A Qualitative Analysis into the Rise and Fall of Preventive Consults for Elderly

Abstract

This article presents conditions at which preventive consults for elderly in the Netherlands seem to subsist best and what elements of these preventive consults seem to work best to reach the goals of the consults. Because of the ageing population in the Netherlands, it seems relevant to investigate interventions that aim to lengthen the healthy years of elderly. The literature review shows that a lot is known on preventive activities for elderly in general, but little is known on preventive *consults* for elderly. Data was collected through nineteen in-depth semi-structured interviews with interviewees from preventive consults that still exist and preventive consults that no longer exist. External stakeholders (subsidisers or researchers), policymakers that were part of the implementation and/or organisation of the preventive consult in their organisation and professionals that work with the consult were interviewed. The findings suggest that for the subsistence of the preventive consults for elderly, preparation is crucial. The preparation consists of creating solid partnerships in the field with at least general practitioners, and embedding the consult in the field by creating a solid base and avoiding competition. In addition, a needs-assessment with the elderly adds to the subsistence, so that the consults correspond to the needs of the elderly and avoid overlap in services. In order for the goals to be reached it seems that realistic proximal goals need to be set, adjusted to the target group, and it seems better to offer the consult at least twice in order to effectuate behavioural changes.

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The proportion of older people in the world is increasing drastically. There is a decrease in deaths at young age, as well as an increase in life expectancy due to better survival at older age (WHO, 2015). In the Netherlands, where the current study will be conducted, 20-24 per cent of the population was 60 years or older in 2015 while it is expected to be 30 per cent or more in 2050. In addition, fertility rates are decreasing which means that the elderly population grows while the young population shrinks (WHO, 2015). This demographic change puts a strain on the economy, the welfare system and the social relations and family relations of the elderly (Bonoli, 2005; Schulz, Leidl & Köning, 2004)

The demographic changes pressure the welfare system since the demand for care increases while most European countries decreased their health spending as a result of the economic crisis. The spending on health care has been growing slowly, however the Netherlands is still behind non-European countries (OECD, 2015a; OECD, 2015b). Together with the budget cuts in health care, in 2015 a new Social Support Act was created (*Wet Maatschappelijke Ondersteuning;* WMO in Dutch). This Act makes municipalities responsible for ensuring that elderly live at home as long as possible, and only receive formal care when the social network is unable to offer the necessary care (Rijksoverheid, 2016a). However, a study by Schulz et al. (2004) showed that higher life expectancy leads to a 63 per cent increase of people in need of long-term care compared to when the life expectancy would have been stable. Thus, the demographic changes lead to an increase in the demand for care, while the transformation of the Dutch welfare arrangements aims to decrease the supply of formal care.

This gap in the supply and demand of care is supposed to be covered by informal care. However due to the increase in women's labour market participation, the availability of informal carers is decreasing. If formal care providers will not provide the long-term care, women have to care for their elderly family members, which will be at the cost of their labour market participation and their well-being (Bonoli, 2005; European Commission, 2009; Schulz, et al., 2004). In addition, the quest for informal care of the elderly burdens the social relations and family relations.

Hence, the challenge is to lengthen the healthy years of elderly so that elderly can longer be part of the labour force, will live longer in good condition, and the burden on welfare provisions and social relations will be limited (Bloom, Canning, & Fink, 2010; European Commission, 2009; Knickman & Snell, 2002). The biggest burden of disease for the elderly is the non-communicable diseases like cancers and cardiovascular diseases, which is related to an unhealthy lifestyle (WHO, 2015). In the Netherlands, the percentage of deaths due to non-communicable diseases was 89 per cent of the total deaths in 2012 and is therefore a big problem (WHO, 2012). Treating non-communicable diseases are often lifelong and costly which strains the healthcare costs (Probst-

Hensch, Tanner, Kessler, Burri, & Künzli, 2011). Therefore, in order to prevent the elderly from getting these non-communicable diseases, early detection and early prevention is key (WHO, 2015).

In 2008, the Dutch government emphasised the importance of preventive care for elderly in a new law, the Public Health Law (*Wet Publieke Gezondheid;* WPG in Dutch). Research was conducted, commissioned by the Dutch government, to find out which preventive interventions for elderly people already existed (Klink, & Bussemaker, 2009). The preventive consult for elderly was one of these interventions, and will also be the focus of the current study.

Intervention: preventive consults for elderly people in the Netherlands

Besides the necessity of healthy ageing from a societal perspective, the elderly themselves are searching for help to maintain or improve their health status as well. That is why in 2003 the first preventive consult for elderly people was created in the Dutch city Leiden (Bakker, Jaspers, Kraakman, & Visser, 2008a), which resembles the internationally implemented comprehensive geriatric assessment intervention (Reuben, Frank, Hirsch, McGuigan, & Maly, 1999; Stuck, Siu, Wieland, Adams, & Rubenstein, 1993). Elderly people were worried about their health status, but did not feel ill enough to go to the general practitioner. At the preventive consult, elderly of 50 years and older receive a screening of their health, which entails physical health, social network, psychological well-being and cognitive functioning. The nurses give a tailored advice to increase awareness and knowledge of elderly regarding their health behaviour, which enables them to make healthier choices. Because of these healthier choices, elderly have a stronger social network; it increases their quality of life; the likelihood of healthy ageing; their autonomy; and it reduces health care consumption. Nurses also guide the elderly to organisations that can provide help so that elderly people know where to go with their problems and what help would suit best. This information increases the autonomy of elderly people, their likelihood of healthy ageing, and makes them more likely to go to these organisations instead of using health care facilities. It is assumed that empowering elderly people to arrange their life in such a way will make them more likely to age healthy (Bakker, et al., 2008a).

Figure 1 shows a graphical display of the program theory, which shows the causal relations policy makers expect. A national platform preventive consults for the elderly was created in 2008 by home care organisations, representatives of the target group, researchers, gerontologists, and the Public Health Services (*Gemeentelijke Gezondheidsdienst;* GGD in Dutch). A document with the goals and a workbook with methods were created by this platform. However, both documents state that these methods are just guidelines and that professionals can decide what suits best for their population (Bakker, et al., 2008a; Bakker, Jaspers, Kraakman, & Visser, 2008b; Bakker, & Slaman,

2011). Hence, it seems like there is little consensus on what the best practice is for preventive consults and big differences might exist between the preventive consults. Multiple initiatives with similar goals and similar methods but different names have risen in the past years, of which some have subsisted and some not. The municipality of Goeree-Overflakkee for instance shut down the preventive consults, while the preventive consults in Losser still exist. Therefore, the aim of the current study is twofold; first, to discover the context in which the preventive consult is most likely to subsist; second, to find out what elements of the intervention seem to work best to reach the goals. The second part will therefore focus on the program theory.

