's world" (Huber et al. 2010). The percentage of female family carers in the

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[3] In the following, the source for references to the EFC will be Lamura et al. (2008a), unless differently stated.

EFC sample is on average three times larger than that of male carers, and this ratio is in line with what is reported by SHARE (2010),[4] according to which more women than men help their old mother (32 % vs. 19 %). However, although the role of spouses, daughters and daughters-in-law is predominant as primary caregivers (Stone et al. 1987), there is an increasing evidence of a more gender-balanced caregiving (Matthews 2002). With regard to sons, in particular, they are more likely now than in the past to provide instrumental support, for instance, in form of financial help, house and car maintenance and paying bills.

In the EFC sample, the share of employed carers (41 %) is smaller than that of non-working carers (59 %). Of the first group, quite a large proportion of carers (15.3 %) reports that they had to reduce the amount of their working hours because of caring-related reasons (see also next paragraph on this issue), while non-working carers are mainly represented by retired people or housewives (26 %).

"Emotional bonds" (i.e. love and affection) constitute the principal motivation for caring (57 %), followed by a "sense of duty" (15 %) and a "personal sense of obligation" (13 %). Just 3.5 % report that "caring makes them feel good" and 3 % "had no other alternative". Nonetheless, although Europeans appear to own clear normative assumptions regarding family care (Daatland and Herlofson 2003), the majority of them also believe that dependent people rely too much on their relatives (71 %). They broadly support that public authorities should provide appropriate home care, as indirectly confirmed also by the fact that 91 % of respondents to the EU-wide survey on long-term care carried out by Eurobarometer (2007) feel they should be given a chance to take a break.

Full-time carers are indeed likely to experience some degree of isolation and/or psychological distress (e.g. depression and anxiety; Huber et al. 2010). In particular, dementia caregivers are vulnerable to higher levels of stress and depressed mood (Balducci et al. 2008). There is strong evidence concerning the risk for carers of becoming "patients" themselves (Reinhard et al. 2008), and indeed carers have been found to be three times more likely to report ill-health than the non-carer population (Singleton et al. 2002). The risk of suffering from a high caregiving burden increases especially when the carers' health status is already bad and they are not adequately supported by formal services. In this respect, it should be noted that less than one-third of family carers across Europe report to use support services addressing their needs (Lamura et al. 2008a).

The lack of services specifically intended for family carers is particularly true in Poland, Italy and Greece. In these countries, the main source of information, advice and socio-psychological support for carers is represented by the GP (11.1 %),

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[4] The Survey of Health, Ageing and Retirement in Europe (SHARE) is a multi-disciplinary and cross-national panel database of micro data on health, socio-economic status and social and family networks of more than 45,000 individuals aged 50 or over. Eleven countries contributed data to the 2004 SHARE baseline study: Denmark, Sweden, Austria, France, Germany, Switzerland, Belgium, the Netherlands, Spain, Italy and Greece (further data were collected in 2005–2006 in Israel). Two "new" EU member states—the Czech Republic and Poland—as well as Ireland joined SHARE in 2006 and participated in the second wave of data collection in 2006–2007 (for further information, consult http://www.share-project.org/).

the hospital often being used there as a substitute for (lacking) rehabilitation and respite care services (2.4 %). Only carers in Sweden, Germany and the United Kingdom report a more systematic and regular use of respite, socio-psychological and information services. Regarding carers allowances, they are on average less developed than services (reaching only 4 % of all carers), also because in general most of monetary transfers address care-recipients (37 % of the EFC sample), rather than carers. The complexity of bureaucratic procedures (13 %) and high financial costs (13 %) are considered to be the main barriers preventing caregivers from using public support services, further barriers being represented by the lack of information on available supports and their low quality (Lamura et al. 2008a).

In spite of the experienced caregiving burden and of the few available support services, 69 % of family carers across Europe state they are ready to increase the level of care provided if necessary, and almost 59 % of them would never consider the institutionalisation of their relatives, this being true especially in Poland and Greece. Only in Sweden a high proportion of carers (70 % vs. a European average of 37 %) considered the residential solution as a viable alternative in case the health of the cared-for older people would get worse (Lamura et al. 2008a). In this respect, the EFC results are in line with the Eurobarometer data (Alber and Kohler 2004), according to which the majority of Europeans are willing to take care of their frail older parents and close kin, thus showing that intergenerational obligations keep on playing a strong role within older people's family networks.

Intersections Between Family Care and Employment: Support Measures to Reconcile Work and Care in Europe

The above-mentioned demographic and social changes taking place in Europe imply that both the population in working age and the number of "potential" family caregivers of older people are shrinking. These trends, combined with a growing female participation into the labour market, stress the relevance of finding appropriate arrangements to ensure a balanced reconciliation of work and care tasks.

The legislation of single European Member States does not always provide adequate support to the reconciliation between work and elder care, whereas the EU governance level (through treaties, regulations, Green and White papers) formulate explicit recommendations on this matter, for example, in order to prevent discrimination on the basis of family responsibilities, type of contract (e.g. to protect part-time workers) and gender, and to promote good working conditions, flexibility and parental (and, more recently, even filial) leaves for urgent family reasons.

According to the SHARE data, 49 % of German, 60 % of Italian and 71 % of Polish working carers provide care almost on an everyday basis. Although the most important motivation to care for an older relative is the emotional relationship, it is not surprising that working carers (albeit to a lesser extent than non-working ones) complain that caring obligations prevent them from doing things they would like to do. This, in turn, can be accompanied by negative feelings: in fact 68 % of Polish, 66 % of Italian and 54 % of German working carers complain about depression problems.

An in-depth analysis of EFC data reveal to what extent the parallel carrying out of paid work and informal elder care tasks can be burdensome, especially when no support from others is available and/or the care recipient is highly dependent (Di Rosa et al. 2011a). Predictably, a factor significantly influencing the level of stress experienced by caregivers is represented by the positive or negative feelings characterising the emotional bonds between the person providing and the one receiving care: the stronger the positive feelings, the lower the negative impact deriving from caregiving and, in addition, the higher the probability of a successful reconciliation of work and care.[5] This result stresses the importance of maintaining strong and reciprocal family ties, as well as of intergenerational transfers, along the life course. The same analysis shows that having access to informal support networks is extremely effective in order to facilitate the reconciliation of care and work. Conversely, carers without an informal support network have 50 % less chances of experiencing a "successful reconciliation": carers without a support network experience more different restrictions (especially working time reduction) and are on average more unsatisfied than carers who can count on such a source of help.

When reconciliation fails, the most common strategy for carers is to reduce working time in all investigated countries (percentages range from 21 % in Germany to 6 % in Poland). However, whether this "part-time" strategy can be considered as a "successful" one, might be questioned, since workers who had to reduce their working time due to parallel informal care commitments consider this choice more often as a restriction, rather than as an actual winning strategy. The second most common "strategy" is to work only on an occasional basis; this pattern characterises 14 % of German and English working carers, and 5 % of Italian and Polish ones.

Surprisingly, being able to remain active in the workforce seems to play somehow a sort of protecting role, thus reducing stress to a great extent. Working carers who work full time have a higher probability to manage better the reconciliation of work and care than those working part-time (Di Rosa et al. 2011a). This aspect is very important, because it might suggest that, generally speaking, workers want to maintain full time work as long as possible, and to devote only their residual time to care activities. The importance of gainful employment becomes also clear when considering the situation of non-working carers since, for example, the possibility to work occasionally makes non-working carers more satisfied compared with those who cannot work at all, a phenomenon, which can be observed in all investigated countries.

With regard to support measures available to working carers, the research project "Carers@Work" provides useful insights on the policy framework of four European countries (Germany, Italy, Poland and the United Kingdom), by analysing the mix of paid leaves, care allowances and/or services provided by the public and private care sectors in each of them. The analysis of these qualitative data reveals that in all

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[5] In this context, reconciliation of care and work was defined as "successful" when the carer perceives that the "right" balance between care and work responsibilities has been achieved.

investigated countries, even if to a different extent, the family itself remains still today the main source of support to reconcile work and care. When the family network is weak or absent, working carers adopt other strategies, whose contents depend upon the set of welfare measures available in their country.

Italian working carers, for instance, hire frequently migrant care workers (i.e. MCW) on a privately paid basis, because of the lack of good quality care services (see also next paragraph for more details on this issue). Conversely, German working carers resort often to public home and day care services, while do not find relevant support at the company level, thus having to rely in general on informal agreements with their line managers. English working carers can instead count on different measures of public support from the state (i.e. attendance and disability allowances to the cared-for individuals to finance their own private care package), from the voluntary and the private sectors as well as through company policies that provide mainly flexibility opportunities. Polish working carers, beyond receiving some support from the health care system and from the third sector, rely primarily on instrumental and individual "psychological" strategies, this meaning a combination of good personal and family organisation and of "thinking ahead" in order to combine working tasks and private life.

On the whole, the Carers@Work findings seem to suggest that company policies to improve the work-care balance are not widespread in the studied countries, with the exception of the United Kingdom. Each measure for working carers analysed is likely to affect the caregiver's life differently, depending upon the characteristics of his/her living condition, employment and environment. The same kind of support measure can therefore be used by one carer to keep on working and another one to have some free time, thus showing that reconciliation indeed becomes a sort of "time-harmonisation game", where the chosen strategies are the result of the combination of different available supports. Within this context, time represents the focal factor: working carers experience indeed a constant "lack of time", in particular when the older dependent relative is affected by a severe impairment and thus presents high care needs. Under these conditions, if time schedules are not flexible, care and work reconciliation turns out to be very hard and stressful. A crucial message coming out from this study is that most working carers might be inclined to sacrifice their social life and well-being for the sake of the care, but would never give up working, not only for economic reasons, but also because they consider work as an important space for personal growth and social achievement.

The Increasing Support from Private Migrant Work in the Elder Care Sector[6]

In the light of the aboveoutlined phenomena, it is not surprising that providing appropriate LTC is becoming an increasing challenge to most welfare states and

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[6] This section contains updated and rearranged data and analyses from the authors' previous works in Lamura et al. (2008b) and Lamura et al. (2010a, b).

families across Europe, particularly when we consider the preference granted by official policies to arrangements promoting "ageing in place" through enhanced home and community care services, and moving away from institutional care (European Commission 2008).

A solution, which is increasingly being adopted to tackle this challenge is based on the employment of migrant care workers (MCWs) by private households, a discreet and to a large extent invisible trend, which is giving rise to a sort of "ethnic segmentation" of the elder care sector across Europe (Lamura et al. 2010a). As a consequence, a growing pressure has been exerted on the workforce employed in this highly labour-intensive care sector (Fujisawa and Colombo 2009), a phenomenon that in the last decade has increasingly taken the form of a powerful "pull" factor for the immigration of low-skilled LTC workers to developed economies. Elder care—the bulk of LTC—is indeed a task that cannot be easily relocated elsewhere from the "point of delivery" (Redfoot and Houser 2005), so that the pressure to employ MCWs is rapidly increasing where domestic labour markets are unable to fill these jobs, like it is the case in many European countries.

The employment of MCWs is currently taking place on a large scale especially in Mediterranean countries—where the private employment of MCWs by families has today become the "normal" solution to face the growing elder care challenge (Lamura et al. 2010a)—but increasingly also in Central European, Bismarckian welfare states such as Austria (Schneider and Trukeschitz 2008) and Germany (DIP 2009). One main difference that can be observed between this more recent phenomenon taking place in mainly Southern and Central Europe, on the one hand, and the care migration patterns characterising since longer time most Northern European countries, on the other hand, is that foreign-born workers are in the former more frequently employed to provide support in domestic settings on a private, individual basis by care recipients or their families, rather than by formal (home or residential) LTC providers as previously defined (Lethbridge 2007). This is clearly reflected by the fact that the percentage of migrants officially employed in the care sector appears to be the highest in countries such as the United Kingdom, Sweden and Norway, where the majority of them are employed by public or accredited service organisations, and are also likely to be represented not by newcomers, but rather by long-settled migrants, who end up working in this sector later on in their migration career. This difference, however, is becoming more and more blurred, as the employment of MCWs by private households is becoming widespread also in countries such as Ireland (Doyle and Timonen 2009) and the United Kingdom (Cangiano et al. 2009), as well as in most, also non-European OECD nations (Fujisawa and Colombo 2009).

As to the quantitative scope of this phenomenon in Europe, it should be acknowledged that the large presence of undeclared work makes official statistics often unreliable in this field. Keeping in mind this limitation, available figures for Italy suggest that well more than two-thirds of the now almost 1.5 million persons employed in the personal care/household service sector are foreign-born (CENSIS 2009). A similar percentage is found in Greece, where foreign workers account for about 70 % of all working in private households (Kanellopoulos and Gregou 2006), while in Spain the official number of permits for domestic work to foreigners rose by seven times between 1999 and 2006, to almost 230,000 (INE 2008). OECD data referring to care services provided at home in 12 European nations (Austria, Belgium, France, Germany, Greece, Ireland, Italy, Luxembourg, Portugal, Spain, Switzerland and the United Kingdom) confirm that the share of foreign-born workers is in most countries larger than that of native-born (OECD 2008). In most cases, MCWs are represented by live in women, often with higher qualifications than those potentially required for the job they carry out, and providing support in form of undeclared work (Fujisawa and Colombo 2009).

One of the main reasons that explain the success of the peculiar LTC solution based on care migration as described above—apart from the "push" factors operating in the sending countries—can be identified in the increasing role played in European care regimes by cash-for-care schemes (Glendinning 2009). Following a general shift towards allowing more individual choice for older persons receiving publicly funded LTC at home, these schemes have been providing—albeit with a high degree of variance both in their use and effectiveness—increasing financial benefits to dependent persons and/or their informal caregivers (Lundsgaard 2005).

While this has certainly helped in tapping into a wider pool of human resources (especially where shortages of professional care workers existed), it has also created, especially in the past, "incentive traps" attracting informal caregivers away from the labour market, where it proved difficult to come back once the caregiving phase is over (Jenson and Jacobzone 2000). These trends explain why, in order to maintain the flexibility of a tailored home care, on the one hand, and to prevent the "informal caregiver trap", on the other hand, these care allowances have been more recently used to employ MCWs, rather than to "financially recognise" the support provided by informal carers in working age (i.e. mainly children of frail older people).

In some cases, the above phenomenon has been intercepted, legitimised and explicitly integrated, if not even fuelled, by public LTC insurance schemes. This is the case, for instance, and already since two decades, in Israel, where today about one out of three older people is cared for by migrant live-in workers employed through such a scheme (Iecovich 2009). More recently, Austria has developed a generous LTCI, which contains specific provisions to facilitate the legalisation and employment of MCWs (Schlette et al. 2009), who represent today more than 20 % of all care workers employed in the country (Schneider and Trukeschitz 2008). In Italy, different policy measures have been introduced in the last few years to regulate the widespread, private employment of MCWs by means of fiscal incentives (to reduce undeclared labour), reserved migration quotas and training and accreditation programs (Lamura et al. 2008b).

Data from an integration of the EFC study focused on migrant care work in Italy (Lamura et al. 2010a) allow to better understand how migrant work impacts on the role played by the family in providing support to dependent older people. These findings show that, when no MCW is employed, providing company, care organisation, shopping and transportation represent the main tasks accomplished by the primary family carer. However, while the first two tasks remain in the hands of the primary carers even when a MCW is hired (no matter whether cohabiting or not), shopping and transportation are more likely to be delegated to the MCW (the first more frequently to live-in MCWs, the second more to non-cohabiting ones). Managing finances and housework are taken upon primary family carers in four out of five cases when no MCW is present, but the second activity is to a large extent "outsourced" to the latter as soon as the family opts to acquire his/her help, keeping for itself only the control over finances (or even increasing it, in case of cohabitation). The live-in status of the MCW is decisive for the more frequent delegation of two further activities, such as meals preparation and personal care, while medicine administration and lifting/moving the older person at home are quite often performed by non-cohabiting MCWs, too.

A second set of findings emerging from the study concerns the non-primary family carers, whose presence in everyday support is in general—compared with the primary carer—much lower for all activities except for providing company. In this case, the impact of the employment of a MCW on the role played by secondary family carers is much stronger (i.e. producing a lower involvement) in case of a live-in solution, with three exceptions: care organisation, providing company and especially transportation (from which secondary carers withdraw already or even stronger when the MCW is not cohabiting). For several activities, however, the presence of secondary family carers increases when a MCW is employed on a non-cohabitation basis.

The findings reported above show thus very clearly that, across Europe, the increasing difficulties faced by families in providing appropriate care to their older dependent members have been more and more often tackled by seeking the help of privately employed migrant care workers, thus revealing a new facet of the intertwined relationship between the two basic demographic phenomena of ageing and migration.

When Support Networks Do not Work: The Phenomenon of Elder Abuse and Neglect in the Community

A phenomenon, which might to a certain extent be considered "symmetric" to support in older age is that occurring when no support occurs or, even worse, when harm is voluntarily caused to older persons. The scientific community speaks in this case of elder abuse (EA) or neglect, a serious and growing problem, which is, however, still considered a taboo in many countries. It is a multi-dimensional phenomenon, which represents both a social welfare and a public health issue. Defining EA and neglect precisely is a hard task and definitions vary across countries, reflecting cultural differences in theories about the nature and causes of abuse of older people. The most widely accepted and used definition is probably that proposed by the World Health Organisation (Sethi et al. 2010): "*a single or repeated act or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person*". EA can assume different forms, i.e. physical, sexual, psychological, financial and neglect (Lachs 1998), can take place in institutional[7] or in domestic settings, and may consist in a single or repeated violent act, perpetrated interpersonally (e.g. a single relative, neighbour, friend, professionals or formal carer) or collectively (e.g. through group violence or marginalisation by institutions; Ferreira 2009).

The incidence of abuse is often underestimated, because of underreporting biases (Ferreira 2009). A systematic review of 49 community-based studies in various countries (Cooper et al. 2008) found indeed a high inter-country variability in EA prevalence rates, which ranged between 3 and 27 %.

According to the ABUEL survey carried out on this topic in seven European countries (Soares et al. 2010), more than 19 % of community-dwelling older people are exposed to psychological abuse, 2.7 % to physical, 0.7 % to sexual, 3.8 % to financial and 0.7 % to injuries. Men reported more frequently than women psychological (20 % vs. 18.9 %), physical (2.8 % vs. 2.6 %) and financial abuse (4.1 % vs. 3.7 %), whereas women were more likely to be victim of sexual abuse (1.0 % vs. 0.3 %) and injuries (0.9 % vs. 0.4 %). With regard to the perpetrators, spouses/partners were the most common ones for psychological (34.8 %) and physical abuse (33.7 %), and friends and neighbours for sexual abuse (30.3 %).

EA is a complex phenomenon, and rarely one single factor eventually leads to it, since it often results from a combination of personal (relevant for victim and perpetrator), family, social and cultural risk factors (van Bavel et al. 2010). There are, however, multiple links between the risk of suffering from abuse and the characteristics of the older person's family network. At a micro level, abuse is correlated with several indicators of deprivation and/or poor health of the victims, i.e. bad physical-mental health, declining functional status, cognitive impairment, dependency in performing Activities of Daily Living, drug and alcohol abuse (Cooney and Mortimer 1995; Biggs et al. 2009) and social isolation in general (Acierno et al. 2010). Perpetrators are more likely to suffer from alcoholism, drug abuse, psychopathological behaviour or mental illness, anxiety, depression, unemployment, financial problems, and financial dependency on the victims (van Bavel et al. 2010; Cooney and Mortimer 1995). They also find themselves in a context of social isolation, have low social and emotional support (Cooney and Mortimer 1995; van Bavel et al. 2010), and experience family conflicts, overburden and stress (Podnieks et al. 2010).

In particular, older person who are cared-for in domestic setting are potentially "invisible victims" behind "closed doors" (Görgen 2009), and the aggressive behaviour of a demented older person can contribute to abusive reactions (Peri et al. 2009). Further reflections on EA and family care of older people in Europe, based on the EFC-related findings, show that this risk is higher when the family carer has to reduce the number of hours worked, reports poor health and provides frequent night care to a non-cohabiting older relative (Di Rosa et al. 2011b).

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[7] Given the focus of this chapter, the phenomenon of elder abuse in institutions is not discussed here, whereas this represents a relevant phenomenon in many European and non-European countries.

There is no single strategy of EA prevention and intervention. Predictably, having a loving and caring family, in particular having regular contact with adult children, protects the older people from being abused (Brozowski and Hall 2003). Secondly, the availability of social support (e.g. friends or other significant persons) is very important and, together with health support, plays a major role in preventing EA when compared with other factors (e.g. socio-economics; Soares et al. 2010).

In the light of the above-outlined findings, a main suggestion formulated by many practitioners and researchers to protect older people from abuse is to adopt formal acts and legal measures, which increase the possibility to detect and report abusive incidents, keeping in mind the substantial diversity of abusive situations (Mowlam et al. 2007) and the need of long-term financial resources to implement the action plans (Soares et al. 2010). Indeed, there are integrated national policies for preventing violence in almost half of the 27 EU member states, but in most cases they address child maltreatment and intimate partner violence (WHO 2010). As a result, reporting an abusive act against an older person is not a frequent "reaction", also because older people are reluctant to denounce abusive episodes, especially when the perpetrators are family members.

These considerations suggest the need for collective actions, in order to create effective support systems. These include the provision of legal and psychological support through multi-professional teams, who seem to facilitate the possibility of an adequately reporting activity. Also, information and prevention, building a dedicated legal framework and an operative network as well as a stronger monitoring of informal care are possible measurers able to increase awareness of the phenomenon, together with the set-up of legal support services and help-lines (Melchiorre et al. 2011).

Summarising, it can be stated that, while the family remains the primary and fundamental social institution providing support in older age, its capacity to properly take care of its more dependent older members is diminishing, so that the prevalence of EA might increase in the coming years. To counteract this risk, family support strategies should be developed through dedicated policies, resources and services (Ferreira 2009). This will necessarily have to include new relevant areas, too, such as the one identified above by the phenomenon of migrant care workers privately hired by family carers. The former can indeed certainly be of help to the latter, but also need to be properly monitored in terms of care quality and possible situations of reciprocal exploitation, to prevent that, instead of preventing and fighting EA, the responsibility of it might be simply shifted from the one informal actor to the other (Di Rosa et al. 2011b).

The Future of Family Care: Policy Implications

The findings presented above show that, across Europe, the long-term care needs are still mainly met by informal carers, who remain the "backbone" of the assistance provided to most dependent older people (Hoffmann and Rodrigues 2010), providing an amount of support that exceeds that granted by formal LTC service providers, as shown by the EFC findings—the estimated value of caregiving in the EFC countries exceeding public expenditure on formal care and care allowances (Rothgang et al. 2006)—as well as by national estimations, such as those on England, where the value of the care provided by family carers exceeds the budget of the National Health Services for the whole United Kingdom (Yeandle and Buckner 2007).

The future availability of family support is therefore an issue of strategic policy importance. On the one hand, the increase in the number of very old people in many European populations, with decreasing family networks and oldest-old support ratio than previous generations, will inevitably lead to a greater care demand. On the other hand, there is a growing concern that recent trends in family life may affect future support and care to older persons, with long-term consequences, and that the reliance on family care is too high and will not be sustainable in the coming years, unless appropriate and substantial measures to improve support to carers will be undertaken, with clear implications for future public expenditure (Grundy 2009; Glaser et al. 2009). This will also affect the balance between formal and informal care, which differs among countries due to political, economic, demographic and cultural factors, Northern European countries reporting higher level of formal service provision and lower family care (Grundtvig 2010).

In this respect, a possible comprehensive solution should include measures providing an answer to four main set of issues:

- Improving the health of older people in order to reduce disability rates, also through a better organisation of preventive and rehabilitative services (Grundy 2009), and by increasing the use of assistive technology (Herrmann et al. 2010).
- Acknowledging family care as work, and recognising the importance of informal carers as key stakeholders, by providing dedicated cash benefits to them in order to compensate the lost income, time and other opportunity costs, and by setting up services aimed at facilitating their caring tasks (e.g. counselling, respite care; Hoffmann and Rodrigues 2010).
- Promoting more accessible, flexible and extensive home support services to family carers, especially in countries with less public/formal home care, stronger pressure on informal care and higher provision of monetary transfers (Melchiorre et al. 2010).
- Integrating social and health formal care with informal/family care, especially in terms of community services, in order to improve the continuity and quality of care to older recipients as well as their caregivers.

Only when a comprehensive, holistic support system will be available to older people and their families, our ageing societies will be able to tackle the challenge of ensuring a dignified end of life to all its citizens. A challenge, which calls for a stronger intergenerational and international solidarity, but also for more culturally sensitive measures to take into account migration-related effects: certainly not an easy task, but also probably one, which Europe cannot afford not to undertake.

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Chapter 10
Factors Influencing Inequalities in the Quality of Life

Elli Ioannidi and Elizabeth Mestheneos

Defining inequalities in the quality of life (QoL) has been a concern of many social and medical scientists over the past 50 years in advanced industrial societies both for moral reasons concerning inequalities in access to human rights, and for the implications inequalities have for public policy. In relation to older people, the increase in longevity provides evidence of the inequalities in life chances (life expectancy, health) and the QoL during the extra years lived.

The QoL is affected by structural and personal characteristics deriving from great divergences in macro factors (income, employment, housing, education and other environmental aspects) and micro factors (perceptions of overall QoL, individual's experiences and values, well-being, happiness and life satisfaction; Bowling 2004). At the macro level, social inequality exists where access to resources, social assets, social prestige or position is systematically skewed to advantage some and disadvantage others. This has consequences on the total QoL, "which can be seen as a core outcome of access and restrictions" (Mollenkopf and Walker 2007).

Gerontological literature (Mollenkopf and Walker 2007) underlines the importance to health and well-being—basic elements in the QoL—of characteristics such as age, gender, race and ethnicity, marital status as well as the past and present socio-cultural environment. Objective socio-economic factors, e.g. levels of income and education, housing standards and the nature of communities and neighbourhoods, social and familial relations including marital status, health and welfare state support have all been identified as affecting QoL for older people (Noll 2007).

Despite the reduction in absolute poverty, the increase in standards of living and in longevity in all European states in the past decades, policy makers and organisations of older people have become increasingly concerned with the QoL of these extra years as all too often they are marked by poor health and social exclusion, though this is

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differentially distributed. The older age cohorts, women, those in disadvantaged rural areas without adequate public and private services and those in worse housing tend to be the major foci of public policy where it seeks to reduce inequalities and support a better life for all.

Objective factors impacting on socio-economic inequalities do not only affect the older segment of the population but it is argued that they have consequences for the health and well-being of all the population (Wilkinson and Pickett 2009). The authors point to the link between the extent of socio-economic inequalities in a society and life expectancy, obesity, stress, depression, crime and other non-positive and destructive aspects of human behaviour in the overall populations (Wilkinson and Pickett 2009). The explanation, also supported by the work of Marmot et al. (1991), is that greater socio-economic inequalities break or reduce the ties of solidarity and mutual support in societies and as a result the QoL declines for all. This has implications for older people, dependent on social solidarity, e.g. pensions, and health and social care if and when needed. At the same time, it can be noted that large socio-economic disparities in wealth and income are to be found amongst older people, and according to age cohorts. Often ignored are the considerable differences in age cohorts normally considered to make up the "older" population, i.e. those from 65 years onwards in Europe (WHO 2011). Older people have large differences in life experiences that relate to variables such as the socio-political changes they have experienced, their educational levels and income.

In the European Union, there are significant attempts to measure existing inequalities in the QoL. The European System of Social Indicators uses the European Social Survey, European Community Household Panel (ECHP) and Euro Barometer surveys broken down by age; focus on subjective and objective measures in the QoL of citizens. A different data set derives from the European Foundation's surveys on QoL starting in 2003 and repeated in 2007, which focuses on subjective appraisals of QoL in 28/32 countries, and is multi-dimensional, considering findings in relation to objective living conditions. The findings, of relevance to older people and inequalities in the QoL, are that deprivation, the inability to afford basic lifestyle goods and services that others have, has the most significant impact, followed by ill health. In addition, lower levels of social support and poor public services affected QoL.

The WHO definition of QoL focuses on subjective factors: "an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. It is a broad ranging concept affected in a complex way by the person's physical health, psychological state, personal beliefs, social relationships and their relationship to salient features of their environment". (http://www.who.int/msa/mnh/mhp/ql1.htm). Subjective factors can be measured by taking into account the individual's perspective on their well-being; most common of the indicators are happiness and life satisfaction indexes. According to Diener et al. (2003), well-being is multi-dimensional encompassing life satisfaction and happiness.

In studies of the subjective QoL of older people (Zahava and Bowling 2004), prime importance was given by older people to social relationships, home and neighbourhood, psychological well-being, activities done alone, health, social roles and activities, followed by financial circumstances and independence. Though subjective factors are really important to older people, however, they are not the focus of this chapter as they are less influenced by public policy interventions.

Some of the objective or macro factors, according to Bowling (2004), structuring inequalities for older people are presented below. These are based on gerontological literature and further supported by data on the QoL reported in a recent survey of older people that was primarily concerned with elder abuse in seven European cities (Soares et al. 2010).

Age and Gender

Age and gender are fundamental structuring factors in inequalities in the QoL and need to be discussed together as they are strongly interrelated. The situation of older people has always depended on the resources they controlled—whether this was property, skills, knowledge or social networks. People with few social resources tend to be marginalised and have a lower QoL (Antonucci and Ajrouch 2007). The privileged segments amongst older people are those having access to more resources such as a higher income, substantial property, political or economic power, extensive social networks and prestige.

Recent decades have seen substantial and rapid increases in longevity throughout Europe. The life expectancy of persons aged 65 in the EU-27 shows that the average man could expect to live an additional 16.8 years in 2006, whilst the corresponding figure for women was 20.4 years. Life expectancy amongst men aged 65 varied by 5.6 years across Member States in 2007, from a high of 18.4 years in France to a low of 12.8 years in Latvia. The range for women was slightly greater at 6.6 years, from 23.0 years in France to 16.4 years in Bulgaria (Eurostat 2010). These differences in life expectancy reflect inequalities caused by place of residence and are discussed further under the section “Socio-Cultural Environment”.

Since income and health status impact on the QoL, older age cohorts are negatively affected by both factors. Data from the European Foundation (2004) provide systematic evidence, which is also in line with the results from the ABUEL study (Soares et al. 2010) where younger age groups (60–64, 65–69 years) reported experiencing a higher QoL than the older groups (70–74, 75–79, 80–84 years).

Subjective data indicate that age and inequalities in the QoL show that being older is associated variably with happiness: the younger age cohorts (60–69) reporting highest levels of happiness as opposed to the oldest age cohorts. The effect of age on happiness inequality follows a concave trend, with those aged 45–54-age class reporting being less happy than those in the older age cohorts. This reverse U-shape trend is consistent with the argument that those in middle age experience time pressures that results in a lower level of happiness, which impinges on the QoL (Engfer 2009).

As people get older, some gender differences become more marked and others tend to disappear (Mollenkopf and Walker 2007). Thus, in all European countries women live longer than men (Eurostat 2010). This has implications for later life in that women are more likely to be widowed, further compounded by the fact that in most European countries women have married men older than themselves, again increasing the risk of widowhood (Neubeck 1996). Marital status has an impact on the QoL, as discussed below.

Living longer exposes women to the increased risk of chronic illness, and indeed women report higher levels of depression and ill health (Pinquart and Sorensen 2000). However, the negative effect on health for women is only partially explained by age. Mental health has a major impact on the QoL amongst all older people but appears to affect older women disproportionately. This appears to be the result of the cumulative effects of lifelong and age-related inequalities. Milne and Williams (2000) argue that older women's mental ill health needs to be seen within the context of their past and present experience of social inequalities and discrimination, with their psychological vulnerability compounded by gendered effects of social policy. Effective care needs to take into account these inequalities and to recognise that mental health needs are related to earlier oppression. In a Greek study on self-reported health (Alexopoulos and Geitona 2009), important factors were gender, age and health insurance fund. Women and older people had an increased risk of reporting worst health, as did those insured through the Agricultural Insurance Fund (OGA), which until very recently was a non-contributory health and insurance fund for farmers and the non-insured and whose levels of payment and services were very low.

Over their lifetimes, older women have received lower levels of education related subsequently to worse incomes (European Foundation 2009), and this is also directly associated with age cohorts and nationality. Moreover lower education is linked with lower levels of health and life satisfaction, particularly evident in the Southern Mediterranean countries where many have received minimal education; however, income appears to be an independent factor in improving the QoL for the less educated (Avendano 2009).

Another gender-related and unequally distributed factor is the presence of children in the life of women. Despite worse health, income and education and greater life expectancy, many older women with children improve the quality of their life by benefiting from their care, financial support, love and companionship. As the size of families decreases throughout Europe, this may be less true for the younger age groups (65–75 years) (Mollenkopf and Walker 2007).

Socio-Economic Status

The European Foundation's Quality of Life survey 2003 (European Foundation 2004) indicated that in Spain, Portugal and Greece the average incomes of older people were lower than for all other younger age groups. Pension levels are associated with age cohorts, with older pensioners tending to have lower benefits than younger cohorts (Bond and Corner 2004) and thus there are declining levels of income in the older age groups and a close relationship between poverty rates and older ages (Zaidi 2006). Poverty rates closely follow older age cohorts; thus older age cohorts, aged 75+, have a higher poverty risk rate than those aged 65–74. This is principally because women dominate the oldest age cohort, as women live longer than men.

This finding is also related to the income level, which according to Winqvist (2002) shows that in all Member States except Belgium and Spain, elderly people living alone were more at risk of poverty than those living with a spouse or partner, and the great majority were women.

Regions and neighbourhoods also reflect and reinforce socio-economic inequalities, e.g. access to social and health and transport services, neighbourhood support and personal safety (Balfour and Kaplan 2002).

