Awareness of, and preparation for loss of independence at older ages among Dutch young older adults

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Abstract
At this moment in time, there are more people aged 65+ than ever before. This increase causes higher old age dependency ratios as the pressure on countries' welfare systems rises, which accounts for health, education and social security. To combat these issues, governments and organizations at both the national and international level have incorporated healthy ageing in their policies in order to decrease medical costs and alleviate the pressure on the working population. One of the countries experiencing these problems is the Netherlands where the Dutch monarch King Willem Alexander announced in 2013 that the nation should be moving from a welfare state towards a participation society where those in need should first seek informal medical care within their own social network before reaching out to the government. Some scholars and journalists are concerned that this approach will cause growing income disparities in the future as not everybody can fend for themselves or find care within their social network. A research commissioned by the Dutch newspaper Trouw has shown that among Dutch people aged 55-75, there are already large differences in financial preparation for retirement. Moreover, many of them mentioned they want to go to nursery homes while this is an area of economic cuts. To gain more insight in awareness of and preparation for decreasing independence when people reach old age (~75+), more in depth research had to be conducted to understand why Dutch young elderly people are as aware and prepared for this period of their lives. It appears that not only health, social capital and mobility are important to understand why people postpone thinking about loss of independence, but that identity, emotion and life experiences are just as important. Therefore, the conceptual model for researching this subject should include these concepts as well to gain a better understanding in why people are aware of their future or not and why people are preparing or not preparing for loss of independence. Further recommendations include more research on the subject, conducting more in-depth interviews and applying the new conceptual model to further research.

Contents

Introduction

Background

Although we associate people aged 65 plus to be of old age, the end of our life expectancy is not yet in sight (Oeppen & Vaupel, 2002) and the number of years spent in retirement is increasing as a result of the increase of quality of medical care around the world. This means a growing share of people aged over 60 in the world, doubling in 2040 to two billion (WHO, 2018). Thus, pressure on welfare systems is rising globally which led to many policy areas as well as research areas adopting the concept of healthy ageing. This concept entails strategies to prolong the life of people in a healthy, active and productive way, and has gained popularity as a topic within the social sciences as well as within policy making for a while now, partly to combat growing medical expenditures on the elderly population of the world. For instance, on September 17, 2013, the Dutch monarch King Willem Alexander held the yearly speech of the throne in 2013, written up by the prime minister and approved by the council of ministers. In this speech the so-called participation society was envisioned, one where people should become less dependent on the state and rely more on informal care. The speech encountered a lot of criticism from informal caregivers (in Dutch called '*mantelzorgers'*) which are people carrying out unpaid, long-term care for old and sick relatives and friends. Informal refers to care not received from the government in hospitals and nursery homes which would be called formal care in this case; traditionally offered to all Dutch citizens in the context of the welfare state. Although local governments aid these caregivers by essentially seeking replacement for them every now and then, the number of caregivers is already declining over time whereas the number of elderly persons needing care does the opposite, leading to increasing pressure. Moreover, many of the informal caregivers are already aged 50-75 and thus need informal care in the future for which the support base is gradually narrowing (Rusman & Van de Wiel, 2018). Others argued that the new participation society meant the reintroduction of a class society where everybody would be dependent on their own income or the income of their families which would lead to growing income disparities in the Netherlands (Pauw, 2013). In short, the welfare society with which the Dutch grew up is not as evident anymore as it once was, and in the new participation society people have to become more dependent on themselves and their social network.

However, a new study on retirement preparation assumes that people do not think about and prepare for losing their independence in terms of health. In August 2019 I&O Research, a societal research agency commissioned by a Dutch newspaper *Trouw*, published a report about how Dutch people aged 55-75 (called young elderly persons by Trouw; 'young elderly persons') prepare for when time comes of higher dependence on others. This is the age range associated with the 'third phase of life' which would be the phase of life between adulthood and 'real' old age containing about twenty remaining years of good health (Timmer & Kanne, 2019). The aim of the research was to find out through a survey the wishes, expectations and experiences of young elderly persons with regard to this third phase of life. Interesting is that, although retirement with its opportunities and challenges has crossed the mind of many and the Dutch welfare state has come under some stress already for some years, most have not taken concrete measures yet such as restructuring their homes or moving to a more suitable living place fitting their physical wellbeing. Arranging for informal care in the future was also pointed out as an issue as many did not want people from their social network – their relatives and friends – to look after them when they became more dependent. Some even thought of ending their lives when losing their independence after retiring as they could not bear the idea of others

caring for them when being in such a reliant and vulnerable state (Timmer & Kanne, 2019). While at the macro level of society we deal with broad problems such as rising healthcare expenditures and threats to the economy, we see at the micro level the importance of preparation for the time of gradually losing independence after retiring.

Research problem

With the ageing of the Dutch population, the number of potential informal care givers will drop from 15 as of now to 6 in 2014 (Timmer & Kanne, 2019). With the loss of independence people of old age often start to experience feelings of loneliness which is then again linked to negative health consequences such as smoking, alcohol consumption, feelings of depression, and higher risks of cardiovascular diseases and strokes (Hakulinen et al., 2018). Older persons will be impacted even more after their social network shrinks due to deaths of relatives and friends, and/or the loss of physical health and mobility with age[1]. Postponing these unfavorable developments is addressed in the article from Trouw where participants of the survey were asked how they will stay active and healthy when they retire and, ultimately, become dependent on others. Although many young elderly persons rate their health 'good' to 'very good' and mention staying active through, for example, cycling, walking and gardening, the article concludes that many have not though well enough about their future as four out of ten would be content with staying in a nursery home if they could not live by themselves anymore, even though this is a form of formal care that is slowly disappearing over time in the Netherlands (Timmer & Kanne, 2019).

It is important to gain insight in the strategies and motivations of young elderly persons relating to their retirement preparations. These insights can show what their strategies are to stay as healthy as possible for as long as possible, how prepared they are for retirement and why they prepared the way they did – or not. The report by Trouw is largely a quantitative collection of data and analysis of the results of a large-scale survey of almost 1200 people in the Netherlands and does not provide enough insight in the motivations of the answers of the participants. In-depth interviews with young elderly persons in a smaller geographical area may add to this research as it will view the problem from the perspective of the young elderly persons themselves. My choice here is the Northern Netherlands and its immediate surroundings as this is my hometown and I have already some connections there. Snowballing from my gatekeepers, which would be my immediate family, will deliver enough participants for my research. My question therefore is: in how far is the Northern Dutch young elderly population aware of and prepared for loss of independence at older ages?