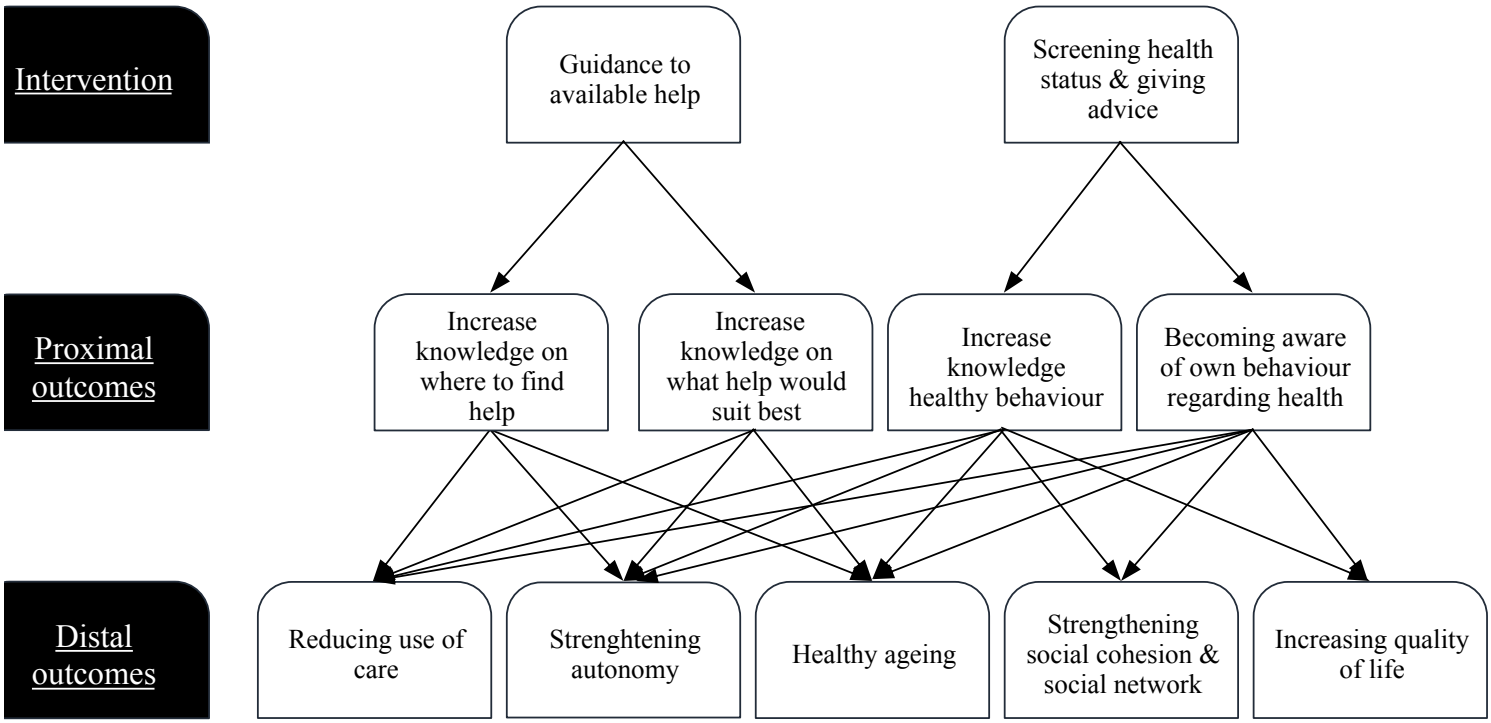

Figure 1. Graphical display of the program theory of preventive consults for the elderly. Based on the document of goals and the workbook for preventive consults for the elderly (Bakker, et al., 2008)

Theoretical framework

As previously mentioned, the aim of the current study is twofold. Hence, first the context in which a preventive consult is most likely to subsist will be discussed, and then the best practice of the consults will be discussed.

The context in which the preventive consults for elderly is most likely to subsist

The subsistence of the preventive consult for elderly can depend upon the context it is embedded in. Often context is not included when evaluating an intervention. However, multiple studies have shown that the context can influence the effectiveness of an intervention (Poland, Frohlich, & Cargo, 2008; Pawson, & Tilley, 1997). Context consists of multiple levels. In the following section first the context on a macro level will be discussed, after that the meso and micro level will follow.

Macro level

Centralisation of the state makes the implementation of policy measures easier since the autonomy of decision-making lies with the government only. In that case, when a policy decision is made, the implementation goes smoother than when multiple local-governments also have jurisdiction. A decentralised state on the other hand, makes it easier to affect the design of a policy by for instance grassroots organisations (Nathanson, 1996). In addition, a decentralised state gives municipalities the opportunity to adjust policies to the needs of their population.

Another role of the government lies in making health promotion a national priority. One of the ways to give voice to this national priority is by political leaders who inform the public about the importance of health promotion. When people are convinced about the importance of health promotion, more initiatives will be launched. Together with the appropriate resources provided by the government, new initiatives on health promotion can get a 'kick-start' (Nutbeam, 1998). Besides informing the public, the government can also influence health promotion by creating facilitating policies and laws so that health promotion interventions are encouraged. Together with an active lobby shows advocacy to health promotion (Nutbeam, 1998; Nutbeam, 2000).

Creating economic incentives is another way in which the government can show the priority of health promotion. A study by Mays and Smith (2011) suggests that an increase in public health spending can be linked with a decrease in preventable deaths. Thus, funding disease prevention can be of huge benefit in the long run, and funding can add to the subsistence of health promotion interventions (Hanson, & Salmoni, 2011; McGinnis, Williams-Russo, & Knickman 2002). Besides funding health promotion interventions, funding also needs to be available for scientific research. Due to scientific research, more is known about what works for whom and why. Evaluation studies

can provide knowledge on the effectiveness of interventions so that interventions are implemented that are proven effective (McGinnis, Williams-Russo, & Knickman 2002).

Meso level

The context on a meso level focuses on the organisation that provides the consults. The first factor that can add to the subsistence of the preventive consults is strong and stable partnerships with other organisations, so that the consults have a solid basis in the field (Gillies, 1998; Ritchie, Gnich, Parry, & Platt, 2008). But not only partnerships with other organisations are important, also partnerships with the target group and the community can add to the subsistence of the consults. The greater the involvement of the target group, the higher the likelihood of having an impact and the greater the likelihood the consults will subsist (Gillies, 1998; Nutbeam, 1998, Neuhauser, et al. 1998; Baum, Sanderson, & Jolley, 1997). Another aspect of successful partnerships is the inclusion of individuals and organisations from different social and cultural background. When the providing organisation recognises the differences between groups and tries to lower the barrier for all backgrounds, the likelihood that elderly will make use of the consults is higher (Levkoff, & Sanchez, 2003). Finally, the providing organisation needs to be independent and stable with little staff turnover. Elderly are less likely to participate when they cannot build a relationship with the professional providing the consults, and the supply of care changes constantly (Baum, Sanderson, & Jolley, 1997).