There is a further link between income and health that also directly affects QoL (Berkman and Kawachi 2000; Wilkinson and Pickett 2009) showing that within countries, poorer health is associated with lower income. Wilkinson and Pickett (2009) provide some powerful data demonstrating the link between relative socio-economic inequality and health, with those in the lower strata experiencing higher levels of obesity, stress, anxiety and depression. In the ABUEL study, older people who depended for financial support on low pension entitlements such as sickness, disability, minimum social security benefits and partner/spouse income, were more likely to report being both financially strained and experiencing a decreased QoL (Soares et al. 2010). In the same study, BMI, depression, anxiety and somatic complaints were negatively correlated with QoL, indicating that the higher the scores on these variables, the lower the QoL experienced. Depression stands out as a critical factor in negative QoL in the research sample, findings, which are in line with European data (Disch et al. 2007)

Education reflects socio-economic differences and thus the QoL. This is evident in the relationship between educational level and health with those with higher levels of education experiencing better health. In the ABUEL survey (Soares et al. 2010), participants with the lowest educational levels (primary or less) tended to score higher on somatic symptoms than those with higher levels of education, particularly on exhaustion and musculoskeletal sub-scales. This may well reflect the kind of work those with less education subsequently undertake during their lifetime, i.e. hard manual labour.

Marital Status and Social Networks

Gerontological literature has tended to stress the benefits of being married for the QoL (Mollenkopf and Walker 2007) as it is usually associated with greater stability, higher income and education as well as intangible resources such as love, commitment and support, all of which are increasingly shown to affect health and well-being. The intangible resources are clearly subjective factors impacting on well-being and cannot be measured using the same kinds of scales. As already mentioned (Antonucci and Ajrouch 2007), people with few social resources tend to be more marginalised, stigmatised and have a lower QoL, which includes both marital status and friendship networks.

In a study of men and women living alone in EU Member States, women reported less satisfaction with life, which the authors (Gaymu and Springer 2010) interpret as a result of their relative disadvantage in terms of health and socio-economic situation. For all the European countries included in their study, women living alone were similar in only one aspect: good health is essential for life satisfaction. In northern Europe, the subjective well-being of women living alone depended strongly on their physical and material independence as well as on their neighbourhood characteristics. In central Europe, life satisfaction of women living alone was more influenced by their relationships with others (frequency of contact with children and leisure activities) and by their educational level. In southern Europe women were less satisfied with life when they had less than daily contact with their children. In southern countries where multi-generational cohabitation is frequent, women who are living alone are different in terms of relationships, education and income. Only the most independent women—financially, psychologically, etc.—will choose and be able to live alone. Women without children are not less satisfied with their lives than those who have daily contact with their offspring, probably because they have built a social network that is not centred on family. On the other hand, those who have less than daily contact with their children are less often satisfied with their lives. In these countries where family ties are traditionally strong (Pitaud 1995; Reher 1998), it is worth wondering if this result reflects a feeling of discordance between the expectations forged by the value placed upon family and the reality of relationships that are less intense than the norm (Gaymu and Springer 2010).

In the ABUEL survey (Soares et al. 2010), married or cohabitant men respondents reported a better QoL than unmarried men or women. In the same study, household size was positively correlated with QoL, suggesting that participants who lived in large households experienced better QoL than those who lived in small households or alone. The QoL studies (Marmolejo 2008; O'Keefe et al. 2007; Aciemo et al. 2010; Mollenkopf and Walker 2007; European Foundation 2004, 2009) underline the importance for QoL of intimate social relations (spouse/partners), the density of social networks, good communities and housing, the availability of various social networks for emotional and practical support. Social relations depend both on structural and personal characteristics, e.g. network size, the frequency of contact, geographic proximity and standards of behaviour in the community.

Social isolation is related to lower income, being female, being older, and thus with less social support, resulting in a lower QoL. For the time being, the newly developing social networks based on ICT such as Facebook that are radically changing some aspects of social behaviour, are least likely to be used by people belonging to the above mentioned categories.

Socio-Cultural Environment

The national and cultural contexts in which older people live, strongly influence the QoL since socio-political environments vary in their capacities to meet the needs of their older members (Kahn and Juster 2002). The capacity and willingness of national, regional and local governments to provide adequate health, social and economic support to older people influences the quality of their life and that of their families (Lowenstein and Ogg 2004). In some cultural groups and regions in the Member States, the provision of care and support for dependent older people differs strongly, as do cultural expectations. The absence of adequate public support services for older people often means that families are forced to be the almost exclusive providers of care. Findings from both the OASIS study (Lowenstein and Ogg 2004) and Lamura et al. (2008) indicated that in these cases the care provided by families did not lead to better QoL either for the older person or for their carers. Changing demands on families, e.g. double wage earners, mobility and the ageing of carers is leading to new forms of inequality—between those with available support from family members in their own home, and those without.

In the ABUEL study, older people from Germany, Spain and Sweden experienced better QoL than those from Greece, Italy, Lithuania and Portugal (Soares et al. 2010). These latter countries are marked by either inadequate overall resources (Lithuania) or by high relative income deprivation, and poor services, (Greece, Portugal), both being related to QoL (European Foundation 2009). Deprivation indexes also show that older people in Portugal, Greece and Lithuania were the most deprived; undoubtedly related to lower education, lower earnings over the life course, lower levels of pension entitlement. In line with findings from the general population surveys, Germany and Sweden are marked by adequacy of income for older people, by better life satisfaction and well-being and by the availability of public services.

The European System of Social Indicators 2001 database indicates that older people in Greece and Portugal have a lower QoL; they also reported their local medical services as being less satisfactory than in other countries—falling below 50 %. This fits in well with the research findings from the European Foundation studies, which note that the quality of public services is generally important to life satisfaction and has an ever greater impact on the subjective well-being of people experiencing deprivation (European Foundation 2009).

Inequalities in the availability of social support have been less explored in relation to QoL. In the ABUEL survey, social support was positively correlated with QoL, suggesting that the higher the scores on this variable, the greater the QoL experienced. Indirectly, for family carers the QoL is also influenced by the availability of social support in their task of caring influencing their satisfaction and willingness to continue caring and almost inevitably having an impact on the QoL of the older person being cared for (Lamura et al. 2008). In Germany, the debate on intergenerational conflict and support suggests that the changes in the form and size of families necessitate the development of more comprehensive formal services as a way of ensuring continuing informal care and inter-generational solidarity (Reichert 2008).

With respect to older people from migrant and minority backgrounds, there is an assumption of them being exposed to greater risk of social exclusion, marginalisation and poverty. However, this is a simplification as there is a great variety amongst migrant groups (Warnes et al. 2004), specifically their generational and national/cultural characteristics associated with differences in financial and social resources. In the

ABUEL survey, the sample of older migrants appeared to have a high QoL in the European Member States surveyed, which may be related to not being in the oldest age cohorts.

Discussion

Inequalities in the QoL of older Europeans are reported in endless numbers of gerontological studies. These inequalities are clearly structured in terms of age, gender, health status, marital status, income, education, place and country residence (rural–urban, North, South) and political, economic and cultural past and current contexts. These factors all influence the QoL but some are clearly more critical.

Causality is multi-factorial for older people and this complexity does not permit simple interpretations. In many cases, it is not older age that worsens the QoL but ageing in poor health and other independent but currently associated factors. Thus, older women have a reduced QoL, partly due to their poorer health status than men of the same age, but also to their lower incomes, their greater likelihood of being widowed leading to reduced social resources and their lower education. Their greater risk of suffering from chronic illness is, of course, age-related as well as being related to their past and present socio-economic status.

One difficulty in discussing inequalities in the QoL is that the former can be measured using objective criteria as outlined in this chapter; however, QoL includes important subjective elements. Many studies (Mollenkopf and Walker 2007; Ferrucci et al. 1995) have indicated, for example that worsening health in older people does not necessarily correlate with their own subjective evaluations of their QoL. These subjective QoL priorities do not have an exact correspondence with the objective conditions experienced by older people. Variations also exist between countries in terms of the QoL, as many European surveys indicate.

In terms of going beyond simply commenting on inequalities in the QoL of older people, it is clear that only some actions can have any real impact. The low income levels associated with increased age, living alone and being female suggest that policies may have to target them in order to improve their QoL, e.g. through the provision of better minimum pensions, and better quality, more extensive services. As poor health also increases the risk of a decline in QoL, the implications for public policy are actions that improve health promotion, rehabilitation, whilst suggesting that particular targeted support is needed for the most disabled and ill, e.g. special programmes for those with depression.

The current economic crisis affecting many European countries may be worsening poverty rates both by age—young and old—and gender. Though poverty clearly affects well-being and QoL, so does access to adequate basic primary care services and drug treatments. This has particular importance for those with multiple, chronic conditions and the long-term effects on healthy ageing, dependency and need for care are unknown for the current generation of older people.

The situation of older people in terms of their social networks and access to support is clearly about to undergo a radical change, at least for coming generations. Whilst the social networks of kin and relatives may be diminishing, other networks are increasing or have the potential to generate new forms of sociability, e.g. interest groups and associations; information and communication technologies-based social networks such as Facebook and Twitter . These latter can be particularly valuable for those with reduced mobility.

Whether new ICT-based social networks can compensate for a reduction in social resources for older people is yet to be documented. However, these cannot entirely replace personal, human relations, especially for the most isolated and frail.

Lifelong inequalities, exposure to health risks, poor health behaviour and poverty cannot be overcome entirely. However, measures that can reduce inequalities in well-being for older people must include a guarantee of an adequate income for those most at risk of poverty, since this is known to have a direct impact on their QoL. Access to good quality and adequate health and social services can also help in counteracting the decline in physical well-being and in confronting serious health conditions. Accessible environments, good rehabilitation services and imaginative social support for the most marginalised older people can also have a substantial impact on inequalities.

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Chapter 11
Older Men in the Community, a United Kingdom Perspective

Kate Davidson

Introduction

In our academic endeavour to explore all aspects of the lives of people as they age, we at the Centre for Research on Ageing and Gender (CRAG) feel there are some important gaps, notably that of older men, especially those who live alone in later life. This chapter comprises four principal parts: the first will give an overview of the more recent demographic shifts in longevity and marital status in the United Kingdom. The second part discusses some of the vast literature on social networks and relates it particularly to the experience of older men. Then, it briefly explores aspects of the enduring sense of masculine identity in later life, despite a reduction in economic and power status, deteriorating health and diminishing social support networks. Of course, not all older men experience such detriments, but these men tend to be the exception rather than the rule. The third part reports the findings from a major qualitative research project with which members of CRAG were involved. This was a UK Economic and Social Research Council (ESRC)[1]-funded study, which compared the health and social networks of 85 older men by marital status. The final part sums up the analysis and reflects on how social support might be maintained and nurtured through formal and informal networks at critical nodal points in the lives of older men such as retirement, the loss of a spouse/partner or the onset of ill health.

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[1] Economic and Social Research Council (ESRC) Growing Older Programme: 'Older men, their social worlds and healthy lifestyles' Project code L480254033. http://www.esrc.ac.uk/my-esrc/grants/L480254033/readwww.esrc.ac.uk/my-esrc/grants/L480254033/read.

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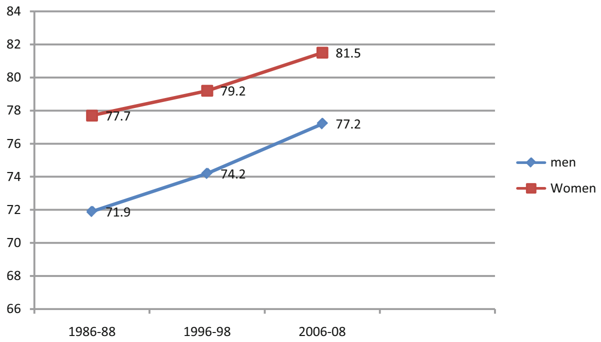

Fig. 11.1 Life expectancy from birth 1986–2008, United Kingdom. (From UK government data, retrieved from: http://www.statistics.gov.uk/STATBASE/ssdataset.asp?vlnk=9551)

Changing Lives, Changing Experiences

The phenomenon of increasing longevity is almost universal and has been well documented elsewhere. Nevertheless, there are a few ‘givens’ and one is that in just about every culture, women on average outlive men. However, recent UK data reveal that the gap in gendered life expectancy is closing. During the short period between 1986 and 2008, the difference reduced from just less than 6 years to just more than 4 years—a more rapid decrease than hitherto experienced (Fig. 11.1).

Of note are the data, which show that men in 2006–2008 are living almost as long on average as did women in 1986–2008 at 77.2 and 77.7, respectively. The Continuous Mortality Investigation Report (CMIR 21) predicted that men may well outlive women by the end of this century (Ridsdale 2004). Interpretation of extrapolating techniques for mortality (in particular from actuarial data) can be somewhat contentious and should therefore be treated with caution. Nevertheless, if current trends continue, the mortality gap between the genders is likely to reduce and even if there is no ‘cross-over’ as predicted, there are far-reaching implications for future generations of older men.

The most remarkable demographic trend in the United Kingdom’s older population is that of marital status. As a result of their biological endowment of a longer life expectancy and the socially constructed propensity of women to marry men older than themselves, they are still more likely than men to be alone when they are old, usually as a result of widowhood. However, predicted trends in marital status of people more than the age of 65 reveal that in England and Wales between 2007 and 2031, the proportion of widowed women aged 65–74 will decrease from 21 to 10 % and those aged 75+ will fall from 61 to 40 %. In line with most of the developed world, divorce rates are increasing, and this is reflected in older generations too. For example, during this period, the percentage of divorced men aged 65–74 will almost double from 9 to 17 % and the proportion of divorced men more than 75 will treble from 4 % in 2007 to 12 % in 2031 (Office of National Statistics 2006; Table 11.1).

Table 11.1 Population projections by legal marital status 2007–2031 (percentages). (From UK government data. Retrieved from: http://www.statistics.gov.uk/downloads/theme_population/MaritalStatusProjection06.pdf.)

	Year	Married	Widowed	Divorced
Women				
65–74	2007	60	24	11
	2031	57	10	20
75+	2007	28	61	5
	2031	40	40	14
Men				
65–74	2007	76	8	9
	2031	64	4	17
75	2007	63	26	4
	2031	61	19	12

The healthiest, wealthiest and most contented men are married (Gardner and Oswald 2004), and there are major social implications for older men facing later life without a partner, which will be discussed later. Therefore, family and support networks need to be viewed in the context of a much changed twenty-first-century lifestyle experience for community-dwelling older adults, and for the purpose of this chapter, especially that of older men. The following section helps us to understand this social context by looking at some of the theories on social networks and support developed over the last six decades or so.

Conceptualising Social Networks of Older Men

There is an abundance of literature on the social life, formal and informal social networks and support, dependence, isolation and loneliness in old age. It emanates from academic scholarship, policy initiatives, health and welfare research and voluntary and statutory publications. It is not feasible to visit all of it here, given the word constraint of the chapter. Rather, I discuss some of the key perspectives from the middle of the twentieth century up to the present day, and relate them to the lives of older community-living men.

It is a common myth that, especially for men, retirement triggers a much increased need for informal support and social care. Such beliefs were proposed from the early gerontological research of Cumming and Henry (1961) who argued that ageing involves a gradual but inevitable withdrawal from social life in mainstream society in preparation for death. They argued that there is a reduction in social interaction, and loss of major role in life and in doing so 'makes room' for younger generations to inhabit the social space.

Nevertheless, although conceived some 50 years ago, Cumming and Henry's findings continue to resonate with lay perceptions of how and why older people come to terms with withdrawal from the labour force and society and ultimately, life.

> Aging is an inevitable mutual withdrawal or disengagement resulting in decreased interaction between the aging person and others in the social system he belongs to. The process may be initiated by the individual or by others in the situation. The aged person may withdraw more markedly from some classes of people while remaining relatively close to others. His

> withdrawal may be accompanied from the outset by an increased preoccupation with himself; certain institutions in society may make the withdrawal easy for him. When the aging process is complete, the equilibrium, which existed in middle life between the individual and his society has given way to a new equilibrium characterized by a greater distance and an altered type of relationship (Cumming and Henry 1961, p. 14).

This *Disengagement Theory* evolved from a longitudinal study of a panel of mainly healthy, financially independent males over the age of 50 in Kansas, USA in the late 1950s. The main criticism of this theory is that it is (white) male-orientated, as exemplified by the wording in the above quote. Women in mid-century post-World War II mid-West America were less likely to have been in long-term employment and thus did not experience the sense of disengagement brought on by retirement. Therefore, it does not take into account the experience of most women, who are more likely to pass retirement age without ‘breaking step’, that is, whether or not they have exited the labour force they continue to carry out the majority of the domestic responsibilities. They are also more likely to have worked within the service industries, frequently an extension of traditional domestic female labour, and thus less of a disengagement from their pre-retirement existence than men might experience (Arber 1993). Women are also more likely to have established a social network of friends, neighbours and family, which they maintain into old age (Scott and Wenger 1995; Jerrome 1996). Men, on the other hand, tend to lose contact with work colleagues when they retire (Thompson 1994), which according to Cumming and Henry (1961) hastens the withdrawal from mainstream society.

The counter-balance to this much criticised positivistic approach to ageing was the proponents of *Activity* (Havighurst 1963) and *Continuity* (Atchley 1971, 1987) *Theories*. The basic premise of these theorists is that successful ageing involves maintaining, for as long as possible, the activities and attitudes of middle age, including social involvement. Lost roles, such as productivity (contribution to the economy) and reproductivity (childbearing/rearing), must be replaced by others activities such as voluntary work and leisure pursuits. The main criticism is that this is unrealistic and does not take into consideration (or marginalises) the experience of women, ethnicity or disability, where role replacement or the maintenance of middle age values is frequently not an option. Voluntary work and leisure activities presuppose a certain amount of disposable income and a degree of physical fitness, not to mention educational and career achievements, which tend to correlate with wealth and health, especially for men (Davidson and Meadows 2010).

Retirement does not herald the collapse of social interaction for men. On the contrary, retirement can open new vistas for social and leisure participation, not previously enjoyed to the full because of the need to be in the labour force. Estes (1979) identified how the commercial opportunities generated in response to the needs and expectations of older adults benefits capital and creates an ‘ageing enterprise’. Indeed, in the United Kingdom, we witnessed a burgeoning of private sheltered accommodation, the business activities of SAGA (holidays, motor and home insurance), and retirement villages/hotel developments in Spain, Cyprus and the Canary Islands offering winter sun and beneficial pension arrangements from the United Kingdom.

More recently, Gilleard and Higgs (2005) interrogated the experience of people growing older in a global world of increasing diversity, erosion of traditional values, powerful influences of consumption and changing attitudes to lifestyle choices. They argue that over time, class and gender differences in later life have become less relevant since the majority of both working and retired people are much wealthier now than in previous generations. Scherger et al. (2011) studied leisure activities in two waves of the English Longitudinal Study of Ageing (ELSA) and found that participants tended to continue their activities regardless of labour market or socio-economic status. However, those who made an early exit from the labour force because of ill health experienced a significant decline in leisure activities. Old age and increasing frailty were greater indicators of diminishing social activity rather than economic inequality, although the types of leisure and social activities did vary by class and access to financial resources.

Stability and change in social interaction and networking can be understood from Antonucci and Akiyama's (1987) social convoy model, which takes a life-span approach to personal networks based on role and attachment theories. Each person, throughout life, is part of a convoy comprising a set of people, family and friends, who provide important sources of affection and support. The composition and density of the social convoy expand and contract as we grow up and grow older: Employment and marital status are major determinants with gender as mediating factors in its formation.

Family and other social networks are crucial to people at all age stages, and rarely is their support uni-directional. Such reciprocity is complex and needs to be viewed within the context of time, circumstance and culture and can be categorised as prospective, contemporaneous and retrospective. Prospective support can be seen in the context of downwards, that is a parent to a child (infant or adult) in the understanding that it would travel in the other direction when the need arose. Contemporaneous support is like that given between spouses, siblings, cohort friends, neighbours. Also, retrospective is the other side of the coin to prospective, when support is given in recognition of past help received. The most complex of all is the support given and received by older people, as their social and family networks encompass every facet of inter-generational transfers of financial, emotional and practical help. The help offered and received is largely gendered. Women at all ages are more likely to give practical, hands-on caring and intimate emotional support while men's contribution is more likely to be giving advice and financial assistance, car driving and sport-orientated activities (Thomas 1994). The ending men's need for breadwinning has been theorised to result in an increase in the capacity for a less self-serving, more caring, style of interacting with others (e.g. Gutmann 1987).

Interestingly, Davidson (2006) found that widowers often report a closer bonding with their grandchildren since the death of their spouse and this relationship included activities more traditionally associated with grandmothering: babysitting, child minding, shopping and having them stay over. Despite this apparent 'blurring' of gender roles, or the reduction in need to present themselves as strong and manly, older men maintain a very strong sense of masculine identity, only comparatively recently a subject for academia.

Maintaining Masculine Identity in Old Age?

There is an increasing literature on the social construction of younger men's gendered lives, and an explosive growth of sociological research on masculinity in recent years (Gough and Robertson 2010). It has concentrated on maleness with reference to violence, race, sexuality, sport, fatherhood and so on. However, it has largely omitted the lives of older men. Even less attention has been paid to the meanings of social interaction for men in later life, or how older men's own notions of gender and self-identity influence their choices around social interaction. According to Thompson (1994, p. 16), what little comparatively recent study done has divided into two camps. There are those who believe that old age emasculates men. Others suggest that old men may have to adapt to fit into a new, but not substantially different, dominant ideological form of masculinity as they age. In other words, they suggest that there are different 'masculinities', which are facilitated by age (Meadows and Davidson 2006). Although older men may no longer be able to compete with younger men in terms of physical strength, earning ability and sexual prowess, their sense of male identity is not diluted, but altered. Davidson (2011) argues that masculinities are elastic, stretching and shrinking within the social context: off the sports pitch to cuddle a baby daughter, or still in control of the family finances despite having suffered a stroke. It is this elasticity, which enables men to maintain their sense of manliness, and only when the stretch is too great, the elastic too thin, that they lose a sense of self-hood. And so, the volunteering, social, sport and leisure activities for men in later life tend to reflect their previous working experience of management, organisation, physical performance, authority and instrumental action.

A few, very few men maintain positions of privilege and power into old age—one can think of some politicians—and this sustained high status is virtually always associated with great wealth. The majority of men, even those whose lives have been shaped by advantage are likely to lose power and influence as they are superseded by younger generations of men. However, compared with most other older men and to almost all older women, they retain their relative power. In doing so, they preserve their sense of masculinity, albeit elasticised. Qualitative research can help unravel and explain some of the complexities of these social dynamics.

Findings and Discussion

The social support, which accompanies marriage enhances quality of life for both men and women, and research has shown that marriage may exert a health-protective effect especially for men (Gardner and Oswald 2004). Older men in particular face distinct challenges in maintaining social networks on the dissolution of their marriage, whether from death or divorce (Davidson and Meadows 2010). Solo living in old age is associated with an increased likelihood of experiencing loneliness, social isolation and depression (Heylen 2010). Older men without partners, for example, are more likely to enter residential care, despite having lower average levels of disability than lone older women (Arber and Cooper 1999). At all ages more than 50, divorced and separated men followed by widowed men report poorer health than never married or married/cohabiting men (Thomas et al. 1998). However, until comparatively recently, the significance of marital status to the lives of older men has been largely overlooked in social policy investigations. Even less attention has been paid to organised community support systems, which may facilitate the maintenance of independence and ameliorate loneliness, particularly for the burgeoning group of older men who live alone in their later years (Davidson et al. 2003).

Throughout the following discussions, I draw on empirical data collected from a sample of 85 men more than the age of 65 (all names are changed to protect anonymity), representing a variety of marital statuses: 30 were married or cohabiting, 33 were widowed, 10 were divorced or separated and 12 never married. Approximately half of the men in the sample were aged 65–74, and half were older than 75. Interviews lasted between 1 and 2 hours and were predominantly conducted by an older male social scientist. The interviews were semi-structured and framed around the men's history, their present circumstances, their perception of family and friendship relationships, social support and health-related behaviour. We also asked them about the extent of their membership of, and involvement with community, leisure, religious, sports, voluntary, charitable, civic and political organisations.

There was a widely held belief by the 85 men interviewed in this project, that women (wives, mothers, daughters, nieces) played a pivotal role in the establishment and maintenance of wide social networks. Older men enjoy and maintain close relationships, although the scope and intensity vary according to marital status. Within the four categories of older men interviewed: married, widowed, never married and divorced, issues of continuity and discontinuities are important in understanding current social involvement.

The married men reported large, stable social networks, primarily (but not exclusively) couple-orientated. In widowhood, these networks contracted and the men tended to rely more heavily on their adult children for support. Divorced men who reported more attenuated relationships with their adult children, tended to seek another close companionship (which did not necessarily involve sexual intimacy). On the other hand, four of older never married men, who had established few close relationships in younger years, did not seek intimacy, and did not report feeling deprived, but they did see themselves as 'different'. They described themselves as 'loners', 'individuals' or 'completely independent':

[The quotes will be prefaced with an anonymised name, their age and marital status.]

> Jeremy (71, never married): I'm a proud individualist. ... I don't seek a lot of human company, I never say anything profound, I don't need someone sitting there particularly. I've never felt this great yearn for companionship.

It could be argued that those who do not particularly seek companionship reflect the concept of 'desirability' or choice of limited social networks. It is difficult to judge whether these men are more solitary because they do not seek social involvement, or whether it is because other people do not, or never have, sought their company.

The circumstances, which mitigated against marriage, especially for men, included amongst others, physical disadvantage, personality traits and poor income prospects. However, a common prejudice is that 'loners' are less happy than gregarious people, but to see happiness as a function of peoples' orientation to their world is simplistic (Shaie and Willis 2002). The never married men, like Jeremy who did not desire 'someone sitting there', were content with their own company. The divorced men, on the other hand, did not enjoy their reduced circumstances, including financial and companionship status:

> Jasper (70, twice divorced): I'm not sufficient unto myself. I've never been a loner. I think one of the things I've always been terrified of all my life is not having a partner and finding myself like this. I'm sort of, kind of, gazing around saying "How did it happen?". I know perfectly well how it happened. But no, that is something which rather terrifies me. I don't like thinking of it.

All the 30 married men we interviewed said they were happy in their relationship with their wife, although several admitted they had had their 'ups and downs', some saying that there were times they would have broken up had it not been for the children. This illustrates the well-documented observation of the 'U'-shaped satisfaction curve in marriage: good at the start, with a dip in the middle and a contentment in later life (Van Laningham et al. 2001). The most frequent comments were 'She's my best friend', 'She's the one who listens to me', 'I wouldn't know what I'd do without her'. Harry (76, married) was typical:

> We do everything together, go out, stay in, eat, laugh, everything. Like we're joined at the hip! I had a heart attack 4 years ago and thought I was a gonner. She pulled me through. After that we were even closer.

> Philip (69, married): We're a great team, especially in the garden. She does the pretty things, I do the useful things. If you can't eat it, I don't grow it. She has such a way with the flowers, my job is the chemical warfare, getting rid of the weeds and the pests. Yes, a good team. Everyone admires our garden.

The theme running through the narratives was togetherness, enjoying each other's company. Going out together was an important aspect, whether to friends or for social events. These aspects were much missed in particular by the widowed men.

These men were often more reliant on close family for support. When asked, if he had friends to confide in:

> Kevin (75, widower): No, not many close friends. I know my neighbors well. They're not friends but we get on extremely well together. But I've not really got any close friends round about here. . . . my daughter is in touch two or three times a week. The other sons certainly telephone me once a week and I visit them both about once a month for lunch or something. . . . I see a lot of the (eight) grandchildren and certainly during the holidays I normally spend a day, possibly individually with them.

Interestingly, childless widowed men reported a good relationship with a niece, almost always the daughter of their sister. Reg (84, childless widower) told us:

> My niece, great niece actually, yes. She passes by every morning when she goes to work by 9 o'clock. . . . Both my niece and my great niece have been very good to me.

Only one of the ten divorced men had a close relationship with his adult children and grandchildren, and that had blossomed comparatively recently. He had never remarried and one of his daughters called to let him know that his ex-wife had died. They met up and their relationship had been restored. One of his granddaughters had taken an interest in bird watching, and they went together on regular trips. Those divorced men, who may not have had a particularly close relationship with their children, or feel that their former wife had 'turned' children against them, are less likely to have maintained or established a good relationship after divorce:

> Dan (72, divorced): .... I hadn't spoken to her for about six years. She bought this house and she said "Oh dad can you come and have a look at it and do some work for me". So of course dad went along and done all the work for her and after that I never heard anything. I mean over the last—about the last six months I have had about three phone calls which are just left on my answer machine and I have got to the point where I think she is using me so I am not responding to her calls now. She has got to come and tell me what sort of a relationship she wants. I just feel that all I am getting is a phone call relationship. And I don't want that. I want something solid.

'A solid relationship' was intensely important for virtually all the men. The exceptions were the 'loners'—four of the never married men who maintained that this was not an issue for them. One of these, Tony 68, a committed Christian, had lived with his mother since his 40s, caring for her for 5 years before she died when he was 61. He said "I suppose I would have been what they call 'gay' now, but I never did anything about it". And, now he thought it was too late anyway, he was so set in his ways. The divorced men were the least contented with their current social lives, but reported that they had enjoyed some years of 'freedom' after the dissolution of their marriage. This 'freedom' tended to entail a variety of health-risk behaviours, which included smoking, unsafe alcohol consumption and poor diets. The divorced men were the youngest in the group, with only one more than the age of 70 (the widowers were the oldest, with only one less than 70 years old) and reported the greatest number of health problems. These were probably attributable to their lifestyle, but ill health was a substantial factor in reduced involvement in social organisations.

Older Men and Community Involvement

Unlike other forms of social attachment, such as involvement in family life or the world of work, informal group membership is nominally accessible to all. Most of the men interviewed were involved in some sort of social group outside the home. These ranged from social and sports clubs to religious groups and civic organisations (such as voluntary agencies, community groups and political parties). Some were overtly leisure-oriented while others appeared to be guided by a spirit of altruism, religious belief or shared principles.

There were notable differences between the organisational activities of partnered, widowed, divorced and never married men. The never married older men were less likely to be members of an organisation than those with a partner, apart from religious organisations. Compared with partnered older men, those who were widowed were more likely to be involved with sports and social clubs, perhaps indicating that leisure associations offer compensations following widowhood. This pattern was not evident for men who were divorced, who had the lowest level of involvement in any organisation and are particularly unlikely to be members of sports clubs or religious organisations. The majority of the men were likely to go to a pub or bar to meet friends and they did not find it daunting to enter alone, unlike older lone women (Davidson 2006). Alcohol consumption varied, much as in the general population, from total abstainers (including two who were recovering alcoholics), minimal, moderate, unsafe, and in one case, dangerous intake. They were also able to have alcohol in most of the social clubs to which they belonged. However, strict drink driving laws or the loss of a car did very much curtail such activity outside the home for the oldest men.

The men in the highest social groups were more involved in sports clubs, which are likely to promote physical health, and in civic and religious organisations, which may include involvement in activities that are altruistic or benefit the community. This contrasted with men with a history of manual labour, who were more likely to undertake sociable leisure. This class disparity has implications for social policy initiatives directed at older people, which seek to combine social interaction with some other ‘benefit’ such as enhanced physical health or community activities. There was no indication that lack of resources impedes membership of sports or social clubs, but there was a decline in membership with increasing age.

The organisations completely eschewed by the men were Day Centres, Luncheon Clubs and other establishments run by local authorities and charitable association specifically targeted at old people. They considered them to be full of bossy old ladies who were only interested in gossip, bingo and soap operas on the TV (Davidson et al. 2003). Mostly, the men said they had nothing in common with people who frequented the Day Centre, whether this related to socio-economic circumstances, mental and physical health or age:

> Gareth (71, widowed): Yes, well that Day Centre isn’t for me. I’m afraid it’s for dear old ladies. Certainly I wouldn’t choose to go there at all. . . . No. Looking through the window is enough for me!
>
> Kevin (75, widowed): No, I don’t think so. I suppose the social activity I’ve got, there is always the golf club and that’s where I meet people and you know with quite similar backgrounds. A lot of civil servants and so on.
>
> Dan (72, divorced): Well I really feel that my own personal view people in Day Centres are just sitting there waiting to die. . . . If you look at them they are all sort of people that—I mean I am very lucky, I have got my health haven’t I?

There is, however, a recognition that the centres ‘do good’, but that the ‘doing good’ is not relevant to them, and their sense of autonomy and independence. However, a few acknowledged grudgingly that in the very last resort, they might consider it:

> Bert (65, never married): I suppose maybe a bit of snobbishness. I don’t feel a need for it. Yes, they do good work. They offer opportunities for social contact and they have a mini-bus which brings people in. Services such as hairdressing. And those who haven’t got a bath,

> there's a bath there I understand. Cheap meals which are adequate, but at the moment I don't feel the need to go there. . . . I suppose if I got past doing my own cooking, then I might go.
>
> David (73, never married): I don't know probably if, probably if I got really incapacitated and forgetting. People would take me perhaps by car to the Day Centre to get me out but it's not something I would do while I can nosey around and get about, yes.

Toby (80, married) summed it up wonderfully, when asked what he thought could be done to make day centres more appealing to men:

> So obviously one has got to try to convince them that it is a good place to go. Day Centres tend to be a 'pink' thing, not a blue thing. Proper clubs would be a 'blue', not a 'pink'.

Similar to Scherger et al. (2011), we found that the majority of the older men, especially the married ones had belonged to social or sports associations for many years and continued membership after retirement and/or widowhood, often in an administrative capacity. Many of these organisations were exclusively or predominantly male and contained a range of age groups. They tended to fulfil the dual purpose of providing social interaction and a forum in which to be active (such as sports) and/or 'useful' such as carrying out fund raising and voluntary work. Even if they belonged to a faith group, which might be top heavy with older women, they tended to have 'responsible' positions such as key keeper, verger, treasurer and so on ('a blue thing') rather than flower arranging and cleaning ('a pink thing'). Being useful and maintaining physical activity conflates with the masculine imperative of work, routine and profitable use of time (Whitehead 2002). In contrast, clubs geared specifically for older people were perceived as providers of passive pursuits—rather than members *doing* for others, members are *done to* by others. Men, who lived alone in later life therefore, would find it easier to maintain social contact within a 'blue' sphere. The difficulty for lone older men arose if they had never belonged to a social club, or had moved home to be nearer family (e.g. widowers) or away from the marital home (e.g. divorced men) and were reluctant to join so late in life. We know that they shun establishments geared to help older lonely people, and so it is likely that they become increasingly isolated as they grow older and frailer.