Structure

To answer my research question, a theoretical framework has to be set up consisting of existing research about the topic. Concepts and theory are described here as concisely and unambiguously as possible and visualized in a early-stage conceptual model. This model functions as a framework and anchor in answering the research question as the concepts that are chosen should explain the state of awareness and preparation of the Northern Dutch young elderly population.

[1] Mobility is generally defined as the ability to move oneself through ones environment. However, a broader definition here is more suitable because of the inclusion of social and psychological spaces next to physical spaces. Therefore, Ziegler and Schwanen's definition is applied in this research: mobility is "the overcoming of any type of distance between a here and a there, which can be situated in physical, electronic, social, psychological or other kinds of space (Ziegler & Schwanen, 2011; p.758).

The methodology section describes the preparation for the in-depth interviews and contains information on participant gathering, operationalization of concepts, questions in the interview guide, ethical considerations, and the collection and handling of data.

Theoretical framework

The report by Trouw showed that many young elderly persons are already aware that they should live in a healthy and active way to continue being healthy in the future for as long as possible. It appeared that these people consider themselves fairly happy and healthy, and of them want to live home as long as possible, do not want their children to become their caregivers and want to participate in society in some way. However, many do not worry (enough) about becoming less independent or about possibility of getting sick. Moreover, few preparations are considered and/or made to make their living spaces more suitable for the lack of mobility in the future in a physical, mental, social, or any other way (Timmer & Kanne, 2019; Ziegler & Schwanen, 2011, p.758). It is stated that although 91 percent of the respondents prefers to live at home as long as possible, 70 percent is not prepared at all (Timmer & Kanne, 2019). Moreover, many do not know what to do with their time when they retire. A study on motivations of early retirement and their consequences showed that people can start feeling disconnected from society and have no or few plans after they retire (Jones et al., 2010). Even though Trouw mentioned the health-gap between lowly and highly educated people and the article by Jones et al. studied solely highly educated and employed people, we still equally see signs of loneliness and ignorance about physical health (Jones et al., 2010). Thus, the importance of social capital must be stressed as no or a small social circle can be harmful to healthy ageing in two ways: next to loneliness being a factor which literally shortens the lifespan of an individual, social capital can arrange for informal care and assistance in the future (Cannuscio, 2003). Pierre Bourdieu argued in his article *The Forms of Capital* (1986) that social capital entails the maintenance of a social network and the quality and quantity of the resources available to keep maintaining this network (Bourdieu, 1986). Robert D. Putnam build on these assumptions in his work *Bowling Alone: Declining Social Capital* (1995), where he mentioned that social capital is dwindling in America which accelerates individualization and causes loneliness, destruction of communities and additionally the sense of purpose in society (Putnam, 1995).

We now get a web of concepts where healthy ageing is linked to mobility and social capital. Since people overall feel healthy at ages 55-75, as pointed out by Trouw, perceptions of mobility and social capital are very important for when and how young elderly persons prepare for their retirement (Timmer & Kanne, 2019). It must be stressed that these concepts will not be literally mentioned during in-depth interviews.

Conceptual model

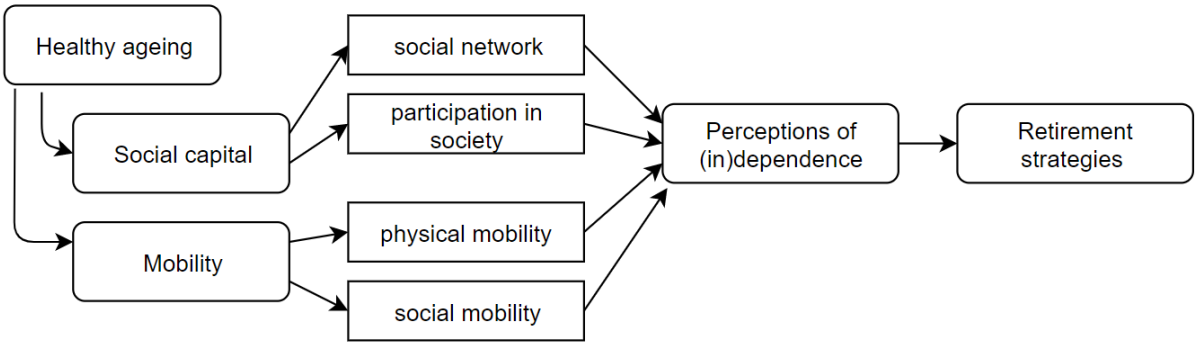

Figure 1: First conceptual model

Healthy ageing in this case deals with the maintenance of social capital and mobility. For social capital in particular, social networks are important and the reciprocity and trust[2] which underpin these networks. Mobility mostly refers to physical mobility as well as social mobility. The latter form suggests how socially active one is and can be about their health and wellbeing. These determinants all have influence on how people perceive their independence which flows from the theoretical framework. The perceptions people have about their health, which in this instance relates to mobility and social capital, determine their strategies which might be non-existent or very much initiated already.

Methodology

Preparation for data collection

To investigate this topic with a qualitative approach, in-depth interviews will be taken of people aged 55-70 as people in this age group are either nearing retirement or have retired already for a short period of time. To research how prepared for, and aware of, they are of the loss of independence at older ages, the concepts in the theoretical framework are operationalized into questions and incorporated into an interview guide (Appendix 2). To find participants, the snowballing method will be used with my own family as a starting point. As my parents fit this age, they function as gatekeepers and give the opportunity to conduct pilot interviews to check whether the interview guide contains the correct questions and to test the length of the interviews. The idea of the questions is to get a sense how the participants perceive their own physical, mental and social health and in what ways they prepare for and are aware of the loss of independence at older ages. Questions about Dutch policies on healthcare and social participation are to check whether they are aware of the problems spoken about in the introduction such as expensive health care, shortages of informal health care workers, and

[2] Reciprocity: a social construct referring to answering positive actions with other positive actions which leads to rewarding positive behavior. This adds to a positive relation between two actors.
Trust: a social construct referring to the belief in the benevolence and competence of another actor. With regard to social capital, trust is important as it builds a relationship between two actors.

loneliness among the elderly population. Perhaps some connections can be made between their opinion or awareness of governmental policies and their own desires, needs and expectations.