Micro level

The micro level context is about the target population and how the individual can be reached and willing to participate. A study among 14 European countries showed that high-educated elderly and elderly with a high-income make use of preventive measures more than lower-educated and lower-income groups. In addition, younger elderly make use more of preventive measures than the oldest-old (Jusot, Or, & Sirven, 2012). A clear target group seems to add to subsistence of the intervention, because then the necessary actions to lower the barriers to participate can be taken. In addition, the consults can be adjusted to the needs of that target group so that the supply fits to the demand.

<u>The best practice for the preventive consult for elderly</u>

The second part of the research is about what elements seem to contribute to the behavioural change the preventive consult for elderly aims to achieve. In order to effectuate behavioural change, it first seems important to find out when someone is ready to make that change. Therefore, first, the Social Cognitive Theory and the Trans Theoretical Model will be discussed which provide guidelines on how to effectuate change. When someone is ready to make this change, it seems relevant to find out

what unhealthy behaviours can be intervened upon among the elderly. Therefore, secondly, behaviour that results into unhealthy ageing and that can be intervened upon will be discussed.

How to effectuate change in health behaviour

One of the goals of the preventive consult for elderly is to improve the health choices of elderly. It is therefore useful to find out what encourages a person to change their health behaviour. The Social Cognitive Theory (SCT) explains *why* someone would change their health behaviour by core determinants. The first determinant is *knowledge* about the benefits and risks for changes in health (Bandura, 2004). When people do not obtain knowledge about healthy behaviour and its consequences, they have little reason to change their current behaviour. Whether the change in health behaviour will be structural also depends on the *self-efficacy* a person has to overcome obstacles. The increase of physical activity and letting go of old habits goes together with obstacles and setbacks. Whether one is able to persevere during these setbacks depends on whether the person beliefs the desired goal can be reached (Bandura, 2004). Another aspect of changing health habits is the *expected outcome* of the change. This outcome can be on a physical, social or personal level (Bandura, 2004). Another determinant is *the long-term and short-term goals* a person sets. Long-term goals are necessary to have a point on the horizon to work towards, while short-term goals help people to keep motivated (Bandura, 2004).

The Trans Theoretical Model (TTM) integrates some parts of the SCT but adds the dimension of *how* people change and *how* to encourage people to change (Prochaska, DiClemente & Norcross, 1992). The TTM consists of five stages of change, ranging from pre-contemplation, where someone is not ready to make a change, to maintenance, where changes in lifestyle are lasting (Prochaska, DiClemente & Norcross, 1992). In order to go from one stage to another, the person needs to go through multiple processes of change. Ten of these processes of change have been identified, such as increasing awareness in which someone becomes aware of their problem behaviour. According to this theory an intervention might be effective for someone when he or she is in the right stage of change. However, the same intervention can be ineffective for someone who is not even thinking about change. Therefore, it seems important to find out in what stage of change someone is and what process is necessary for someone to go to the next stage of change (Prochaska, DiClemente & Norcross, 1992). When applied to the preventive consults for elderly, it seems like only one consult cannot effectuate change since it is unlikely to increase someone's feeling of self-efficacy and guide someone through all the stages of change in only one consult. Therefore, multiple consults seem necessary to guide the person through the stages of change in order to maintain the behavioural

change. In addition, it seems that the content and guidance of the consult needs to be adjusted to the individual, depending on the stage of change that person is in.

Factors that contribute to healthy ageing

In the previous paragraph two theories are discussed on *why* and *how* people change their behaviour. The second step is to find out what unhealthy behaviour amongst elderly can be intervened upon to effectuate behavioural changes that lead to healthy ageing. In a literature review by Menichetti, Cipresso, Bussolin, and Graffigna (2015) on interventions that encourage healthy and active ageing among elderly people, five goals have been derived: increase physical activity, a healthier diet, increase social ties and social activities, increase health status, and increase psychological well-being and cognitive functioning. When it comes to promoting physical activity, exercising shows long-term benefits on mortality, morbidity, mental well-being, a feeling of meaning in life and physical functioning after 8 years (Kahana et al., 2002). A study by Resnick (2003) confirms that the individual approach can be effective in reducing smoking among elderly, reducing alcohol consumption and increasing physical activity.

Regarding psychological well-being, a review by Sutipan, Intarakamhang and Macaskill (2016) on positive psychological interventions for elderly shows that these interventions have positive effects on psychological well-being and life satisfaction. Reijnders, van Heugten and Boxtel (2013) reviewed thirty-five studies on cognitive interventions and found that individual cognitive interventions are effective when it comes to improving "memory performance, executive functioning, processing speed, attention, fluid intelligence and subjective cognitive performance" (p. 272). It is also shown that a healthy lifestyle leads to 60 per cent less cases of dementia and cognitive impairment (Elwood, et al. 2013). Thus, positive psychological interventions and individual cognitive interventions combined with a healthy lifestyle affect psychological and cognitive well-being.

To encourage a healthy lifestyle and decrease health risk factors, health education and counselling increases the likelihood that elderly people go to health screenings and makes them more aware of their health status (Menichetti, et al. 2015). Ellingsen, Hjermann, Abdelnoor, Hjerkinn, and Tonstad (2003) conducted a follow-up study to the effect of diet advice and non-smoking advice on the prevalence of coronary heart disease. It showed that the advice had reduced the risk of coronary heart disease 23 years later. This shows that increasing the knowledge on health behaviour can have long lasting health behaviour changes.

Another aspect of active ageing is social functioning. Social activities are important for elderly because it can increase social contacts and decrease care-reliability, among other things

(Holmes & Joseph, 2011). The focus in counselling should be on reducing stress amongst the elderly and increase their feeling of competence regarding social activities (Chong, 2007). Elderly should be empowered and a healthy lifestyle should be promoted to increase physical, mental and social functioning (Chong, 2007).

But in order for preventive measures to work, adherence to the advice is necessary. A review on adherence shows that the most often used technique is providing information about the consequences of certain behaviour to participants. Especially the interventions that are provided by health-professionals have a positive effect on adherence (Jones, Smith, & Llewellyn, 2013). A preventive measure led by health-professionals instead of a volunteer can therefore be more successful. Finally, the advantages of healthy behaviour should be explained, since this encourages healthy choices. Short-term advantages are regarded as more valuable than long-term advantages, especially among the oldest-old (Resnick, 2003).

The preventive consults for elderly: What do we already know?