Summing Up and Reflections

In the United Kingdom, the current population more than the age of 65 is healthier, wealthier and longer living than any previous cohort. Yet the rates of reported loneliness and reduced social networks have not lessened, especially for the oldest old who live alone (Victor et al. 2002) an increasing number of whom will be men. The lifespan perspective of Antonucci and Akiyama's (1987) social convoy helps capture the diversity and heterogeneity of older men's lives. After retirement from the paid workforce, men become more dependent on friends and neighbours for social interaction. As one set of friends, acquaintances and work colleagues move to the social network margins, others take on more importance. Those older men who spent years commuting to work and long hours out of the family home, during retirement are even more likely to depend on a spouse to maintain local contacts. The men who lived alone were less likely to give or receive favours than married men. For example, many of the married men helped widowed neighbours with garden chores, talking to workmen, giving car lifts for shopping, etc. These favours were more often than not, instigated by their wife. Widowed men reported a smaller circle of friends than when they were married, but they had maintained and in some cases strengthened their relationship with their adult children and grandchildren. Divorced men in the sample were the least contented with their social situation and viewed the prospect of ill health and loneliness in old age with considerable anxiety.

We concluded that most men never lose their masculine identity as they age, despite failing health, reduced social and economic status regardless of marital status and changed living circumstances. This sense of masculinity enabled them to keep control of their lives, giving them the resilience to cope with ageing. However, it can be detrimental to their health and social networks, especially those without a spouse or partner, because of their reluctance to seek help. Our findings indicate a need for greater vigilance from family, neighbours, health and welfare professionals, in order to identify points at which an older man might slip off the social radar. Life transitions such as the loss of a spouse or onset of ill health can often trigger isolation.

A seemingly obvious solution to ameliorating such loneliness is the provision of a service, which will offer companionship, trained professionals who cater to specific needs and activities to suit all levels of physical and mental ability—in other words, a Day Centre. The reality is that there is very low participation from older men who do not view such places as male friendly (or a blue thing). The inclusion of male-orientated activities such as a computer club, snooker table, darts board and so on would enhance an establishment. Also, very welcome would be the opportunity to have some beer or wine with a meal. In fact, it should be possible to offer the sort of atmosphere that they had enjoyed in a pub, but with cheaper meals and available transport.

Older men's involvement with formal associations represents an under-valued resource, which may contribute to the quality of life of older men by facilitating social interaction and providing a context for continued social productivity. While all facilitate social interaction, some additionally offer the opportunity to pursue a personal goal (such as health maintenance) or to make a recognised social contribution through community activity. The opportunity to be part of a socially productive organisation may bolster the well-being of older men by compensating for some of the losses following retirement from paid work. Advanced age is one of the major determinants of reduction in formal social involvement. However, restricted economic resources and poor health also contribute to this decline. Interaction with family and friends is likely to be influenced by an older person's access to material resources, including car ownership, physical and mental health and degree of physical mobility. The older divorced and never married men had more restricted networks with kin, friends and neighbours. This lack of social embeddedness makes them more vulnerable to social isolation in later life. Finally, we conclude that it is imperative for policy makers to take greater account of the differentiation of older men according to partnership status and living circumstances.

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Chapter 12
The Social Networks of Older Europeans

Howard Litwin and Kimberly J. Stoeckel

Introduction

Research has demonstrated that quality of life in old age is positively related to social networks in a range of societies (Pinquart and Sorensen 2000). Studies that examine the relationship between social network factors and various aspects of well-being in late life tend to confirm a positive association between these two realms (de Leon et al. 2001; Gray 2009; Seeman et al. 2001). Berkman et al. (2000) point out, however, that the effects of social networks may be conditioned by the social and cultural context to which one belongs. It is important, therefore, to study the current state of the social networks in which older Europeans are embedded, to identify differences that may exist in social network structure and social network dynamics across different regions of Europe, and to examine the associations that reign between social networks and well-being.

Although there is general agreement about the positive contribution of social networks to quality of life, there is much less agreement as to how best to measure the network construct. There is even some dispute as to what constitutes the essence of the network phenomenon. Review of the literature indicates that there are three dominant realms of social network. These include network structure and interaction, social exchange, and social engagement. The first of these domains—network structure and interaction—draws upon a role-relation methodology to identify the types of people who make a difference in the lives of older persons and the nature of the contact with them. Some studies suggest that family members are the ones in the network who matter most (Tesch-Romer et al. 2002).

The domain of social exchange draws upon exchange theory, which maintains that the transfer of resources is a key aspect of social network relations (Litwin et al. 2008).

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Study of social exchange among older people is particularly relevant, insofar as changes may occur in late life in the accessibility that one has to resources of different kinds. Social exchange is expressed both in the provision of resources and in their receipt. The resources in question may be composed of either practical help, usually conceived as time transfers, or money, usually termed as financial transfers. Research seems to suggest that the provision of help or money to others tends to benefit older people more than the receipt of the same from others (Litwin 2009).

The third common domain of social network is social engagement, that is, one's involvement in meaningful or otherwise rewarding activity (Litwin and Shiovitz-Ezra 2006). Participation in activity is considered a part of the social network phenomenon because it is through activity that one has exposure to others with whom one interacts. Thus, activity frequently provides not only what to do, but with whom to do it. This domain is particularly relevant in late life when there may be a decrease in activity due to retirement, relocation, disability, and/or bereavement.

Social Networks and Older Persons in the European Context

There are several publications that consider selected aspects of social networks among older Europeans in different countries. A number of these relate especially to family and household structure. For example, a meta-analysis underscored that people with spouses had lower mortality risks than the widowed, divorced/separated, and never married (Manzoli et al. 2007). Moreover, this estimate did not vary between Europe and North America. Interestingly, there is a reported increase among Dutch older adults of unmarried cohabitation and living-apart-together relationships (Gierveld and Perlman 2006). There is also an increase in childlessness across European societies. Data from the first wave of the Survey of Health, Aging, and Retirement in Europe (SHARE) showed that although the support networks of childless older people were weaker than those of parents, they reflected stronger links with lateral relatives and with nonrelatives (Albertini and Kohli 2009). In addition, data from the Italian sample of the MOBILATE 2000 study showed that average household size was larger in rural settings than in urban areas (Marcellini et al. 2007).

There are a growing number of sources that address social exchange among European older adults, inclusive of social support exchanges and financial resource transfers. Several studies report a net downward flow of resources from older people to members of the younger generation (Albertini et al. 2007; Litwin et al. 2008). Moreover, it is claimed that family relations are mostly driven by one's resources and needs (Kohli et al. 2009). One particular study looked at the exchange of support in four former Soviet-Bloc countries (Goodwin 2006). It found a small but, nevertheless, meaningful decline in overall support across age.

As for the realm of social engagement, Hank and Stuck (2008) found that volunteer work, informal help, and care tended to covary among Europeans aged 50 and older. They also found, however, that these patterns varied across countries. Specifically, there were relatively high participation rates in Northern Europe and correspondingly low participation rates in the Mediterranean countries (Erlinghagen and Hank 2006). Further analysis indicated, moreover, that changes in volunteer activity stemmed from time-invariant individual resources as well as from changes in one's resources (Hank and Erlinghagen 2010).

As already hinted, there is ample evidence that social networks vary across countries and across cultures (Burholt et al. 2007; Minicuci et al. 2003). In a review of SHARE data, Kohli et al. (2009) confirmed the presence of meaningful regional variation in the levels of social connectedness and in their dynamics. In contrast, a study of community-dwelling older adults in three different settings—London, Hamburg, and Solothurn (Switzerland)—found that social network factors identified older people at risk for social isolation in all of the settings (Lubben et al. 2006).

One recent study of note compared the social networks of older persons in Mediterranean countries (including Israel) to those in countries in the North and West of Europe (Litwin 2009). The inquiry was based upon data from the first wave of SHARE. The data revealed that the older Mediterranean respondents had larger families, more children in the household, and more exchange of assistance within the household. This finding gave support to the claim that the social networks of older persons in the Mediterranean were more family-oriented in nature than networks elsewhere in Europe (Kalmijn and Saraceno 2008). Interestingly, however, the respondents from the non-Mediterranean countries reported having greater exchange of assistance outside the household. Apparently, these men and women maintained meaningful interaction with adult children and others at a distance (Silverstein et al. 1998). The implication of this finding was that older adults in the North and West of Europe did not necessarily maintain less familial social networks, but rather they had familial networks that extended over greater distances. This same study also showed that male respondents from the non-Mediterranean countries were less likely to be employed, but more likely to participate in social activity than their counterparts in the South of Europe and Israel. This was not the case among the women. On the basis of these and other findings, the study concluded that the social networks of older people are contextually bound and may well differ in different sets of countries. It further pointed out that social networks should be viewed within "their unique regional milieu and in relation to the values and social norms that prevail in different sets of societies" (Litwin 2009, p. 607).

This brief review of the literature underscores the importance of clarifying and understanding the current trends in social network structure and function among older Europeans. Toward this end, we report the results of an empirical analysis that was undertaken especially for this chapter. We address three major research questions. First, what is the current composition and state of social networks among older European adults? Second, do regional differences prevail across Europe in the realm of social networks? And third, are social networks indeed related to a good old age, as measured by a state of well-being in late life?

The Study

The empirical analysis drew upon data from the 13 countries from Continental Europe that took part in the second wave of SHARE (Boersch-Supan et al. 2005). The SHARE survey collects information on a wide range of topics from representative household samples of the community-dwelling population aged 50 and older in each of the participating countries. The second wave of the survey was executed in 2006.

The current study sample was drawn from the entire sample (longitudinal respondents and a surplus vignette sample), but it limited the respondents to the one household member who was designated as the "family respondent." In SHARE, the family respondent answers most of the social relationship questions. We chose this analytic strategy because a unique focus on one household respondent maximizes the independence of the individual observations. In cases in which relevant household information was supplied by another respondent from the same household, as, for example, income or wealth, these data were copied to the family respondent as well. In addition, we limited the current investigation to community-residing family respondents aged 60 and older, the age by which most Europeans have retired. Mean values were imputed for respondents with missing values for the count outcome variables (CASP and Depression) when less than 20 % of count variable data information were missing. Respondents with missing values on one or more of the other measures were excluded from the multivariate analyses. Sample weights were applied, as appropriate.

Social Network Composition Among Europeans Aged 60 and Over

In the first part of the analysis, we examined social network factors among the entire European sample, looking at three main groups of network variables: family structure and interaction, social exchange, and social engagement. The family structure and interaction measures included having a spouse or partner in the household, number of children, number of children residing within the household, number of grandchildren, and frequency of contact with the most contacted child. Social exchange was measured by six kinds of assistance that were given and/or received in the past year or so. These included help with personal care tasks at home, help of any kind outside the household, and private transfer of € 250 or more. Social engagement was measured by three indicators: current work status, the number of different activities engaged in the previous month), and the frequency of the most frequent activity.

Table 12.1 presents the summary statistics for the study sample. It shows that slightly more than half the sample currently had a spouse or partner within the household. The average number of children was about two, and the average number of grandchildren was about three. The majority of respondents had no adult children living with them, with the average number of coresident children close to zero. Average frequency of contact with at least one child was fairly high, that is, weekly

Table 12.1 Social network characteristics among Europeans aged 60 years and older

	Mean	Percentage (%)	SD
Family structure and interaction			
Spouse or partner in household (HH)[b]		52.6	
Number of children[a]	2.2		1.42
Number of children living in HH[a]	0.2		0.54
Number of grandchildren[a]	3.1		2.91
Frequency of contact with child[a]	5.6		2.04
Social exchange			
Gave help to person within HH[b]		5.4	
Received help from within HH[b]		4.7	
Gave help outside HH[b]		22.2	
Received help from outside HH[b]		24.5	
Gave financial help[b]		25.1	
Received financial help[b]		5.0	
Social engagement			
Currently working[b]		10.9	
Number of activities[a]	0.6		0.99
Frequency of activity[a]	0.8		1.07

$N = 14{,}317$

[a] Scale ranges: number of children (0–6+); number of children in HH (0–4+); number of grandchildren (0–10+), frequency of contact with child (0 "never"–7 "daily"); number of activities (0–5+); frequency of activity (0 "never"–3 "daily")

[b] Dichotomous variables: 1 = Yes; 0 = No

or more. A small minority of older Europeans (5.4 %) provided personal help to someone within the household, and an even smaller percentage (4.7 %) received such help. A bit more than a fifth of the sample gave help to someone outside the household, and almost a quarter received such help, but only 6 % both gave and received such help. About a quarter gave financial help to family members or friends, while only 1 in 20 received financial assistance. Some 11 % of respondents were actively employed and, thus, had contact with others through their work. Finally, about 40 % of the respondents engaged in at least one social activity, and those who did, did so on a weekly basis or less.

We also took several background characteristics into account. On average, members of this sample of Europeans aged 60 or older were 71.5 years of age, and 57 % of them were female. The average level of education, according to the International Standard Classification of Education (ISCED-1997), was at the lower secondary level (2). Household income was divided into equal quintiles based on all SHARE respondents, aged 50 and older. Approximately 15 % of the analysis sample had an income in the lowest 20th percentile quintile, compared with more than a fifth with income above the 80th percentile. The income measure was a self-report of income received from any source (e.g., employment, pension). Similar distributions for wealth were found, with 18 % in the lowest quintile and 25 % in the highest wealth quintile. Wealth was computed as the combined values of assets minus liabilities.

Key health characteristics were also considered. On average, members of this sample had two chronic diseases (e.g., arthritis, diabetes, cancer) and two physical

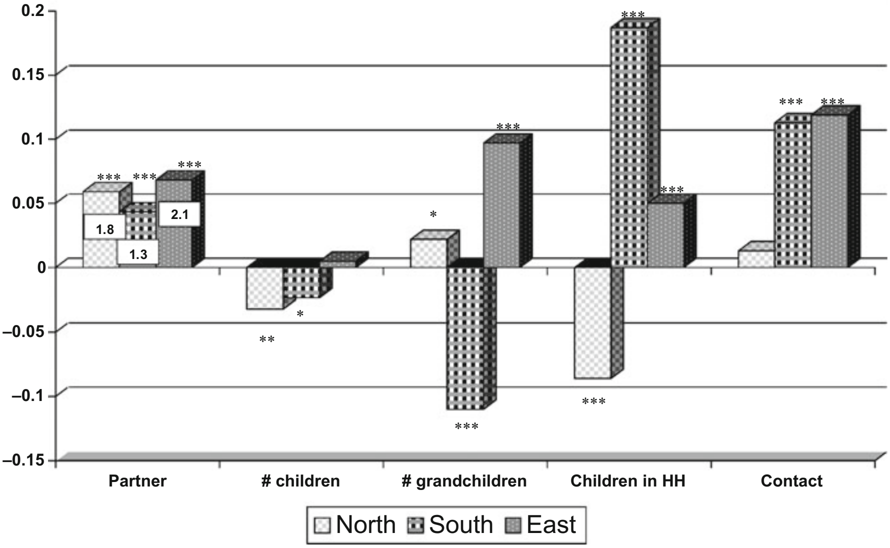

Fig. 12.1 Association of region and family network structure (OR and betas)

symptoms (e.g., back pain, breathlessness). The average count of difficulties in activities of daily living (ADL) was 0.3 on a scale of 0–6, and 0.5 on a scale of 0–7 for difficulties in instrumental activities of daily living (IADL).

Social Network Differences Across European Regions

In the next stage of the inquiry, we considered the differences that exist in the social networks of older Europeans across different regions. We divided the participating countries into four major geographical areas that reflect a range of sociocultural and economic differences, as noted in the literature review. The respective regions and their country components were as follows: (1) Northern region (Sweden and Denmark), (2) Western region (France, Germany, Belgium, the Netherlands, Switzerland, and Austria), (3) Southern region (Spain, Italy, and Greece), and Eastern region (Poland and the Czech Republic). In order to identify the differences, we executed multiple regressions in which each of the social network measures was regressed on region controlling for selected background and health characteristics, as relevant. The Western European countries served as the reference category in these analyses. Linear or logistic regressions were employed according to the level of measurement of each network variable. The results are presented in Figs. 12.1, 12.2, and 12.3.

Figure 12.1 shows the regional differences for the family network structure and interaction measures. The findings reflect the degrees to which respondents from the three European regions (North, South, and East, respectively) diverged significantly

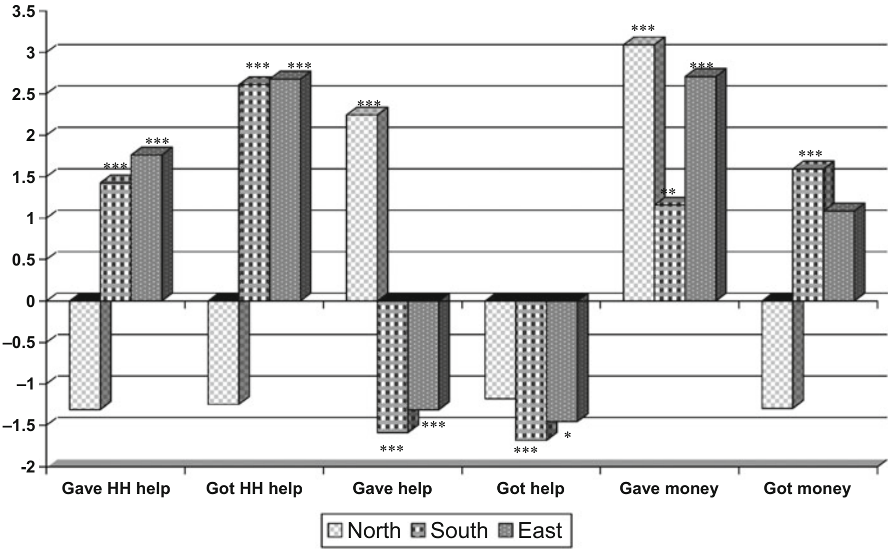

Fig. 12.2 Likelihood of engaging in social exchange by region (OR)

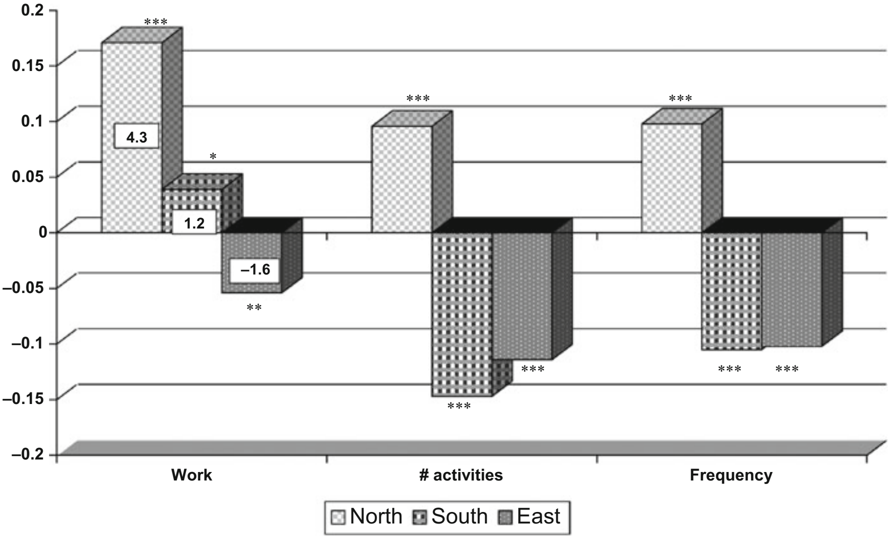

Fig. 12.3 Association of region and social engagement (ORs and betas)

from respondents from the Western European countries on each of the variables. The first set of bars on the left side of Fig. 12.1 shows the odds ratios for having a spouse or partner. Clearly, respondents in all three regions had a higher likelihood of having a partner than their counterparts in Western Europe. Those in the Eastern region were twice as likely, and those in the North were almost twice as likely. Respondents in the Southern region were almost a third more likely than Western Europeans to have a spouse or partner.

The remaining bars in Fig. 12.1 show the beta coefficients for region in relation to each of the other family structure and interaction measures. The graph shows that respondents from the North and South had fewer children than those from the West. As for grandchildren, respondents from the North reported having slightly more, while those from the South reported having less. Respondents from the East had many more grandchildren. Turning to children within the household, the figure shows that the Northern region was inversely related to the number of coresiding children while the Southern region was positively related. The East was also positively related, but to a more modest degree. Finally, respondents from both the South and the East had more frequent contact with their children than those from the West, but those from the North did not.

Additional analysis found that the number of grandchildren appears to be impacted by an age effect. We analyzed the distribution of respondents with five or more grandchildren according to region and age categories (60–69, 70–79, 80+) to better ascertain why older people in the South have so fewer grandchildren than Western counterparts. Among those aged 60–69, only 11.2 % had five or more grandchildren in the Southern region compared with 18.2 % in the West. Among the oldest old (age 80+), no regional differences were found. These results indicate that younger generations in the South are having fewer children than may have been the historical trend in these more familial regions.

Figure 12.2 shows the results for the social exchange measures, all in terms of odds ratios. The figure shows that respondents from the Southern and Eastern regions of Europe were more likely to have exchanged practical help within the household, that is, both giving and receiving, and less likely to have exchanged practical help with persons outside of the household. Respondents from the Northern region stood out mainly in relation to providing practical help to persons outside of the household. As for the exchange of money, the graph shows that respondents from all three regions were more likely than those in the reference category (the Western region) to have given financial assistance, with the highest likelihood observed in the North and the East. In contrast, only the respondents from the South were significantly more likely to have received financial assistance from members of their social network.

Figure 12.3 summarizes the data on social engagement. The first set of bars on the left side of the figure show the odds ratios for working. The bars indicate that respondents aged 60 and older from the North were some four times more likely to be working than those in Western Europe. Respondents from the South were somewhat more likely to be working, while those from the East were somewhat less likely. The remaining bars in the figure show the beta coefficients for region in relation to the other social engagement measures. The graph shows that the Northern region was associated with a greater number of different social activities than was the Western region, and that both the Southern and Eastern regions were associated with lesser social activity. These same trends were replicated in relation to the frequency of participating in the most frequently reported activity.

Social Networks and Well-Being Among Older Europeans

In the final phase of the study, we looked at three measures of well-being in relation to the social network and control variables, separately for each region. The first well-being outcome was the EURO-D depression scale, which counts self-report of up to 12 depressive symptoms such as trouble sleeping and excessive guilt feelings (Castro-Costa et al. 2007). The second measure was the CASP-12 scale, which examines quality of life as indicated by feelings of control, autonomy, self-realization, and pleasure (Hyde et al. 2003). The third indicator—life satisfaction —was assessed on a 4-point global measure that ranged from very dissatisfied to very satisfied. Multivariate linear regressions allowed consideration of the associations between the social network variables and the well-being indicators in each of the European regions.

In order to focus on the net associations between region, network, and well-being, we controlled for the respondents' background and health characteristics. These factors had similar effects in most cases. That is, higher education was generally related with better well-being (less depression, more life satisfaction, and higher CASP scores). Both of the functional disability indicators (ADL and IADL) were associated with poorer well-being (greater depression, less life satisfaction, and lower CASP scores). The health measures were mostly similar to the functional measures in their associations with the well-being outcomes (poorer health was related to poorer well-being). Female gender was not only related to greater depression, but also to greater life satisfaction and higher CASP scores in all regions but the South. Age was mostly unrelated to well-being, after having controlled for health, but was positively related to life satisfaction. The income and assets measures showed some mixed associations.

As noted, our main goal was to consider the associations between social network and well-being among European older adults, independent of the background and health characteristics. The analyses showed that the network variables explained a small but significant amount of the variance in the well-being measures after controlling for the background and health factors. This ranged across regions from about 1–1.5 %, in the case of the depression outcome to 2–4 % in the CASP scale; and 3.5–6 % in explained life satisfaction. It was apparent, therefore, that social network factors were indeed related to well-being among older Europeans.

The next goal was to clarify which of the network characteristics had significant relationships with well-being and whether these relationships were the same in each of the regions. In order to answer this query, we identified the social network variables that maintained significant and consistent associations with at least two of the three well-being measures. Figure 12.4 presents a summary of the main findings from this analysis. As shown in the figure, the solid light gray cells reflect positive associations with well-being (i.e., less depression, higher CASP scores, and/or greater life satisfaction). The dark striped cells reflect negative associations with well-being (i.e., more depression, lower CASP scores, and/or lesser life satisfaction).

Network characteristic	European region			
	NORTH	SOUTH	EAST	WEST
Partner	---	---	░	░
# children	---	---	---	---
# grandchildren	---	---	---	---
# children in HH	---	---	---	---
Contact with child	░	---	░	░
Gave help in HH	▨	▨	---	▨
Received HH help	---	---	---	---
Gave help outside HH	---	---	---	░
Received help outside HH	---	▨	▨	---
Gave money	---	---	░	░
Received money	---	---	---	---
Work	---	---	---	░
# of activities	---	---	---	░
Frequency of activity	---	---	---	---

Legend ░ Positive well-being ▨ Negative well-being

Fig. 12.4 The association between social network characteristics and well-being by European region: Summary table

First of note is that not all of the network factors maintained significant associations with well-being in all the regions, as operationalized in the preceding paragraph. However, those that were related seemed to have had the same general associations across regions. That is, in no case was a given network characteristic positively associated with well-being in one region, but negatively associated in another one.

Two network variables were significantly associated in almost all the regions (three out of four). Frequency of contact with the most contacted child was positively related to well-being everywhere, except in the South. That is, a key correlate of positive state among older Europeans is maintaining frequent contact with adult children. Paradoxically, this was not the case in the Southern countries where frequency of contact with children was among the most frequent among the European countries. Perhaps differing expectations regarding relations with one's offspring in the South is what neutralized a potentially positive association between their frequent contact and their perception of personal well-being.

The second variable significant in almost all of the regions was the giving of personal help to a member of the household. This variable was negatively related to well-being everywhere, except in the East. Long-term caregiving of a loved one is known to be associated with a possible sense of burden and stress, and this could well be the source of its negative association with respondents' well-being across most of Europe. Interestingly, this negative association was significant in the Northern countries in spite of the fact that respondents from that region actually reported the lowest rate of such in-home caregiving. Even more interesting is the lack of association on this variable in the East, where the extent of providing help at home was the greatest among all the regions. It might be that older persons from former Eastern-Bloc countries still maintain more traditional outlooks in which the family responsibility for personal care of family members remains dominant.

Another set of variables was significantly related to well-being in half of the regions. It included having a spouse or partner in the household, getting help from outside the household, and having given financial support to someone in the network. Having a partner and giving money were positively related to well-being in both the East and in the West, but perhaps for different reasons. The Eastern countries demonstrated the highest proportions of in-household partnerhood and a relatively high proportion of private financial transfer. It could be that these particular aspects of social relations constituted a prevailing social norm in those societies, and their practice was consequently a source of well-being in that context. In contrast, the countries in Western Europe exhibited the lowest degrees of partnerhood and private financial transfer. Nevertheless, these two aspects of social network relations constituted a significant correlate of well-being in those societies as well. The third variable in this set of variables—getting help from outside the household—was significant in the South and in the East, both of which exhibited higher numbers of coresident children. Although these regions received less help from outside the household than was the case in Western Europe, getting help from outside the household was still negatively associated with well-being in these settings.

The last three variables that maintained associations with well-being (all positive) were: giving help to someone outside of the household, being employed, and the number of social activities in which one engaged. All three variables were significant in one region only—the West. A common theme that runs through these particular social relation variables is the notion of agency. People who provide help to others outside the domicile, and those who work and/or participate in social activities, all demonstrate initiative and productivity—factors that are associated with better well-being in late life. Why this association emerged only in the Western countries requires further analysis.

Looking at Fig. 12.4 from another direction, that is, by region, we can see that the Western European countries had the largest number of social network correlates of well-being. In comparison, the Northern and Southern countries had only two such correlates each. Moreover, in the South, both of the significant factors showed negative associations only. Stated differently, the chart seems to suggest that social networks constitute mainly positive correlates of well-being among older persons in the West of Europe and, to a lesser degree, in the East as well. However, social networks seem to be less related to well-being in the North, and to the extent that the association exists there, it is not unidirectional. In contrast, social networks in the South showed only negative associations with well-being among its older population.

An explanation for these findings is that Western and Eastern European countries are largely family based up to now, at least among the older cohort. Family-related contact and exchange in these societies still constitute a pillar of their social fabric. Consequently, it is not surprising to find significant associations between social network factors and well-being in this context. The Northern countries, in turn, are more collectivistic in their orientation to support provision and more individualistic in their interpersonal exchanges. In those societies, therefore, social networks are less associated with well-being.

In contrast, the negative associations that were found between social networks and well-being in the South of Europe might be understood as a function of high expectations that have not been met. That is, the Southern countries are ostensibly the most familial among all the European countries and the least collectivistic in their formal structures of social support provision. In these societies, older people expect to be embedded in supportive familial and communal structures. When such expectations are challenged, even to a minor degree, the result may be more harmful than in societies in which support levels and exchange were lower to begin with.

Conclusions

This analysis considered the nature and the function of social networks among older Europeans at the outset of the twenty-first century. The inquiry was based upon a role relational approach to the study of social networks. The results showed that older European adults are generally socially connected and that family ties are still quite prevalent in their lives. At the same time, however, only some of them were actively engaged in the exchange of help of some kind, whether as providers or recipients. This finding might be suggesting that many older Europeans are not in need of help, rather than saying that they are not actually embedded in supportive social networks.

The study also showed significant regional differences in the structure of social networks and in their dynamics. When compared with older people in the West of Europe, it seemed that older people in the South and in the East generally had more intimate familial ties and exchanges (although this might be diminishing in the South). Those in the North were less connected, in this regard, but still can be said to be maintaining intimacy at a distance.

Finally, the analysis demonstrated that the social networks of older Europeans are associated with their well-being in late life to varying degrees across the regions of Europe. Social networks seem to matter most in Western Europe, in that this region had the greatest range of network characteristics that were related to well-being, all else considered. Social networks were important to one's well-being in the East, but to a somewhat lesser degree, and to an even lesser extent in the North. Interestingly, the only associations that emerged between social network and well-being in the South of Europe were negative. It could be, therefore, that high expectations for support from the family still prevail among the older generation in this region, but that changing demography and changing norms among the younger generations are making it more difficult to have these expectations fulfilled.

We should note that the analysis presented in this chapter was based upon the role relational approach because this has been the basis for addressing social networks in several of the main aging surveys around the world, including SHARE. However, we must recognize that social networks are also a very subjective phenomenon. That is, for example, people with the same number of children might feel very different about how socially connected they are. Therefore, social network analysis needs to take into account one's subjective appraisal of the interpersonal environment in order to better understand the phenomenon.

The SHARE survey will be providing a major innovation in this respect. Starting with the fourth wave of the survey, administered in 2011, a new social network module will be included in the instrument. This module, which is based upon a name-generating approach, will allow analysts to address the social networks of older Europeans as perceived by them, thus adding an important new element to the study of the construct and its correlates. With this increased analytic capacity, it should be possible to further clarify the extent of the association between the social network and a good old age, and to better understand the varying pathways by which social relations can impact upon personal well-being in late life.

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Chapter 13
Financial Literacy in Retirement Planning Context: The Case of Czech Older Workers

Lucie Vidovićová

Introduction

This chapter aims to introduce the concept of financial literacy and its specific explanatory potential in retirement planning within the cultural and social context of the Czech Republic. We could translate or substitute the general term literacy with skill or ability and hence understand financial literacy in a simplified way as a functional skill in the financial area. If we look at the definition of financial education as understood by OECD (2005), we can define financial literacy as an understanding of financial products and concepts with the help of information and advice, as an ability to identify and understand financial risks and make informed decisions. Our research targets the financial literacy of elderly people and that a decade prior to reaching standard retirement age (understood as the average retirement age). We presume that this is a period of increased interest in planning for old age as well as of more intense financial activity and investment. These age groups belong among the so-called baby boomers generation and they practice new sociocultural and consumer patterns that will most likely reform/reformulate the experience of old age in quantitative as well as qualitative terms (Gilleard and Higgs 2000).

Literacy is generally understood as a condition of success (or the minimalization of failure), as a prevention of permanent marginalization, as a basis of full social participation, and consequently as a precondition of an individual's and a society's prosperity (Rabušicová 2002). Financial literacy —i.e., the ability to count, to navigate in financial systems, and react adequately to risks—gains importance not only at times of economic instability but also in later stages of life. Similar to the more general functional literacy, financial literacy also has three basic characteristics: *relativity*, *variability*, and *continuity*. The term *relativity* here refers to the "current state and the expected development of a given society. The more complicated the context and the more developed the technologies, the stronger the demands on the

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inhabitants' literacy" (Rabušicová 2002, p. 42). In our context, this means that the more complicated and more complex, for example, the rules for the calculation of pensions and the relevant legislation, and the less clear the economic situation, the higher the demands on financial literacy. *Variability* has two components: *individual* as we can expand and develop literacy skills in the course of our lives but we can also limit or lose these depending on the extent to which we use a given skill. The other component is *contextual* as demands on the individual change in time and space and depending on the performance of various social roles and the cultural context. This fluidity actually influences the definition and measurement of (functional) literacy and it makes it impossible to talk about a duality of literate–illiterate. That is why literacy is understood as a *continuum* between these two poles that is typical of an individual and the different types of his/her literacy skills as well as of a whole society. Hershey et al. (2006), for example, explore the cultural context and relativity directly in relation to preretirement financial planning. When comparing American and Dutch workers, they arrived at the conclusion that "both individual and cultural differences in the psychological predispositions of workers (should be taken into account) when considering pension reforms that stress individual responsibility for (retirement) planning and saving" (Hershey et al. 2006, p. 1).

