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Toward Age-Friendly Policies: Using the Framework of Age-Friendliness to Evaluate the COVID-19 Measures from the Perspectives of Older People in the Netherlands

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ABSTRACT

Protective measures that were taken during the COVID-19 pandemic, targeted older people as an at-risk group. The objective of this article is to investigate how older people in the Netherlands experienced the mitigation measures and whether these measures endorse and promote the idea of an age-friendly world. The WHO conceptual framework of age-friendliness, which consists of eight areas, has been used for a framework analysis of 74 semi-structured interviews with older Dutch adults, that were held during the first and the second wave of the pandemic. The results of the analysis indicate that the areas of social participation, respect and inclusion were affected most, and the measures concerning communication and the health services were experienced as age-unfriendly. The WHO framework is a promising tool for assessment of social policies, and we suggest its further development for this purpose.

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Age-friendly; COVID-19; framework analysis; internalized ageism; pandemic; social policy

Introduction

In the face of the COVID-19 pandemic, older people are an at-risk group (Lithander et al., 2020; WHO, 2020), therefore, it is important to ensure that the COVID-19 policies meet their needs and expectations. The governmental COVID-19 policies worldwide reflect the national levels of economic and political development, and the cultural contexts for implementation. Furthermore, they are closely linked to the national policies on aging and long-term care (see e.g., Béland & Marier, 2020; for Canada, or Kruse et al., 2020 for the Netherlands). As a result, the COVID-19 policies lead to highly varied results worldwide. For instance, Japan has a developed long-term care system for older adults, and while its initial response to COVID-19 resembles the measures taken in the US, the mortality rates among older people in Japan remain comparatively low (Estévez-Abe & Ide, 2021). Similar results are shown in Denmark where timely lockdown policies prevented increase in

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excess mortality during the first wave of the pandemic (Mills et al., 2020). The US COVID-19 policies are channeled through the prevailing social safety nets, like paid sick leave and access to health insurance. The protection of the at-risk groups, which includes older people, plays there a smaller role (Warner & Zhang, 2021).

Zooming into the COVID-19 policies that focus directly on the health and wellbeing of older people, we find more literature on policies addressing long-term care facilities, than those focusing on needs of community-dwelling older people (e.g., Lum et al., 2020). The interest of policy makers for the long-term care facilities reflects their aim to reduce the mortality rates, that were especially high at the beginning of the pandemic (Sepulveda et al., 2020). Community-dwelling older people become a subject of interest where compliance-seeking policies are concerned. These policies are driven either by cost-effectiveness (the price of life versus the economic damage), or by the risks that the healthcare capacity would be overwhelmed (Balmford et al., 2020). Therefore, they concentrate on the attitudes and acceptance of mitigation measures by the various population groups, with particular attention to older people as an at-risk group (Daoust, 2020). A UK -based study illustrates how difficult it is to assess such policies (Evandrou et al., 2020): the governmental appeal to older people to stay at home resulted simultaneously in more and in less informal care. On the one hand, the measures stimulated broad support at the community and family level. On the other hand, the most vulnerable older people who have difficulties with basic daily activities received less support during COVID-19.

Given the highly precarious position of the older population during COVID-19 and the possibility that a similar situation can occur in the future, it makes sense to look at the existing policies from the point of view of older people themselves. Studies were conducted that explore older people's experiences during the pandemic from various perspectives, including access to healthcare, fear for infection and coping strategies, to name a few (Han et al., 2021; Verhage et al., 2021; Yang et al., 2021). In this article we expand this body of literature by investigating how community-dwelling older people in the Netherlands experienced the COVID-19 policies introduced by the Dutch government, using the framework for age-friendliness to assess age-friendliness of these policies.

The World Health Organization (WHO) has defined age-friendliness as "encouraging active aging by optimizing opportunities for health, participation and security in order to enhance quality of life as people age" (WHO, 2007, p. 1) The framework allows for a broad assessment of the COVID-19 policies, because it incorporates eight areas: outdoor spaces, transportation, housing, social participation, respect and social inclusion, civic participation and employment, communication and information, and community and health services (WHO, 2007). This framework provides us with

a comprehensive tool for a policy evaluation; its value has been demonstrated in studies about housing, urban and rural planning, community/health services and other areas (Garner & Holland, 2020; Hancock et al., 2019; Mahmood et al., 2022). In our study we apply the framework as a critical lens for analysis of the Dutch policies during the COVID-19 pandemic.