The participants are not chosen at random which means I will conduct nonprobability sampling in my research. It is difficult to note what number of participants would be enough. Therefore, I will continue interviewing until my information begins to saturate and new participants are not needed anymore (Bernard, 2006), or when the timeframe does not allow more interviews.

Ethical considerations

With ethical considerations in mind, the recorded and informed consent of the participants should always be requested when doing in-depth interviews. Interview locations will be held where the participant feels most comfortable and data will be stored anonymously and transparently with agreeance of the participants. I have to be aware of the perspective I employ as a social geography student which could pull my train of thought towards policy-based ideas on how to gain information on the issue of inadequate retirement preparation. Moreover, I need to be aware of the position I take in the interviews and treat and observe all interviewees as equals. Gaining information on retirement plans and on the health and wellbeing of people can be sensitive in some cases. Besides, conducting a research on retirement preparation suggests people being old or becoming old which might make people feel uneasy. Questioning must be done in a considerate way and with consideration for the participants' privacy and feelings if necessary. To get an idea which questions are important and personal, a pilot study with immediate family is helpful.

After interviewing the data is transcribed verbatim and coded with mixed coding techniques. As many people in and around Friesland speak the Frisian language, it is considered to take the interviews in Frisian which are then transcribed directly into English. It is important to note emotions, hesitations to speak, and specific interpretations and perceptions of health, mobility, social capital and retirement. This will be done when transcribing verbatim the interviews as taking fieldnotes on the emotions of participants could distract them. After coding, they can be categorized to find certain themes in the responses of the participants (Saldaña, 2009).

Setting up interviews

Two pilot interviews were held before conducting the rest using the interview guide in Appendix 2. After these, the conceptual model was revised with health as a third concept next to mobility and social capital. Perceptions of health proved to be important as well next to the existing concepts as these perceptions seem to influence participants' strategies for maintaining and prolonging independence later in life. The interview guide was also revised as some questions were not clear enough or did not provide useful answers.

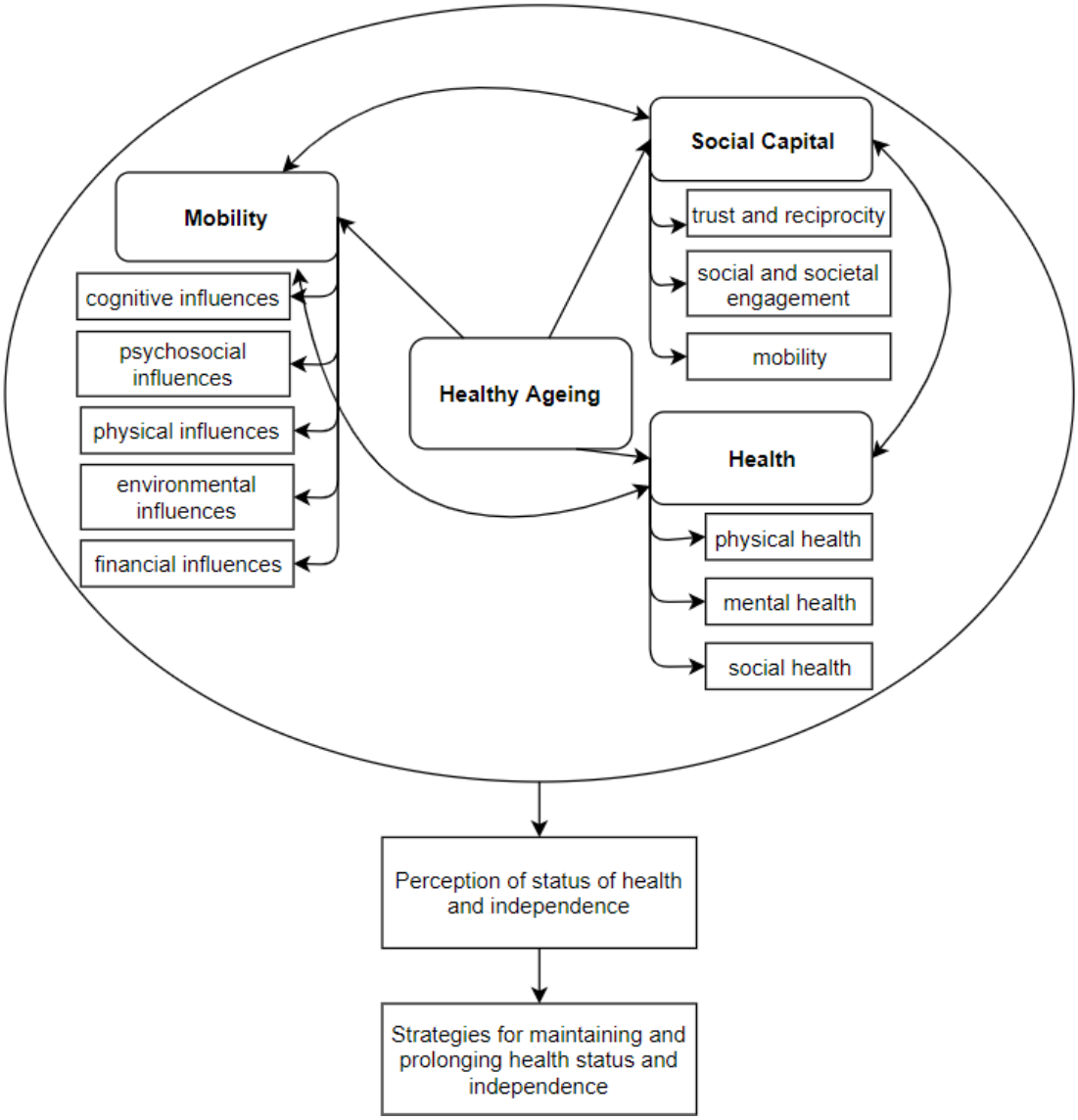

Figure 2: Second, adjusted conceptual model

Conducting interviews

In total, sixteen in-depth interviews have been conducted using the revised interview guide in Appendix 3. Additionally, each participant, apart from their consent (form in Appendix 4), was asked for their age, education and profession or occupation. Information about profession was reduced to job categories to maintain anonymity. Findings participants proved to be more difficult than originally thought. Therefore, some participants have ages above or below the range of 55-70. Additionally, after conducting the interviews, the information on education and profession did not appear to be very useful for this analysis as the research's aim is not to connect awareness of and preparation for decreasing independence at later life with completed education. Even though connections could of course be made, the information is not of value for this research and thus not considered for data analysis. The participants' information is displayed in the table below (table1):

Participant no.	Age	Gender	Retired
1	55	Female	No
2	52	Female	No
3	62	Female	No
4	55	Female	No
5	55	Female	No
6	59	Female	No
7	59	Female	No
8	71	Male	Yes
9	63	Male	No
10	62	Female	No
11	66	Female	No
12	70	Male	No
13	68	Male	Yes
14	71	Male	Yes
15	66	Male	No
16	64	Female	No

Table 1: Participants

The interviews were conducted within two months and had a timespan of 12:34 to 1:10:49 with an average of 31:52 per interview. Unfortunately, a mistake was made during the first interview as the recording paused and split into two separate audio files of which the second one was accidentally deleted. Therefore, only half of that interview was available for data analysis.