As the literature review shows, a lot is known on preventive activities for elderly people. But what do we already know about the preventive *consults* for elderly in the Netherlands? When looking at the structure, the preventive consults resemble the preventive consults for children in the age of 0 to 4. These offices are nationally implemented in the Netherlands and provide a physical check on children; information on health and upbringing; vaccinations and the nurses can refer the child to a specialist when necessary (Rijksoverheid, 2016b). In their approach, the preventive consults for the elderly resemble the comprehensive geriatric assessment intervention (CGA). In this intervention, elderly of 65 years or older receive a screening from a nurse, a social worker and a physical therapist. The goal of the CGA is to improve the quality of life of elderly (Reuben, et al. 1999). The effectiveness of the CGA has been a cause for debate. A review by Stuck et al. (1993) provides evidence that CGA is effective when elderly receive the CGA with long-term guidance. However, CGA does not affect mortality rates and physical and cognitive status when it is provided to outpatients, unless provided at the home of the elderly (Stuck, et al. 1993). The study by Reuben, et al. (1999) refutes this by showing that outpatient CGA does benefit the quality of life of community-dwelling elderly.

Expectations

Based on the literature review expectations have been derived for both parts of the research. Regarding the context in which the preventive consults for elderly seem to subsist best, the following expectations have been derived:

1. Preventive consults that are high on the (local) political agendas are more likely to subsist than the ones that do not;
2. preventive consults that are organisationally stable with little staff turnover are more likely to subsist than the ones that do not;
3. preventive consults that have strong partnerships with other organisations and the local community are more likely to subsist than the ones that do not;
4. preventive consults with a clear target group are more likely to subsist than the ones that do not.

Regarding the elements that seem to contribute to behavioural changes amongst elderly, there seems to be a discrepancy between the program theory of the platform preventive consults for elderly and the academic literature. Guidance to other organisations, so elderly know where to go with their problems, is not reflected in the literature. Therefore, the following expectations have been derived from the literature, regarding the elements that seem to contribute to reaching the goals of preventive consults for elderly:

1. Screening health status and giving advice seems to lead to better awareness of the health behaviour of elderly people and increases their knowledge on health behaviour;
2. guiding elderly to organisations is not related to increasing knowledge on where to find help or what help suits best; nor indirectly to the distal outcomes of increasing the autonomy of elderly; the likelihood of healthy ageing; and reducing care consumption of the elderly;
3. awareness of the health behaviour of elderly seems to increase the quality of life; strengthen the autonomy of elderly; increase the likelihood of healthy ageing; create social cohesion and expand social network; and reduce care consumption of the elderly;
4. knowledge on health behaviour seems to increase the quality of life; strengthen the autonomy of elderly; increase the likelihood of healthy ageing; create social cohesion and expand social network; and reduce care consumption of the elderly.
5. providing multiple consults that are adjusted to the individual seem to increase the likelihood of reaching the goals

Research questions

The current study will first try to find out what distinguishes preventive consults that do subsist from the ones that do not. As the literature research showed, the macro, meso and micro level context is crucial when it comes to the subsistence of the preventive consult for elderly. The first research question will therefore be:

What conditions explain the rise and fall of preventive consults for the elderly in the Netherlands and why?

In order to answer this research question, the following sub questions will be answered:

1. Which political factors might explain the rise and fall of the preventive consults and why;
2. which organisational factors might explain the rise and fall of the preventive consults and why;
3. which factors regarding the target population might explain the rise and fall of the preventive consults and why?

To enhance the knowledge on the best practice of the preventive consults for elderly, it is also of interest to find out what their goals are and whether they are reached. Therefore, the second research question will be:

How, and to what extent, do preventive consults for the elderly reach their goals?

This research question will be answered by the following sub questions:

1. What are the goals of the preventive consult and why;
2. to what extent do they reach these goals and why (not);
3. what are the elements that make the preventive consult work for which groups of elderly and why?

Methods

The current study has an explorative nature since little is known about preventive consults for elderly in the Netherlands. As the literature review shows, there is quite some knowledge on preventive activities for elderly but not specifically on preventive *consults*. Besides the quantitative studies on the effects of preventive activities, this study seeks to discover in what context the preventive consults for elderly seem most likely to subsist. The goal is to increase the understanding of why some consults do subsist while others do not. In addition, the study aims to identify the realistic outcomes that can be expected from the preventive consults and what elements of the consult add to those outcomes and what elements do not. Gathering more in-depth information from the people working with the consult can provide comprehension on this topic (Chandler, Reynolds, Palmer, & Hutchinson, 2013). In order to find out the point of view of the people working with the consults, in-depth semi-structured interviews were chosen. This gave interviewees the opportunity to freely discuss their opinions and thereby possibly provide new information for the interviewer, while

relevant topics could be brought up by the interviewer to investigate the entire scope of the context and outcome (Chandler, Reynolds, Palmer, & Hutchinson, 2013).

Data collection

In order to gather information from different perspectives, interviews were held with external stakeholders (financers of the consult or external researchers), policymakers (of the organisations that provide the consults) and professionals who give the consults. Based on information gathered through different channels, for instance contacts with the authors of the previously mentioned documents and search engines, organisations were approached that still provide the preventive consults as well as organisation that no longer provide preventive consults. First all the organisations were approached by e-mail, in case they did not respond two weeks later the organisation was called to find out whether someone was willing to cooperate. When an organisation was willing to cooperate a date was picked in April or the first week of May.

Interviewees

In the current study, nineteen people were interviewed. According to Chandler et al. (2013), on average three to four in-depth interviews should be held per subgroup. In this case there were three subgroups: external stakeholders, policymakers and professionals. Unfortunately, for the preventive consults that still exist not enough external stakeholders were willing to cooperate due to busy schedules. For the preventive consults that no longer exist not enough policymakers were willing to cooperate, due to busy schedules or the feeling of not being able to provide any information. Therefore, of the preventive consults that still exist two external stakeholders were interviewed; four policymakers were interviewed that are part of the implementation and/or organisation of the preventive consult in their organisation; and five professionals who give the consult were interviewed. Of the consults that no longer exist three external stakeholders were interviewed; two policymakers were interviewed that were part of the implementation and/or organisation of the preventive consult in their organisation; and three professionals who gave the consult were interviewed.

The interviews were held at the offices of the interviewees and took thirty minutes to an hour. One interview was (unexpectedly) with two people at the same time, and one interview was conducted via telephone due to time limits of the interviewee. The interviews were recorded. Beforehand, the interviewee had to sign an informed consent.