The term "age-friendly" is well-known in the Netherlands, among local policy makers, academic researchers, social- and care professionals and older people themselves who take part in the participatory research projects (Groot & Abma, 2018). Several Dutch cities already joined the WHO's network, and by now several areas of age-friendliness have been incorporated in local policies (Van Hoof et al., 2020). This study helps to understand whether age-friendliness has been incorporated in the Dutch governmental policy during the COVID-19 pandemic. The decisions of the Dutch government form the background of this study. The Dutch COVID-19 policies were predominantly developed on the basis of information provided by (bio)medical experts (Groeniger et al., 2021). The response of the government took time, which generated public critique, given the high death rate among older people, increased loneliness and limited freedom due to the lockdown (Van Tilburg et al., 2021).

In the Netherlands, as well as worldwide, the measures that were introduced, were accompanied by public discourses that were questioned with regard to their ageism (Ayalon et al., 2020; Previtali et al., 2020), including so-called compassionate ageism. This type of ageism, implicit and difficult to detect, is based on the perception of older people as warm and likable but nonetheless incompetent and helpless (Swift & Chasteen, 2021; Vervaecke & Meisner, 2021). Literature points out that many policy measures that were intended to be age-friendly and to protect older people, turned out to be inherently "ageist," demonstrating a paternalistic behavior toward older people by labeling them collectively as vulnerable (Reynolds, 2020). These findings underline the necessity to assess the age-friendliness of policy measures in times of crisis.

Our study focuses on the experiences of older people to find out how the eight areas of the framework have been impacted and which lessons can be learnt to better respond to a similar situation in the future. Our question is: how have older people experienced the Dutch government's measures that were introduced during the COVID-19 pandemic and to which extent do these measures endorse and promote the idea of an age-friendly world?

Methods

This is a qualitative study, based on a secondary framework analysis of 74 semi-structured telephone interviews with Dutch older adults, conducted in

March-April and October 2020. The full description of the study design can be found elsewhere (Verhage et al., 2021).

Ethical approval

This study was reviewed and declared not to be subject to the law on research involving human subjects by the Institutional Review Board of the Medical Ethical Committee Leiden-Den Haag-Delft for observational studies, registered under number CoCo 2020–014. The protocol was reviewed, assessed and considered to comply with scientific due diligence.

Data collection

For this study three researchers conducted 74 semi-structured telephone interviews during two rounds, based on two interview guides (see supplement). The first round of interviews ($N = 59$, average age 75.5 yrs (54–95) with diverse living, background and income situations, see (Verhage et al., 2021) took place between 27 March and 20 April 2020. The second round ($N = 15$) with purposely selected interviewees took place in October 2020. We reasoned that while in the first phase disbelief and anxiety were prominent, people might have other experiences later, like boredom or feeling lonely. To capture the dynamics of the COVID-19 pandemic and mitigation measures such as social distancing, and how this influenced the experiences of older people, we reinterviewed a group, representative for the diversity of perspectives and coping strategies that were identified in the first interview period. This strategy ensures credibility of the results, one of the rigor criteria of qualitative research.

The choice for telephone interviews was determined by the COVID-19 measures that were taken by the Dutch government, which prevented face-to-face encounters. The interviews could therefore not provide the usual visual information, showing the body language and behavior of respondents. However, they allowed for more anonymity of the participants and more equality and inclusion regarding the sample, because some participants may have explicit preference for an interview at a distance (Saarijärvi & Bratt, 2021; Sturges & Hanrahan, 2004). The telephone interviews allowed us to directly tap into the experience of older people during the crisis, offering a listening ear and creating an opportunity to share their experiences. The average duration of the interviews is 45 minutes (range 27–80).

Sampling and participants

Limited by the lockdown measures, we used snowball sampling to reach potential respondents via our own and other peoples' networks (Bernard,

2018). We aimed to include diverse perspectives and therefore searched for a diverse sample of respondents, considering several potentially relevant background factors: gender, age, living situation, residence, country of birth and socio-economic situation (see Table 1). We maintained an age threshold of 60 years old, knowing that individuals in more precarious living situations can experience age-related challenges at a younger chronological age. During the interviewing period, we decided to not exclude one respondent below this chronological age, a 54-year-old resident of a long-term care facility suffering from cognitive decline. We reached data saturation after 40 interviews and met the rigor criterium of transferability by continuing inclusion based on the aforementioned characteristics to ensure diversity of perspectives (Verhage et al., 2021). For the second round of interviews respondents were selected based on factors that could influence their experiences, such as household composition, living situation and coping strategies (Leyden Academy, 2020).

Procedure

The purpose of the first round of analysis was to assess the experiences of older adults with COVID-19, in order to understand how they perceive the pandemic and cope with it (Verhage et al., 2021). This primary analysis of the data provided us with additional themes that went beyond the initial research question, focusing on coping. The topics triggered the secondary analysis of the current article, focused on the age-friendliness of the measures.