Of the participants, ten were female and six were male. Most participants have had higher vocational education or higher and many of them work in health care. The mean age was 62.4 years. For males, the mean age is 68.2 while for females this is 58.9 which is substantially lower. Besides that, not one female participant was already retired, while two thirds of the male participants were in fact. These facts have led to the decision of removing some participants from the data analysis which were participants 2 (female, 52), 12 (male, 70) and 14 (male, 71). Even though participant 8 (male, 71) was essentially outside the age range of 55-70, his interview turned out to be inspiring for this research as it showed some strong suggestions that identity determined many of the aspects considered in the conceptual model. Therefore, his interview is still used for data analysis. These changes lead to the following and final list of participants:

Participant no.	Age	Gender	Retired
1	55	Female	No
2	62	Female	No
3	55	Female	No
4	55	Female	No
5	59	Female	No
6	59	Female	No
7	63	Male	No
8	62	Female	No
9	66	Female	No
10	68	Male	Yes
11	66	Male	No
12	64	Female	No
(13)	71	Male	Yes

Table 2: Revised list of participants

It is important to note here that the participants numbers have changed. This does not have consequences for the data analysis, but it should be kept in mind. In the new list of participants, four are male while 9 are female. The average age is now 61.9; 59.7 for females and 67 for males. Two participants are retired. The average duration of the interviews was 33:31. All the interviews were transcribed verbatim.

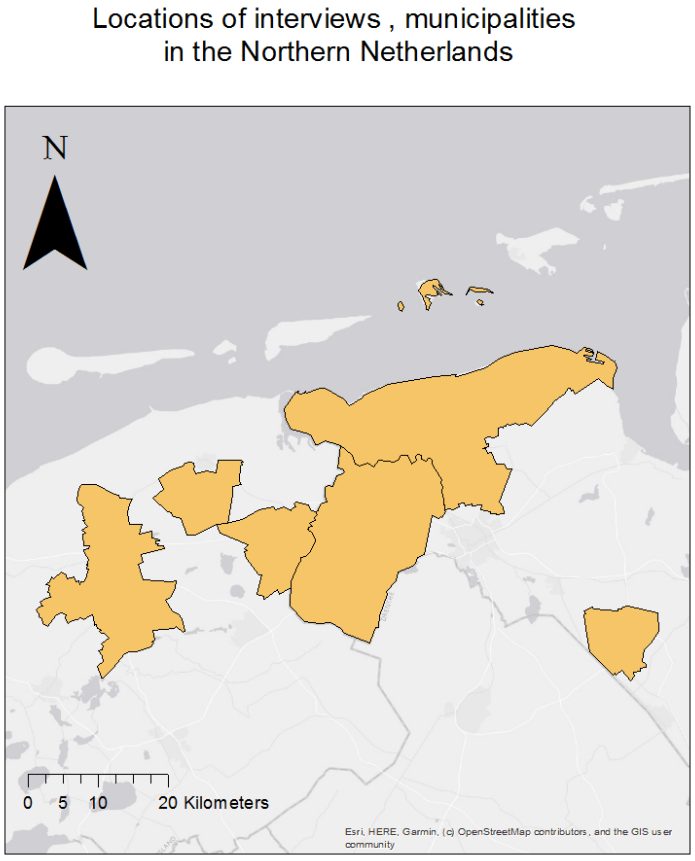

Figure 3: GIS map of locations of interviews

Coding

After transcribing the interviews, they were subsequently coded using mixed coding techniques using the *Coding Manual for Qualitative Researchers* by Saldaña (Saldaña, 2009). The coding was done inductively: fragments relating to the concepts were coded, but also fragments relating to emotions, feelings, experiences and desires as these could influence how they perceive their health, social life and mobility, or influence their strategies of maintaining independence. These could lead to *in vivo* codes that could turn into important and relevant themes which could aid in answering the research question of this thesis (Bernard, 2006). The codes were subsequently put into code groups and categories, eventually leading to a set of themes. The result of the coding is a code tree (Appendix 5) which gives an overview of how the code groups, categories and themes/concepts are connected and/or influenced by one another.

Results

After coding, some important themes came up in explaining the state of awareness and preparation of the participants. Next to the existing concepts, which are health, social capital and mobility under the umbrella of healthy ageing, it appeared that identity, emotion and life experience were important themes or concepts that impacted how and why the participants prepared for loss of independence in later life. The initial concepts proved to already intertwined and the new themes have created an even more elaborate and complex framework with which to look at this topic.

Concerning health status, most of the participants perceived their own health as good. To stay healthy, almost all state that they exercise and try to eat well. Some mentioned illnesses and complaints such as diabetes, arthrosis, hip problems and overall fatigue. One participant (female, 55) mentions that she is afraid of becoming dependent because of her diabetes as many in her family passed away already. These impede their health and or mobility, or have influence on their social life, but not greatly. What stands out is that almost none of the participants mention they try to live healthy in order to maintain independence. Moreover, none apart from one has made an effort to ameliorate their complaints such as fixing hip problems or arthrosis. One participant (female, 59) mentions she has overall fatigue and went to several specialists to decrease the pain and move around more freely and carefree. Another participant (female, 59) mentions she does not really look into the future since she compares herself to some old and healthy family members:

“I’ve got two very old uncles, the oldest one has passed away a few years ago, and they are both in their late eighties and live in their own home with an upstairs bedroom, they manage their own garden. So yes, I thought by myself: “I can do that too”.”