Three different lists with interview questions were created based on the subgroup the interviewee was in. However, after three interviews it was found that the external stakeholders could

tell more about the content than expected and the professionals could tell more about political context than expected. Therefore, after three interviews all the interviews were conducted with the same list of interview questions, which included political context (such as the influence of national laws and local policies), organisational context (such as staff turnover and budget cuts) and population factors (such as target group). In addition, their opinion on preventive consults and the content of preventive consults were discussed (Chandler, et al. 2013). The entire list of interview questions can be found in Appendix A.

Data analysis

In order to analyse the data, the interviews were transcribed verbatim. Based on the literature review, themes and codes were created a priori, which were transformed into a code tree. Based on this code tree the interviews were coded with the help of the Nvivo program. In most cases the a priori themes and codes were verified, however, in some cases the code tree was not sufficient. In those cases an interaction took place between the a priori codes and the interview data. This process led to a few new codes but also to the combination of multiple codes into one code. No new themes were created. Then, patterns were sought between codes, between themes and codes, and between themes (Baarda, de Goede, & Teunissen, 2005). The code tree that was used can be found in Appendix B.

Results

The following section will provide the findings from the interviews. These findings will be structured by the two research questions and their sub questions. Therefore, the findings on subsistence of the preventive elderly consults will be provided first. After that, the findings on the outcome of the preventive elderly consults will be discussed.

The conditions that explain the rise and fall of the preventive consults for elderly

National and local political factors

In 2015, some of the care-responsibilities of the state were transferred to the local municipalities. Together with the decentralisation, new laws and policies regarding health care were created. All of the interviewees who talked about political factors agreed that the decentralisation made their work more difficult, for some more than others. It created more administrative hassle or the workload increased. An external stakeholder explains:

"For instance the nurses who provide the consults are getting swallowed up by re-indicating their patients. Everyone who is entitled to homecare needs to get an indication for homecare. As soon as the municipalities received money to redistribute, they of course re-examined everyone with an indication to see whether they didn't receive too much hours of homecare. Nurses are doing those indications. So they had to do a lot more work and we notice that there are periods in which the nurses are difficult to deploy for the consults" – External stakeholder 2, preventive consult still exists

Another factor that is related to national and local politics is financing. Because of the decentralisation, the funding streams changed. Previously, the preventive consults for elderly could get a subsidy directly from the national government. However, in 2007-2009 the Dutch government outsourced the subsidy for home care organisations to ZonMw, which is a Dutch institute that provides grants to for instance healthcare research and new health related interventions. In 2010-2012 this subsidy was extended but transformed into another subsidy also provided by ZonMw. The subsidy became much smaller and the restrictions much tighter. Therefore, some of the preventive consults no longer fitted to the requirements for subsidy, and were therefore cut. Another funding stream is the subsidy by provinces. The provinces received less money from the government to subsidise preventive activities and therefore the subsidy of preventive consults was often stopped. A pattern is found in that those consults funded by governmental subsidies only, no longer exist. The consults that were funded through for instance co-financing (where multiple organisations contribute financially) or the Health Insurance Act (*Zorgverzekeringswet;* Zvw in Dutch*)* were able to subsist.

"Because of the co-financing, the costs of the preventive consult are relatively low. The extra costs of the consults are divided over the organisations. That's not a lot but it is something, and it does show the willingness to maintain the consult" – External stakeholder 2, preventive consult still exists

In addition, some of the interviewees of the consults that no longer exist explained that the subsidy was not extended because of a lack of results they were able to show. In two cases a researcher had conducted an effect-study and found that the consults were not effective since the nurses were unable to contribute to a change in lifestyle. The other cases were unable to show results due to the fact that they did not conduct a study on the effects of the consults, or the outcome was difficult to measure. This difficulty relates to goals such as 'increase awareness' instead of

measurable goals like ‘decrease BMI’. An external stakeholder explains the difficulty of showing results:

> *“I do think that elderly are in need of a check-up or a conversation, but elderly do not necessarily change their behaviour or make very different choices. At least, on a short-term they won’t. And when you’re unable to measure short-term results, it will be stopped quickly I think”* – External stakeholder 1, preventive consult no longer exists

Another aspect of the political conditions is the political lobby and making health prevention amongst elderly a national priority. The majority of the interviewees of preventive consults that still exist state that there has been a lobby for their consults, either recently or at the start. This lobby came from a political party in the Netherlands, which actively advocated for the consults and increased publicity for the consults. This led to interviews and television shows about their consults. The lobby also came from interest groups of the target group, or from the municipality. A few of the interviewees of preventive consults that no longer exist were also talking about a lobby, but more on a general basis. This lobby also came from political parties, but was more generally aimed at increasing the supply of preventive activities for elderly, instead of specifically the preventive consults. Therefore, it could be that only lobbies specifically aimed at the consults have an effect on the subsistence of the preventive consults.

Organisational factors

When analysing the answers on partnerships with organisations it shows that all initiatives have partnerships with other medical and social organisations. However, the interviewees of existing preventive consults have partnerships with a general practitioner, or claim to slowly gain trust of the general practitioner and are now starting to work together. An external stakeholder explains why these partnerships add to the subsistence of the preventive consults:

> *“These days, elderly people value the advice of the general practitioner. So it has a special role for the elderly. The older people get, the bigger the bond of trust is with the general practitioner. (...). He or she has a special role, and especially when one receives a health related advice of someone else but the general practitioner doesn’t confirm that advice, the advice is being undermined.”* – External stakeholder 3, preventive consult no longer exists

None of the interviewees of the no longer existing preventive consults had partnerships with general practitioners, but they did recommend these partnerships. Often, when there was no partnership with a general practitioner, it was claimed that the general practitioner was seen as an obstruction. The general practitioner seemed to undermine the advice that was given or discouraged elderly to go to the consult. Another aspect is that there was some form of competition at which the preventive consults cannot compete with the consults of the general practitioner:

> *"You see nowadays that the assistants of general practitioners are also able to carry out these kind of check-ups, or they pretend that they can. You see a certain kind of competition at which in the long run you need to question yourself whether you want to continue with the consults. When general practitioners are actually considering these kind of check-ups as their co-business, they have better contacts with their people and with health insurances"* – Policymaker 3, preventive consult still exists

Regarding the location of the consult, there was an equal division between providing the consults at home or at an office. In addition, no differences were found in the professional background of the ones providing the consult, all of the consults were provided by a nurse (of at least level 5 of the Dutch healthcare system). There was however a difference in the stability of the organisation that provided the consults. Interviewees of the preventive consults that still exist claim that their organisation is stable, while the opposite is true for the consults that no longer exist. With stability is meant little staff turnover, so most of the nurses who provide the consult have been working there a long time, no big budget cuts, clear coordination of the preventive consults, and the content of the consult is stable, so elderly know what to expect. For the preventive consults that no longer exist it was mentioned that entire departments disappeared due to major budget cuts, the organisation was chaotic in the start-up so no one knew what to do or it was not coordinated properly:

> *"It might seem really rude, but the preventive consults were another half-hearted attempt of the municipality. It wasn't substantiated by any research and we were all just doing something"* – Professional 1, preventive consult no longer exists

Population factors

No differences were found in the way of recruiting the target population, there was an equal division between an advertorial in the local newspaper and a personal letter. The age of the target population ranged from 55 to older than 75. A few consults did not target age groups but targeted elderly based on their health issue (for instance smoking, cognitive impairment). These consults were better able to reach the target population, but some raised the question whether the consults were aimed at avoiding the problems to become worse instead of being preventive. A pattern can be found in the reason why the preventive consults came to life. Of the preventive consults that still exist the majority had done a needs-assessment or research with the target population, and others started because of the quest for help from elderly. This needs-assessment or research consisted for instance of identifying the problems of a population, and whether the target population would be open to the consults. When the initiative started because of a quest for help from the elderly it was often through an interest group or senior councils. While of the preventive consults that no longer exist only one of the initiatives did involve the opinion of target group in their preventive consults. The others started with the consult because of a political stimulus, which was a quest for preventive activities for elderly people, or because organisations themselves thought that it might be a good idea.

<u>The outcome of the preventive elderly consults</u>

Are the goals of existing preventive consults reached?

In order for a goal to be reached, there needs to be a goal. Less than half of the interviewees of which the preventive consult still exists were able to provide an explicit goal of the preventive consults, while all the interviewees of which the preventive consult no longer exists could. Also, when the first-mentioned interviewees were able to identify goals, these goals could differ within the same organisation. In addition, the means to reach the goal and the goal itself were often intertwined:

> *"The goal beforehand was identifying social, psychological and also physical issues. And advising people about a healthier lifestyle, that is the goal"* – Stakeholder 2, preventive consult still exists

It seemed, however, that screening for problems before they get out of hand is a goal as well. The majority of the interviewees discussed that topic during the interview and it was also mentioned as the added value of the preventive consults. The preventive consult is there before a problem gets

worse and before the problem is big enough to go to a general practitioner. It increases the ability of elderly to fix their problems without using care facilities.

Another topic that came back in almost all the interviews was the target group. Almost all preventive consults were aimed at elderly who are avoiding care, and the Non-Dutch elderly that often have an unhealthy lifestyle. However, these groups were difficult to reach since they were in their country of origin for most of the year or did not come to the second consult.

> *"I thought it was rather shocking that people who live in the Netherlands for over twenty years or who are born in the Netherlands speak Dutch so badly that you can't have a conversation with them. When it's just the physical measurements it's fine but when it comes to advising people and asking them about their lifestyles it is very difficult when someone doesn't speak Dutch"* – Professional 5, preventive consult still exists

The elements that make the preventive consult work for certain groups and why

To answer this sub-question the content of the consults was analysed. Most of the interviewees from both existing and no longer existing preventive consults stated that the consult included physical measurements, took the social environment into account as well as psychological wellbeing. All the professionals could adjust the consult to the needs of the patient and were not bound to stay true to a fixed methodology. Only one preventive consult existed only out of physical measurements, that consult no longer exists. Regarding the frequency of the consults, the preventive consults that still exist offer the consult at least twice to elderly. A small majority of the preventive consults that no longer exist also provided the consult at least twice, and the others only once.

A successful element that came back into almost all the interviews was the element of time. In the consult the professional takes time for the elderly person and also listens to the issues. Often the consults took an hour, which gave the elderly the freedom to discuss certain issues more in depth. In other care facilities like the consult of a general practitioner not much time is available and only one issue can be discussed. This element was often mentioned as the added value of the preventive consult.

Linked to the element of time is the fact that almost all interviewees of preventive consults that still exist mention the problem of ever increasing loneliness among elderly people. Since care provisions are decreasing because of budget cuts, elderly see less people during the day. Previously, there was for instance more budget for power wheelchairs so that elderly people were mobile and could visit friends. Those facilities are now cut, which decreases the opportunities for elderly to meet people during the day. The preventive consult can help these elderly by for instance guiding them to

volunteering organisations that can link them to a buddy. A professional illustrates this when asked who could benefit the most from the consult:

> *"I think the people who are lonely, they just want someone to really listen to them. You notice that there is a lot of loneliness and it's only getting worse. People appreciate a familiar face that asks them how they are doing. Linked to that are the informal carers who take care of their partners and who just want to tell their story without the person being there. It gives them the energy to fight again"* – Professional 5, preventive consult still exists

In addition, when asked who could benefit the most from the consults two target groups were mentioned: the young-old (between 55 and 65), and the oldest-old (75 and older). The oldest-old were often mentioned because of the previously mentioned loneliness. The young-old were often mentioned because they start a new chapter in their life:

> *"A very important factor is that they are becoming grandparents and they want to live healthy and be an active grandparent as long as possible. So that is why that's the age at which the elderly themselves want to work on prevention"* – External stakeholder 3, preventive consult no longer exists

Discussion and conclusion

In this chapter the findings of the current study will be discussed and conclusions will be drawn. Finally the limitations will be discussed and recommendations will be given.

The Dutch population is ageing, which leads to an increase in the demand for care (Schulz, et al., 2004). This pressures the welfare system because of higher costs of care, and the social relations and family relations of the elderly because of the increase in demand for informal care (Bonoli, 2005; Schulz, Leidl & Köning, 2004). One way to resolve this issue is to lengthen the healthy years of elderly so the aforementioned pressure becomes limited. One of the interventions aimed at ageing healthy and making healthier choices is the preventive consults for elderly people. A lot is known about preventive interventions for elderly people in general but little is known on preventive *consults*. Therefore the current study aims to increase the knowledge on preventive consults for elderly by finding out what conditions add to the subsistence of the preventive consults and whether the goals of preventive consults are reached. The findings of the study will be discussed based on the two research questions.

What conditions explain the rise and fall of preventive consults for the elderly in the Netherlands and why?

The research question will be answered by three sub questions, starting with the first sub question: "Which political factors might explain the rise and fall of the preventive consults and why?". It was expected that preventive consults that are high on the (local) political agenda are more likely to subsist than the ones that do not. The results show that a political lobby from a national party or interest groups specifically aimed at preventive consults for elderly adds to the subsistence of the preventive consults, which corresponds with the findings of Nutbeam (1998; 2000). In addition, it seems that when the consults are low on the political agenda, they are less likely to subsist. The results show that the preventive consults that no longer exist often were fully dependent on governmental subsidies. Due to stricter requirements on results, preventive consults struggled with meeting these requirements, which often led to a discontinuation of the subsidy. The literature shows that subsidizing the preventive consults and creating facilitating policies might add to the subsistence of the consults (Hanson, & Salmoni, 2011; McGinnis, et al. 2002; Nutbeam 1998; Nutbeam 2000). The current study implies that it also works the other way around: When the subsidy stops it becomes difficult for preventive consults to subsist. It therefore seems that dependence on only one subsidiser jeopardises the subsistence of the preventive consults for elderly. Creating support from organisations by for instance co-financing or crowdfunding might create more financial stability. When grassroots organisations collect their power, the likelihood that local municipalities co-finance increases, which corresponds with the findings of Nathanson (1996). The findings are therefore in line with the expectation, since being high on the political agenda seems to be beneficial, while being low on the political agenda seems harmful.