For the purposes of our general study (Šlapák et al. 2010)—that this chapter draws upon—we operationalized financial literacy on the basis of the OECD definition along three dimensions: *ability*, *values*, and *information*. We tested abilities mainly as basic numerical skills in the form of tasks (numeracy); values were tested as preferences for a certain investment, savings and consumer lifestyles; and information as knowledge about the possibilities of ensuring financial stability in old age. Hence, we were not interested purely in an ability to calculate but rather in a developed or advanced (as it is sometimes characterized) ability to navigate in financial markets and to use the information to develop one's own potential, potential well-being and (financial) security, and hence expect and minimize economic risks[1] that can be related to postretirement and old age. We believe that active and healthy ageing involves advance planning in the form of active interventions in various areas and we can expect that financial security is one of the most important conditions of the success and quality of such planning. Hence, here we decided to explore whether those who have a decade or less before retiring demonstrate attitudes that link financial literacy to other areas of planning for old age. We take into account the fact that the heterogeneous senior population does not view old age pensions as a universal and unified experience and the urge to plan can vary depending on the expected/planned lifestyle in retirement.

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[1] We believe that most risks in old age can be characterized as financial ones. Health, adequate housing, social participation, as well as interpersonal relationships are easier to achieve with sufficient financial resources. Although these are not the only necessary conditions, they doubtless represent a positive intervening factor.

Methodology

The data presented here originate from a unique representative survey "Financial literacy" (Grant No. 2D06004 ASORA). Involving people of preretirement age. The respondents had a maximum of 10 years left till retirement, i.e., men aged 51–61 and women 47–57—this reflects the gender differentiated statutory as well as actual age of retirement in the Czech Republic. Respondents who already retired (including early retirement), were excluded from the survey. The data were collected in November 2007 and individual standardized interviews took place in respondents' households. We used quota sampling and had a total of 1,541 respondents. The sample was weighted and analyzed using SPSS software.

In the following, we discuss selected findings of the survey according to the three dimensions of financial literacy. We start with the context of values and attitudes to pensions and the characteristics of the pension system. Numeracy is explored next followed by information about the pension system. The final discussion highlights links among these dimensions and their significance for retirement planning.

Values and Attitudes: Key for Retirement Planning

The Czech pension system has been the subject of long-term continued efforts at reforming the "pay-as-you-go" (PAYGo) to a three-pillar system with an "opt-out" and a gradual increase in the statutory retirement age (Vidovićová et al. 2005; Lisický 2003). These efforts date back to the early 1990s, however, it is only recently that they are reflected in legislation. The wide debates about the direction of reforms, marked by political disagreements, undoubtedly had an overall negative influence on the general public's perceptions of retirement as a period of uncertainty, poverty and a general decrease in the quality of life. The uncertain future of the pension system probably also contributed to a high take-up of early retirement (Rabušic 2004; Vidovićová et al. 2008). The decade before retirement represents a phase that could—or perhaps should—involve planning for the final third or quarter of one's life. If we concentrate on the attitudes of people in this phase of life, we find that when asked "At what age would you like to retire if it were entirely your decision?", men on average would answer 59.6 (median 60) and women 56.1 (median 55) years. However, both sexes *know* that they can expect to retire much later, 62.8 years being the average given to this second question by men and 60.1 years by women—both of these figures being somewhat closer to the target retirement age defined by latest reform legislation.

Since expectations about necessary financial and other provision in old age depend on life expectancy, we also asked about how this generation assesses the duration of retirement. Despite possible methodological issues with this indicator, men realistically (taking into account male life expectancy at the age of 63) expected to be dependent on a pension for about 18 years while women underestimated this period by 4 years, giving the average answer of slightly less than 19 years while female life

Table 13.1 Did you do any of the following as part of growing older and “preparing for old age”? (in %). (Source: Survey “Financial Literacy”; Šlapák et al. 2010, p. 24)

	Yes, actively	Just thinking	No, not even thinking
Financial back-up (insurance, investment)	49.3	23.9	26.9
Securing adequate accommodation	46.9	23.1	30.0
Leading a healthy lifestyle	35.8	33.5	30.8
Planning activities for retirement	16.0	37.0	47.0
Looking for paid work for the elderly	8.8	38.8	52.4
Getting information on special services for seniors	4.0	22.5	73.5

expectancy at the age of 60 is almost 23 years. These expectations have a sociopolitical dimension as the respondents see their ideal income in retirement consisting of a state pension (78 %), income from employment (10 %), savings (8 %), social benefits (3 %), and support from children (1 %). The expectation of financial dependency on state provision is therefore quite high (and long to stay) in this particular generation of future retirees. This expectation is most pronounced in the case of lower-educated segments of the population, where almost 40 % of respondents expect to depend fully on a state pension compared to 17 % of university educated ones.

In terms of quality of life in retirement, the ability to make advance plans in a number of areas plays an important role. However, the willingness to plan depends on a number of factors, including perceptions of old age (conditioned by ageism) as of a life stage of lower quality, its denial, or disinterest in it (Nelson 2002). Our findings indicate that the intensity of planning grows with the retirement approaching and it is significant in three areas: financial planning, planning of adequate housing, and adjustments to lifestyle (Table 13.1).

Other areas appear to be potentially interesting rather than involve active planning. Information on special services for the elderly seems to be of marginal interest, despite the fact that already our respondents represent a generation with longer-living parents and therefore this area can involve not only self-interest but also being informed on the basis of care for previous generation. The influence of education was significant in the majority of researched dimensions and also in this case more intense planning is linked to higher levels of education. There are no gender differences apart from healthy lifestyle—this is more often stressed by women (45 % vs. 29 % of men).

Expectations of life in retirement represent further significant intervening factors in planning for old age. Vidovićová (2005) adopted Hakim’s (2000) preference theory and showed in a similar survey of preretirement population that a lifestyle preference has a decisive impact on the timing of retirement and on the “delicacy” of various relevant sociopolitical measures. Our study also suggests the influence of these expectations on retirement planning. Table 13.2 shows that proactive expectations initiate more active preretirement planning in various areas.

Variability in the distribution of responses in Table 13.2 highlights the heterogeneity of this subpopulation in terms of retirement life projects as well as the intensity of planning for retirement. These expectations also infer other links that were highlighted in research (not published here in detail). For example, those who think of

Table 13.2 Intensity of planning for old age depending on preferred retirement lifestyle. (Source: Survey "Financial Literacy," author's calculations)

What should your ideal life in retirement be like?	%	Average number of areas of planning	*N*	Std. deviation
Retirement as leisure time, watching television, or reading papers	9	1.1	136	1.2
Retirement as time devoted to the family or other people	23	1.6	347	1.4
Retirement same as life prior to it—employment	18	1.6	275	1.5
Retirement as time devoted above all to myself, to hobbies, and the development of my personality	33	1.7	504	1.3
Travelling, exploring new things, and an active social life	16	1.8	244	1.4
Total	99[a] ($N = 1{,}532$)	1.6	1,506	1.4

[a]The variants "other" and "none" make up the 100 %

the ideal as continuing working in retirement are consistent in this view, they want to continue working for the reason of enjoyment. In contrast, those who think of the ideal as "leisure," do not intend to work even if their pension proves insufficient. Moreover, these ideals are somewhat gender-specific, with men more often preferring leisure, employment, as well as doing nothing while women mostly opting for altruism—focus on the family and a second career—travelling and an active social life. We can add that almost 22 % of future retirees did not have any specific plans when they will actually leave the work force, 50 % plan to retire exactly at the statutory age, 10 % plan early retirement, 13 % will delay retiring, and less than 5 % do not plan to retire at all. The figures are much lower than suggested by recent population polls among US baby boomers.[2]

Last but not the least, expected income and expenditures in old age may be an important part of the overall picture. About three-fourth of our respondents correctly stated that the ratio of the pension to previous income is between 50 and 60 % while those with university education tended to underestimate it and those with primary education to overestimate it compared to the average, which confirms a tendency to the novelization of pensions that has been thus far inbuilt in the Czech system. Due to the complex calculation of individual pensions that takes into account individual incomes since 1986 and depends on a number of individualized conditions, a lay person actually has no simple and reliable way of knowing his/her expected pension.

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[2] That is, Time, April 18, 2011 (p. 9) quotes LifeGoesStrong.com: 1 in 4 baby boomers say they'll never retire and about the same percentage say they have no retirement savings.

Table 13.3 Dynamics of expected expenditures in older age (in %). (Source: Survey "Financial Literacy"; Šlapák et al. 2010, p. 23)

What will you spend on more or less when you retire?	More	Same	Less
Health	82	15	3
Overheads	66	30	4
Housing	42	50	8
Food	22	58	20
Transportation	32	37	30
Leisure	19	43	38
Alcohol, tobacco	8	46	47
House equipment	9	38	53
Clothing	6	37	58
New technologies	4	37	59
Education	5	31	64

Figures rounded up

The relatively new service of providing a so-called "informative personalized record of pension insurance" has been used by a tiny fraction of respondents and this record does not provide information on the expected pension either. This has to be calculated with the help of calculators available online while only 46 % of the surveyed future retirees at least sometimes access the Internet (Šlapák et al. 2010). Only 16 % of the respondents who are only a decade or less away from retiring actually have some idea about the value of their pension. In contrast, there is rare agreement across gender and educational categories in assessing that a 50 % higher pension than the state one would be required to cover their expenses. In other words, there seems to be an understanding that the expected pension provided by the state via PAYGO will only cater for two-third of future needs. There is an inherent dynamic in our respondents' expectations of expenditure, as summarized in Table 13.3.

While health and overheads, and partly housing, represent increased expenditure that respondents will have to cope with, house equipment, clothing, new technologies, and education clearly represent *discretionary* expenses.

In terms of values and attitudes linked to the pension system and planning for retirement, we alerted to a paradox—although personal preferences and demands on the formal pension system are in effect unrealistic (respectively, the expectation that if retiring early, the state pension will cover all the retiree's expenses), at the same time respondents are aware of the *actual* situation that they have to *count on*. And it is—literally—the ability to count that is discussed in the next section.

Skills: Numeracy

We assumed that financial literacy —in its broadest sense—depends on the ability to conduct basic mathematical operations that underlie the functioning of the financial system. The comparative Second International Adult Literacy Survey explored three dimensions[3] of functional literacy in 20 countries and the Czech Republic actually ranked third in numeracy (the ability to manipulate with numbers), following Sweden and Denmark (Rabušicová 2002).

Respondents of preretirement age were given five numeracy tasks, which were inspired by Lusardi's and Mitchell's study (2007). While solving the tasks, respondents could use a pen and paper. The first task tested the respondents' ability to calculate percentages.[4] The wording of the task: "If there is a 10 % risk of catching a certain illness, out of 1,000 people how many are likely to fall ill?" Eighty-seven percent of respondents gave the correct answer: 100 people.[5] The same share of respondents also answered the second question correctly: "If five people win the lottery of 2 million Czech crowns, how much will each of them get?" Somewhat fewer respondents—ca. 84 %—correctly stated that with an annual savings rate of 1 % and inflation rate of 2 %, at the end of the year they will be able to buy less. The relatively higher ratio of incorrect answers can be attributed to the use of two technical terms (i.e., savings rate and inflation rate). Despite this, the respondents' knowledge can be classed as satisfactory. A problem occurred with the last task: "You have 20,000 crowns in your savings account with the annual savings rate of 10 %. When you add up all the items in your account, what will be the balance in two years' time?" The correct sum of 24,200 crowns was given by less than 25 % of respondents. A further 37 % of respondents forgot to add the interest gained in the first year and stated 24,000. However, even if we disregard this mistake, this task proved to be the most difficult with 38 % of completely wrong answers. As expected, numeracy is influenced by the respondent's education. While no university educated respondent gave a total of 0 correct answers, 6 % of those with primary education did. All the four tasks were correctly answered by three times as many respondents with university education than with primary one. Yet, it is interesting that with the most frequent level of knowledge (i.e., three correct answers) there is minimum variation according to education (Table 13.4).

Our findings are similar to those of Lusardi and Mitchell (2007) whose study involved an ethnically heterogeneous sample of Americans aged 51–56 years in the Health and Retirement Study in 2004. Yet, significantly fewer of their respondents could divide the lottery win (56 vs. 87 % in our study). They also found a link between numeracy skills and the likelihood of retirement planning and that even when a wide of range of possible intervening characteristics (including education) were controlled for. This was proven also in the Czech context—the share of respondents who claimed to be actively planning finances for old age grew with the number of

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[3] Apart from numeracy, SIALS also explored literacy in relation to textual information (prose literacy) and information contained in documents like questionnaires and figures (document literacy).

[4] In the representative survey Ageism 2007, 7 % of the respondents stated that the share of the elderly in the Czech population was 50 % or more (there were also answers of 100 %). Vidovićová (2008) argues that these reflect inadequacies in numeracy skills (confusing "share" with "percentage" in this case) rather than a lack of knowledge of demographics.

[5] Missing answers were also coded as incorrect, these represented on average less than 1 % for all the four tasks.

Table 13.4 The number of correct answers (in %). (Source: Survey "Financial Literacy"; Šlapák et al. 2010, p. 40)

	Total	Education			
		Primary	Secondary without GCSE	Secondary with GCSE	University
0	2.1	6.5	2.0	1.5	0.0
1	6.9	11.9	7.3	4.6	7.2
2	19.7	21.4	23.9	19.3	7.2
3	50.0	45.8	51.3	51.3	46.8
4	21.4	14.3	15.6	23.3	38.7

correctly answered numeracy tasks. When controlling for education, the correlation coefficient is slightly weakened yet it remains statistically significant.

Information: Subjective and Objective Knowledge of the Pension System

The Czech pension system works with a relatively complex set of entitlement conditions linked to chronological age and the duration of insurance, including a range of so-called substitute noncontributory periods of insurance and is differentiated by gender and some employment categories. The system is maintained by the Czech Social Security Administration (CSSA) that runs individual records for the insured and is de facto as well as de jure the only source of personalized information about entitlement to old age pension. Recent years have seen an increase in the contribution of various public bodies in the dissemination of information about the system, its deficiencies, and the required changes within the context of discussions on the need for a pension system reform. For example, in a speech the Prime Minister Petr Nečas argued against a popular perception about the Czech pension system: "*Nobody makes any savings anywhere*" (Nečas 2011). The traditional role of mass and electronic media in transmitting such messages cannot be ignored, however, we can identify a new development—the topic of retirement also appears in lifestyle magazines. While those of preretirement age tend to seek information about financial issues from specialist institutions such as financial savings or tax advisors (34 % of respondents)—and bank leaflets (33 % of respondents), they rely on more informal channels for information on the pension system. This involves acquaintances, friends and family (80 % of respondents), newspapers (71 %), and television (70 %). Less than 47 % of respondents contact their employers for such information, less than 29 % use the Internet for this purpose, and 34 % use the above mentioned magazines. In contrast, 22 % of respondents used formal information sources such as the information bureau at CSSA, a similar percentage uses the offices website, 13 % use the website of the Ministry of Labour and Social Affairs, and 7 % the CSSA call centre.

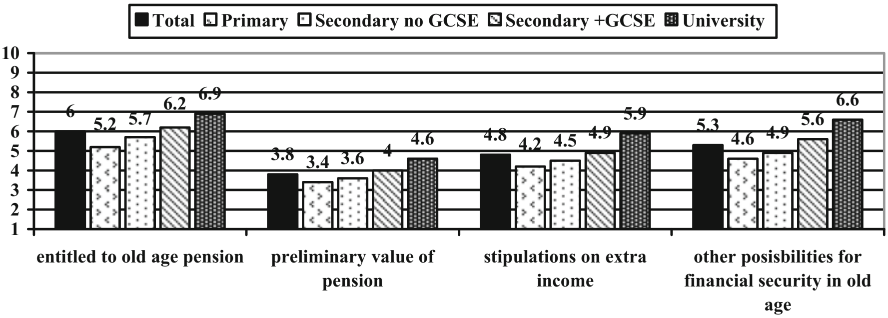

Fig. 13.1 Subjective knowledge about pension entitlements by respondent's education. (Source: Survey "Financial Literacy"; own calculations)

Despite the available and actually used information channels, the subjective knowledge of pension entitlements continues to be relatively low in the population that will retire in a decade. We measured this indicator on a scale of 10 with 1 "I have no information" and 10 "I have all the necessary information," see Fig. 13.1.

The findings confirm that respondents of preretirement age are least certain about the value of their future pensions. Although in this case again subjective knowledge increases with the respondent's education, neither university educated respondents reached half of the scale. This represents an objective limitation in financial planning for old age and in more general the necessary financial literacy. The oldest respondents are most confident about entitlement issues. Yet, when testing their objective knowledge, they most frequently answered the question about their retirement age incorrectly—27 % gave a correct answer, 23 % an incorrect, and 50 % none. Although in general the objective and subjective levels of knowledge about the pension system correlate positively, in this case the discrepancy between them is relatively high. Hence, we can assume that subjective knowledge reflects the intense information and political campaign that accompanied the decision to increase the retirement age and although the message that "retirement age will increase in the future" reached the general population, the subsequent pension calculation is not intuitive as, for example, the increase for individual age cohorts does not involve years but months.[6] Apart from the question on retirement age, a high share of incorrect answers also involved extra income in early retirement (only 42 % of correct answers) and early retirement age (35 % of correct answers). Somewhat higher shares of correct answers were provided about the average value of old-age pension (46 %), minimum insurance period for entitlement (59 %), extra income in old age retirement (69 %),

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[6] For example, the informative table on retirement age of those born 1936–1968 has 34 rows (birth cohorts) and 8 columns (men and women with different numbers of children). The retirement age of a man born in 1952 is 62 + 10 months, of a woman born in 1952 with two children 59 years. Old age pension consists of a universal basic assessment and an individually calculated percentage assessment according to the insurance period (hence, it is influenced by how long the person was insured and how much s/he earned). The final pension is calculated in six steps, i.e., mathematical operations. For information in English, see http://www.mpsv.cz/en/8672.

Table 13.5 Correlation matrix for retirement planning and financial dimensions

	Education	Objective level of information	Subjective level of information	Numeracy
Objective level of information	0.110			
Subjective level of information	0.220	0.292		
Subjective level of information	0.212	0.273	0.208	
Planning for old age	0.195	0.226	0.259	0.170

Note: All the correlations are significant at the 0.01 level (two-tailed)

and periods of unemployment (75 %) and sick leave (81 %) as noncontributory insurance periods. On average, 4.3 out of 8 questions were answered correctly; those with higher education and those nearer retirement age achieved better results. There were no gender differences in the share of correct answers.

Thus, we do not have a clear finding on the knowledge of the Czech pension system as it varies according to subjective and objective and also to the various segments of the subpopulation of future retirees. If we generalized somewhat, we could say that welfare literacy, i.e., knowledge of the system, is low to medium and there is a significant potential for various actors to increase it.

The complexity of financial literacy in the context of retirement planning Earlier on, we have introduced the multidimensional concept of financial literacy in the context of retirement planning. The dimensions of abilities, values/attitudes, and information can be operationalized in a number of ways and their exploration can result in somewhat different findings. Here, we concentrated on introducing financial-retirement literacy as a set of subjective and objective information about the pension system and numeracy, conditioned by the intensity of planning for old age. Understandably, these dimensions are interlinked and interact on an individual as well as societal level. The complexity of these relationships is outlined in Table. 13.5.

The centre of the model is made up of actively pursued planning for old age. This proactive planning is essential for all concepts linked to active, healthy, and successful ageing. The figure shows that planning is influenced by respondent's education and numeracy skills. However, there is stronger correlation between planning and objective and subjective knowledge, which are conditioned by numeracy, i.e., contextual functional literacy, which is again dependent on—although not identical with—the level of education. The correlation coefficient that we found between numeracy and education is in fact weaker than Rabušicová's (2002, p. 110) in Czech adult population as whole (i.e., 0.40) and hence confirms Wagner's observation (1992) that education correlates with literacy but does not explain the variability of the phenomenon.

The figure does not include planned expenditure as it does not enrich the model to a similar extent as the other dimensions. Whether we explore planned expenditure in its full scale or only so-called *discretionary* expenses, we find a statistically significant yet rather weak correlation with realized preparations. The expenditure further correlates with objective knowledge and somewhat stronger also with income (i.e., people with higher income also plan to spend more on these items), yet none of these relationships are of equal strength to the others in the model and are not so complex. Similarly, the respondent's income does not play a significant role. Income itself is influenced by education ($r = 0.161$, $p < 0.01$) and slightly influences the number of areas of active planning ($r = 0.073$, $p < 0.05$) but we do not find a significant correlation with any other of the researched dimensions.

The complexity of the whole model resembles the complexity of a living organism, its individual organs are interconnected and its existence depends on correct functioning of each one of them. This comparison is essential for explorations of possible interventions that will increase the efficiency of planning for old age. The aim of such interventions is to safely decrease the involvement of the state and increase individual responsibility for securing one's life in old age. This requirement—regardless of the cultural, social, and welfare characteristics—appears to be almost universal in undergoing pension and finance reforms in the (post)recession period despite the fact that its necessity is not always argued in a balanced manner, as recently suggested by Herrmann (2001).

Rabušic (2006) has argued that education and the individualization of the social state are closely related. The possible reliance of individuals on the state for security in old age is decreasing while, in contrast, the necessity to take responsibility for one's living standards and quality of life (particularly in old age) increases. Hence, a sort of new necessity "to learn to age" and that is in various areas of life. In knowledge-based societies, continued education is the only guarantee of success and successful ageing (however defined) represents the mantra of many recent sociopolitical interventions. Nonetheless, to persuade the general population about the necessity of financial education can be a hard task. Although subjective knowledge is relatively low (ca. 50 % of respondents have at maximum 50 % of the necessary information while 5 % have all/almost all information), 42 % of respondents feel that the pension system is too complicated. OECD (2006, p. 4) quotes research, in which respondents suggested that the selection of appropriate pension savings is more stressful than a visit at the dentist's. At the thought of planning retirement, 33 % of our respondents claim to feel stressed out and more than 40 % agree with the statement that "at the moment it is premature to plan retirement as it is too far away."

We should keep in mind that the research involves a sample, a cohort of a specific subpopulation of Czech older workers whose education, e-literacy, and to a certain extent also proactive individualized lifestyles are lower or less frequent than in the case of subsequent generations (Senioři 2011). Even if the formal education of the elderly will increase with the ageing of Czech population, the knowledge being updated is not necessarily ensured although this is vital in dynamically developing societies. This, however, does not involve only formal institutionalized education but also informal and purposely sought information, including financial education, which has a real impact on everyday knowledge. Yet, participation in various forms of education tends to decrease almost universally in older age (Rabušic and Rabušicová 2008) and that not only in the Czech context (Eurostat 2005).

Alternative forms of increasing financial literacy that lead to better planning for old age and retirement have their objective limitations. Although there is a number of inspiring tools abroad,[7] their usefulness for the given generation of Czechs is very limited as these are mainly Internet-based and require a relatively high level of functional and computer literacy. Paradoxically then, following from so-called Mathew effect ("those who have, will get more") and theories of cumulative disadvantage/advantage (Dannefer 2003), these can contribute to deepening the differences in financial literacy as they require some preexisting basis. Both these channels, informal/formal education and the Internet, can have a possible impact on numeracy, objective and subjective information, and knowledge of the functioning (and navigating) of the system but their impact on values and attitudes is not straightforward. Strengthening of individual agency, willingness, and power to maintain one's autonomy and independence as long as possible are not typically taught in lifelong education. Yet, they are, at least to some extent, an inherent part of financial literacy in the context of retirement planning, and this is where the *relativity*, *variability*, and *continuity* of the literacy concept can be seen most clearly.

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[7] See, e.g., www.choosetosave.org, http://retirementrevised.com/, http://work.lifegoesstrong.com and others that use journalistic style to guide through general retirement as well as specific financial planning. For the official version of the Czech tool for the calculation of retirement age, see: http://www.mpsv.cz/cs/2435 (in Czech).

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Chapter 14
Home Nursing in Cyprus

Christiana Kouta and Charis Kaite

Introduction

The increase of the elderly population challenges existing health, welfare, and economy sectors, such as health services, family relationships, and social security as well as pension programs. Aging is a global issue, varying across regions (U.S. National Institute on Aging 2007). Elderly people prefer to be in their own homes and communities in order to be independent (European Commission 2008a).

Europe has the highest proportion of people aged 65 and more (16 %). From 2000 until 2050, the world's population aged 60 and above will be more than triple increasing from 600 million to 2 billion (World Health Organization 2007). This is occurring mostly in developing countries, where the number of older people will rise from 400 million in 2000 to 1.7 billion by 2050. During the period from 1970 to 1996, the proportion of people aged 65 and more in Japan doubled; China is expected to have the same demographic changes on a much larger scale (U.S. National Institute on Aging 2007). In sub-Saharan Africa, the elderly are projected to make up 4 % of the total population in 2030, a slight increase over today's levels. Population aging in these countries is taking place in the context of an HIV/AIDS pandemic and chronic poverty. Subsequently, many African societies confront population aging without traditional kin support or formal security systems (National Institute on Aging, US Department of State 2007).

Strongest population growth is expected to be found from 2008 to 2060 in Cyprus (+66 %), Ireland (+53 %), Luxembourg (+52 %), the United Kingdom (+25 %), and Sweden (+18 %) whereas the most declines are in Bulgaria (–28 %), Latvia (–26 %), Lithuania (–24 %), Romania (–21 %), and Poland (–18 %; Giannakouris 2008). Furthermore, the old age dependency ratio is estimated to be more than 60 % in Bulgaria, the Czech Republic, Lithuania, Poland, Romania, Slovenia, and Slovakia and less than 45 % in Denmark, Ireland, Cyprus, Luxembourg, and the

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United Kingdom (Giannakouris 2008). It must be added that women represent the largest number and proportion of older people in almost all societies (ICN 2006).

Demographic projections in the developed world include growth in the population of older adults, particularly those over 85 and decline in younger age groups, reflective of lower fertility rates and delayed childbearing among baby boomers (US Census 2000, 2001, cited in Young 2003). The demographic changes suggest an increasing demand on formal services and a significant reduction in family caregiving. However, in the United States, a shortage of nurses and direct care workers in long-term care has been noted which raises concern for the ability of the formal system to respond with the human resources required (Pezzin 2000, cited in Young 2003; National Association of Community Health Centers–Robert Graham Center 2008).

The census of population in Cyprus for 1992–2001 (this is the latest census; the next one was to be conducted in October 2011) shows the composition of the population into three broad age groups, which gives 21.5 % of the population in the young ages 0–14, 66.8 % in the working ages of 15–64, and 11.7 % in the old ages 65+. These percentages differ somewhat with respect to gender. The proportion of boys' ages 0–14 is slightly larger because of the gender ratio at birth, while the proportion of old-aged females is larger than the corresponding proportion of males as a result of the higher female life expectancy (Statistical Service, Cyprus Census of Population 2001).

In addition, the distribution of the population into the three broad age groups differs between urban and rural areas. The proportion of population of working areas is higher in urban areas (68.4 %); on the contrary the proportion of elderly persons with age 65 and above is greater in rural areas (13.8 %) than in urban areas (10.7 %). The age composition of the population in the Census of 2001 shows a continuing drop of fertility and the gradual aging of the population, and in comparison with the Census of 1992 the proportion of children is decreasing from 25.4 to 21.5 % and the proportion of old-aged persons is increasing from 11.0 to 11.7 % (Statistical Service, Cyprus Census of Population 2001).

Definitions

For the purpose of this chapter, the following definitions will be used:

Community Nursing is the synthesis of nursing practice, public health practice, health promotion, and primary health care. The nature of community health nursing is directed towards the individual, families, and the communities at large. The community health nurse has received public health nursing preparation. Public health nursing is population-focused community-oriented nursing (American Nurses Association 1980; American Public Health Association 1996; Quad Council of Public Health Nursing Association, cited in Maurer and Smith 2004).

Home care Nursing is a specialization of community nursing. Home care nurses assist patient and family members in their goal of maintaining a patient in their own environment (Erb 2006, p. 18). Regular home visits by home care nurses play an important role in health promotion and disease prevention while the follow-up of chronically ill patients and elderly is taking place at their own homes (Erb 2006, p. 18).

Literature Review

The European Commission's report: "Long-term care in the European Union" (European Commission 2008a) indicates that the demands for and costs of long-term care provision in the EU will rise significantly by 2050. Almost 9 out of 10 Europeans, favor home- or community-based care than residential care or hospitalization (European Commission 2008a). Elderly have the expectations of a long and healthy retirement free of major disability. They hope to spend their retirement in their own homes for as long as they choose to do so, rather than staying in residential care, where recent reports of poor conditions, neglect, abuse, and medical errors have captured EU attention (European Commission 2003; Thomas and McHacon 2001).

The main challenges for the governments in long-term care provision are:

a. Ensuring easy access for all to long-term care services.
b. Securing financing for long-term care through an adequate mixture of public and private sources of finance and potential changes in the financing mechanisms.
c. Improving coordination between social and health services that are involved in the provision of long-term care services.
d. Promoting home- or community-based care, than institutional care, to help dependent people remain in their own homes for as long as possible.
e. Improving recruitment and working conditions of formal carers and supporting informal carers.

Ninety-three percent of European people believe that public authorities should provide appropriate home care and/or institutional care and 86 % of the Europeans stated that they would like to be cared at their own homes or that of a relative, while 8 % indicated that they prefer the institutional care (Health and Long-Term Care in the European Union 2007). Trying to meet the needs of the increase of elderly population, a vast continuum of long-term care service has emerged, ranging from nursing homes to noninstitutional settings (home health care, residential care, and care management services). Measuring quality of care in long-term care had become an essential issue for local, regional, and national policy makers. In addition, recent reports of poor conditions, neglect, and abuse especially in nursing homes have captured EU-level attention both for providers and quality assurance organizations (European Commission 2003).

According to a report of the European Commission (2008b, p. 11b), on Quality in and Equality of Healthcare Services:

> Member States should invest more in research on how to improve the knowledge of elderly health and care issues among health and care professions. Member states should consider

increasing multidisciplinary research on stigma, antidiscrimination, health promotion and integrated community-based services.

By 2020, it is estimated that three-quarters of all deaths in developing countries could be aging-related due to cancer, diabetes, etc. In more developed regions, major chronic conditions affecting older persons include musculoskeletal diseases (e.g., arthritis), sensory impairments, and others (ICN on Healthy Ageing n.d.). The goal of nursing care is to assist elderly in achieving optimal health, well-being, and quality of life, as health is described by the elderly is a "state of mind" (ICN on Healthy Ageing n.d.). The most frequent clinical issues in caring the elderly include: (a) confusional states, (b) immobility, (c) sensory loss, (d) nutrition disturbances, (e) loss/grief, (f) depression, (g) incontinence, (h) mental illness, (i) substance abuse, and (j) death and dying (ICN on Healthy Ageing n.d.)

Healthy aging is defined in terms of the ability to function autonomously, within a given social setting. Health care of elderly includes helping older people maintain adaptive behavior, promoting wellness, and providing care during acute and long-term illness (ICN on Healthy Ageing n.d.)

Among European countries, professional registered nurses, differing only by definition, e.g., Community nurses in Cyprus, Home care nurses in the United States, District nurses in United kingdom, provide professional nursing care, such as wound care in the patients' home, in an effort to keep hospital admissions and readmissions to a minimum offering professional care, advice, and support to the elderly and their families.

The values, which the Western culture supports, such as independence and productivity, influence the older members of the society. However, cross-cultural differences are obvious, since in some countries, elderly are considered incompetent to work, while in others they are appreciated for their wisdom (Nies and McEwen 2001). It is important that the elderly have a good quality of health care, in their own home within the community. The perception of aging as a positive experience helps in the maintenance of the feeling of usefulness and plenitude (Nies and McEwen 2001).

Recently, a study conducted by the Research Unit of Behaviour and Social Issues in Cyprus, with 100 in-depth interviews of elder people, to measure the quality of life of the elderly in Cyprus in order to examine among others: (a) the degree of dependence of the elderly on their families and/or on state services and (b) to investigate the extent of elderly social exclusion. The majority of the participants of this study recommended among others: (a) pension increase (as to ease their participation in social life) and (b) further development of the community services (Research Unit in Behavior and Social Issues 2009).

A phenomenological study by Porter (2008) reported that home care nurses should attempt to have individualized interactions with each client as much as possible. In addition, De Jonge et al. (2009) described a model of coordinated home-based health care, called Independence at Home (IAH), operating on a limited basis in many US communities and in the Veterans Affairs System. IAH-type teams deliver a full range of health and social services at home to seriously ill elders and thereby reduce overall health care costs. There is strong evidence supporting that IAH can lower total costs by 25 % or more and improve patient satisfaction and outcomes (De Jonge et al. 2009).

A study conducted by Hung et al. (2003), evaluating a continuous home visiting program designed for disabled patients and for educating caregivers with 126 participants who were transferred from several hospitals to community to be cared by caregivers, showed improvements in Activities of Daily Living (ADL), Life Satisfaction Scale (LSS), and Caregiver Burnout Scale (CBS) in the intervention group, compared to the control group. Recommendations were made as far as the coordination of medical and public health resources within the community, in order to provide both disabled patients and their caregivers with specific training and care giving skills (Hung et al. 2003). These recommendations could also be beneficial to the elderly population.

Systematic reviews and meta-analyses of research on the efficacy of community-based programs showed that such programs are efficient in consumer and family satisfaction with services but failed to neither show evidence for health improvement or functional status of the participants nor cost savings for care (Gaugler and Jarrot 1999; Hedrik, Zarit and Wellsert 1994, as cited in Young 2003).

Community Home Care in Cyprus

Types of Community Home Care Provided in Cyprus

Community Home Care is provided by the Cyprus Association of Cancer Patients and Friends (PASYKAF) since 1992, by medical and nursing care, symptoms control, and psychosocial support. Specially trained nurses, psychologists, social workers, and physiotherapists compose the team that provides executive services to patients outside the hospital settings. Among the services that are being provided are: (a) nursing care, (b) palliative care and symptoms control, (c) advice and training to the family concerning the patient's safety, (d) nursing of wounds, etc. (The Cyprus Association of Cancer Patients and Friends website 2003).