Some participants mentioned they have regular health checks because of earlier problems with kidneys, the heart and the liver. One participant found this confronting and said she did not need the health checkups (female, 55). She mentioned I was confronting since, as she thought, it was mainly to prolong the lives of people whereas she had the lifestyle of caring more about the quality of life than the quantity:

"I don't have to become 100 years old. (…) If I look around me and watch, the experience I have with people over 80 does not make me happy. I don't want that. I don't want to be dependent on someone, and be lonely all day. I want to enjoy life now, not in order to become 100 years old to constantly check everything."

Most also perceive their mobility as good. Some admit that they have some arthrosis or hip problems which sometimes impede their mobility, but most are mobile on all levels, meaning essentially from the living room to the other side of the world. Mobility seems closely related to health as the latter often causes the former: hip problems cause limited mobility. Sometimes a strong identity or personality can cause mobility. One participant (male, 71) mentions that he consciously does not apply for a drivers' license and does not drive a car as it is bad for the environment. He realizes that this is a limitation but mentions he does not miss it either.

Concerning social contact, most participants mention that their social life is healthy. Some explicitly mention that they maintain social contact to remain connected to the world. This in turn implies a fear of social isolation or loneliness. Other participants make clear that a partner in life can greatly alter your decisions or look at life. For example:

"But I think that if we reach that age, together, we will work it out. Because it is just an unwavering faith that we have. And it does not matter what others thin of it. We will work it out, together." (female, 66).

Another example would be of a man who lost his wife to cancer a few years ago:

"And then you think husband and wife, growing old together, well nice. But it did not work out that way, it went otherwise. And that is regrettable." (male, 63).

A partner in life proves to be a large contributor to having a goal in life and to not feeling alone. As the latter participant mentions, he had plans for him and his wife to grow old together and suddenly this goal falls apart which has caused depression.

Besides growing old together, a partner could also perform informal care. One participant sees this as self-evident (female, 64). Thus, there is a great difference between living with and without a partner.

One participant (female, 66) stated that she did not necessarily need social contact as this was just who she was:

"And we also have it very nice together. I think that that is one of the reasons why it is easier to say together instead of going out all the time. We both are not, not my husband, not me, we are both not very social in those things."

This identity becomes more and more evident in the interviews. For example, it is the reason one participant (male, 68) would not want to do voluntary work:

"No, I dont want that, I dont need that. If someone calls for help I help, but it is not the case that I say I have to visit everywhere. I am not like that."

Another participant (male, 71) responds to the question why he maintains social contact and health in his particular way with that it is his identity, his Christian vision on life, that guides him through life:

"Well, for me it is the reason of my identity, from a Christian point of view, or a humanist one, but is has to do with being part of society. You get things from society and I think it is your duty to do something back for society. That is the reciprocity I think."

His own particular identity is so strong, that he does not change because of others' opinions and has structured his whole life in a particular way. He mentions he is vegan, runs every day, is still active in several organizations as chairman because of his own identity. Moreover, he states he does not want to look into the future as it would make no sense. You live in the moment, as he says, since you cannot look into the future: *"I am also not busy with the fact that I could come to die tomorrow and I would have to make a planning for that and etc, etc, etc. No, I am not occupied with that, I live in the now."*

Identity is also a factor in the choices that participants make when asked if they would accept informal care by their friends or family. Some do not want to as they think their children have their own lives. Many agree that it would be hard to facilitate as children can move far away or have busy jobs. Some mention that it would be pleasant to have close family or friends taking care of you:

"My circle of friends, no, i dot think there is someone suitable. But i dont know, i just think that if you stand really close to a person it can be nice. (…) From your own environment, from your own circle." (female, 62)

Others want to remain independent and state they feel like they would be a burden to others:

"Not just that I do not want to burden them, because that is towards them, but also for myself that I do not want it. I don't know, (…) no, they have to think about us, but no 'mantelzorg'." (female, 66).

Opinions differ greatly on this subject which could be explained by their own identity and life experiences as many give examples of their parents refusing informal care.

When asked about preparation for retirement, many mention that they have thought about or prepared for financial security. Some have specific plans for their time after retiring, most of them do not. Some also mention that they are afraid of falling into a black hole, meaning they do not know what to do with their time after working for so long. To avoid this, they try to remain socially active and gradually quit working.

All participants wanted to stay at home for as long as possible instead of going to a nursery home. The comfort at home is mentioned a lot which essentially entails the independence to do whatever you want to do. The fear of the loss of independence really comes forward when asked about policy measures taken by the Dutch government. The fact that many old persons live at home, but are immobile, lonely or sick is an unpleasant image for all. Almost all have negative experiences with nursery homes where people get hospitalized quickly and argue that their independence is often taken away by nurses doing all the chores for them. Some examples:

"I think you just wither away and die in such a nursery home haha." (female, 55).

One participant (female, 59) mentions that her father recovered from a broken hip in a nursery home:

"He was one week there, and you just see that there is not much life over there. You know, everything gets done for you: they have to wait for this and for that and there is just no independency.".

The opinion that nursery homes are places to die is not shared by all participants. One participant (male, 68) was very positive about nursery homes and mentioned that he regrets it that the government is closing them all. He mentions that these homes have care at close distance and peers with which you can socially interact. Some also state that people can feel burdened to ask for help:

"Yes, and dont forget; some people find it hard to ask for help, and if you are solely dependent on 'thuiszorg', no, I would call for a return of nursery homes and elderly homes where care is near and people look after each other." (female, 62).

Shame could be a reason for this, but a generation gap between the current generation of young elderly persons and the Silent Generation is also mentioned by one participant who works in home care (*thuiszorg* in Dutch):

"I think that has to do with the generation of, well guys, we need to save our own hide, we need to maintain our household ourselves, that is our job and we don't need any help, huh, while we might ask for help easier." (female, 64).

Concerning measures for maintaining independence, almost nobody has done anything to adjust their homes. One person has created a larger showed, some have bought plastic window frames to reduce maintenance, but not with the future in mind. Suggestions, however, are abundant and include a downstairs bedroom, removal of door frames, moving to another home, outsourcing maintenance, installing a stairlift and living with their parents in a "*kangoeroewoning*" or "*aanleunwoning*" which essentially is supported housing for the elderly where two families live together and provide care and support.

With identity as a new theme and concept, we get the following adjusted conceptual model where identity directly influences the triangle of healthy ageing with mobility, social capital and health as concepts, and indirectly influences the participants' strategies proposed or taken for maintaining independence.