The second sub question is: "Which organisational factors might explain the rise and fall of the preventive consults and why?". It was expected that preventive consults that are organisationally stable and that have strong partnerships with other organisations and the local community are more likely to subsist than the ones that do not. The results show that it seems important to collaborate and distinguish the consult from other provisions to avoid competition or overlap of facilities, since the preventive consults share common ground with other care provisions. A profound investigation is needed into how the preventive consults fit within the care provisions that are already there. This corresponds to the studies of Gillies (1998) and Ritchie et al. (2008), which state that the preventive consult needs to have a solid basis in the field. In the current study, especially partnerships with general practitioners were highlighted, since they have short ties with the target group and funding organisations. The importance of the general practitioner did not come forward in the academic

literature. This might be because those studies were based on collective health promotion and therefore less similar to a consult from the general practitioner than the preventive consults for elderly. Because of the resemblance, the influence of the general practitioner might be bigger because they have valuable knowledge of and ties with the target group. Partnerships with local communities like Levkoff and Sanchez (2003) discussed did not come forward in the interviews. This might be because the preventive consult is an individual consult and is therefore not community-based. Finally, the organisational stability that Baum, Sanderson and Jolley (1997) discussed also came forward in the current study since well-organised preventive consults with little staff-turnover seemed more like to subsist than less stable organisations. Thus, besides the partnerships with local communities, the findings are in line with the expectations.

The final sub question is: "Which factors regarding the target population might explain the rise and fall of the preventive consults and why?". It was expected that preventive consults with a clear target group were more likely to subsist than the ones that do not. The results are in line with this expectation, since the consults that conducted a needs-assessment with the target group seem more likely to subsist than the ones that do not. The needs-assessment can specify the target group, increases the knowledge on how to reach this target group and gives the opportunity to adjust the consult to what the target group needs or seems to benefit from. As Jusot, Or and Sirven (2012) state, lower-educated and lower-income groups make less use of preventive measures. When the aim is to reach these groups, the needs of the group deserves special attention since they are more difficult to reach.

Thus, the overall answer to the first research question: "What conditions explain the rise and fall of preventive consults for the elderly in the Netherlands and why?" is: preparation. The influence an organisation has on national politics is marginal so it is therefore more important to know how to deal with the situation. Partnerships with other organisations and general practitioners are key when it comes to embedding the preventive consult in the existing care provisions and to create a solid basis. In addition, when care is decentralised this solid basis increases the likelihood of having an impact on local policymaking and therefore local subsidies. Another aspect of embedding the preventive consult in the existing care provisions is doing a needs-assessment. In that case one finds out what is already there, what is missing and what the target group could benefit from. This decreases the likelihood of overlap between different initiatives and competition, and increases the added value of the preventive consult.

How, and to what extent, do existing preventive consults for the elderly reach their goals?

The second research question will be answered by three sub questions as well. The first sub question is: "What are the goals of the preventive consults and why". It was expected that the goals were similar to the goals in the program theory. However, many of the preventive consults that still exist did not explicitly state the goals of the preventive consult. Most interviewees agreed that the goals of the preventive consult should not be physical goals like 'decrease BMI', but should be about 'creating awareness' since the first-mentioned goal is unrealistic. As soon as a consult had to meet set criteria based on physical goals, the goals were less likely to be reached. That might be why the distal goals of the program theory, similar to the goals identified by Menichetti et al. (2015), implicitly resemble the goals of the preventive consults, but were not as explicitly mentioned. Only the proximal goals of the program theory were explicitly mentioned, therefore the findings are partly in line with the expectation.

Building further upon this, the second sub question states: "To what extent do they reach these goals and why (not)?". Based on the academic literature and the program theory it was expected that screening health status and giving advice would be related to better awareness of the health behaviour of elderly and would increases their knowledge on health behaviour, which would be related to their quality of life, autonomy, healthy ageing, social cohesion, social network, and care consumption of the elderly. Guiding elderly to other organisations was expected to not relate to anything. The proximal goals were reached, which is in line with the research of Resnick (2003) that stated that especially short-term advantages triggered elderly to persist their change in health behaviour. The expectations based on the distal goals were not explicitly discussed. Therefore it is still a question whether the proximal goals seem to lead to the distal goals. Another finding is that, against the expectations, the preventive consult often existed of guiding elderly to organisations that could help them with their problems. In the literature this was not reflected, but it was part of the program theory of the preventive consults. Because of the decentralisation, elderly often did not know where to go or did not know to what extent they were entitled to care. Therefore, it seems that the guidance increased their knowledge on where to go with their questions and what help would suit best. Again, whether the distal goals were reached was not explicitly stated. Thus the expectation regarding the relation of health screening with the proximal goals was in line with the results. The expectation regarding the relation of guidance to organisations with the proximal goals was not in line with the results.

The final sub question is: "What are the elements that make the preventive consult work for which groups of elderly and why?". It was expected that providing multiple consults that are adjusted

to the individual seem to increase the likelihood of reaching the goals. The first element that was often mentioned was time. The elderly often found it pleasant that they had the time to discuss all their issues instead of the necessity to focus on only one topic. Especially elderly people without a social network found it pleasant to have the time to discuss all their issues, which was why the lonely oldest-old was considered as benefitting the most out of the consults, together with the young-old who often became grandparents. However, the target group many preventive consults aimed to reach was missing: the care-avoiders and the Non-Dutch elderly. It is interesting that the preventive consults aimed at a specific target group based on health issues, were better able to attract their target group to the preventive consult. So it might be true that when elderly are specifically recruited based on their care-avoidance or health behaviour, they are easier to reach. According to the Social Cognitive Theory (Bandura, 2004) and the Trans Theoretical Model (Prochaska, et al. 1992) a person needs to be open for change in order for the change to happen. Since often the elderly were allowed to go only twice or three times to the consult without further guidance, the likelihood that the goals are reached with elderly who avoid care or who do not want to change is small, according to these theories. These groups of elderly might need more consults than others with different content and more guidance. Thus the fact that these target groups are missing, is in line with the expectation since more consults with more guidance seem necessary.