Mental Community Health Services is another type of Community Home Care provided in Cyprus through the Ministry of Health. Services are addressed to: (a) any adult or individual that faces familial or interpersonal difficulties causing stress in their relations with other people, explosions of anger, insomnia, anorexia, etc. (b) individuals with chronic mental health problems that require continuous support and mobilization in their familial and professional environment, and (c) elderly individuals that present similar problems (Ministry of Health of the Republic of Cyprus, Mental Health Services website 2005).

Mental Health Community Centers include multidisciplinary teams: (a) Psychiatrists, (b) Psychologists, (c) Community Nurses, and (d) Occupational Therapists. The team has direct collaboration with all structures of Mental Health Services, with the Department of Social Welfare and Health Center Professionals (Urban and Rural; Ministry of Health of the Republic of Cyprus, Mental Health Services website 2005).

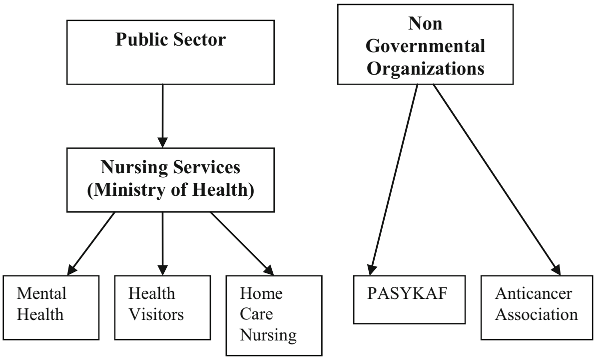

Fig. 14.1 Community nursing services in Cyprus (nongovernmental organizations and public sector)

Health visitors visit the Maternity wards of the public hospitals and inform women about the operation of Maternity and Child Welfare Clinics and the services they provide. They can also visit the parents and their children in home and assess the normal growth of the child; monitor the child's physical, mental, and social development and generally counsel the families about child's normal growth. As far as the elderly are concerned, health visitors provide health education for the elderly people related to problems of aging and prevention of diseases (Ministry of Health of the Republic of Cyprus Website 2005).

Home care (not nursing care) service is also provided by the Social Welfare Services in Cyprus, aim is to support vulnerable groups of people such as the elderly and the disabled with a purpose to enable them to live at home, to develop their personal skills, and to support their families to accommodate them (Social Welfare Services of the Republic of Cyprus Website 2003—Public Assistance, Old persons with Disabilities, Services for the elderly and the disabled). Carers that are being employed by the Social Welfare Office or are self-employed for this purpose and visit people at their own homes in order to provide personal hygiene, house-cleaning, washing of clothes, cooking, payment of bills, shopping, and help people in need with their activities of daily living. Compared to the qualified community nursing staff, they are not educated or experts on the health part in order to provide health assistance (Social Welfare Services of the Republic of Cyprus Website, 2003—Public Assistance, Old persons with Disabilities, Services for the elderly and the disabled). Figure 14.1 provides a schematic representation of Community Nursing Services in Cyprus.

Nursing Care at Home: Cyprus

Home nursing in Cyprus was first provided by the mental health nurses. In particular, the asylum model of mental care began to recede in 1985 following the philosophy of community mental health from 1985 (Ministry of Health of the Republic of Cyprus, Mental Health Services website 2005). In 1993, the psychiatric health hospital was renamed as Athalassa Hospital and the psychiatric services were renamed as mental health services. At the same time, efforts began for intensification of out of hospital structures in order to prevent institutionalization, with certain rehabilitation and reestablishment programs of chronic patients in community structures (Mental Health Services 2005).

Home care nursing in Cyprus began in 2004 aiming to minimize the health care costs and providing a quality care at home. Under the Cypriot law (1(I)/2005), The Safeguarding and Protection of the Patients Rights Law, 2004, article 6(b):

> When the patient is discharged, and if his condition so requires, community and home services, shall be provided, provided that is compatible with the functioning of the health care system (Law 1(I)/2005, art.6 (b)).

Home nursing care in Cyprus can be provided by several public and governmental or voluntary organizations such as Nursing Services of Ministry of Health and the PASYKAF. Home care provided by the Ministry of Labour and Social Insurance, Social Welfare Services consisted of carers (not nurses) who help with house-cleaning, washing of clothes, cooking, payment of bills, shopping, etc. (Social Welfare Services of the Republic of Cyprus Website 2003—Public Assistance, Old persons with Disabilities, Services for the elderly and the disabled).

Home nursing care in Cyprus is provided to:

1. Elderly Individuals that reside in their own homes and have needs for nursing care.
2. People with medical or severe mental disorders or special needs living at home.
3. Individuals with acute health problems.
4. Individuals that are discharged from hospital and still need nursing care at home.
5. Individuals that need palliative care or are at the final stage of their lives (Nursing Home Care Programme 2006).

Programs of Community Nursing Home Care (Governmental) in Cyprus

Two programs exist in general home care that mainly involves elderly persons:

Short-Term Care is the care that is provided to individuals after evaluation by home care nurses and can be provided within an interval of 2 months (Nursing Home Care Programme 2006).

Long-Term Care is the care provided to individuals after evaluation by home care nurses and lasts more than 2 months (Nursing Home Care Programme 2006).

Referrals

Referrals are undertaken by the following:

1. Governmental doctor.

2. A general, mental, or school health nurse.
3. Other health professional.
4. Social worker.
5. The individual itself.
6. A relative or a friend of the patient (Nursing Home Care Services 2006).

The Home care nurse has a telephone communication with the client and informs him/her about the referral to the Community service. An appointment is then scheduled for the first visit of the client and the client is evaluated. The responsible community nurse for every subsector is in charge and after collecting the oral or written information, the client is integrated in one of the two programs mentioned above (Nursing Home Care Services 2006).

Protocols, Guidelines in Providing Care at Home

Several protocols and guidelines were developed by the home care nurses team and the ministry of health. These were based on US, Australia, and Greece guidelines. The guidelines approved by the Ministry of Health are currently used by Home care Nurses.

Indicatively some include:

1. Admission to long-term care program (nursing history).
2. Admission to short-term care program.
3. Medical Referral.
4. Referral to a community nurse.
5. Keeping a record of the number of patients they visit and the form of specialized care they needed (Nursing Home Care Programme 2006).

Framework of Home Nursing Care

Home care nurses are responsible to evaluate the health of the patient in relation to his/her environment with a purpose to: (a) identify needs and problem solving and (b) to benefit nursing care and complete diagnostic activity, prevent diseases, disabilities, or accidents (communicable diseases, inherited diseases, accidents at home).

The Home care nurses collaborate and work with a multidisciplinary team for the benefit of a holistic care. They collaborate very closely with the general practitioner doctors of community centers from which they receive most of the referrals.

Also, within the frames of philosophy for the benefit of home nursing care, they collaborate with other health care team members, such as social welfare workers and doctors within private sector, multidisciplinary teams of mental health, and other institutions in the community (Nursing Home Care Programme 2006). However, this multidisciplinary team does not formally (by the authorities) exist yet in elderly home care. Its success depends on the good professional collaboration of each home care nurse with other professionals (e.g., doctors). This may influence the quality of elderly care.

1. Counseling needs and education of patients and carers in relation to health matters.
2. Management of medicine prescription.
3. Personal hygiene (e.g., bed-bath, mouth care, skin care, care of genital region, etc.).
4. Healthy/suitable diet according to the patients needs (e.g., diabetes mellitus, hyperlipidimaea, constipation, diarrhea, dehydration, and gastritis, individuals that are nourished via gastrostomy or gastrointestinal tube).
5. Taking preventative measures for evasion of problems or complications that result from a situation or diseases (e.g., handling of chronic diseases as heart diseases, diabetes, and degenerative diseases. Correct management of contagious diseases as gastroenteritis, hepatitis A, cessation of smoking, exercise, suitable diet).
6. Environment modification in order to be facilitated in the activities of daily living and for the prevention of accidents (e.g., arrangement of furnitures to ease movement, ramps for easy access in and outside the house, use of shower instead of bathtub).
7. Promotion of client's self-care (e.g., education and encouragement of independent eating, for body hygiene and for mobility).
8. Creation and maintenance of a healthy and safe environment and adoption of healthy life style (e.g., evasion of exposure in a polluted environment, healthy diet exercise, and stress management).
9. Check of glucose levels with glucometer and insulin injection.
10. Wound care at all stages.
11. Gastrostomy care.
12. Colostomy care.
13. Tracheostomy care.
14. Suction of bronchial excretions.
15. Health education—primary prevention (e.g., check-ups, exercise, diet).
16. Psychological support to individuals in order to accept their disease.
17. Support and encouragement to the carers and their families in order to bear care.
18. Communication (by phone or by fax) and/or meeting doctors/clients.
19. Communication with other services and the family for coordination of the therapeutic program or with meetings or by phone or fax.
20. Evaluation of vital signs.
21. Removal of sutures.
22. Urinary catheterization.
23. Intradermal injections (e.g., flu vaccines, anticoagulants).
24. Intramuscular injections.
25. Meetings with colleagues and supervisors related to policy of services and discussion of clinical cases (Nursing Home Care Programme 2006).

Referral Criteria for Short-Term Care Program

Individuals that require home care in less than 2-month interval in case they:

a. Are restricted in home or in bed due to postoperative reasons or for any other medical problem and they need home care.
b. Are walking and need counseling and training in health-related issues (Nursing Home Care Services 2006).

Referral Criteria for Long-Term Care Program

- Hospital card holders (a hospital card that can be published for Cypriot citizens but not all are allowed for free care). Free health care is provided to:
    - Individuals that have low income as indicated and explained by the law (Ministry of Health of the Republic of Cyprus, Application for medical card n.d.)
    - Members of family with four or more children.
    - Enclaved persons and members of their families.
    - Dependants of missing persons.
    - Individuals and their family members receiving public assistance (Ministry of Health of the Republic of Cyprus, Application for medical card n.d.).
- Individuals aged 18 and over.
- Community residents that each program covers.
- Individuals that do not have a supportive environment and need counseling and guidance in health issues.
- Individuals that are on bed rest or have limited mobility or any other health problem.

Interruption Criteria for Both Programs

Patients can interrupt the program:

1. In case of death.
2. When the client abandons the country or moves in a region where it is not possible to be taking care from another sector of Community Service.
3. When the patient is permanently moved to a residential care.
4. In case that the client wants to interrupt the service on its own will.
5. When it is evaluated that the client and his family no longer need support and care.
6. When it is evaluated that there are unsafe conditions for the presence of a Community Nurse.

An Evaluation of Home Nursing in Cyprus for the Elderly: The Study

The aim of the study was to evaluate the present situation in relation to the provision of home nursing care, the development of good practices, policies, and interventions regarding the care of the elderly. This is an innovative study, as it addresses for the first time the evaluation of nursing home care services in Cyprus.

Methodology

This was a 3-year study. Both quantitative and qualitative methods were applied and in particular, 100 individual in-depth interviews with participants, two focus groups with community home care nurses, and six in-depth individual interviews with key informants.

In this chapter, only the qualitative data of the research study will be discussed concerning: (a) the two focus groups with home care nurses ($n = 11$, group A = 6 and group B = 5) and (b) the interviews with ($n = 6$) key persons coming from key positions in Cyprus, related to the aim of the project.

Research Tools

1. For the purpose of conducting the two focus groups with Home Care Nurses ($n = 11$), a focus group guide was designed following the literature review (Begat et al. 2005; Ellen Becker 2004). The focus group guide included four main areas of investigation: (a) the work frame of home care nurses, (b) perceptions of home care nurses for the evaluation of the service, (c) cooperation with other services, and (d) future plans/services needs. Each focus group was conducted in Greek, lasted 1.5 hours and was taperecorded with the participant's informed consent.
2. For the purpose of conducting the key informant's interviews, an interview guide was formed following the literature review (Bauman 2007). The Interviews included the following areas of investigation: (a) work frame of each organization or Ministry that is involved with health issues and/or related community nursing, (b) evaluation of their organizations related to health issues and/or community nursing, (c) cooperation with other services, and (d) future plans for promoting community nursing care. The key interviews lasted about 1 h.

Analysis of Data

The recordings of the focus groups and the interviews were transcribed verbatim and analyzed using thematic analysis including the following processes: (a) processing, (b) categorizing, (c) clustering, and (d) identifying patterns and meaning, i.e., words or phrases that participants used and which we identified as being of interest or importance. The coded significant meanings were clustered and the relationship between them identified. In general, the analysis was an application of Colaizzi×s method. The same qualitative analysis was followed for the key informants and pilot study as well (Saunders 2003).

Ethical Issues

Following a written consultation from the Cyprus National Bioethics Committee, a formal ethical approval was not required. A permission from the Commissioner of Data Protection safety was also requested, but this was not necessary, according to the formal response of the Commissioner, since according to article 6 (h) of the Cyprus Legislation of Personal Data (Protection of Individuals) Law 138 (1) 2001: processing of the data is performed solely for statistical and research purposes on condition that all necessary measures were taken for the protection of the data participants and according to article 11 (1) of the same Legislation participants were informed prior to their participation. A formal approval was given by the Ministry of Health. All participants, home care nurses, and key informants were asked to sign an informed consent form for their participation in the study.

The first contact with the service users was done by their home care nurse in order to have the primary approval from clients and not to intrude. The participation of the patients and nurses in the study was voluntary. The interviews were audiotaped, with the participant's permission, transcribed and subsequently coded and analyzed.

In general, ethical principles drafted by Belmont Report (1979) were applied:

1. *Respect for persons*: Protecting the autonomy of all people and treating them with courtesy and respect and allowing for informed consent.
2. *Beneficence*: Maximizing benefits for the research project while minimizing risks to the research subjects.
3. *Justice*: Ensuring reasonable, nonexploitative, and well-considered procedures are administered fairly (the fair distribution of costs and benefits; The Belmont Report 1979).

Results: Focus Groups

Home care nurses stated that there is lack of evaluation and monitoring from the Ministry of Health regarding the quality of their work in the community. There is no other form of formal evaluation being done for these community services, other than keeping statistical records (e.g., the number of the patients that request care, the kind, the area of living).

Home care nurses suggested the following:

1. Human resources must be increased.

Home Nurse 7: "We need in each region someone to do the administrative work and taking care of small group of clients, e.g., five."

2. The formation of a multidisciplinary team for providing holistic care to the clients.

Home Nurse 5: "More services should exist and more professionals from different disciplines should be involved, such as psychologists, physiotherapists, occupational therapists and doctors, but not only doctors. A person might suffer from a stroke and need, for example. a physiotherapist."

3. The necessity of mobile phones and phones with memory in order to keep messages while home nurses are seeing clients in the community.

Home Nurse 1: "We are using our personal mobile phones for work. It would be better if a phone with memory and answering machine was placed at the office in order to go to the office and find the missed calls from clients."

4. A more "clear" hierarchy and a better coordination between the two administrative schemes are required.

Home Nurse 1: "We have a supervisor (as home care nurses) that is also the matron of the hospital. This means that has lots of duties from both positions. This for me is a big error not to have a clear hierarchy for the whole community program. Each region has its own supervisor. Each supervisor gives its own opinions and administers the program on its own way. In addition, not all supervisors are informed about the program needs. There is lack of coordination and communication between staff and supervisors as well as between supervisors."

5. Home nurses should have a common meeting base center.

Home Nurse 7: "It's difficult, if all community nurses had a common meeting base center, then they could go out at the community in turn, and one of them could stay inside to answer the phones and do the administrative work."

6. The need for establishment of legal framework for home nursing.

Home Nurse 8: "There is no legal framework for home nurses for certain nursing practices, e.g., intravenous injection. However, there are policies from the Ministry of Health that we follow."

Focus groups analysis points out the problems that the program is facing in relation mainly to organizational structure and administrative issues. It seems that before the program is expanded in a Pan Cyprian basis, lots of administrative issues and technical problems should be resolved such as: (a) the legal framework of the service and (b) the formation of a formal multidisciplinary health care team—further recommendations are being made for the formation of a multidisciplinary care plan by the government.

Researchers' observations during the session showed that there was an essential need of the participants to speak and reveal their problems since no formal periodic audit or counseling sessions are being conducted by Community Nursing Services. Home Nurses suggested that debriefing sessions (group or one-to-one) should be available from the service and be facilitated by a psychologist or a counselor. In other words, an interdisciplinary forum should be formed that would provide the opportunity for Home Nurses to: (a) discuss their feelings, (b) the type of stressful situation experienced, and (c) the coping strategies used as well. Debriefing sessions would offer: (a) a supportive environment for the home nurses (b) give access to peer support, and (c) enhance the sense of belonging.

Key Informants

Face-to-face interviews were conducted with key informants coming from key positions in Cyprus. The selection criteria were based on their position and relation to Community Nursing and/or health in relation to the elderly. The interviews of key informants were used in an effort to: (a) describe the service process, (b) explore individual differences between participants' experiences and outcomes, (c) understand the meaning of the program, and (d) to document variations in program implementation in different sites (Creswell 2003).

Recommendations of the key informants were the following:

1. There is a need for a strategic plan that promotes collaboration between formal/statutory services, such as nurses, doctors, physiotherapists, pharmacists, psychotherapists, etc. and informal/nonregulated services such as welfare care workers, voluntary organizations, and service users.
2. The development of the guidelines for working conditions and training of home nursing care workers.
3. The provision of home nursing care throughout Cyprus.
4. The establishment of quality indicators for the service to be used for periodic audit and evaluations.

Conclusion

Aging demographic changes suggest and demand taking care of older people at home. According to the European Commission's report, "Long-term care in the European Union" (European Commission 2008a), 86 % of the Europeans stated that they would like to be cared at their own homes or that of a relative and almost nine out of ten Europeans, favor home or community care. In Cyprus, home nursing care is provided by governmental services and nongovernmental organizations. Also, home care (not nursing) services are provided by the Social Welfare services. Home nursing care is provided by the Ministry of Health in few geographical areas. The need for a strategic plan that would promote collaboration between formal/statutory services such as pharmacists, psysiotherapists, and informal/nonregulated services was a recommendation highlighted both from key informants and home care nurses, as well as the provision of home care nursing throughout Cyprus and the establishment of quality indicators for the service to be used for periodic audit and evaluations. Furthermore, debriefing sessions (group or one-to-one) should be available from the service and be facilitated by a psychologist or a counselor. An interdisciplinary forum should be formed that would provide the opportunity for Home Nurses to: (a) discuss their feelings, (b) the type of stressful situation experienced, and (c) the coping strategies used as well. Debriefing sessions would offer: (a) supportive environment for the home nurses, (b) give access to peer support, and (c) enhance the sense of belonging.

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Chapter 15
Quality of Life and Older People: An Empirical Study amongst Older Cypriots

Constantinos Phellas

In several societies, the definition of "Third Age" is predominantly identified with the age limit for retirement; in others, with the loss of a person's abilities, both physical and mental, to handle the needs of daily life Coleman et al. (2001). "Old age" and "overage" are identified with depression and deterioration of health, which inevitably and naturally occurs as part of the biological cycle. During this process, people become more vulnerable to factors that may lead to illness and/or death Bond et al. (2001).

According to Eurostat data, one of the steepest changes that have occurred over the past 50 years has been the dramatic increase of the number of people more than 70, 80, or even 90 years. In fact, today, the proportion of people aged 75 and over comprises 7.5 % of Europe's population, whereas that figure is expected to rise to 14.4 % in 30 years. In Cyprus, according to official state statistics, the proportion of people more than 65 is now estimated at 11.6 % (12.5 % if counting only Greek-Cypriots) of the population of Cyprus, and is expected to reach 20 % by 2030.

The rise in the percentage of people in their Third Age as compared with the general population is mainly due to low birthrate and an increase in life expectancy, as a result of improved public health conditions and advances in technology and medicine (Coleman et al. (2001)). Additionally, as indicated by the Social Integration Plan 2004–2006, the elderly are included in the vulnerable population groups, which are aimed to be socially integrated, since most women over 65 and elderly people living in the countryside face economic problems. Even more vulnerable are those living far from their children.

As defined by Laslett (1987), Third Age is a category estimated on the basis of chronological age in relation to life expectancy.[1] In the context of this breakdown, four age categories run the span of human life. The First Age usually describes a period of dependence, socialization, immaturity, and education. The Second Age

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[1] Bond and Corner (2004, pp. 37–38).

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covers a long range of life and is usually associated with economic activity, a period of independence, maturity, and responsibility, but above all, profit. The Third Age is a span during which the targets of individual life have been fulfilled. It lasts until the advent of the Fourth Age. Third Age provides one with the opportunity to live more individually and develop a different level of lifestyle away from the work sphere, which is the predominant feature of the Second Age. The age limit for retirement marks the point when people abandon economic activity and by extension qualify for the Third Age category.

Even though this approach could be seen as fostering class and gender discrimination since it has been largely based on considering retirement through the lens of a middle-class man, it has, nevertheless, been generalized as an idea that has prevailed especially during the last decade of the twentieth century. In fact, consideration on the basis of class differences has been expanded by Falkingham and Victor (1991), who have used the term WOOP—well-off older persons to denote a small proportion of retired men who are wealthier and have bigger incomes—a theory, which essentially underlines the difference between the rich and the poor across all age strata. However, along general lines, for each one of the social classes, which mold the structure of Western societies today, Third Age is defined as the period during which an individual moves from the work sphere to the level of more personal life.

The Fourth Age carries specific features such as weakness, disability, various age-related illnesses, and social exclusion as a result of weakened physical and mental abilities. Consequently, people of Fourth Age are usually dependent on others for their survival. Fourth Age is often characterized as "*Overaging*."

Research into the social problems of the Third Age was intended to investigate the extent to which elderly people in Cyprus depend on their family or on State services for their basic needs; the extent to which people live in active retirement; the impact of age-related changes on the quality of life and the submission of suggestions about the social reintegration of the elderly. In this context, the research team conducted 100 in-depth interviews based on a semistructured questionnaires (Higgs et al. (2003)), readjusted to Cypriot factual information. Open-ended questions were added to the questionnaire, giving respondents the opportunity to better express their views on the topics under study.

Methodology

Methodologically, the research work "The social problems of Quality of Life & Older People: An Empirical Study amongst Older Cypriots" rests on conducting 100 in-depth interviews based on semistructured questionnaires. It should be noted at the outset that the term "*Third Age*" denotes people more than 65 years of age, including the overage, often referred to as "The Fourth Age" in the bibliography. Survey sampling was mainly drawn from the following categories of people in their Third Age.

People who

1. Reside at home alone and tend to their own needs.
2. Reside at home in the care of their family/relatives.
3. Live at home in the care of a foreign caretaker.
4. Reside at home with in-home care provided by state/community services.
5. Visit day-care centers for the elderly.
6. Reside at state homes for the elderly.
7. Reside at private homes for the elderly.

The selection of names in every province was carried out using stratified sampling, through lists of people furnished by the Pancyprian Federation of Association for the Welfare of Elderly People and from municipal day-care centers. The same method was applied to the selection of homes for the elderly, both state and private ones, through lists furnished by the Social Welfare Services.

Structure of Sample The sample included 43 men and 57 women more than 65 years of age. Of them, 65 % came from urban areas and 35 % of rural areas across all provinces of Cyprus. The participants comprise two broad categories: 25 % live in homes for the elderly and 75 % live independently, either by themselves or with relatives. Of the latter subgroup, some are tended to by foreign housemaids, a few are tended to by employees of state in-home care services, and some visit day-care centers. Most of them are widows/widowers (58 %), whereas 23 % are married, 11 % are unmarried, 5 % are divorced, and 3 % "other" (live with another person). Only 14 among them are childless. In terms of socioeconomic class, 15 come from the upper social class, 53 from the middle classes, and 31 from the lower class. As far as the educational status is concerned, the majority (71 individuals) are graduates of elementary education, 5 of secondary education, 9 of higher education, and 3 are holders of a postgraduate title. Six individuals never attended school. Thirty-three percent Î¿f the sample are refugees, which is also the exact ratio of refugees to the total population of Cyprus.

Results

Changes in Their Life Over the Past Year

Very few individuals (eight) stated that as compared with the previous year they are now in much better health. As few as 11 stated that they feel somewhat better, whereas 28 reported feeling the same. More than half feel worse than last year. In particular, 29 individuals said that they feel rather worse whereas 24 feel much worse than they did the previous year. Those feeling worse are mainly women rather than men, older people, those not residing at homes for the elderly (most of the people who reside at homes reported that their health has remained unchanged for the past year), people from lower socioeconomic classes, and refugees. Those feeling better are people engaging in physical activity.

Approximately one-third of the respondents (30 individuals) consider that life causes them the same amount of stress as it did the previous year. A rather large number (28) feel much more stressed now than a year ago. As few as 14 individuals are a little more stressed, but there is also another subgroup (15 individuals), which purported no stress whatsoever. Increased stress was mainly declared by women, people not residing at homes for the elderly, younger ages, people of lower socioeconomic status, and predominantly residents of urban areas. It seems, therefore, that the older one gets, the less stressed one becomes. For stressed people, the sources of stress lie mostly in various family situations, poor finances, and bad health.

More than half of the respondents (54) stated that their general economic status is more or less the same as it was the previous year. Approximately one-third of the respondents said that their finances are poorer than a year ago (rather poorer for 10, much poorer for 20.) Only three individuals declared much better finances, whereas 12 said that they are somewhat better than a year ago. Of those who stated that their finances are poorer than a year ago, most are women, people aged 75–85, people whose income is less than enough to cover their needs, people from low social classes, and refugees. As for the main reasons they cite for their adverse economic condition, these are not merely restricted to very low pensions but mostly refer to the rise in prices of staple commodities and consumer goods.

With regard to how their life has changed within the past year, a little less than half of the elderly people (46) who participated in the study feel more or less the same about their life as they did the previous year. Merely 19 individuals reported now feeling better (nine feel somewhat better and ten feel much better). Among the rest, 18 stated they now feel rather worse about their life than they did the previous year, whereas 16 reported feeling much worse. Twenty percent of people residing at homes for the elderly feel much better than they did the previous year whereas in those feeling worse there is a preponderance of women, people more than 75 years of age, and refugees.

Assistance with Daily Tasks

Among those who do not reside at homes for the elderly, approximately one-third replied that they do not need any help with their daily tasks. Of the rest, about 15 % receive help from a person employed either by themselves or by their children. In most cases, this person is a foreign housemaid. The help they receive is mostly focused around cleaning and laundry. Only seven individuals make use of the state/community system of in-house care. More people stated they do not need any assistance with shopping and going to the bank whereas only eight receive help for the above tasks from the housemaid. With shopping and going to the bank, they mostly entrust their children. Nevertheless, eight individuals stated they do not receive help with such tasks, despite needing it.

Table 15.1 Analytical presentation regarding concern with neighborhood

	Yes (%)	No (%)
I really feel I belong in my neighborhood	90	10
I often feel alone in this neighborhood	40	60
Most people in this neighborhood are trustworthy	82	12
I am afraid to walk alone when it is dark (only those nonresiding at homes for the elderly)	39	35
Most people are friendly	93	4
People here try to take advantage of me	10	86
In case I had some kind of problem, there are people here who would help me out	83	12
I generally like living in this neighborhood	91	5

Accommodation

Of 64 individuals who answered the relevant question, 19 said that their house is not equipped with the necessary facilities. Twenty-five stated that their house is in need of repairs, which they cannot undertake mainly because they cannot afford it (13) and partly because they do not know who they should apply to (4). Only two individuals said they cannot take the responsibility for repairs upon themselves, whereas one participant has no one to undertake repairs on his/her behalf. As far as *gender* is concerned, women appear to be in a more adverse situation, since twice as many women than men live in houses, which lack the necessary facilities (13 women and 6 men). In terms of *age,* most individuals who live in houses without the necessary facilities are aged between 70 and 84 years (15 in all). It should be noted that of 19 people who stated that their houses do not have the necessary facilities, 16 belong to the category of individuals whose pension income is less than would be required to cover their needs.

Of the respondents, as few as eight individuals said that they do not feel safe in their place of residence. The main reason of insecurity is that they live alone and worry lest something occurs at night when there is no one there to help them.

As far as their neighborhood is concerned, most individuals reported being satisfied with living in that particular neighborhood, that they feel safe in the neighborhood where they live and that there are people in the neighborhood whom they can trust. The Table 15.1 provides an analytical presentation of their answers. Probably, the most significant finding is that 39 % of participants reported being afraid to walk alone at night.

Self-Image

The issue of self-image was determined through answers to different statements concerning the way people feel about themselves but also the way they think others see them. The Table 15.2, which was based on the satisfaction with life/feelings

Table 15.2 Demonstration of decisive impact of age and health on self-confidence

	I agree (%)	I disagree (%)	I am not certain (%)
Age keeps me from doing things I would have liked to do	73	26	0
I feel I can control anything that may happen in my life	68	16	15
I feel free to plan the future	51	32	16
I feel I take part in social activities	56	42	2
I can do the things I want to do	58	37	4
I feel I can make myself happy with the things I do	82	8	8
My health condition keeps me from doing the things I want	78	21	0
Lack of money keeps me from doing the things I want	58	39	3
I look forward to each new day	75	17	4
I feel that my life has meaning	74	18	7
I enjoy the things I do	90	7	2
I enjoy the company of others	92	6	1
I look back upon my life with feelings of happiness	83	9	7
I feel filled with energy	59	32	9
I feel satisfied with the way my life has unfolded	74	17	8
I feel that life is full of opportunities	62	28	9
I hope that my future will be good	80	9	10

for life Index, demonstrates the decisive impact age and health have on their self-confidence and on the extent to which they can remain active.

The aforementioned table on feelings about life consists of 17 questions, which have been analyzed both separately and as a whole in order to demonstrate the image people have of their own selves and of how they think others see them. The analysis was followed by reverse coding; in other words, the answers were recoded depending on whether respondents agreed or disagreed with a positive or negative statement.

Using reverse coding, the entire number of answers was summed up for every person, as follows:

Answers with a positive message were graded with a 3. Answers with a negative message were graded with a 1. “I don’t know” or “I am not certain” answers were graded with a 2. Therefore, the most negative attitude was graded with 17–29, the average attitude with 29–39, and the most positive one with 40–51. As a result, on this particular basis, 8 % of the respondents appear to have very low self-esteem, 32 % have average self-esteem (they do not know or are not sure), and 60 % have good self-esteem.

The question about how they think other people see them, which also reveals the level of support they feel they have from their surroundings, revealed that very few individuals feel they have no one to count on. Nevertheless, a rather large percentage stated that support is only sometimes available and not at any given time. The “Sometimes true” option was predominantly (66 %) chosen for the statement “There are people who make me feel I am an important part of their lives,” where only 23 % of the respondents said that this applies at any given time, and 10 % stated it never applies. A significant percentage up to 74 % chose “Always true” for the statement “There are people who make me feel loved”—yet the fact that 23 % replied this applied only “sometimes” should not go unnoticed (Table 15.3).

Table 15.3 Characteristic analysis about the people view of thinking

	Not true (%)	Sometimes true (%)	Always true (%)
There are people who do things that make me happy	2	44	52
There are people I can count on no matter what	8	22	59
There are people who accept me just the way I am	3	20	72
There are people who support and encourage me	8	27	62
There are people who make me feel loved	3	23	74
There are people who make sure I receive care when I need it	7	25	68
There are people who make me feel I am an important part of their lives	10	66	23

Furthermore, to a special question about the extent to which people feel that others reject them because of their age, only four respondents reported feeling rejected by people *from within their own family*. Yet, the number of those who feel rejected by *the broader society* because of their age rises to 13. That figure includes three of the four respondents who said they feel rejected from their families. Of the 13 respondents, 3 reside at homes for the elderly.

To a special question about how they believe society treats the elderly, even though more than half (55 %) believe that society treats them with respect, quite a few of them agree that "They are mocked at as 'old' and 'elderly'" (46 %). Others (46 %) agree that young people consider them a burden on society, whereas 44 % agree with the statement that "They consider the elderly useless to society."

Family and Social Networks

According to Diana Harris,[2] the majority of third age people are greatly attached to at least one of their children. Even though most elderly parents live away from their children, they maintain close contact with them, whereas there seems to be a relation of mutual assistance between children and their parents, mainly economically wise. Harris claims that the relation between elderly parents and their daughters is closer than that between elderly parents and their sons. Victor (2005) considers that daughters offer more on the sentimental level and sons on the financial one.

Both researchers also refer to the close bond there is between grandparents and their grandchildren, which in fact, in Cypriot society, is aptly demonstrated through the expression "my child's child is twice my own child." In many families, grandmothers undertake the care of their grandchildren if the mother works. In that manner, they provide considerable help to their children while at the same time enjoying the sentimentally rewarding relation they build with their grandchildren. In fact, many grandchildren are closer to their grandparents than to their own parents.

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[2] Harris (2007).

Another family bond deemed quite important is that between siblings and relatives. It is a bond, which seems to have changed in form from what it used to be, with the advent of technology in our lives. With technological advances, physical personal contact has been limited, replaced to a large extent by the telephone.[3] The same applies to the broader social networks maintained by people of older generations. Relocations and the geographical distance that may separate people from their relatives and friends have also curbed the frequency of social exchanges.

Due to the age of the participants, the vast majority of their parents are deceased. Only three stated that they have living parents. Of the respondents, 25 said that their husbands/wives are alive, whereas the number of their living children ranges from 1 to 14. The highest rate (29 %) comprises of those who have three children, followed by those who have two (23 %), four (13 %), and one (7 %). Fourteen respondents said that they have five plus children. The rest of them, 14 in all, are childless. Also, 75 respondents reported having living siblings. A large number of respondents (81) stated they have grandchildren, whereas 41 among them have great grandchildren.

To the question how often they meet members of their family, most participants (42) replied *they had met with* a member of their family in the past 7 days, whereas 39 participants met with a member of their family on the day the interview was conducted. Only four had met with a member of their family within the last 2 weeks from the day the interview was conducted; five had met with members of their family within the last month whereas four stated they *never* meet with members of their family. Seven participants mentioned additional meetings with other members of their family. The 42.7 % of those who do not reside at homes for the elderly and 40 % of those who reside at homes for the elderly had met with a member of their family within the past 7 days before the interview was conducted. In the past 2 weeks, 1.3 of those not residing at homes for the elderly and 8 % of those residing at homes had met with a member of their family. The 1.3 % of those not residing at homes and 12 % of those residing at homes stated that they never meet with members of their family. It is inferred from the above that people who reside at homes for the elderly meet with members of their family much more sparsely than people who do not reside at homes. It should also be noted that of those who reside at homes for the elderly, no one ever talks on the phone with members of their family, whereas of those who do not reside at homes, most talk on the phone with relatives on a daily basis (75 %).