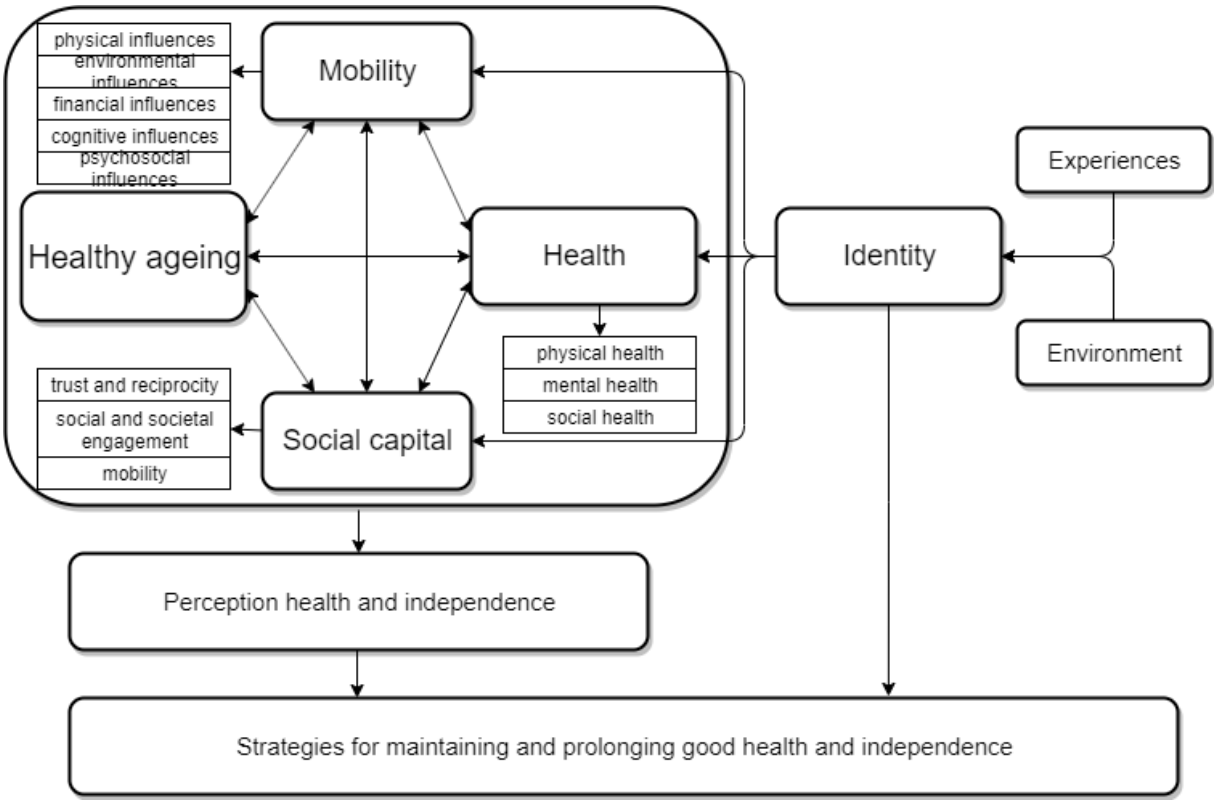

Figure 4: Adjusted conceptual model

Discussion

The perception of health does not seem to do very much with the preparation of people for the loss of independence. Of course, this is years away and people do not want to think about becoming ill or completely dependent on others. But concerning their age and the fact that budget cuts are made in elderly care more and more frequently, it should be more on the minds of people. Social interaction highly depends on the identity of people. Some don't need social interaction, while others are already afraid of losing this when retiring or when losing independence in the future. Identity may also lead to making some decisions or not making them. Many participants mentioned they life in the present and don't want to look into the future. This might be part of the identity of people but can also be because of ignorance. As people grow older and thinking about this subject is postponed more and more, it can cause problems for them in the future.

Speaking about governmental policies has given more answers than originally thought. The perception of health, social life and mobility are equally important than identity, emotion and life experience. The latter two shape the identity which influences the original concepts greatly as losing a loved-one or becoming ill has a great impact on people's lives and minds.

It seems that people are more creative with their strategies than the article by Trouw presents. Some have thought about living with their parents in a so-called 'aanleunwoning' which makes it easier for both the participant and their parents, or the participant and their children/child to care for each other. Some think it would be better to live together with people of similar ages

in an intermediate form between living at home and living in a nursery home. This way, people take care of each other and do not get lonely. Moreover, preparing for the future is more complicated than Trouw presents and therefore more research should be conducted to get a better representation of the Dutch young elderly population concerning preparation for loss of independence.

Conclusion

Not only health, social capital and mobility important to gain an understanding of how aware people are of a future of decreasing independence. Identity, emotions and life experiences shape how people deal with life and thus determine how they prepare for loss of independence in later life. People aged 55-70 should think more about their future, which is totally not the case. More research should be done to get a better representation of the Dutch young elderly population.

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Appendixes

Appendix 1

Information form shown before conducting the interviews.

ONDERZOEK NAAR VOORBEREIDING OP VERMINDERDE ONAFHANKELIJKHEID NA DE DERDE LEVENSFASE ONDER JONG OUDERE NEDERLANDERES

Geachte,

Het doel van mijn onderzoek is om inzicht te krijgen in hoeverre Nederlanders van 50-75 jaar oud zich voorbereiden op de tijd wanneer zij uiteindelijk afhankelijker worden van anderen. Hierbij moet worden gedacht aan de tijd dat onafhankelijkheid niet meer vanzelfsprekend is als gevolg van het ontstaan van lichamelijke en geestelijke gebreken. De voornaamste onderwerpen die aan bod komen zijn gezondheid, onafhankelijkheid, mobiliteit, het sociale netwerk, en het pensioen. Hiermee kan worden gekeken in hoeverre de doelgroep bewust is van, en voorbereid is op, hun tijd van verminderde onafhankelijkheid. Ook wordt onderzocht hoeveel men bezig is met de invulling van de derde levensfase welke vaak begint als mensen met pensioen gaan en veel vrije tijd hebben. NB: er zijn geen goede of foute antwoorden en alle antwoorden tellen als waardevolle informatie.

Het interview bestaat uit een aantal vragen waarbij informatie naar voren wordt gehaald over deze zaken. De antwoorden bevatten persoonlijke informatie en daarom moet worden benadrukt dat ik als interviewer vertrouwelijk omga met deze gegevens. Omdat het interview in opdracht van de Rijksuniversiteit Groningen wordt gehouden, zullen deze gegevens in haar database voor maximaal drie jaar worden bewaard om vervolgens vernietigd te worden. Deze informatie zal niet met derden worden gedeeld. Bovendien mag u het interview te allen tijde stopzetten op elk moment en bent u niet verplicht vragen of delen van vragen te beantwoorden.