Thus, the answer to the second research question: "How, and to what extent, do existing preventive consults for the elderly reach their goals?" is not one-dimensional. Firstly, proximal goals like 'creating awareness' seem better reachable with the preventive consults than goals based on physical measurements like 'decrease BMI'. Related thereto is the interaction between the target group and the goals that are set. When Non-Dutch elderly and care-avoiders are the target group, more guidance and more consults might be necessary than with other healthier target groups. Therefore, it seems that first a target group needs to be chosen based on a specific age group or health status for instance, then proximal goals need to be set that are adjusted to this target group.

Limitations and recommendations for future research

The current study also has its limitations. The first and foremost limitation is that because of the small scope, the target group was not included in the study. Therefore, the study misses an important perception, since only the elderly themselves can provide insights on their experiences with the preventive consult. The second limitation is that due to the set-up of semi-structured interviews the conversations were lively, however, sometimes not all questions within the scope of this study were answered. Therefore, more research is necessary on the distal outcomes of the preventive consult. Finally, the interviewees' opinions might be coloured based upon whether the preventive consult still

existed or not. However, all the interviewees seem to be able to be critical and therefore no extra consideration was given to the reliability of their answers

Future studies could complement the current study by adding a quantitative empirical component that would give better opportunity to generalise the results and to prove the effectiveness of this intervention. In addition, a study on the long-term effects can also complement the study. Finally, the biggest struggle for all preventive consults, whether they still exist or not, was to reach care-avoiders and Non-Dutch elderly. A study on how to reach these target groups and decrease drop-outs would therefore be of great value.

Recommendations for practice

The following section will provide recommendations for future and/or current preventive consults to subsist and to reach their goals. Firstly, when it comes to the subsistence of the preventive consults it is recommended to conduct a profound investigation into what facilities are already there, and what the needs are of the target group to avoid overlap and competition. In addition, it is recommended to unionise with partners in the field, especially general practitioners, to establish a solid base and increase the influence on local politics in order to get a subsidy, or to increase the likelihood of national politics advocating for the consults. Often, the subsistence is dependent on the subsidy. It is therefore recommended to not be dependent on one subsidiser but to create a co-financing structure. When one subsidiser falls out, the preventive consult does not have to stop immediately. If that seems impossible, a change in mind-set seems necessary, because the experienced effect *is* possible to measure and can also be enough to maintain the subsidy.

When it comes to reaching the goals, firstly proximal goals seem more realistic to reach than long-term goals. In addition, it is recommended to adjust the goals and content of the consult to the target group and the individual in order to anticipate to personal factors.

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Appendix

Appendix A, interview questions

Start

In 2003 is het eerste consultatiebureau voor ouderen geopend in Leiden, omdat de doelgroep behoefte had aan meer zekerheid over hun gezondheid. Hoe is uw consultatiebureau ontstaan?

Politieke factoren

Sinds 2003 zijn er veel consultatiebureaus zijn gestart, maar ook weer zijn gestopt. Hoe komt dat denkt u?

Hoe wordt het consultatiebureau gefinancierd?

In hoeverre heeft de nationale politiek volgens u invloed gehad op het ontstaan van het consultatiebureau?

In hoeverre heeft de nationale politiek volgens u invloed gehad op het blijven bestaan van het consultatiebureau?

Heeft de lokale politiek hier ook een rol in gespeeld volgens u? Zo ja, hoe?

Organisatie factoren

Heeft het consultatiebureau samenwerkingsverbanden met andere organisaties/gemeenten/bedrijven? Zo ja welke?

In hoeverre hebben deze samenwerkingsverbanden invloed op het voortbestaan van het consultatiebureau denkt u?

In hoeverre wordt de doelgroep betrokken bij de organisatie van het consultatiebureau?

Is de organisatie stabiel in bijvoorbeeld het personeelsverloop, het aanbod van de consulten?

Wat is de professionele achtergrond van de medewerkers die de consulten geven?

Populatie factoren

Kunt u mij iets meer vertellen over de mensen die gebruik maken van het consultatiebureau?

In hoeverre lukt het om de beoogde doelgroep te bereiken?

Hoe komt het dat dit wel/niet lukt?

Worden er acties ondernomen om de beoogde doelgroep te bereiken? Zo ja, welke?

Hoe wordt het consultatiebureau ontvangen bij de doelgroep?

Doelen consultatiebureau

Wat zijn volgens u de doelen van het consultatiebureau?

Waarom denkt u dat dit de doelen zijn van het consultatiebureau?

In hoeverre worden deze doelen bereikt volgens u?

Wordt dit gemonitord, en zo ja hoe?

Methode consultatiebureau

Wat houdt volgens u een consult precies in?

Wie geeft het consult?

Zijn de consulten voor iedereen hetzelfde qua inhoud, of wordt er onderscheid gemaakt tussen bijvoorbeeld leeftijdscategorieën?

Hoeveel is vastgelegd in een methodiek en wat mag de professional zelf bepalen?

Welke onderdelen van het consult werken volgens u om het hiervoor genoemde doel te behalen?

Hoe komt dat denkt u?

Welke doelgroep heeft volgens u het meeste baat bij de consulten?

Hoe komt dat denkt u?

In hoeverre denkt u dat de consulten aansluiten bij wat de doelgroep nodig heeft?

Appendix B, Code tree

Politieke factoren

- Invloed nationale politiek
    - Effect decentralisatie
        - Wetten
        - Aanbod zorg
- Invloed lokale politiek
- Financiering

Organisatie factoren

- Voorbereiding
    - Peiling van de behoeften
- Samenwerkingsverbanden
    - Huisartsen
        - Faciliteren
        - Belemmeren
    - Overig
- Professionele achtergrond mensen die het consult geven
    - Training professionals
- Stabiliteit van de organisatie
    - Personeelsverloop
    - Stabiel aanbod, weinig wijzigingen
    - Interne stabiliteit, tevredenheid

Populatie factoren

- Doelgroep
    - Gemiste doelgroep
    - Gewenste doelgroep
    - Bereikte doelgroep
    - Meeste baat bij consult
- Werving en selectie
    - (Persoonlijke) brief
    - Krant/commercial

Stoppen of doorgaan

- Initiatief na preventief consult
- Oorzaak blijven bestaan
- Oorzaak stop
    - Financiën

    - Huisarts
    - Onmeetbare resultaten
    - Slechte voorbereiding
    - Verkeerde doelgroep

Doelen

- Gezond oud worden
- Kennisoverdracht
- Kosten besparen
- Ondersteuning huisarts
- PR en Marketing
- Service leveren
- Signaleren

Methode

- Inhoud van het consult
    - Vaste methodiek
    - Vrijheid in inhoud consult
    - Wijzen op hulpbronnen
- Monitoring
    - Werkzaamheid
        - Doelen behaald
        - Toegevoegde waarde