In terms of gender, women appear to meet with members of their family more often: 43.9 % of women as compared with 32.6 % of men met with a member of their family on the very day the interview was conducted. The 38.6 % of women and 46.5 % of men had met with a member of their family within the last week, 3.5 % of women and 2.5 % of men over the past 2 weeks, and 4.7 % of men over the previous month.

Seventy participants reported meeting with friends on a daily basis, whereas 16 participants meet with friends more sparsely. Only eight participants, six of whom

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[3] Victor (2005, pp. 187–189).

reside at homes, said they never meet with friends. Twenty-two never talk with friends on the phone and almost all of them reside at homes for the elderly.

Quite interesting are the answers to the question “How often do you go on an excursion?” to which 55 reported they never do. The highest rate of people who never go on excursions is in those residing at homes for the elderly (68.3 %).

Approximately half of the respondents said that apart from their immediate family, they are close (namely, they share their troubles and secrets) with more than 5 people, whereas 23 respondents reported being close with 2–5 people. Nine respondents said they are close with one to two people. However, 17—primarily women (21.4 % as opposed to 11.6 % of men)—replied they are not close with anyone. In terms of socioeconomic class, it appears that the lower it is, the higher is the number of those who do not maintain close relations with anyone. This translates to 0 % for the upper classes, 14.8 % for the upper-middle class, 24 % for the lower-middle class, and 22.6 % for the working classes. As far as refugees are concerned, the rate of those who are not close to anyone is higher than that of nonrefugees (24.2 and 13.6 %, respectively).

Of the respondents, 49 reported assisting their children, as opposed to 37 who do not. The main form of support parents offer to their children is psychological, even though the rate of respondents who provide financial assistance to their children is also quite significant, rising to about one-third. A breakdown of the answers to the relevant question reveals the following manners in which parents assist their children:

- Financial assistance 28 %.
- Taking care of grandchildren 21 %.
- Housecleaning 19 %.
- Psychological support 43 %.
- Other 6 %.

To the question whether they receive help from their children, 72 replied in the affirmative. Correspondingly to the aforementioned findings, in this case too, the prevalent kind of assistance is psychological support, followed by help with transportation. More analytically, the answers of participants in terms of the kind of help children provide to their parents are as follows:

- Financial assistance 33 %.
- Housecleaning 17 %.
- They take me to the doctor 50 %.
- Psychological support 59 %.
- Help with transportation 54 %.
- Other 12 %.

Outings

It is commonly accepted that Cyprus does not have an adequately developed public transport network therefore people rely mostly on private vehicles for transportation.

To the relevant question, 69 respondents responded having access to a car as opposed to 31 who do not.

The majority of respondents (66) said they never go shopping. Approximately half of them (48) never go to the bank whereas only 13 visit day-care centers. Almost half of the respondents (49) said they rarely visit their children whereas 35 said they rarely visit any relatives at all. The majority of those who rarely or never go out reside at homes for the elderly and are mainly women. Also, the highest rate of those who do not go out (approximately 76 % of those who reported never going out) is in those who declared poor health for the past year.

It is therefore inferred that poor health is an inhibiting factor for outings. At the same time, however, replying to a relevant question, 50 % of the respondents said they had trouble moving either because of their health condition or because of financial adversities, disability, bad mood, lack of self-confidence, dependence on others, or lack of a vehicle.

In addition, quite a few among the respondents who stated they rarely go out reported safety problems during their transportation, for instance: careless drivers (38), loss of balance (34), lack of pavements (23), and lack of wheelchair ramps (12).

Boredom, Stress, Depression, Loneliness, and Anger

In light of the above, special reference should be made to the natural consequences of limited physical, personal contact both with family members and with the wider social networks, which oftentimes drives people to *loneliness* and *social isolation.* The change in roles, manifested through the transition from working life to retirement, from the role of the provider to the role of the dependent, often leads to loneliness.

Loneliness describes a situation in which a gap is created between the desired and the real levels[4] of social participation. There are different levels of loneliness, according to which one may be alone because one spends much time alone, because one lives alone or because one is socially isolated—an idea associated with the level of social involvement of people (and groups). On several occasions, loneliness appears as the effect of the loss of one's partner, which by extension leaves one alone. Even though isolation and loneliness contain the same risk factors, they are two different things and one does not necessarily entail the other. In other words, one may be socially isolated without experiencing loneliness.

Of 97 respondents, 30 said they never feel *bored.* Of the 67 who reported feeling bored, 31 said they are sometimes bored, 18 are bored rather often, and 18 are bored all the time. More specifically, of those not residing at homes for the elderly, 32.9 % reported never feeling bored, as opposed to 25 % of those residing at homes. Furthermore, significant differences are observed between men and women, with women declaring boredom to a greater extent than men: 39 % of men stated they never feel boredom, as opposed to 25 % of women. Of particular interest is the rate

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[4] Victor (2005, pp. 214–215).

of people who feel bored all the time, with merely 7.3 % for men as opposed to 26.8 % for women. Divorced men and widowers have the highest rates among those who feel bored all the time, with 40 and 25 %, respectively, as opposed to 4.3 % of married men and 0 % of unmarried men. Of those engaging in various activities, it appears that members of political parties, unions and environmental organizations, or other organizations of this kind prevail among those who reported never feeling bored (around 53 %). They are followed by those participating in charity organizations, with 48 %.

In terms of whether participants feel stressed, 65 replied in the affirmative. Of those, 23 feel strained and stressed sometimes, 15 rather often, whereas 27 respondents reported feeling strained and stressed all the time. The 41.7 % of those residing at homes and 31.1 % of those not residing at homes never feel stressed. As far as gender is concerned, it appears that women are the ones feeling stressed more often, as 41.1 % of women reported feeling stressed all the time as opposed to merely 9.5 % of men. High rates among those who never feel stressed belong to people taking part in various activities. More specifically, those participating in church activities have the lowest rate of those who stated they never feel stressed (32.6 %). However, between 45.8 % and 64 % of those taking part in other activities reported never feeling stressed, as opposed to 40 % of those abstaining from any activity who stated they feel stressed all the time. There also seems to be a rather strong correlation between stress and health conditions, since half (50 %) of those who purported poor health over the past year, also reported feeling stressed all the time, as opposed to 34.1 % of those who stated that their health condition had been tolerable and 0 % of those who declared perfect health. As far as work is concerned, it appears that those working feel stressed to a much lesser extent than those who do not work. At the same time, work seems to be a positive factor in stress avoidance since the rate of those working and never feel stressed is as high as 66.7 % as opposed to a meager 22 % of those not working.

The majority of respondents (59 individuals) reported feeling depressed. Of those, 26 are depressed sometimes, 15 quite often and 18 all the time, with an increased prevalence of depression among women. The percentage of women who reported feeling depressed all the time is 26.8 % as compared with 7.1 % of men. In terms of family status, married people prevail among those who never feel depressed, at 69.6 %, whereas divorced people feel depressed all the time, at 60 %. Answers become even more interesting when the place of residence, whether in a rural or urban area, comes into play—with people residing in rural areas feeling depressed more often than residents of urban areas. More specifically, 44.4 % of residents of urban areas and 31.4 % of residents of rural areas stated they never feel depressed. A wide variation appears between those who reported feeling depressed all the time, with 14.3 % for urban areas and 25.7 % for rural areas. Taking part in activities seems to have a positive effect in this case too, as among those engaging in activities, the rate of respondents who stated they never feel depressed ranges between 50 and 70 %, with the exception of religious affiliation, where that particular figure falls to 30.2 %. As far as the correlation between health and depression is concerned, here too, it appears that the healthier one feels, the least depressed one gets. In particular, those who declared excellent health during the past year have the highest rate among those who never feel depressed (88.9 % as compared with 27.3 % of those whose health had been poor). Furthermore, the highest rate of people who never feel depressed is in people who work, with 80 % as opposed to 30.5 % of people not working. Last, there appears to be a higher incidence of depression in refugees as compared with nonrefugees. Refugees who stated they never feel depressed stand for 18.8 % as opposed to 50 % of nonrefugees. At the same time, 28.1 % of refugees feel depressed all the time as opposed to merely 13.6 % of nonrefugees.

Health

The World Health Organization (WHO) defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[5] Negative health, according to WHO, may not only refer to the organic level but also the functional and social ones, with transient processing disorders or static and persistent ones (WHO (1948)).

According to Christina Victor (2005), even though it is very difficult to distinguish between the terms "illness," "disease," and "health," theoretical approaches vary. "Illness" is used to describe the medical term for a dysfunction or anomaly of a part, process, or system of the body. Therefore, in this case health is defined by its opposite; namely, it is not illness; it is the lack thereof. If you are not "ill," then you are "healthy" and healthy people are defined as those who are not ill. Medicine primarily looks into the causes of illness and focuses on physiology and pathology. At the same time, it makes a clear distinction between body and mind, categorizing medical conditions into physical and mental/psychological.

Another dimension, which, according to Victor, afflicts Third Age is that of infirmity or disability. The World Health Organization defines disability as any restriction or lack of ability to perform daily "usual" or "normal" activities. Infirmity is not necessarily followed by disability, but disability relates to the manner in which society defines daily usual activities, therefore distinguishing between nondisabled and disabled people.

Due to lack of an internationally acceptable way of measuring disability, most studies examine the ability to see, hear, communicate, and move.

In the biomedical model, a disease is either a deviation from the natural operation of an organism, based on measurable biological parameters, or the presence of fixed pathological lesions.[6] Contrarily, according to the sociological approach to health, *illness* is defined more subjectively, since it refers to how one feels rather than whether one is ill or in good physical or mental health, as opposed to *disease*, which is objective. A disease tends to only affect a particular individual, whereas illness encumbers both the individual as well as society at large, mainly due to the financial

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[5] Tountas (2004, p. 15).

[6] Tountas (2004, p. 23).

dimension of health and medical expenses—while it often causes the dependence of the ill on their immediate and/or wider social surroundings.

Another dimension of illness is the ensuing social stigma, mostly for people suffering from chronic illnesses, both physical and mental. Third Age is predominantly afflicted, as the incidence of chronic illnesses in the elderly is much higher than in younger ages. Therefore, specific social stereotypes are formed which, according to the sociological analysis, link Third Age to chronic illnesses—so much so that the elderly themselves consider illness in the Third Age as unavoidable, to an extent that on many occasions they do not even seek necessary medical care.

Furthermore, a large variation exists between the way in which people perceive their illness and the practical reality of their situation.However, elderly people are not that different from other age groups in terms of their attitude towards health-but there are specific features such as gender, social class, and nationality which influence one's attitude (Victor et al. (2005)). The elderly, according to Victor, tend to define health in functional terms rather than as welfare. Hence, their approach lies closer to the theory, which defines health as lack of illness. Therefore, in studies such as this, it is especially important to take into account how the elderly themselves perceive their health rather than what is actually the case, since their main criterion rests on the degree of their functioning, namely their ability to go about what they define as daily habits. It also appears that perception of one's health is interlinked with one's broader perspective on the quality of life.

Only nine of the respondents said that over the past 12 months they had felt that their health had been excellent. Twenty-two declared good health. A large rate (46 respondents) stated that over the past 12 months their health had been tolerable and 22 purported bad health. Men generally have a better outlook on their health condition than women. In particular, 16.3 % of men as opposed to 3.6 % of women purported excellent health. Work appears to be a determinant of good health, with working people declaring excellent and good health in larger numbers than nonworking people. Specifically, 26.7 % of working people purported excellent health and 40 % good health, with 5 and 16.7 % for nonworking people, respectively. On the contrary, 50 % of nonworking people stated their health had been tolerable over the past year, as compared with 33 % of working people, whereas 28.3 % of nonworking people purported bad health. Among working people, no one declared bad health.

Retirement

A person is considered *retired* when they stop working full time throughout the year, if they receive social security benefits and pension, either state or private, and if they are considered retired either by themselves or by society.[7]

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[7] Crandall (1991, p. 414).

Retirement is a relatively recent phenomenon (Fischer 1977). Even though people have been retiring for centuries, the idea of retirement as an activity involving the masses is of recent origin. In the past, only rich and powerful people could retire. As indicated above, mass-scale retirement has been linked to industrialization. The first factor, which has contributed to its establishment, is the rise in life expectancy: humans are now more likely to reach Third and Fourth Age. Contemporary society is marked by advances in medicine and human knowledge, improved health conditions, better production and distribution of foodstuffs—factors, which have significantly reduced illnesses and famine, thus increasing longevity and enabling more people to reach old age.

The second factor is that contemporary industrial age has made possible the provision of support for a large proportion of the nonworking population. In the past, the survival of a group depended exclusively on the work of each member who could afford financial contributions. Industrialization has opened the way for supporting a large number of pensioners. The third factor is that, in industrial society, demand for the skills of older people is very low and oftentimes they are encouraged to retire and create employment opportunities for younger people.

The fourth factor is that the development of industrial society has led to the establishment of social security systems with their respective bureaucratic support structures, as well as to the setting up of private pension schemes, which have made retirement financially feasible. In the past, workers found it difficult to save enough money for their retirement. Today, all working people are secured for a minimum pension for the rest of their lives. The fifth factor is that the meaning of retirement has changed: it used to be considered as a necessary process for those who could no longer contribute something or were thought of as “useless.” Now, it is the vested right of every working man or woman.

To the question regarding the source of their income, 80 participants replied that they live on their social pension, 22 receive widow’s pension, only two stated they earn a salary, whereas two receive income from shares or immovable property. Furthermore, 28 respondents said they receive allowances and 20 said they have other kinds of income.

Quite interesting is the fact that 55 respondents consider that their pension income is lower than would be required to meet their needs; 26 said it barely meets their needs and only 13 declared it more than enough.

Forty two respondents said that during the past year they had felt depressed due to lack of money. In fact, 29 admitted that lack of money stopped them from meeting members of their family as often as they would have liked. Also, 26 said that due to lack of money they had not met their friends as often as they would have liked.

To the question how they felt once they retired, 53 replied they felt relieved because they had gotten tired. Thirty-one declared they would finally be able to do the things they didn’t have time to do before; 25 felt depressed or useless and 25 reported different emotions. This last category includes people who returned to active working lives postretirement, either taking up a different job or working as volunteers.

Even though more than half consider that society treats elderly people with respect (55 %), respondents declared that on occasion society treats the elderly with scorn. In particular, 46 agree that "They are mocked at as old and elderly," 49 agree that "The elderly are considered useless to society," whereas 46 agree that "They are considered a burden on society."

Conclusion

It appears that the elderly in this particular sample live to a great extent in a state of social exclusion with the exception of those still engaging in various activities or working. Poor health stands out as the prevalent factor of social exclusion, impeding people from keeping up with or becoming involved in activities and continuing to work. Poor health is also an inhibiting factor for social or other pleasure trips, while at the same time being a source of stress and boredom.

Social exclusion is exacerbated in cases where bad health is combined with financial adversities. In fact, the correlation is quite obvious, since 55 respondents consider that their pension income is less than would be required to meet their needs. Twenty six respondents declared it barely adequate. Tight finances, which appear to apply for a rather large number of participants, put a curb on spending. The three basic sectors, which affect the respondents' wallet are: the market for elder care services, the healthcare market, and heating. Also, many complain that the prices of consumer goods have become disproportionately higher than their income.

The "oldest" older adults with poorer education and of lower socioeconomic classes generally feel they are in a disadvantageous position whereas women and refugees appear to feel worse across almost every parameter. On the other hand, those who are involved in activities and continue to work appear to be in a more prosperous situation in terms of their health, financial status, psychological disposition, and engagement with the broader social networks. Finally, this research has shown that Quality of Life for older people it is an issue which is not reducible to any one influence. Furthermore, contextual influences appear to be more important than lifecourse influences and that Quality of Life can be thought about in terms of the ability to participate in everyday life.

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Chapter 16
Cohort Change in Living Conditions and Lifestyle Among Middle-Aged Swedes: The Effects on Mortality and Late-Life Disability

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Background

In general, aging research has been dominated by the identification of age effects. However, much of what appears to be an effect of age can actually be due to cohort membership (Ahacic et al. 2007) as well as effects of different periods. If we want to understand the aging process, we have to understand which effects are functions of the biological aging process, which are the result of belonging to a specific birth cohort, and how these aging, cohort, and period effects interact with each other.

What do we know about coming cohorts of elderly people? We know that in Sweden, as in most industrialized countries, coming cohorts of old people will be larger in size than previous cohorts. And, we know that people are living longer. At the beginning of the twentieth century, life expectancy at birth was 56.9 years for women and 54.5 for men in Sweden. By the 1950s, life expectancy had increased to 74.1 and 70.8 years, respectively, and by 2010, figures were 83.5 and 79.5 years. During the same period, the size of the Swedish population increased from 5.1 million in 1900 to 7.0 million in 1950 and to 9.4 million in 2010 (Settersten 1999; Statistics Sweden 2011).

Lower fertility rates and longer life expectancy (LE) lead to an aging of the population, i.e., the proportion of old people in relation to young and middle-aged people increases. There is concern that there will be more people outside the labor market (children, students, and retired persons) than people of working age. That is, the so-called dependency burden on working people will increase. The needs for medical care and social services increase with age, so the question arises if future generations of working people will be able to support and care for the growing numbers of retired persons.

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The increased life expectancy is the result of the remarkable successes during the past century in regards to improved living conditions and health care. At the beginning of the twentieth century, Sweden was one of the poorest countries in Europe. Industrialization came late to this rural agricultural country, characterized by harsh living and working conditions and high rates of contagious disease and alcoholism. The concept of the welfare state began to take shape in the 1920s and within a single lifetime, Sweden emerged as one of the most developed welfare states in the world. Housing and working conditions began to be regulated with high standards for hygiene and safety. Health care developed rapidly and became available to the entire population, regardless of means. Those people born during the first half of the century have witnessed incredible changes in social policy, living conditions, and opportunities for education and leisure time activities.

But have these improvements in living conditions, and the accompanying increases in life expectancy, led to corresponding improvements in health at old age? Are more recent cohorts of older persons healthier than cohorts before them? If coming cohorts of old people are healthier, costs for eldercare may not increase proportionately with age. And, if people in their sixties are healthier, it may be possible for them to work longer, that is, to raise the age of retirement, to rebalance the dependency burden.

There are many ways to investigate health trends in the population. Results from various studies vary greatly depending on the data available: the time period and age groups studied, and, in particular, the health indicators used (Parker and Thorslund 2007). One way to speculate on the health of coming cohorts of elderly people is to study the health of successive cohorts of middle-aged persons. Only a few population surveys have been conducted over sufficiently long periods of time to make this kind of analysis possible. A nationwide study from the United States of cohorts aged 51–56 years from 1992 to 2004 suggested that the coming wave of postwar “boomers” do not have better health than previous cohorts (Weir 2007). Another US study of boomers’ health (Martin et al. 2009) found more chronic conditions among current 40–59-year-olds compared with previous cohorts at that, an increase that could be due to better diagnosing. Their levels of functional limitations did not differ from previous cohorts. A study covering the period 1971–2002 compared cohorts born before and after 1945 in regards to obesity and arthritis (Leveille et al. 2005). The prevalence of obesity increased with earlier onset with each successive cohort. The authors conclude that because of obesity we can expect higher rates of musculoskeletal problems and accompanying disability in the future (Leveille et al. 2008). Olshansky et al. (2005) goes so far as to suggest a decline in life expectancy in the United States due to the dramatic rise in obesity, especially among underprivileged groups.

A large British study (Rice et al. 2010) compared a 10-year birth cohort born before and during the Second World War with the cohort born after the war at ages 50–61. They also found increased body mass index (BMI) and prevalence rates for reported chronic conditions. However, blood pressure was measured in both cohorts and was lower in the postwar cohort.

A Dutch study showed that a middle-aged (ages 55–65) cohort in 2002 was not as healthy as the 1992 cohort of the same ages (Hoogendijk et al. 2008). The more recent cohort showed poorer health behavior. Disability among women was greater in 2002, and the association between disability and low education was stronger.

A Swedish study of persons approaching retirement age, 50–64 years old, compared samples from 1968 to 2000 and found mixed results in regards to health. Mobility and dental status showed improvement, but hearing impairments, diabetes, and overweight had become more prevalent in this age group (Parker et al. 2010).

Common to all the cohort studies was the surprise on the part of the authors that more recent cohorts did not have better health given all their advantages in regards to education, living and working conditions, and access to care services.

A dilemma in the field of gerontology is the fact that each emerging cohort of "elderly people" is more or less unique in regards to living conditions, health, and well-being. The effects of belonging to a specific birth cohort and living during a specific period are intrinsically intertwined and contribute to the historical uniqueness of each successive birth cohort (Ryder 1965; Settersten 1999). Historical events such as wars, famines, depressions, and epidemics set their imprint on a cohort, an imprint that is different depending on the age at which the event occurs. An economic depression with food shortages may set indelible marks on an infant, leading to health effects even in old age. The same conditions may not have long-lasting effects on the health of 20-year-old persons, but may well affect their attitudes, their mental health, or their opportunities for higher education. Economic and social policies also shape a cohort's living conditions, and consequently the health and well-being in late life of that cohort. Likewise, the effects of policy affect people differently depending on their concurrent stage of life. Social and gender norms also change over time and limit or expand opportunities, e.g., choice of occupation, retirement age, lifestyles. In other words, much of gerontological research can be compared with shooting a moving target.

In this chapter, we will compare mid-life health indicators and how they relate to later health outcomes, controlling for mid-life health and other factors associated with health. This approach is an effort to, at the very least, describe the moving target.

Cohort Comparisons

Data are taken from nationally representative longitudinal data from four survey waves (1968, 1981, 1991, and 2000) to compare birth cohorts at mid-life (ages 55–64) in regards to lifestyle, socioeconomic, and health factors. Data are from the Level of Living Survey (LNU), a longitudinal interview survey of persons aged 18–75. The cohorts studied are born 1904–1913, 1917–1926, 1927–1936, and 1936–1945. (The gaps and overlaps are due to irregular survey intervals.) These birth cohorts represent yesterday's, today's, and tomorrow's elderly populations. We follow-up the three older birth cohorts to examine associations with 15-year mortality using the Swedish date of death register. We follow-up the two oldest birth cohorts in regards to disability, measured as limitations in daily activities in the Swedish Panel Study of the Living Conditions of the Oldest Old (SWEOLD) surveys from 1992 and 2004.

SWEOLD is a follow-up of those persons who were included in the LNU sample and who passed the age ceiling of that survey. Together, the LNU and SWEOLD provide ideal data for studying changes in both aging and cohort effects in health, living conditions and lifestyle, and how mid-life factors affect mortality and late-life health. More information about the surveys and indicators used can be found in the appendix.

Table 1 shows all four cohorts and prevalence rates of lifestyle factors (smoking, participation in sociocultural and political activities, social network, and civil status), socioeconomic factors (education, occupational status, cash margin, and economic hardships in childhood), and health (circulatory problems, psychological distress, mobility, and dental status) for men and women separately.

Lifestyle Factors

While smoking has decreased in the population as a whole, in this age group the decrease is only among men who smoked moderately. Smoking among women increased and, most alarmingly, the prevalence of heavy women smokers increased from 3.5 % in 1968 to 15.6 % in 2000 (for a study of age, cohort, and period patterns of smoking in Sweden, see Ahacic et al. 2008).

Participation in sociocultural and political activities has increased for both men and women, and the proportion of people with poor social networking activities has decreased. Increases in activity participation, particularly in sociocultural activities (e.g., cinema, theater, study circles), are to a large extent due to increased availability. Activity participation tends to be a behavior carried into old age and increases in different kinds of leisure activities have been reported also among older persons (Agahi and Parker 2005; Agahi et al. 2006). The decrease of low social network activities may go hand-in-hand with the increased activity level.

The past decades have witnessed a large increase in divorce rates. This increase can also be seen among persons aged 55–64. However, more people were married (or cohabiting) in 2000 than in 1968. The increase is due to the fact that women were less likely to be widowed in 2000 compared with 1968, and because remarriages are more common. For both women and men, rates of divorced persons increased and rates of never-married persons decreased.

Socioeconomic Factors

As described above, the individuals studied have seen tremendous changes in the Swedish economy and society. The mean years of education increased from about

7 years in 1968 to about 11 years in 2000 for both men and women. Among women, the proportion of housewives declined markedly as more and more women entered the labor market. The patterns of occupational levels reflect the transition from a primarily blue-collar workforce to a primarily white-collar workforce. The percentage of persons reporting that they have no cash margin (i.e., they would not be able to get a specified sum of money from their own account) decreased in later cohorts, as did the percentage of persons reporting that their family experienced economic hardship during their childhood. These decreases are seen among both women and men, and in all social groups (not shown in Table 1).

Health

Circulatory problems (myocardial infarction, chest pain, heart weakness, high blood pressure, and dizziness) decreased among women and increased among men. Indicators of psychological distress (depressions, anxiety, nervousness, general fatigue, and sleep problems) showed very little change over time. Limitations in mobility (walking and going up and down stairs) decreased for women and men. Dental status improved markedly. In the 1904–1913 birth cohort, a majority of the persons aged 55–64 years reported having bad teeth or being toothless, while less than 15 % of the 1936–1945 birth cohort reported poor dental status.

Changing Lives, Changing Health

The patterns seen in Table 1 in lifestyle, health, and socioeconomic factors reflect the myriad of social and political changes during the twentieth century. Next, we turn to the question of how these factors are related to outcomes. Table 2 shows 15-year mortality rates for the three oldest birth cohorts and disability scores in late life (ages 77+) for two of the oldest birth cohorts. As expected, mortality rates decrease with more recent cohorts, from 28 to 20 % ($p < 0.05$). The percentage of persons with no disabilities (measured as limitations in activities of daily living) is greater for the survivors of the 1917–1926 cohort compared with the 1904–1913 cohort. However, the percentage of persons with high disability scores does not change.

Mortality

Table 3 shows hazard ratios for 15-year mortality after year of survey for the three birth cohorts: 1904–1913, 1917–1926, and 1927–1936. The first multivariate model examines the association between lifestyle factors and mortality, the second model investigates socioeconomic factors, and in the third model all variables, including health indicators, are added simultaneously. All models control for age and gender.

Smoking is correlated with mortality for all three cohorts, even when adjusting for socioeconomic and health indicators. The association is strong; smokers have nearly twice the risk compared with nonsmokers. Separate analyses by gender (not shown) show that the association was significant for both men and women in all cohorts with the exception of women in the 1904–1913 cohort.

Associations with activities vary by type of activity, between the three cohorts, and for women and men. Separate analyses by gender (not shown) showed that cultural activities seem to be particularly protective for women. Low social network activities seem to become increasingly disadvantageous for men in more recent cohorts. Men in the 1927–1936 cohort had a significant hazard ratio of 2.5. Middle-aged men with low levels of social activity seem to become a more select group over time.

Unmarried persons have the highest mortality risk in all cohorts, although the association is strongest for the most recent cohort (1927–1936). Selection into the unmarried group is stronger in more recent cohorts, that is, more people are married. Selective factors have probably changed over time as well, for example, women from earlier cohorts who wanted a career often chose not to marry.

Mortality risk for divorced persons showed interesting gender differences. Divorce was associated with significantly higher mortality for men. For women, it was associated with lower mortality, but not significantly.

Higher education is associated with lower mortality, although the hazard ratio is significant only for the most recent cohort (1927–1936). Having no cash margin is associated with higher mortality rates, although the association is not significant when health indicators are entered into the models. Surprisingly, economic hardships in childhood show a negative association with mortality for the 1904–1913 cohort and no association with the later cohorts. One possible explanation is that of higher selective mortality in the very beginning of the century. For example, 73 % of the persons born in the year 1904 reached the age of 55, while 80 % of persons born in 1917 reached 55 years. Mortality in early life was higher among the lower classes. Another study of the effect of childhood living conditions on mid-life mortality showed no significant relationship with economic hardships in childhood for cohorts aged 25–69 in 1968 (Fors et al. 2011).

Health indicators are generally associated with higher mortality risk. Addition of the health indicators weakens the significance of some of the lifestyle and socioeconomic factors. The strongest association for all cohorts is with impaired mobility. The association between mid-life circulatory problems and mortality seems to become weaker for later cohorts, whereas the association with poor dental status is somewhat stronger for later cohorts. The weakened effect of circulatory problems could reflect better care (early diagnosis and treatment). The stronger effect of poor dental status most likely reflects the stronger selection into this classification. That is, more than 60 % of the earliest cohorts had poor teeth. In the 1927–1936 cohort, the people with poor dental status (about 18 % of the cohort) were a much more select group. Dental status in this cohort is probably a marker for poor general health and lack of access to dental care (dental care is not included in the Swedish national health system).

Late-Life Disability

Table 4 shows odds ratios from ordered logistic regression for disability after age 77. The two earlier cohorts could be analyzed: 1904–1913 and 1917–1926. Late-life disability was based on the older persons' actual situation at the time of follow-up in 1992 (for those interviewed in 1968) or 2004 (for those interviewed in 1981). The disability index included five primary and three secondary activities of daily living (ADL and IADL) items.

Mid-life smoking is correlated with late-life disability, as well as mortality. However, the association was not significant for the 1917–1926 cohort. Likewise, the associations between mid-life activities and late-life disability are not significant for this cohort in the full model.

Similar to the pattern seen with mortality, the negative effect of never being married is higher in the later cohort, from insignificant odds ratios for the 1904–1913 cohort to odds ratios of 4 for the 1917–1926 cohort. As seen in Table 1, the percentage of never-married persons decreased between these cohorts. Therefore, selection into this group was stronger in 1917–1926. As marriage rates increase, the never-married represent a more marginalized group.

Separate analyses by gender showed important gender differences between the cohorts. Never being married in 1968 was associated with less late-life disability among women (OR = 0.5, n.s.), but never-married men had a significant higher risk of late-life disability (OR = 13.0, $p < 0.001$). Never being married in 1981 was associated with higher rates of late-life disability for both men and women.

Experiencing economic hardship during childhood and poor mobility in mid-life are associated with late-life disability for the 1904–1913 cohort, but none of the socioeconomic or health indicators were significant for the 1917–1926 cohort.

Changes in Society, Changes in Population Health

We have described the prevalence of various lifestyle, socioeconomic, and health indicators in birth cohorts at mid-life (ages 55–64 years), and their association with 15-year mortality and disability in old age (more than 77 years).

In general, socioeconomic and health indicators improved in successive birth cohorts. Patterns of lifestyle factors were mixed. Activity participation levels increased. Divorce rates increased. Rates of marriage and cohabitation increased somewhat for women due to the decrease in widowhood. The percentage of never-married persons decreased. Smoking rates decreased for men and increased for women.

Mortality analysis based on factors from mid-life showed that smoking is consistently a strong predictor of death across all cohorts. The strength of the association between never being married and mortality increases in successive cohorts. The associations between socioeconomic and health indicators at mid-life and 15-year mortality weaken in successive cohorts.

Analysis of late-life disability showed that only age and having never married were significantly associated with disability in the 1917–1926 cohort, while in the 1904–1913 cohort, smoking, participation in political activities, economic hardships in childhood, and impaired mobility in mid-age were associated with disability in late life.

These results confirm the uniqueness of each cohort, both in patterns of lifestyle and socioeconomic factors, and in how these factors are associated with late-life outcomes. As we see with civil status, selection into certain groups changes over time. That is, not only do birth cohorts differ in regards to lifestyle, socioeconomic, and health indicators, but the effect these indicators have on late-life health also differs for different cohorts. Our health is the cumulative result of multiple interactions between individual and biological factors with contextual and historic conditions.

Therefore, we cannot assume universal aging effects across cohorts, nor are the associations with various indicators constant over time or between cohorts. Does this mean that comparing cohorts is primarily of historical interest? Or, can it really help us predict the health of future cohorts of elderly people and their needs for care?

Another aspect that is difficult to include is possible period effects. We can assume, for example, that the improvement seen in later cohorts in dental status is largely a result of better access to dental care, both in childhood and adulthood. For many people in the earliest cohort, dental care consisted of what the local blacksmith could do with his tongs. Whereas the people born in 1936–1945 were likely to have been seen by a dental hygienist during grade school, and more likely to have had regular dental visits. We can also assume that working conditions experienced by the earlier cohorts may well have contributed to their mortality rates and late-life disability. Studies that include indicators of general social policy and living conditions at specific times may help understanding of period effects.

The health of future generations depends not only on measureable, and somewhat foreseeable indicators of, e.g., education, health behaviors, civil status, but also on advances in technology, in particular housing conditions and medical treatment. In the LNU 1968 survey, respondents were asked if they had access to warm water, central heating, WC, and a telephone in their home (between 8 and 10 % did not). Needless to say, these items were dropped in later waves of the survey. Forty years ago, cataract surgery involved general anesthesia and 1 week of total bed rest. Obviously, it was not carried out on very old people. Twenty years ago, there were no good antidepressive medicines that could be safely used with elderly patients. The health of future generations will be shaped by individual characteristics in the context of the conditions, services, and treatments available. That, in turn, depends not only on what advances have been made, but also on how accessible they are. Will we have a health care system that provides care based on need, regardless of means and regardless of age? Will future cohorts have equal access to good housing, good nutrition, and opportunities for social engagement ? These questions are more difficult to foresee, but they will determine both the health status of coming cohorts of elderly people, and the costs for their care.

Likewise, the question of whether coming cohorts of people in early old age will be able to stay in the work force beyond current retirement ages depends more on what happens in the workplace than on individual characteristics.

Studies of how behavior and living conditions are associated with health in different birth cohorts can contribute to our understanding of the causal relationships behind associations. The results above, and similar studies, show associations over time. Similar to most epidemiological research, causation can only be implied. Being able to follow individuals over time strengthens the possibility to make causal implications, but more work is needed to identify the many pathways and mechanisms that lead to late-life health. Studies that can incorporate macrocontextual factors will make a contribution. All studies must take account of how selection into different social groups and categories, e.g., never-married or highly educated, has changed over time. Especially important is how gender roles have changed over the past century.