Om te gaan beginnen heb ik eerst uw schriftelijke toestemming nodig om het interview te mogen afnemen en met een geluidsrecorder op te nemen. Indien u vragen heeft voor, tijdens of na het interview, stel ze gerust. Alvast bedankt voor uw tijd en medewerking.

Appendix 2

Interview guide used to conduct the pilot interviews.

Achtergrondinformatie en demografische data

1. Wilt u het interview liever afnemen in het Fries of in het Nederlands?
2. Wat is uw leeftijd?
3. Wat is uw beroep/bezetting?

Hoofdvragen

Met pensioen gaan

1. Bent u al met pensioen? Zo ja, hoe lang al?
2. Hoe heeft u deze verandering in uw leven ervaren?
3. Hoe beleeft u uw pensioen tot nu toe? (Als participant met pensioen is).

Gezondheid

1. Hoe gezond ziet u uzelf op dit moment?
2. Hoe ziet u uw gezondheid over tien jaar? En over twintig jaar? (Sociale kring: denk hierbij aan familie, vrienden, kennissen).
3. Wat doet u om fysiek gezond te blijven?
4. Bent u ook bang om fysiek minder zelfstandig te worden? Waarom?

Sociaal netwerk

1. Hoe belangrijk vindt u het contact met uw sociale kring?
2. Spreekt u vaak af met vrienden, kennissen of familie?
3. Hoe ziet u uw contact met uw sociale kring over tien jaar? En over twintig jaar?
4. Bent u ook bang om sociaal contact kwijt te raken wanneer uw minder zelfstandig wordt? Waarom?

Onafhankelijkheid

1. Zijn er op dit moment zaken die uw gezondheid beperken? Hoe belangrijk is dat voor u?
2. Heeft u aanpassingen gedaan in en om uw huis of overwogen te gaan verhuizen met de toekomst in gedachten? (M.b.t. onafhankelijkheid).
3. Zou u liever zo lang mogelijk thuis willen blijven wonen of liever naar een verzorgingstehuis willen gaan? Waarom?
4. Hoe ziet u de tijd voor zich wanneer u minder onafhankelijk wordt en dus meer afhankelijk van anderen?
5. Zouden mensen in uw sociale kring het goed vinden en tijd hebben om voor u te zorgen wanneer u afhankelijk bent van de zorg van anderen (mantelzorg, zorg door familie)?
6. Zou u het zelf goed vinden als mensen in uw sociale netwerk voor u gaan zorgen? Waarom?

Beleid ouderen gezondheidszorg (eventueel uitleg over verschuiving naar participatiesamenleving)

1. Wat vindt u ervan dat de overheid verwacht dat mensen, als ze ouder worden, worden gesteund door mensen uit hun sociale kring? Waarom?
2. Vindt u dit eigen verantwoordelijkheid of de verantwoordelijkheid van de overheid? Waarom?

Hartelijk bedankt voor uw deelname aan dit interview. Nogmaals wil ik benadrukken dat met deze informatie op een vertrouwelijke manier wordt omgegaan. Zijn er verder nog vragen die u heeft met betrekking tot dit interview of vragen met betrekking tot het onderzoek?

Appendix 3
Revised interview guide used for the interviews.

Om te gaan beginnen heb ik eerst uw schriftelijke toestemming nodig om het interview te mogen afnemen en met een geluidsrecorder op te nemen. Indien u vragen heeft voor, tijdens of na het interview, stel ze gerust. Alvast bedankt voor uw tijd en medewerking.

Achtergrondinformatie en demografische data

4. In welke taal wilt u het interview afnemen (standaard: Nederlands)?
5. Wat is uw leeftijd?
6. Wat is uw hoogst genoten opleiding?
7. Wat is uw beroep/bezetting?

Hoofdvragen

Gezondheid

5. Hoe gezond ziet u uzelf op dit moment?
6. Kunt u iets vertellen wat u doet om uw gezondheid op peil te houden?
7. Gezondheid omvat naast fysieke en mentale gezondheid sociale gezondheid. Bij sociale gezondheid kunt u denken aan het onderhouden van contacten met vrienden of familie en het ondernemen van sociale activiteiten zoals bij een sportvereniging of club zitten, maar ook maatschappelijke activiteiten zoals bij een politieke partij zitten, stemmen, of vrijwilligerswerk verrichten.
   Kunt u iets vertellen over deze vorm van gezondheid naast uw fysieke en mentale gezondheid?

Sociaal netwerk

5. Kunt u iets vertellen over uw sociale netwerk? (Omvang, cohesie, proactief)
6. Hoe belangrijk vindt u het contact met uw sociale kring? Waarom?
7. Hoe ziet u uw contact met uw sociale kring op latere leeftijd?
8. Hoe zou u het vinden als het sociaal contact minder wordt als u minder zelfstandig wordt?

Mobiliteit

1. Mobiliteit wordt gezien als het vermogen u te bewegen van één plek naar een ander op verschillende niveaus. Deze niveaus gaan van kleine schaal zoals uw woonkamer naar grotere schalen zoals de straat, de buurt, woonwijk, de stad en verder daarbuiten. Kunt u iets vertellen over hoe mobiel u zichzelf ziet?
2. Zijn er dingen die uw mobiliteit beperken of versterken? Denk aan eventuele fysieke beperkingen, uw omgeving, sociaal contact.

Onafhankelijkheid

7. Heeft u aanpassingen gedaan in en om uw huis of overwogen te gaan verhuizen met de toekomst in gedachten? (M.b.t. onafhankelijkheid). Kunt u daar iets over vertellen? Wat waren uw beweegredenen hiervoor?
8. Zou u liever zo lang mogelijk thuis willen blijven wonen of liever naar een verzorgingstehuis willen gaan? Waarom?

9. Zouden mensen in uw sociale kring het goed vinden en tijd hebben om voor u te zorgen wanneer u afhankelijk bent van de zorg van anderen (mantelzorg, zorg door familie)?
10. Zou u het zelf goed vinden als mensen in uw sociale netwerk voor u gaan zorgen? Waarom?