The challenges of shooting a moving target, in a moving contextual background, can seem overwhelming. Conducting cohort studies is one way to tackle the challenge. Another way is to look at different countries in Europe. Gender roles and other contextual factors have changed at different rates in different countries. A recent study of gender differences in life expectancy took advantage of the diversity found in 25 European countries. This study looked at associations between active life expectancy and macrolevel structural indicators such as inequality of income distribution and expenditure on eldercare (Van Oyen et al. 2010). They found, e.g., greater gender differences in years with activity limitations in countries with smaller gross domestic product, less spending on eldercare, less lifelong learning and less equality of income distribution. Differences between countries can help us understand how social policy may influence population health. The European Union provides a virtual smorgasbord of opportunities to study how health is shaped by contextual factors.

Each cohort moving through time is, by definition, unique, with a unique set of living conditions and social norms. Also, the extent to which these conditions and norms are associated with later health outcomes also changes over time. Studying these changes and differences may help us uncover underlying principles and mechanisms beyond simple equations of exposure, dose, and response. This understanding can, in turn, help us influence current living conditions and social policy to promote better health in future generations.

Appendix for Cohort change in living conditions and lifestyle among middle aged Swedes:The effects on mortality and late-life disability

Material and Methods

Data material Data come from the Level of Living Survey (LNU), a nationally representative study of the Swedish adult population aged 18–75. LNU was first carried out in 1968, and subsequently in 1974, 1981, 1991, 2000 and 2010. Younger individuals and immigrants are added to the sample to keep it nationally representative. The LNU surveys were followed up by the Swedish Panel Study of Living Conditions of the Oldest Old (SWEOLD). The SWEOLD sample consists of persons who were included in the LNU sample but passed the upper age limit of 75 years. Data collections were carried out in 1992, 2002, 2004 and 2010.

In both surveys, professional interviewers conducted structured interviews with participants in their homes. The interviews addressed questions about work life, family situation, health behaviours, economic conditions, living conditions and health status. The SWEOLD interviews excluded questions about working conditions and instead had more questions about health, function and the ability to manage everyday life.

Together, the surveys have both a cross sectional and a longitudinal character. While each survey wave represents a cross section of the Swedish population at the time, there is also a panel of individuals that is followed over time. This study uses data from middle-aged adults (ages 55–64) from the LNU surveys conducted in 1968 ($n = 935$), 1981 ($n = 812$), 1991 ($n = 698$) and 2000 ($n = 843$). Table 16.1 uses this repeated cross sectional design, while results in Table 16.4 are based on a longitudinal design with follow-ups of the birth cohorts from 1968 (followed up in SWEOLD 1992) and 1981 (followed up in SWEOLD 2004).

Outcome Variables

Mortality The follow-up time with regard to mortality was 15 years from the time of interview. Consequently, the sample interviewed in 2000 was not included in these analyses. Date of death was obtained from the Swedish National Cause of Deaths Register.

Late-life Disability This measure includes both *instrumental activities of daily living (IADL,* including food purchase, food preparation, and cleaning of the house) and *activities of daily living (ADL,* including the ability to eat by yourself, to visit the toilet, to dress and undress, to get in and out of bed, and to bathe or shower). Each IADL disability given 1 point, inability to bathe or shower 2 points, and each ADL disability 3 points. The final score ranged from 0–15, grouped into the following categories: 0 points (no disability), 1–2 points, 3–6 points, 7–15 points (disabled). Late-life disability/function was based on the older persons' actual situation at the time of follow-up in 1992 (for those interviewed in 1968) or 2004 (for those interviewed in 1981). Data came from the SWEOLD study.

Independent variables

All independent variables were measured at mid-life (average age 59) in 1968, 1981, 1991 and 2000.

Table 16.1 Descriptive characteristics of the study sample, divided by gender and cohort. (Values in percentage)

	Women					Men				
	1968, birth years 1904–1913 ($n = 457$)	1981, birth years 1917–1926 ($n = 398$)	1991, birth years 1927–1936 ($n = 360$)	2000, birth years 1936–1945 ($n = 404$)	p for trend	1968, birth years 1904–1913 ($n = 478$)	1981, birth years 1917–1926 ($n = 414$)	1981, birth years 1917–1926 ($n = 338$)	1981, birth years 1917–1926 ($n = 439$)	p for trend
Mean age	59.4	59.6	59.5	59.1		59.2	59.5	59.4	59.1	
Lifestyle factors										
Current smoking										
No current smoking	83.8	74.9	76.7	73.4	**	48.5	61.8	68.9	76.5	***
Moderate smoker	12.7	13.6	10.6	10.9	ns	32.4	18.8	10.9	8.2	***
Heavy smoker	3.5	11.6	12.8	15.6	***	19.0	19.3	20.1	15.3	ns
Socio-cultural activities	47.7	60.3	66.7	82.2	***	42.5	56.0	67.5	75.8	***
Political activities	21.7	29.3	36.4	48.8	***	53.0	60.1	59.2	64.8	**
Low social network activities	11.8	8.1	4.7	3.5	***	18.6	11.1	9.1	6.6	***
Civil status										
Unmarried	10.5	6.3	4.7	6.2	**	13.4	10.4	7 .7	8.0	**
Divorced	4.8	8.0	10.8	12.1	***	4.8	6.0	9.4	9.1	**
Widow/widower	16.2	11.8	9.4	6.9	***	2.5	3.9	1.8	2.5	ns
Married/cohabiting	68.5	73.9	75.0	74.8	*	79.3	79.7	81.1	80.4	ns
Socioeconomic factors										
Mean years of education	7.2	7.9	8.9	10.9	***	7.4	8.0	9.9	11.0	***
Own occupation										
Unskilled blue-collar worker	46.1	51.4	41.0	27.9	***	33.2	26.8	20.2	16.8	***
Skilled blue-collar worker	26.6	15.3	10.5	15.1	***	30.2	27.6	24.6	26.9	ns
Lower white-collar worker	11.5	20.0	28.5	27.1	***	20.5	23.9	19.6	15.9	+
Higher white-collar worker	15.7	13.2	20.1	29.9	***	16.1	21.7	35.6	40.5	***

Table 16.1 (continued)

	Women					Men				
	1968, birth years 1904–1913 ($n = 457$)	1981, birth years 1917–1926 ($n = 398$)	1991, birth years 1927–1936 ($n = 360$)	2000, birth years 1936–1945 ($n = 404$)	p for trend	1968, birth years 1904–1913 ($n = 478$)	1981, birth years 1917–1926 ($n = 414$)	1981, birth years 1917–1926 ($n = 338$)	1981, birth years 1917–1926 ($n = 439$)	p for trend
Employment status										
Employed	40.0	53.5	63.7	64.5	***	88.9	81.9	76.9	70.7	***
Housewife	45.7	21.1	8.4	6.0	***	0.2	0	0.9	1.1	*
Other (e.g. retired)	14.2	25.4	27.9	29.5	***	10.9	18.1	22.2	28.1	***
No cash margin	33.3	21.6	18.7	19.1	***	35.6	17.8	19.8	14.6	***
Economic hardships in childhood	30.3	32.2	21.1	21.0	***	43.1	37.6	26.0	17.1	***
Health status										
Circulatory problems										
No problems	60.2	54.3	64.1	66.8	*	72.3	63.5	63.6	67.0	+
Moderate problems	19.6	30.4	25.6	21.8	ns	17.0	24.9	26.6	21.4	*
Severe problems	20.2	15.3	10.3	11.4	***	10.7	11.6	9.8	11.6	ns
Psychological distress										
No problems	49.0	53.5	51.0	51.0	ns	67.2	73.8	67.5	68.8	ns
Moderate problems	24.2	23.6	27.9	25.2	ns	16.2	18.2	20.4	18.2	ns
Severe problems	26.8	22.9	21.2	23.8	ns	16.6	8.0	12.1	13.0	ns
Impaired mobility	30.4	24.9	20.0	20.5	***	24.1	20.0	13.9	13.9	***
Bad teeth or toothlessness	66.5	48.1	18.3	10.1	***	64.0	49.0	23.4	14.8	***

+$p < 0.1$, *$p <= 0.05$, **$p <= 0.01$, ***$p <= 0.001$

Table 16.2 Outcome variables: 15-year mortality and late-life disability (23–24 years of follow-up)

	1968, birth years 1904–1913 (n = 935)	1981, birth years 1917–1926 (n = 812)	1991, birth years 1927–1936 (n = 698)
Total sample			
Died during follow-up (15 years)	28.3 (265)	24.8 (201)	19.9 (139)
Survivors	n = 372 (39.8 %)	n = 355 (43.7 %)	
Age at follow-up	82.7	81.9	–
Disability score in late life			
0 points (no disability)	53.5	60.2	–
1–2 points	24.5	19.2	–
3–6 points	13.7	10.7	–
7–15 points (disabled)	8.3	9.9	–

Current smoking was divided into no current smoking, moderate smoking (less than 10 cigarettes or equivalent per day) and heavy smoking (10 cigarettes or more). In the analyses investigating associations with mortality and late-life disability, a dichotomous variable of current smoking (no/yes) was used.

Three activities were included in the index of *socio-cultural activities*: going to the movies, going to the theatre, museums, exhibitions, and attending study circles. Participation frequency for each activity was rated as never (0), sometimes (1), and often (2). The index was dichotomized, with persons scoring 1 or higher on the index were coded as active.

Political activities included questions about ever having contacted an authority in order to influence a decision, delivered a speech at a meeting, written an article or a letter to the editor, or participated in a demonstration. Persons answering yes to any of these questions were coded politically active.

Low social network activities consisted of two questions regarding visiting friends and visiting relatives. Responses were never (0), sometimes (1), and often (2). Persons scoring 0 or 1 were categorized as having low social network activities.

Civil status was self-reported and coded as unmarried (never-married), divorced, widow/widower and married/cohabiting.

Education was measured as years of schooling. Since the level of education has increased remarkably since the 1960s, we dichotomized education based on quartiles in the analyses of mortality and late-life disability. Persons in the highest quartile were categorized as highly educated. In the analyses of late-life disability a separate education variable was used that separated the highest education quartile among survivors only.

Occupation was measured as own occupation, categorized into unskilled blue-collar worker, skilled blue-collar worker, lower white-collar worker, and higher white-collar worker. Housewives were coded according to their husband's occupation.

Table 16.3 Associations between lifestyle factors, socioeconomic factors and health status with 15-year mortality, divided by cohort. Hazard ratios

	Women and men aged 55–64 years								
	1968, birth years 1904–1913 ($n = 918$)			1981, birth years 1917–1926 ($n = 782$)			1991, birth years 1927–1936 ($n = 684$)		
	Model 1	Model 2	Model 3	Model 1	Model 2	Model 3	Model 1	Model 2	Model 3
Age	1.10***	1.09***	1.07**	1.11***	1.12***	1.10***	1.08*	1.07*	1.07*
Gender (women)	0.6***	0.5***	0.5***	0.7*	0.6***	0.5***	0.6**	0.6**	0.6**
Lifestyle factors									
Smoking	1.5**		1.7***	1.9***		1.9***	1.9***		1.8**
Cultural activities	1.0		1.1	0.6**		0.7*	1.0		1.2
Political activities	1.0		1.1	1.2		1.1	0.9		1.0
Low social network activities	1.4*		1.3 +	1.1		0.9	1.6 +		1.8*
Civil status									
Unmarried	1.4 +		1.3	2.0**		1.7*	2.5**		2.6**
Divorced	1.5		1.3	1.6 +		1.5 +	1.3		1.2
Widow/widower	1.0		1.0	1.3		1.3	1.7		1.7
Married/cohabiting (ref)	1.0 (ref)		1.0 (ref)	1.0 (ref)		1.0 (ref)	1.0 (ref)		1.0 (ref)
Socioeconomic factors									
Highly educated (highest quartile)		0.9	0.9		1.0	1.2		0.6*	0.6*
No cash margin		1.3*	1.1		1.8***	1.3		1.4	1.1
Economic hardships in childhood		0.8*	0.6**		1.2	1.0		1.1	1.0
Health status									
Circulatory problems			1.4*			1.3 +			1.1
Psychological distress			1.2			1.3 +			1.0
Impaired mobility			1.9***			1.7**			1.7*
Bad teeth or toothlessness			1.2			1.0			1.4+

+$p < 0.1$, *$p <= 0.05$, **$p <= 0.01$, ***$p <= 0.001$

Table 16.4 Associations between lifestyle factors, socioeconomic factors and health status in midlife with late-life disability (index of ADL and IADL), divided by cohort. Odds ratios from ordered logistic regressions

	Women and men aged 55–64 years					
	1968, birth years 1904–1913 ($n = 367$)			1981, birth years 1917–1926 ($n = 347$)		
	Model 1	Model 2	Model 3	Model 1	Model 2	Model 3
Age	1.23***	1.23***	1.21***	1.22***	1.21***	1.22***
Gender	1.1	1.0	1.1	1.5 +	1.4	1.4
Lifestyle factors						
Smoking	1.9**		1.9*	1.3		1.3
Cultural activities	0.7 +		0.7	1.3		1.4
Political activities	0.6*		0.6 +	1.1		1.1
Low social network activities	1.5		1.3	2.2 +		1.9
Civil status						
Unmarried	1.4		1.4	4.4***		4.7***
Divorced	0.6		0.5	1.2		0.9
Widow/widower	0.8		0.7	1.5		1.6
Married/cohabiting (ref)	1.0		1.0	1.0		1.0
Socioeconomic factors						
Highly educated (highest quartile)		0.8	1.0		1.0	1.0
No cash margin		1.7*	1.3		1.5	1.5
Economic hardships in childhood		1.7**	1.6 +		1.2	1.2
Health status						
Circulatory problems			1.0			1.0
Psychological distress			1.1			1.3
Impaired mobility			2.2**			1.2
Bad teeth or toothlessness			0.9			1.0

$+p < 0.1$, $*p <= 0.05$, $**p <= 0.01$, $***p <= 0.001$

Employment status was categorized as “employed” (working for pay), “housewife” and “other”. The “other” category consisted of persons who were retired (mostly disability pension), on sick-leave, unemployed, studying etc.

Having *no cash margin* indicates not being able to withdraw 12,000 SEK (year 2000) from own account within a week. In 1968, 1981 and 1991 equivalent amounts were used.

Economic hardships in childhood was measured retrospectively, possible answers were yes and no.

The index of *circulatory problems* consisted of myocardial infarction, chest pain, heart weakness, high blood pressure and dizziness. These items were subjectively rated as no problems (0), moderate problems (1) and severe problems (3). Myocardial infarction gave 3 points independent of severity. The summed score was divided into no problems (0 points), moderate problems (1–2 points), and severe problems (3+ points). In the analyses investigating associations with mortality and late-life disability a dichotomous variable of circulatory problems (no/yes) was used.

The index of *psychological distress* consisted of self-reported depressions, nervous problems (e.g., anxiety and nervousness), general fatigue and sleep problems. The variable construction was the same as that of circulatory problems. In the analyses investigating associations with mortality and late-life disability a dichotomous variable of psychological distress (no/yes) was used.

Impaired mobility is a composite measurement of the respondents’ self-assessed ability to walk 100 m fairly briskly without difficulties and going up and down stairs without difficulties. Individuals who are able to perform these two tasks are coded 0; the others are considered to have impaired mobility and are coded 1.

Dental status is a self-reported item where the respondents are asked to judge their own dental status. People reporting that they had most of their own teeth, either in good shape or with many fillings and crowns, were considered to have good dental status. People reporting that their teeth were in bad shape or that they had no or few own teeth were considered to have poor dental status.

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Chapter 17
Late-Life Learning in the European Union: Implications for Social and Public Policy

Marvin Formosa

Introduction

This chapter puts the spotlight upon the European Union's (EU) conviction that lifelong learning holds a key role towards the achievement of a sustainable policy framework for an ageing Europe. For the EU, lifelong learning is a policy strategy that holds unlimited potential towards meeting wider economic, social and demographic challenges. More specifically, it is argued that the participation of older workers and adults in lifelong learning not only can aid senior citizens to upgrade their pension by earning extra income, but it also has the potential to contribute towards their further integration in civic society. This chapter contends that although these objectives are all positive developments towards the establishment of 'active ageing' societies, the interface between lifelong learning and later life is a more complex phenomenon, and includes social, cultural and humanistic components that cannot be overlooked.

Late-Life Learning

The reasons underlying the rising number of older adults participating in late-life learning are complex. The combination of increased longevity with a number of other social factors—ranging from improving health status, rising pensions, to more positive values and beliefs about ageing—has opened up a new phase in life, the third age, in which significant numbers of older persons spend a considerable amount of relative active years following exit from work. Indeed, the third age has engendered a period of some 15–20 years between middle age and frail old age (Laslett 1989). On its own, however, the third age does not explain why older adults became increasingly attracted to learning activities rather than choosing to spend their later years either in sheer indolence, leisure pursuits or in the company of their family circle.

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Primarily, the feminisation of ageing meant that learning programmes found an unprecedented pool of possible clients (Formosa 2005). Older women hold lower levels of educational attainment than males, and hence, it is only normal for them to be enthusiastic about the prospect of taking part in learning activities. The fact that their household responsibilities decrease substantially when children leave home and husbands retire, facilitates their engagement in late-life learning. Moreover, the positive correlation of participation in secondary education with continuing learning is one of the strongest, as well as most enduring, scientific axioms of adult education. Late-life learning is no exception, and as each incoming cohort of older persons holds a better educational status, the yearly record levels of older adults in learning activities are far from surprising (Findsen 2005). Finally, current cohorts of older persons face a temporal kind of anxiety—that is, having a longer period of retirement on one hand, but no definite social role on the other. This sets in a tension in their daily lives, spurring feelings of uncertainty, which induces them to search for and participate in leisure activities. For Russell (2009, p. 213), "the choice of learning... enables people in later life to actively and meaningfully participate in life", especially as they realise that their needs for self-actualisation and self-development can be met through learning. Far from simply acquiring commodities such as skills or knowledge, learning enables older persons to locate their 'authentic' self.

Despite establishing itself as the fastest growing branch of lifelong learning, late-life learning still holds a Cinderella status in official policy circles, and as such, comparative analysis of participation rates are rare (Percy and Frank 2011). Indeed, most educational statistics—including those issued by Eurostat—take the age of 65 as a cut-off point. The limited available research on participation rates (e.g. Aldridge and Tuckett 2007, 2010; Phillipson and Ogg 2010) leads to three key inferences. Firstly, that there is a negative correlation between age and levels of participation in learning with one key 'break' point is around the age of 55. Secondly, that most of the opportunities available in late-life learning are in the non-formal realm of learning avenues. And thirdly, that whilst the most popular subject is ICT, with increasing age it is 'pleasure in the act of learning', rather than 'acquiring some credential skills', that is the strongest motivation to engaging in learning. Studies note that typical older learners tend to be from dominant ethnic groups, hold a middle-class background and female; hence, suggesting that sparse efforts are invested in outreach initiatives (Formosa 2010). Another key concern in late-life learning relates to the limited learning opportunities for older people facing mobility and mental challenges, who are typically housebound or living in residential/nursing homes. In present times, the quiet older person dozing in a comfortable chair, waking up for meals and complying with the requests of carers is considered as a 'failure' rather than an efficient and sensitive model of care (Jarvis 2001). Although the link between mental fitness and good health is a slippery one and may never be unequivocally resolved, older people who continue to engage in cognitively stimulating activities have been found to be in a better position to adopt strategies assisting them to augment their well-being and independence (Mehrotra 2003). Despite damaging stereotypes, empirical studies leave no doubt that the quality of learning participation, processes and outcomes in 'fourth age learning', is capable to be impressive and exceeding all expectations (Aldridge 2009).

EU Policy on Late-Life Learning

The EU discourse on late-life learning is found as part of a comprehensive policy agenda on lifelong learning. As the EU gradually grew from an initial six countries to a 27-nation inter-governmental organisation, it became confronted with two key challenges: (1) the introduction of a new form of active citizenship that celebrates the "sharing of common values, and the development of a sense of belonging to a common social and cultural area" (European Commission (EC) 1997, p. 4) and (2), making the EU the most competitive and dynamic knowledge-based economy in the world so as to close the gap "between those who are sufficiently qualified to keep afloat in the labour market and those who are falling irrevocably by the wayside" (EC 2000, p. 7). Faced with such a complex predicament, the concept of lifelong learning was established as the paramount solution in both policy and practice arenas. For the EU, "learning opens the door to building a satisfying and productive life" (EC 2000, p. 9). Indeed, the year 1996 was declared the European Year of Lifelong Learning, and a series of policy papers were issued by the European Commission (EC) to promulgate lifelong learning as the mantra of European public policy (EC 1995, 2000, 2001, 2006, 2007). Defining lifelong learning as "all learning activity undertaken throughout life, with the aim of improving knowledge, skills, and competences within a personal, civic, social, and/or employment-related perspective" (EC 2001, p. 9), the EU established four objectives for lifelong learning: social inclusion, active citizenship, individual development and economic productivity.

Despite the EU's fixation with lifelong, as opposed to adult learning, older persons still remained for a long time completely overlooked. It was only in *Adult Learning: It is never too late to learn* (EC 2006) that late-life learning was first brought at the forefront of the discussion. Herein, the EU claims that the changing demographic situation calls not only for raising the average retirement age, but also for 'active ageing' policies, which address citizens' needs during both middle age and later life. Stressing that the growing numbers of retired people in Europe are a potential source of adult educators and trainers, *Adult Learning* posits two objectives:

> To ensure a longer working life, there is a need for up-skilling and increasing lifelong learning opportunities for older workers. It is widely acknowledged that in order to keep older workers employable, investment is needed throughout the life cycle and should be supported by government, professional bodies and sectors. Special attention should be given to those entering their mid career. [and]
> An expansion of learning provision for retired people is needed (including for instance increasing participation of mature students in higher education), as people are reaching retirement in better physical and mental health, and post-retirement life expectancy is extending. Learning should be an integral part of this new phase in their lives. . . the Commission invited universities to "be more open to providing courses for students at a later stage of their life cycle". Such provisions will have a vital role in keeping, retired people in touch with their social environment (EC 2006, pp. 8–9).

A year later, the EU published an *Action Plan on Adult Learning* (EC 2007), which reiterated the need to ensure sufficient investment in the education of older people, although one notes that such an objective was strongly coupled with migrant education. Member States were called on to invest in older people and migrants, through education and training that matches the needs of the learner, and to raise awareness about the important role of migrants and older people in the EU. Immigration, it was affirmed, can be seen as a partial counter-balance to an aging population and skills shortages in certain sectors. In an attempt to link policy with practice, the EU coordinates the Grundtvig programme, which provides funding for projects on lifelong learning for all clients irrespective of age. The EC voices a determination to improve the quality and breadth of older adult learning, stating how "it has now become accepted that education and training have a vital role in helping older people make decisions and exercise choices about their quality of life" (EC 2010a, p. 1). Recently, Soulsby (2010) undertook a mapping exercise of known EU-funded initiatives concerned with older adult learning. Results identified some 200 networks and projects covering a range of learning activities, but mainly, inter-generational, e-learning, mentoring and volunteering.

The Hegemony of Productive Ageing

It is positive that late-life learning is no longer an overlooked area in EU policy and funding rationales. Whilst in the recent past older generations had no role to play in the strengthening of European society, as if elders were no longer needed, in current times they are frequently posited as key players in civic engagement. It is commendable that from the onset of the EU's concern for lifelong learning, citizenship has always been perceived as a major policy initiative (EC 1995). Nevertheless, a critical overview of the whole oeuvre of lifelong learning policy locates a strong link between citizenship and employability. In *Towards a Europe of Knowledge*, we find that the:

> . . . citizens of Europe will be able to develop their **knowledge**, and this area will facilitate the **enhancement of citizenship** and **the development of employability through the acquisition of competencies** made necessary through changes in work and organisation (EC 1997, p. 2—bold in original).

Despite efforts in future documents to downplay the relationship between citizenship and employability, the EU's vision for lifelong learning is ultimately based on notions of human capital theory, where the key assumption is that there will be economic payoffs if a society broadens access and opportunities for lifelong learning (Borg and Mayo 2006). The economic bias that characterises the EU policies on lifelong learning implies that it is the "future worker-citizen" rather than the "democratic-citizen who is the prime asset of the social investment state" (Lister 2003, p. 433). This bias is nowhere more apparent than with respect to the role of older adults in a learning society. Indeed, the position promulgated in *Adult Learning: It is never too late to learn* (EC 2006) and *Action Plan on Adult Learning* (EC 2007) for late-life learning is unashamedly economic, where the solution to the 'ageing' problem is put as simply finding a way for older people to be economically useful. The part of the EU's discourse jars strongly with the current drive of the EU to found all Member States upon a rationale of 'active ageing'—that is:

> . . . the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age. [Active ageing] allows people to realize their potential for wellbeing throughout their lives and to participate in society according to their needs, desires and capabilities (EC 2010b, p. 2).

However, achieving the goals of active ageing will remain unfulfilled if discourses on lifelong learning continue to be increasingly shaped by the language of the global marketplace where learners and education are denoted as clients and a commodity, respectively. The EU vision on late-life learning never escapes the greater project to render Europe more competitive in the face of fierce competition from the transitional and multinational corporations' ability to reap the advantages of economies of scale through the expansion of international capital mobility. Evidence of this constitutes the EU's extensive drive to improve the e-learning skills of older. Although this is not in itself wrong, one has to query the EU's neglect of the whole range of abilities needed by the extensive assortment of productive sectors. Here, it is noteworthy that there is hardly any evidence to support the usefulness of a strong human capital theory for older persons (Cole 2000). Research indicates strongly that the increase of opportunities for late-life learning does not result in a surge of older persons going back into either full- or part-time employment, but only a rise in pensioners becoming increasingly active in community and civic engagement affairs (Findsen 2005). As a result, the need to help older people stay in paid work is only one priority amongst others in late-life education. Other priorities include recognising the diversity of older persons, challenging stereotypes of ageing, maximising participation, maintaining personal independence and retaining a sense of purpose and meaning. Of course, this does not mean that policies seeking to improve the skilling of older adults should be thrown out of the window since the crucial role of productive ageing to well-being is well-documented (Morrow-Howell 2010), but only to underline that the vocationalisation of late-life learning will not on its own solve the future structural lag in employment or non-sustainability of pensions. So that the integration of older persons in the labour market becomes a real possibility, policies must break down barriers to labour market entry with active and preventive measures such as job search assistance, guidance and training. Late-life learning must be supplemented by measures that break down barriers between age groups in the work place, by taking a holistic approach to the needs and wishes of older workers with respect to motivation, time management and income and social protection issues. Older adults are empowered to combine partial retirement with part-time work only in so far as work remains within their capability as their life situation changes.

Another shortcoming of EU policies on lifelong learning is overlooking that when the agenda for lifelong learning is shaped primarily by market forces, older adults are frequently disadvantaged. One can never under-estimate the extent that older adults inhabit a life world typified by unique structural inequalities that limit their potential to engage in lifelong learning. As people reach the latter phases of the life course, they start experiencing ageist forms of systematic stereotyping and discrimination that embed them in a subaltern status in society—in other words, "prejudice and discrimination. . . based on the belief that ageing makes people less attractive, intelligent and productive" (Ferraro 1992, p. 296). Older persons whose lives are characterised by other lifelong ‘otherisms’—such as women, the working class, ethnic minorities and gays and lesbians—face even more intense levels of exclusion and oppression since such statuses combine with ageism to produce double, and sometimes, triple jeopardise. Moreover, there can be no doubt as to the increasing probability of physical and cognitive decline with increasing birthdays, which renders older persons increasingly unable to exercise their choice to make use of the lifelong learning marketplace. Here, one cannot fail to mention that the belief that older persons in contemporary capitalism hold unprecedented levels of agency has led to the de-institutionalisation of retirement—namely, a “dismantling of welfare state provisions making work essential for many elders rather than work being the result of active choosing” (Townsend 2007, p. 21)—which is making it harder for vulnerable elders to integrate themselves fully in contemporary European society. As Phillipson (1999, p. 323) claims, the coming of late modernity did not result in the end of traditional forms of inequalities but only a “growth of new inequalities alongside the continuation of traditional social divisions”. Indeed, as much as 19 % in the European Union (a total of 16 million or approximately one in five)—are living at the risk of poverty (Zaidi 2010). Taking in consideration that productive policies are biased in favour of persons with dominant types and extensive volumes of cultural capital, what the EU offers to late-life learning is ultimately ‘a model of knowledge economy for some’ as opposed to ‘a model of a knowledge society for all’ (Healy and Slowey 2006).

The lacunae present in EU policies on late-life learning validates Perkins et al.’s (2004, p. 15) argument that valuing and championing those “population groups ill-suited to the labour market calls for broader social policy goals and a recognition of other forms of contributions as well as the simple one of economic participation”. Indeed, educators and policy makers need to carefully assess what they mean when taking up notions of learning and later life. Hence asking, “when we invest in lifelong education, what kind of learning is being fostered?” (Gouthro 2007, p. 145). The implication of this question for late-life learning is the subject of the coming section.

Policy and Social Implications

Lifelong Learning for ALL

Although we can celebrate the fact that life expectancy is increasing, and with it the opportunities to live an active life, it remains that some groups of older persons are at a higher risk of social exclusion. Whilst ensuring that the freedom of those who choose not to be included is not taken away, lifelong learning policy and practice has the obligation to facilitate the inclusion of older persons who, shackled by structural inequalities, are unable to participate. In listening to older persons’ life histories in various empirical projects (e.g. Formosa 2000, 2005, 2007, 2009, 2010), it is clear that such persons are not the exception. It is naive to presuppose that working class elders are naturally disinclined to participate in late-life learning. Indeed, a study on working class elders' engagement with further and higher education demonstrated that not only is there a thirst for formal learning outside the conventional middle classes, but also that working-class elders have unlimited competence to continue to learn both within and external to the academy (Findsen and McCullough 2008). The same can be said with respect to older men and others from minority ethnic backgrounds. Golding et al.'s (2007) and Dadzie's (1993) studies are unequivocal in that if learning activities are planned and carried out in gendered and culturally sensitive ways, there is no reason to believe that one cannot have gender-balanced and multicultural learning environments. Similarly, Mott (2008) shows that if learning opportunities are made available in rural areas and are coupled with age-sensitive transport plans, a rural–urban balance in participation rates is equally feasible. Finally, the absence of homebound elders and those living in residential/nursing homes in lifelong learning is essentially the result of a relative lack of outreach and distance learning opportunities, as well as the stereotypical assumption that fourth agers have no learning interests. It is lamentable that there is no place for frail elders and carers in EU policies on lifelong learning, and to my knowledge, no Grundtvig-funded project has yet focused exclusively on fourth agers. The EU is thus called upon to: (1) advocate learning opportunities for informal family carers of older persons to enable them to focus on the dynamics of caring as well as empower the development of frail elders, and (2) call for learning sessions in residential and nursing care homes so that all older persons, even those suffering from confusion or dementia, have an opportunity to participate.

The key for a lifelong learning for ALL is to look for those class-, ethnic-, gender- and ageist-specific barriers that hinder the realisation of a more democratic version of lifelong learning practice. Such barriers may range from insufficient income, language issues, biased curricula and a lack of age-friendly premises. There is also a serious need to counter the psychosocial barriers such as the stereotypical and ageist belief in the adage 'I'm too old to learn', make use of user-friendly enrolment procedures (such as low fees, appropriate venues and exciting methods of teaching and learning), and overcome communication problems such as brochures printed in too small type and crammed formatting, or a failure to display brochures in places, which older adults frequent. Achieving a lifelong learning for ALL necessitates the implementation of a 'widening participation' agenda. Policy makers and providers must work together to think out of the box so that late-life learning initiatives attract older adults who could or would not usually participate in traditional organised provision. The achievement of this objective will indeed be facilitated if central governments award local authorities a clearer role in the coordination and lead development of lifelong learning.

Lifelong Learning for 'Active' Citizenship

EU policies on late-life learning are consistent with the expectation of lengthier working careers, which would require older persons to participate in formal learning to update their skills. Such a standpoint, however, infuses a neo-liberal bias that equates citizenship with a 'productive' rationale as the key means for older persons to remain independent, and prove their value and worthiness. What this standpoint fails to confront is that although lifelong learning and civic engagement come across as a personal choice, preferences are often structured by social, economic and institutional factors (Ettiene and Jackson 2011). Keeping this in mind, it is warranted that lifelong learning policies embrace a broader perspective of citizenship that includes a mix of political and social rights. In other words, also calling for the right to participate in political processes and the right to live (supported by state and local authorities' services if necessary) in a civilised lifestyle according to societal standards (respectively). This will certainly not be achieved by any type of learning environment but only if educators and learners embrace a critical epistemology. Calling for attention to the triumvirate of knowledge, power and control, a critical standpoint asks fundamental questions such as: Why do we teach? Whose interests are really being served? Who controls the learning process? Why is education 'good' for people? How is quality of life enhanced by education? Educators who embed late-life learning in a critical framework (e.g. Glendenning and Battersby 1990; Formosa 2000; Findsen 2007) follow Paulo Freire's (1972, 1998) philosophy, which emphasises that the primary goal of education is to enable learners become in control of their thinking, and thus, be aware of their social and political rights. This is possible if educators are fully conversant with the socio-cultural context in which older adults conduct their lives. A critical epistemology for late-life learning posits educators and learners in a relationship of collaboration whereby the former do not only understand the constraints of the situation brought on by structural conditions, but are also at grips with the potential of learners to overcome oppressive practices via collective social action. It embraces a transformative rationale that not only dissects the realities surrounding older citizens, but also enables them to imagine and work together towards the realisation of a social world than is governed by life-centred values rather than the ideology of the market.