Pensioeninvulling

1. Met pensioen:
    - Hoe is de overgang gegaan van werken naar met pensioen gaan?
    - Op welke manieren had u over met pensioen gaan nagedacht?
    - Wat had u graag willen doen met uw vrije tijd tijdens uw pensioen?
    - Is met pensioen gaan gegaan zoals u verwacht had?
    - Wat voor invloeden had met pensioen gaan op uw gezondheid? En op uw sociale netwerk?
2. Niet met pensioen:
    - Op welke manieren hebt u over met pensioen gaan nagedacht?
    - Wat zou u graag willen doen met uw vrije tijd als u met pensioen gaat?
    - Wat voor invloeden zou met pensioen gaan hebben op uw gezondheid? En op uw sociale netwerk?

Beleid ouderen gezondheidszorg (eventueel uitleg over verschuiving naar participatiesamenleving)

3. Wat vindt u ervan dat de overheid verwacht dat mensen, als ze ouder worden, worden gesteund door mensen uit hun sociale kring? Waarom?
4. Vindt u dit eigen verantwoordelijkheid of de verantwoordelijkheid van de overheid? Waarom?

Hartelijk bedankt voor uw deelname aan dit interview. Nogmaals wil ik benadrukken dat met deze informatie op een vertrouwelijke manier wordt omgegaan. Zijn er verder nog vragen die u heeft met betrekking tot dit interview of vragen met betrekking tot het onderzoek?

Appendix 4

Consent form.

TOESTEMMINGSFORMULIER

Betreft: onderzoek naar voorbereiding op en bewustzijn van de periode van verminderende onafhankelijkheid op latere leeftijd

Hierbij geef ik toestemming om het interview te laten opnemen en te laten gebruiken voor wetenschappelijk onderzoek. Ik begrijp dat de informatie niet met derden wordt gedeeld en er op een vertrouwelijke manier wordt omgegaan met de informatie. Ik begrijp tevens dat de gegevens anoniem worden verwerkt en niet herleidbaar zijn tot de persoon.

Datum interview: _____

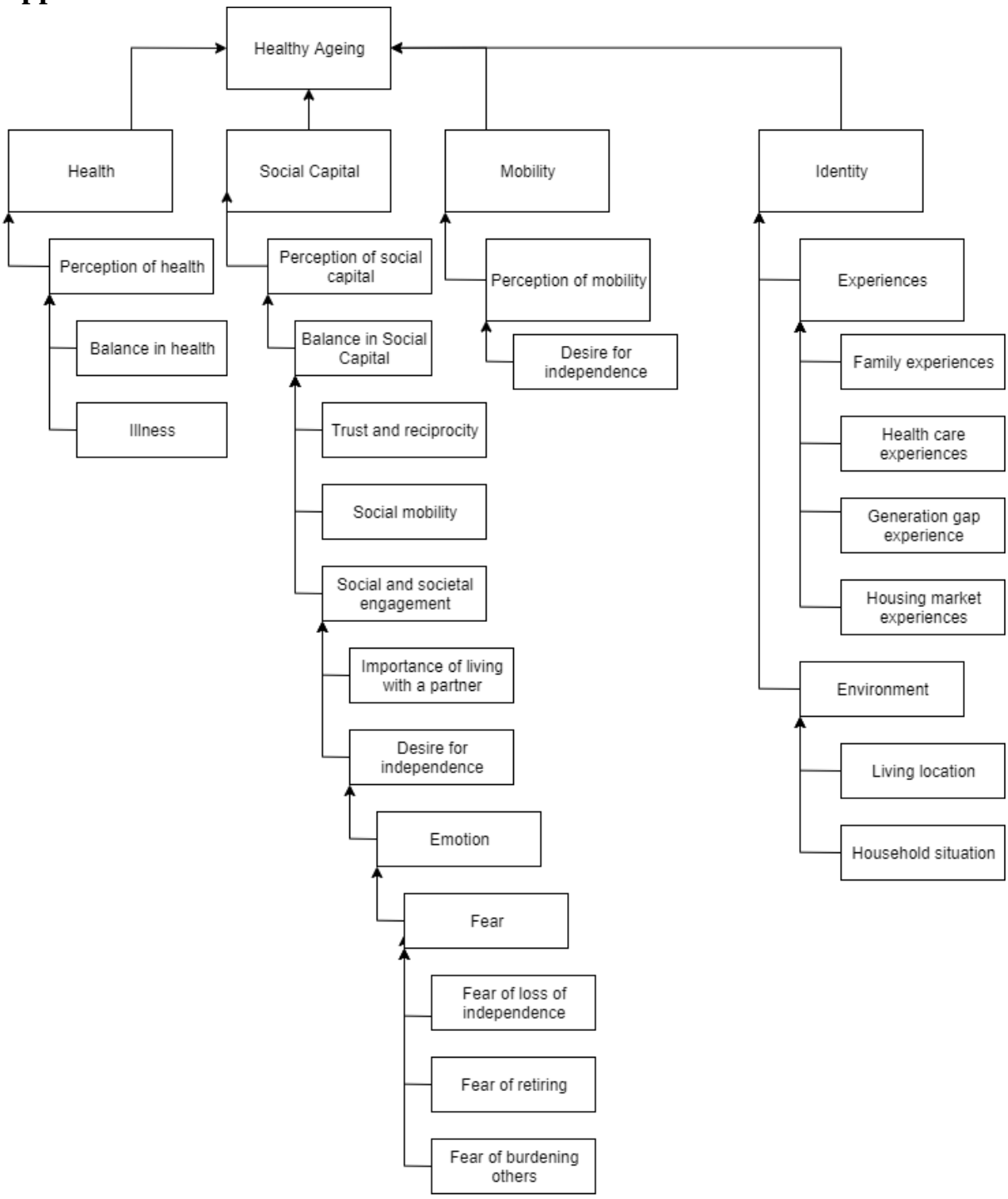
Voornaam participant: _____

Handtekening:

Voornaam onderzoeker: Johannes

Handtekening:

Appendix 5


Healthy Ageing
Health
Social Capital
Mobility
Identity
Perception of health
Balance in health
Illness
Perception of social capital
Balance in Social Capital
Trust and reciprocity
Social mobility
Social and societal engagement
Importance of living with a partner
Desire for independence
Emotion
Fear
Fear of loss of independence
Fear of retiring
Fear of burdening others
Perception of mobility
Desire for independence
Experiences
Family experiences
Health care experiences
Generation gap experience
Housing market experiences
Environment
Living location
Household situation