A critical stand towards late-life learning has huge potential to expand the opportunities for 'civic engagement' for those older persons who choose such a path, and wish to go beyond the traditional volunteerism that is generally expected from older generations. Most centrally, it holds much promise to lead towards higher rates of political activism, a type of activity that despite being central to citizenship has been delegitimised and relatively absent from the official agenda of civic engagement (Biggs 2001). The promotion of senior volunteerism as the only type of desirable civic involvement, whilst ignoring the value of political participation, "reinforces a trend among the citizenry to shy away from political participation and replace efforts to create systematic change upstream with one-to-one efforts downstream" (Martinson 2007, p. 63). Lifelong learning will only be successful in leading learners towards true and adequate levels of 'active' citizenship only if structural inequalities are addressed and possible alternatives proposed.

Lifelong Learning for Transcendence

Lifelong learning is not a solely social and political phenomenon but is also closely linked to learners' psychological development. As one expects, later life is not personified by strong levels of purposefulness since the goals being reached for do not have the same existential nature as having a family, raising children or work and career. On the contrary, it is especially typified by external events that bring about and mark the transition such as children leaving the home, losing a job, taking early retirement, a divorce or death of a loved one and for women the effects of menopause (Illeris 2009). In fact, many elders participate in late-life learning because learning is experienced as important or interesting, or it has the nature of something one needs to prove to oneself and to others that she/he is still well capable of facing and overcoming cognitive challenges (Jarvis 2001). The emphasis of the EU policies on the potential of lifelong learning to lengthen working careers stands at odds with the main psychological traits in later life, especially when you consider that older individuals tend to experience "a shift in meta-perspective, from a material and rational vision to a more cosmic and transcendent one" (Tornstam 1989, p. 60). Indeed, there is a need for policies on late-life learning to address the psychological needs and interests of older persons. Moody (1988, 1990) argues that late-life learning must adopt a developmental perspective, which would emphasise gains as well as losses that result with the onset of ageing. Most important of all, learning environments must not let the learners forget that they are old, must tie their rich life experience in the classroom and facilitate the conversion of life experience from an obstacle into a source of strength. For Moody (1988, 1990), if older persons are to be educated for new roles and activities, then this must be based on an acceptance of their time limitations and taking responsibility for the well-being of generations. It is for this reason that the idea of 'leisure-time' learning is rejected since it suggests that late-life learning is not serious. One key goal of education in later life, then, lies in acknowledging learners' own finitude and death, and to strive for personal transformation—that is, transcendence. In short, transcendence learning provides the opportunity to explore learning goals that people at earlier stages of the life course are often too busy to pursue, such as contemplating the meaning of life, coming to terms with one's past as a preparation for death and the quest for self-fulfilment and spiritual advancement.

Lifelong learning for transcendence complements a lifelong learning for 'active' citizenship as both standpoints strive for transformation. However, whilst the latter takes the form of political struggle and revolutionary consciousness aimed at transforming the world, lifelong learning for transcendence is an existentialist project targeting personal transformation. Lifelong learning for transcendence highlights how later life is also a process of psychological individuation or self-realisation—that is, "returning to our origins to become the total, unified personality symbolized by the archetype of the self" (Moody 1990, p. 35). In practice, this entails learning sessions that take to task the fact that retirement remains an incomplete ritual due to the fact that society has yet to evolve ways of dealing with retirees in a purposeful manner. This is the chief priority of pre-retirement planning courses, which strive to make older workers aware of the key ingredients for a successful retirement—namely, health prevention, social networking, adequate housing, sufficient income and an adequate personal philosophy. Unfortunately, no mention of pre-retirement planning courses is found in EU policies on lifelong learning, and to my knowledge, there has been Grundtvig funding for this type of learning environment.

Conclusion

This chapter has indicated how the EU's vision for late-life learning includes a strong economic bias. The achievement of productive ageing is only one possible rationale for late-life learning, and only one of many components, which leads older adults to age successfully. Policy on late-life learning should consist of meaningful pursuits, which contribute towards the holistic well-being of older adults, his or her family, the local community and society at large and should not only be concerned with paid employment or production. Following Walker (2002, p. 124), "this is not to downgrade the importance of employment, which remains the leading method of inclusion, but to recognize that activity means more than paid work". This article has argued that a more socially democratic and humanist policy on late-life learning necessitates the EU to cultivate a sensitivity towards the fact that many older persons' engagement in lifelong learning is obstructed by structural barriers, ensure that late-life learning to further the participation of older adults in political activism, and finally, conduct learning programmes that in tune with the psychological development traits that tend to characterise later life.

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Chapter 18
Transnationalism and the Study of Aging and Old Age

Sandra Torres

This chapter focuses on the theoretical and empirical fruitfulness that a transnationalism-informed agenda poses and will delineate—albeit briefly—some of the challenges to gerontological research, policy, and practice transnational lifestyles bring to fore. This chapter will address three questions: what does transnationalism mean, what characterizes transnational lifestyles, and what implications do these have for gerontological research, policy, and practice. As such, this chapter addresses a topic that has received very little attention in the social gerontological literature even though the social scientific debate on this international migration trend has been going on for more than a decade (e.g., Faist 2000a, b; Glick-Schiller et al. 1992). It is for this reason that this chapter will begin by alluding to the debate on the globalization of international migration; a debate that we need to acknowledge if we are to understand what "the age of migration"[1] means in general and for transnational migrants flows and the lifestyles they lead to in particular (cf. Castles and Miller 1998).

In this respect, it seems appropriate to note that "the number of older people who have been international migrants and have cultural differences from the host population will undoubtedly increase during the coming decades" (Warnes et al. 2004, p. 309). On the basis of this, Warnes et al. have posited that the globalization of international migration is as important to the study of old age as population aging is. Curiously enough, however, few social gerontologists seem aware that the globalization of international migration—which is believed to have brought about

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[1] *The Age of Migration* is the name of a book by Castles and Miller, which was published in 1998 and which argued that "the global order based on sovereign national states is giving away to something new" (Castles and Miller 1998, p. 1). This new order is witnessing not only the intensification of international migration but also the feminization (cf. Slany et al. 2010) and differentiation of migration waves across the world. These international migration trends are therefore deemed to be different than the ones we had a couple of decades ago.

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"the age of migration"—will affect the study of aging and old age in numerous ways. It is because of this that European gerontologists interested in migration welcomed the European Research Area on Aging Network's initiative to focus exclusively on the issue of international migration in one of the Forums on Aging that they organized a couple of years ago (see ERA-AGE NET 2008 report). In doing so, this network acknowledged that the age of migration will demand that gerontological agendas across Europe become more aware not only of older migrants' perspectives on aging and their specific needs but also on the implications that migrant care workers have for the deliverance of high-quality and user-friendly elderly care.

Some earlier European initiatives—such as the European Science Foundation Research Network on "*International Migration in Europe: Welfare Policy and Practice Implications for Older People*" (led by Anthony Warnes between 2001 and 2003) and the Exploratory Workshop on "*Intergenerational Relationships, Migration and Aging: Policy and Behavior*" (that the same organization sponsored in 2003 and which was led by Simon Biggs, Ariela Lowenstein, and Ruth Katz)—tried to do the same. What was groundbreaking about the Forum organized by ERA-AGE NET at the end of 2007 in Paris is that it aimed to promote the exchange of ideas between researchers, policy makers, funders, and end-users about the implications of migration for aging research in general and not just for the subfield of gerontological inquiry that is concerned with ethnicity and migration issues. One could therefore say that this Forum was an important step in increasing European social gerontologists' research, policy, and practice agendas through a discussion of the kinds of priorities that are needed when the situation of older migrants is the focus of research and/or when their needs are to be taken into consideration as old-age policies and practices are designed and implemented. This chapter can be regarded as an attempt to move yet another step beyond what the ERA-AGE NET's Forum in Aging and Migration accomplished by arguing that we need to consider not only how "the age of migration" is going to affect the study of aging and old age but also how specific trends associated with it—such as transnationalism—offer numerous *theoretically* profuse opportunities to expand the gerontological imagination.

Transnationalism: What Does This International Migration Trend Entail?

As suggested already, transnationalism is a specific international migration trend associated with the globalization of international migration or "the age of migration." The difference between globalization and transnationalism must be addressed if we are to formulate an answer to the question this section begins with. Faist (2000a) describes the relationship between these phenomena by stating that:

> transnationalization overlaps globalization but typically has a more limited purview. Whereas global processes are largely decentered from specific nation-state territories and take place in a world context above and below states, transnational processes are anchored in and span two or more nation states, involving actors from the spheres of both state and civil society (Faist 2000a, p. 192; see also Faist 2000b).

Vertovec's (1999) definition of transnationalism reads as follows:

> transnationalism describes a condition in which, despite great distances and notwithstanding the presence of international borders (and all the laws, regulations and national narratives they represent), certain kinds of relationships have been globally intensified and now take place paradoxically in a planet-spanning yet common—however virtual—arena of activity (Vertovec 1999, p. 447).

In a similar fashion, Kearney (1995) argues that transnationalism and globalization are phenomena in conflict with the jurisdiction and power of states, which is why he proposes that they should be regarded as transstatal. Portes et al. (1999)—who are also part of the emerging transnationalism theorists—argue that although back and forth movements by migrants have always existed, it is only in the past decade or two that the intensity and simultaneity of long-distance, cross-border activities have brought about the distinctive normative social structures and social fields that we call transnationalism. These fields are composed of a growing number of people that live dual lives. This means that that they speak two languages, have homes in two countries, and make a living through continuous regular contact across national border. Both the former and the latter are, of course, not as applicable to older transnational migrants, which is why I would argue that much of the literature that focuses on transnationalism (especially the theoretical literature on this trend) is old-age oblivious. Empirical research on transnational lifestyles has shown, for example, that older transmigrants live lives that are very much characterized by intense long-distance mobility, cross-border activity, as well as social interaction patterns (especially those focusing on family relations) that are transnational in character even though they may not always speak two languages, have homes in two countries, or make a living through continuous regular contact across national borders (see, e.g., Ackers and Dwyer 2002; Baldassar 2007; Dwyer 2000, 2001; King and Vullnetari 2006; Lunt 2009; Treas 2008; Treas and Mazumdar 2002).

Transnational exchanges are therefore among the trends expected to change the way in which studies of international migration and migrants are conducted (Faist 2000b). Cultural anthropologists Glick-Schiller et al. (1992, 1995)—who are thought to be the first to have articulated what transnationalism entails back in the early 1990s—have asserted, for example, that the politics of "belonging" have started to become transnational in the case of some migrants. Of particular interest here is the fact that they are speaking of *some and not all* migrants. In respect to this, Portes et al. (1999) argue that we must be careful not to use the term transnationalism or the denotation transmigrants in inadequate ways. The concept should only be used to denote the types of networks and "activities that require regular and sustained social contacts over time across national borders for their implementation" (Portes et al. 1999, p. 219). Not all contemporary immigrants belong, in other words, to the transnational category since it is only those that have access to the transportation and technological prerequisites of transnationalism that can sustain such ties over time. Glick-Schiller et al. (1992) write that transnationalism is:

> The process by which immigrants build social fields that link together their country of origin and their country of settlement (Glick-Schiller et al. 1992, p. 1).

Transmigrants have therefore been described as the immigrants who build such fields by maintaining a wide range of affective and instrumental social relationships across national borders (Basch et al. 1994). It is because of this that (Faist 2000a) has urged us not to use the concept to denote the occasional and fleeting contact between migrants and the relatively immobile people with which they interact in both their countries of origin and their host country.

Transnationalism: What Does This Trend Mean for Migration and Culture-Related Studies?

Having described what transnationalism is and how it differs from international migration, it seems appropriate to move on to describe what transnationalism is expected to imply for international migration and ethnic relations' research and the manner in which we collect information of migration and migrants. Transnationalism is namely expected to have unprecedented implications for all aspects of migration studies: from the way in which we study migration movements and their implications for national and international policies (Castles and Davidson 2000), to the manner in which we approach the study of migrants and policies relevant to their needs (Kivisto 2001). In regard to the study of migration, Richmond (2002) argues that globalization weakens the distinction between "sending" and "receiving" countries, as well as the stereotypical assumptions about immigrants and refugees that are often made. These assumptions are also, of course, assumed to be challenged by transnationalism.

The fact that transnational ties are bound to challenge the way in which the study of immigrants' culture of origin and host culture is conducted is also particularly relevant. After all, culture's relationship to "locality" is shaken by transnationalism just as much as it is challenged by globalization. Anthony King suggests that the study of culture has become much more complex since "it's not just that, increasingly, many people have no roots; it's also that they have no soil" (King 1991, p. 6). This is why Kearney (1995) notes that transnational spaces, identities, and communities pose an ethnographic challenge. Transnational migrants are after all people that stay "connected" with (and are simultaneously influenced by) more than one culture at a time. This is why migration scholars have referred to transnationalism's influence on culture in "translocal" terms (Smith and Guarnizo 1998). Thus, transnationalism brings about what has been referred to as the "hybridization" of cultures (Nederveen 1994). The being-in-between culture that is characteristic of the first stages of immigrants' adaptation is a permanent state of affairs for transnational migrants. This is why, in the case of transnational migrants, it can become difficult to speak of territorially bounded cultural values. Hence, Vertovec's (1999) use of terms such as "social morphology" and "diasporic consciousness" when talking about the implications that transnationalism will have on social life.

Transnationalism is making the formulation of immigrant policies and the "business" of coping with cultural diversity much more complex (Faist 2000a; Kivisto 2001). The weakening of the sovereignty of national boundaries that globalization entails means that established models for the "handling" of cultural diversity are also being destabilized. In regard to the impact of transnationalism on culture, Portes et al. (1999) argue for the distinctiveness of current forms of immigrant adaptation, making the point that:

> the immigration literature has generally assumed that, once newcomers arrive, they settle into the host society and undergo a gradual but inevitable process of assimilation... for immigrants involved in transnational activities and their home country counterparts, success does not so much depend on abandoning their culture and language to embrace those of another society as on preserving their original cultural endowment, while adapting instrumentally to a second (Portes et al. 1999, pp. 228–229).

Moreover, the way in which the mode of cultural reproduction, capital resources, and sites of political engagement are affected by transnationalism must be taken into consideration since this phenomenon is expected to affect how we think of cultural, social, and economic capital. Hence that Faist (1999) urges us to distinguish processes of transnationalization in the economic sphere from processes in the political and cultural realm. With regard to the latter, he argues that transnationalism could end up forcing us to abandon national citizenship in favor of transnational citizenship arrangements (cf. Kastoryano 2000; Schmidtke 2001). Last but not least with respect to what transnationalism is, it should be mentioned that Portes et al. (1999) urge us to differentiate between what Guarnizo (1997) refers to as "transnationalism from above," which is where economic and political transnational activities belong and "transnationalism from below," which is what he calls the transnational migrants and networks whose interactions and activities bring to fore the kind of sociocultural transnationalism mentioned earlier. This differentiation is interesting for gerontological research, policy, and practice since transnationalism is bound to challenge all three although in different ways. The next section will therefore delineate some of the gerontological research areas that could be affected by transnationalism.

Transnationalism: What Are Some of the Research Questions That This Trend Poses?

The globalization of international migration and the differentiation of migration that this phenomenon is bringing about suggest that the discontinuity that characterizes the life course of older migrants is an interesting source of information about the way in which old age and aging is experienced and understood (cf. Torres 2006a, 2009). In one of the special issues put together by the European Science Foundation's Research Network mentioned earlier, Warnes et al. (2004) argue—in accordance to the issue of differentiation—that:

> in European countries today, older migrants include people who are among the most deprived and excluded in our societies/.../ and others who are in the vanguard of innovative, developmental and positive approaches to later life (Warnes et al. 2004, pp. 310–311).

Older migrants come, in other words, in all shapes and forms. In regard to this diversity, it seems appropriate to mention the typology of older migrants in Europe that

Warnes et al. (2004) formulated as part of the work they did through the Research Network financed by the European Science Foundation, which was titled *International Migration in Europe: Welfare Policy and Practice Implications for Older People* and was mentioned in the introduction. Their typology—which was formulated through a literature review on older migrants in Europe—proposes that there are four different types of older migrants. Some older migrants have migrated between European countries while others have come from outside our region.[2] Some have migrated late-in-life—either from within or from outside of Europe—while others have migrated for family reunification purposes.[3] As argued elsewhere (see Torres 2009), this typology does not acknowledge that some older migrants' decision to migrate may not be as voluntarily as the types they propose suggest. Older refugees, for example, who have migrated for political and/or religious reasons and who have done so both early and late-in-life are not addressed in this typology. Thus, although Warnes et al. (2004) typology does address the differentiation that "the age of migration" is associated with, it should not be regarded as a typology that has extenuated all the potential types of older migrants there are. Irrespective of what we think about this typology, it seems fair to say that this typology does propose that migration theorists often claim; i.e., the diversity of backgrounds and motives for migration is, in other words, greater these days.

With respect to the phenomenon in focus here (i.e., transnationalism), it seems appropriate to clarify that not all older migrants' lives can be described as transnational. It is, in other words, important that we differentiate between older migrants and older transmigrants since the former's lifestyles need not be as characterized by the intense long-distance mobility and cross-border activities that are at the very core of the transnational lifestyle. Hereby it is, however, argued that the older migrants whose lives can be described as transnational are bound (much more than older migrants whose lives are not) to have understandings and experiences of aging and old age that are challenged by the being-in-between and the hybridity of cultures that their lifestyles presupposes, by the differences between the values they upheld prior to migration and the ones they uphold now and as well as by the degree of integration they exhibit (which can have been influenced by their migration motives but which probably entails not just one societal setting but two).

The diversity of older migrants and the peculiarities of their migratory life course generate therefore interesting research questions for gerontology. One of them concerns the topic of intergenerational relationships. Of interest here is the work done by migration researchers such as Judith Treas, Loretta Baldassar, and Jorgen Carling to name a few. The latter has explored the implications that the geographical dispersal of migrant families has for their relationships over time. In one of his latest articles

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[2] In Warnes et al. (2004), these migrants are referred to as EILM, which stands for European International Labor Migrants and NEILM, which stands for Non-European International Labor Migrants.

[3] In the typology in question, these migrants are referred to as FIRM and AIRM, respectively; the former stands for Family-Reunification International Retirement Migrants while the latter is the acronym they used to refer to Amenity-Seeking International Retirement Migrants.

on the human dynamics of transnationalism, Carling (2009) makes a convincing case for what he refers to as the "asymmetries of long-distance closeness." This term refers to the intrinsic asymmetries that exist in the transnational relationships that migrants have with those they leave behind in their countries of origin. Research on migrants' relationships with their families and friends back home shows that the process of migration can be a guilt-inducing process within what Hage (2002) has called "the moral economy of social belonging." This generates undoubtedly the following research questions: how are the "gifts of communality" repaid in transnational relations; how does the "moral economy of social belonging" work for those migrants that are transnational; how do the "asymmetries of long-distance closeness" that characterize transmigrants' relationships affect older people; how do older transmigrants handle the guilt-inducing processes that their constant mobility bring about?

Questions like these ones draws attention to the pillar of the gerontological debate on intergenerational relationships—i.e., the construct of intergenerational solidarity—and the numerous assumptions that underlie this gerontological construct. Hammarström (2005) argues a convincing case for the need to deconstruct these assumptions. She poses, for example, that we need to problematize the taken-for-granted assumptions that this construct makes as far as value similarity across generations, the societal changes that lead to changes in the division of labor within families, and the type of solidarity that can be expected between generations. All of these assumptions seem particularly propitious to explore from the perspective of older migrants in general and transnational migrants in particular since family disruption is one of the consequences of migration for most migrants. Shared values regarding, for example, filial obligation are not therefore always a given when dealing with migrant families. The fact that expectations regarding family solidarity are culturally determined but can be challenged by migration (see Torres 2001b, 2002) also means that older migrants whose families are dispersed across national borders can face considerable difficulties in maintaining intergenerational relations.[4]

The work of migration researcher Baldassar (2007) must be mentioned here. She has studied three cohorts of Italian Australian transnational families and shown that different migration histories and experiences lead to different intergenerational relation patterns. Moreover, her study suggests that distance and passage of time do not necessarily diminish the way in which care arrangements are made in migrant families. Similar findings have been found by Judith Treas who has studied how transnational older migrants in the United States regard their families' "filial failings" (Treas and Mazumbar 2002) as well as the ingenious ways in which they maintain intergenerational relationships across national borders (Treas 2008).

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[4] The study of older migrants' intergenerational relations is relatively underdeveloped at present. However, there are some European studies in this area, such as (besides the ones mentioned above): Katz and Lowenstein (1999) and Cylwik (2002) whose samples were constituted primarily of EILM; de Valk and Schans (2008) whose sample was constituted of people that belong to all four groups in Warnes et al. (2004) typology (i.e., EILM, NEILM, FIRM, and AIRM) and Zechner (2008) whose sample was exclusively constituted of EILM. Few studies on AIRM seem to have focused on intergenerational relations per se (O'Reilly's (2000) study seems to be the exception).

Zechner's study (2008) is also of interest here. She explores the very impact that migration and transnationalism have on how care to older people is provided in migrant families and shows that migrants need to navigate differing cultures of care and societal policies if they are to succeed in providing care to their older relatives. It is on the basis of all of these studies that one could argue that the specifics of the migratory life course (both in general and with respect to those migrants whose lifestyles can be described as transnational) provide a profuse point of departure from which a variety of research questions about intergenerational solidarity can be formulated.[5]

The other research topic that could be brought to fore as far as transnationalism's challenges to gerontological research is the area of gerontological studies concerned with understandings of key concepts as quality of life, well-being, life satisfaction, and successful aging. These are all concepts that are highly value-laden and subjective and that are, as such, particularly prone to be impacted by the kind of uprooting and subsequent adaptation processes that international migration implies not to mention the kind of culture hybridity that characterizes transnational lifestyles. The fact that there is ongoing debate on some of these concepts suggests that insight into the actual values people uphold is needed if we are to further develop these areas of inquiry.[6] My own work on Iranian immigrants to Sweden has shown, for example, that cultural values can determine the way in which we think about successful aging (e.g., Torres 2003) and that migration to a culture that upholds different values than those in one's culture of origin can lead to the renegotiation of the meanings people attach to the construct of successful aging (e.g., Torres 2001a, b, 2004). The reason for this being that the being-in-between cultures that the process of migration brings about can sometimes lead to exposure to "foreign" ideas regarding what constitutes a good old age. A synthesis of ideas occurs, in some cases, which does not, in the end, resemble neither what is considered to be typical of one's culture of origin nor what is assumed to be characteristic of the host culture that has become one's own. The fact that transnational migrants are, by virtue of their lifestyle, simultaneously exposed to two (often different) cultures over long periods of time suggests therefore that their experiences and understandings of aging are a profuse source of information for gerontology. The work on immigrants that are not transnational suggests this. As does the work on retirement migration and transnationalism done by Gustafson (2001) who has shown that older retirement migrants adapt to their transnational lifestyles differently. According to him, some opt for what a "multilocal adaptation," which combines "advanced ideals of mobility, strong multiple place attachment with a focus on difference and a high degree of cultural adaptation"; others prefer a "translocal normality," which is characterized by "modest ideals of mobility, strong multiple place attachment with a focus on similarity and a low degree of cultural

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[5] In this respect, it must be mentioned that when discussing the impact of migration on intergenerational solidarity those that are left behind are also affected (cf. Coles 2001, King and Vullnetari 2006; Miltiades 2002 who have studied [in Turkey, Albania, and India, respectively] how elderly parents cope when their adult children migrate).

[6] See Halvorsund and Kalfors (2007) for insight into the debate on quality of life and Torres (1999, 2001b, 2003, 2006b) for insight into the debate on successful aging.

adaptation” while a third group exhibits a transnational lifestyle pattern, which he calls “routinized sojourning” and which is characterized by “little or no multiple place attachment” (Gustafson 2001, p. 390). All of this also generates the question of how these different transnational lifestyles may affect the understandings of old age that older transmigrants uphold as well as the strategies for aging that they employ.

Last but not least with regard to transnationalism’s impact on gerontological research, it must be mentioned that studies on civic engagement are beginning to show that older migrants involved in transnational social fields are playing important roles, which could have an array of positive implications for their identity-maintenance practices. This seems therefore also to be an area, which should be explored as a transnationally aware research agenda for gerontology is delineated. As is the issue of agency in old age, which Wray’s (2003) work has explored in the United Kingdom and Al-Sharmani (2006) has explored with respect to Somali women living in transnational households in Cairo. Both of these researchers’ work shows that although transnational lifestyles and the communities that these establish can be challenging, they can also offer numerous opportunities for empowerment for older people. Transnational lifestyles seem to, in other words, sometimes lead to propitious conditions for a good old age and therefore need to be addressed as an interesting source of information about productivity in old age.

Transnationalism: What Are Some of the Challenges That This Trend Poses to Gerontological Policy?

In respect to the implications that transnationalism could have on gerontological policy, it seems appropriate to mention the different studies on older migrants that are becoming available across Europe, which show that policy gaps and service deficiencies are widespread and that these are creating income deprivation, social exclusion, and unmet social support and health care needs for some older migrants. Ackers and Dwyer’s (2002) groundbreaking study on the implications of retirement migration for senior citizenship and the latter’s work (e.g., Dwyer 2000, 2001) on retirement migrants’ welfare and health care rights must be mentioned here since their work suggests that older retirement migrants across Europe face numerous difficulties as they “fall through support gaps” (cf. Hardill et al. 2005). Ackers and Dwyer’s (2002) work also shows how older migrants’ attempts to handle these difficulties has lead to the development of different strategies in order to access the health and social welfare systems in both the countries they have left behind and the countries to which these older retirement migrants move. Although their work does not explicitly address the implications that transnational lifestyles per se have for senior citizenship, it does implicitly suggest that social citizenship rights need to be formulated irrespective of where mobility practices may take us. Transnationalism has, in short, numerous implications for the political economy of care (cf. Phillipson 2002) and the health and social welfare policy that are formulated to cater to older people’s needs.

Besides the implications that transnational lifestyles have on older people's access to health and social care, it seems appropriate to mention that transnationalism impacts social policy at a more general level. Transnationalism questions namely the idea that policy can be formulated when only national borders are taken into consideration.[7] The opposite is also true, of course, since social policy can determine the future of transnational communities (Faist 2000b). One specific policy angle, which has received some attention as far as transnationalism is concerned, is immigration laws (see, e.g., Acker and Dwyer 2002; Lunt 2009; Treas 2008) since they dictate, among others, the conditions under which family reunification can take place across national borders. Kofman (2004) has reviewed European studies on family-related migration and argues quite convincingly that "when we speak of family migration in the European Union context, we mean the nuclear family as defined by the state (and that) migrants cannot (in fact) determine for themselves the persons that constitute their family" (Kofman 2004, p. 245). It is, among others, for this reason that older transmigrants and their families tend to be creative in the way in which they utilize immigration laws to their advantage. With respect to this—and on the basis of older transmigrants in the United States—Judith Treas (2008) has examined how the transnational caregiving loyalties of older migrants match (or rather do not match) the visa categories that regulate who migrates to the United States for family reunification purposes. Through interviews with 54 transnational older migrants, she was able to question how little bearing American immigration categories actually had on the transnational lifestyles of these older people. In this respect, she writes:

> Virtually all informants fell into one of the three immigration categories—temporary visitors, permanent U.S. residents, or naturalized U.S. citizens. The narratives of older adults, however, revealed several incongruous types. There were 'permanent' visitors, permanent residents who were not permanent, and U.S. citizens who naturalized to maintain ties to another country. Given existing immigration law, older adults worked out strategies to reconcile their desire to be close to their U.S.-based children with their affection for their homeland and family members left behind. Their strategies bore little resemblance to the tidy immigration categories and stated requirements of U.S. law (Treas 2008, p. 472).

Similar findings have been found in Europe by Ackers and Dwyer (2002) who have shown the creative ways in which older migrants move across Europe and use immigration laws and pension regulations to their advantage as they navigate health and social care systems. Of interest here is the issue of pension portability; an issue of great importance for older migrants in general as well as for older transmigrants in particular (cf. Dwyer 2000, 2001). Related to this is Lunt's (2009) argument that the organization of most national social security schemes is not adapted to the transnational lifestyles that some older people live these days. With respect to this as well as other challenges related with transnational lifestyles, he poses also that in order to create policy that is adequate for transnational families, we need to move beyond migration statistics that are geographically contained on the basis of national states.

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[7] Here, it seems appropriate to draw attention to the special issue on transnational social policy published in 2005 by *Social Policy and Society* in Vol. 4, No. 4.

The same argument is posed by Kofman (2004) who also argues for the need to formulate policy responses that are sensitive to transmigrants' lives.

Another angle of importance to a discussion on transnationalism's implications for gerontological policy making is the one provided by Ackers and Dwyer (2002) who have shown that income inequalities in old age can be exasperated when social policies do not recognize that transnational lifestyles are a given for some older migrants. With regard to the latter, Lunt (2009) argues that:

> most national pension schemes were not designed with mobility in mind; portability is a major issue for transnational retirees and, with increased population exchange and lengthening life spans, is likely to become ever more pressing. If the issue is viewed from the perspective of someone choosing to retire overseas, then *where* they choose to retire can have a major bearing on their pension entitlement (Lunt 2009, p. 247).

The transnational lifestyle of some older migrants' poses, in other words, challenges for gerontological policy and suggests that the formulation of old-age policy needs to become transnationalism-aware.

Transnationalism: What Are Some of the Challenges That This Trend Poses to Gerontological Practice?

Last but not least and in relation to gerontological practice, it seems necessary to mention that European research on older migrants has shown that there is a widespread need and indeed obligation to develop culturally sensitive and responsive services, but the spread of such services is slow. Hence, as I mentioned in the introduction, ERA-AGE NET's decision to specifically address the needs of older migrants in one of their forums. With respect to the culture sensitiveness of services created for older migrants, it seems necessary to point out that the "hybridity of culture" that characterizes their lives poses in and by itself a challenge since it is difficult to know which culture exactly one should refer to when addressing their needs. The capacity of practitioners to provide adequate guidance on the prevalent problems and unmet needs of older transmigrants requires that they understand the peculiarities associated with the transnational lifestyle. The development of feasible and effective services for this group of older people is also a challenge since they are most likely not that many of them in one place to be able to prioritize their needs over the needs of other groups of older people. Many studies report, for example, not only the absence of interpreter services in health and welfare agencies and facilities, but also the unsympathetic reactions of "front-line" staff, a consequence of lack of training and employers' failure to raise practitioners' awareness of the issues at stake. With respect to gerontological social work practice in particular, it has been argued elsewhere, for example, (see Forssell and Torres 2012) that the migratory life course poses particular challenges to the need assessment process (also called case/care management in elderly care). Emilia Forssell (2012) has also studied how care managers in elderly care handle transmigrants' requests for need assessment and how challenging it can be to provide and monitor the services that such older migrants are granted.

With respect to the role that older transmigrants play in immigrant families, Treas (2008) writes:

> Older adults are seldom family decision makers, but prevention and intervention efforts that fail to engage grandparents run the risk of missing key players. Unless they are sensitized to the roles of older adults in immigrant families, family practitioners may underestimate their importance (ibid: 476)/. . . / Just as the ethnic diversity of the immigrant population demand culture sensitivity, diverse legal circumstances also call for special attention (Treas 2008, p. 477).

What Treas is alluding to here is the need to increase gerontological practitioners' awareness of the numerous challenges with which a transnational lifestyle in old age are associated. Related to this is Lunt's (2009) argument that a better understanding of how transnational lifestyles shape older people's welfare is needed if we are to formulate social policy that can be sensitive to their needs. In this respect, he argues that some of the policy responses we need to respond to these older people's needs must be:

> . . . addressed at the national level (e.g. caregiving), many of which will require cross-national agreement (e.g. immigration, pensions), with perhaps others requiring the attention of institutions of global governance (Lunt 2009, p. 249).

The types of potential care inequalities that affect older migrants in general and older transmigrants in particular require, in other words, major initiatives within receiving countries, especially in relation to the organization of social security and related services. However, crucial issues must also be considered in relation to problems affecting resource issues between poorer and richer nations as these relate to health and social care provision. Considering that transnationalism challenges how we conduct research and formulate policy about aging and old age, it seems natural to assume that gerontological practice must also reckon with the potential implications that this phenomenon could have in the future.

Transnationalism and the Study of Aging and Old Age: Setting a New Agenda for the European Gerontological Imagination

This chapter aimed to show that the relatively new trend of international migration, which is called transnationalism, is a societal trend that social gerontologists must reckon with. As stated in the introduction, transnationalism challenges not only how we have tended to conceive migration movements and their implications to both national and international policy making but also how we approach the study of migrants and the practices and policies that are designed to cater to their needs. Transnationalism also challenges the formulation of immigrant policies and the very ways most countries have used to address (and cope) with culture diversity. In addition, this chapter has argued that transnationalism affects the way in which we study culture, migration, and the so-called periphery (cf. Torres 2006a) and poses an array of challenges to gerontological research, policy, and practice. In this respect, it seems worthy of mention that some migration researchers recognize old age as an interesting point of departure for studies on transnationalism even though the majority of the literature on transnationalism is old-age oblivious. Gustafson (2001) has, for example, argued that:

> . . . studies of older persons may contribute to the understanding of transnationalism and globalization/. . . / Further investigation of retirement migration and other forms of later life mobility may therefore provide new knowledge, not only about aging and wellbeing, but also about globalization and transnationalism (Gustafson 2001, pp. 391–392).

In a similar manner, Treas (2008) poses that "because older immigrants feel the pull of past places, later life is a strategic time for the study of transnational processes" (Treas 2008, p. 469). Both of these researchers have, in other words, posed that a focus on older transmigrants is propitious for the study of transnationalism. As a social gerontologist, I am, in turn, arguing that the migratory life course in general offers a profuse source of information about how aging and old age is experienced and understood (e.g., Torres 2001b, 2004, 2006a, 2009) and that the same holds true for the specific lifestyle that is characterized as transnational. Transmigrants' lifestyles pose, in other words, an interesting focus for gerontological research, policy, and practice. Social gerontologists should therefore seize the numerous theoretical and empirically profuse opportunities that this phenomenon poses. A transnationalism -aware agenda for the study of aging and old age could namely expand our gerontological imagination.

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