Data analysis

For the data analysis, we used qualitative data software MAXQDA (2020), which ensured dependability of the results as a rigor criterium. The framework analysis was conducted in five steps: familiarization, selective coding, applying and adjusting the conceptual framework, charting the data and interpretation (Gale et al., 2013).

Familiarization: the first author (who was not involved in the primary analysis) familiarized herself with the data by reading the original transcripts and the codes from the first analysis.

Selective coding: the focus of the selective coding was to search for examples of (anti) ageism as experienced by the respondents, based on the age-friendliness framework. With our research question in mind, we found no difference in codes used for the interviews from the first and the second rounds of data collection; therefore, we decided to not differentiate between them in this article. The comparison between the codes strengthened dependability of our results. The first author fine-tuned the new codes and interpretations with the fellow-researchers

Table 1. Participant characteristics.

Characteristics	N=59[a]	N=15[b]
Demographic		
Age (mean, range)	75·5 (54–95)	76 (63–95)
Female	34 (57·6%)	9 (60%)
Married/widowed/divorced/living together/single	31 (52·5%)/13/4/3/8	5 (33·3%)/6/1/1/2
State pension only[c]	7 (12·1%)	2 (13·3%)
Migrant background	17 (28·8%)	5 (33·3%)
Living situation		
Living independently	55 (93·2%)	15 (100%)
Living in long-term care facility	4 (6·9%)	0 (0%)
Living alone/with partner	26 (44·1%)/33	9 (60%)/6
Living environment (city/smaller city/village)	14 (23·7%)/30/15	5 (33·3%)/6/4

Note: [a] Data of 4 interviewees were excluded, 2 living in a long-term care facility and 2 with a migrant background; because of language and comprehension difficulties we were unable to ensure informed consent.
[b]Characteristics of the 15 people who took part of the second round of interviews during October 2020.
[c]The National Old Age Pensions Act (*AOW*) is the Dutch state pension providing a basic pension for everyone aged 67 or over, 70% of the current minimum wage when living alone, 50% when living together, for those who lived in the Netherlands between the ages of 15 and 65.

during two group discussions, to reach consensus about the assigned codes.

Applying and adjusting the framework: the framework of age-friendliness was lined up against the selective codes, in order to compare them. The first author compared the generated codes with the description of the areas of age-friendliness and adjusted the WHO framework to the context of the COVID-19 measures, in accordance with the experiences of the respondents (Table 2, column 3). The members of the research team discussed the results of the primary and secondary analysis to corroborate the results (confirmability criterium).

Charting the data: the data was critically assessed and categorized. Due to the large volume, the representative quotations were selected by at least two researchers (credibility criterium), after which the codes and the data were charted into the analytical framework.

Interpretation of the data: during the last two stages the research team used an iterative process, going back and forth to compare the designated meanings of the charted extracts and to reach consensus on the interpretations that emerged from the analysis. This way the confidence in the results was ensured and the criterium of confirmability was met.

Results

The framework analysis of the data allows for specification of each of the eight areas of age-friendliness, based on the experiences of older people in the context of the COVID-19 measures in the Netherlands. An overview of the findings per area can be found in Table 2, first outlining the WHO areas of age-friendliness and their most relevant elements, and then specifying how these areas arise from the analyses of our interviews.

Table 2. Specification of the areas in the context of COVID-19.

WHO area	Relevant elements of each area (WHO)	Specification in the context of the COVID-19 measures, based on the perspectives of interviewees
Outdoor spaces	Green spaces, walkways, outdoor seating	Importance of the right to go outside; the basic need to be in nature, not feeling locked up, possibility to meet family and friends outside.
Transportation	Public transportation, taxis and roads	Long-distance mobility becomes less relevant, mobility as a health opportunity becomes more important e.g., bicycling, but also access to public transport, and the opportunity to use this safely.
Housing	Affordability, living environment	Unequal opportunities for people in different living situations to cope with the mitigation measures and to follow them in a safe manner.
Social participation	Accessibility of events and activities, isolation	Strong reduction of social activities and contacts. Learning new digital technologies of communication as a response. Need for bodily contact.
Civic participation/ employment	Volunteering, employment, training, valued contributions	(Voluntary) work and meaningful everyday activities become limited or disappear for many. Unlimited "free" time can lead to boredom and depression but also to engagement in (new) leisure activities and personal development.
Respect and social inclusion	Public images of aging, respectful, inclusive services	The COVID-19 measures refer to older people as a homogeneous group mainly as vulnerable and at-risk. Diversity is not taken into account.
Communication and information	Information, language, computer and internet	Experiences vary with how the media report on mitigation measures, the access to this information and the opportunities and abilities to assess and interpret this information, as well as the way it represents and addresses older adults.
Community and health services	Accessibility, emergency planning and care	Special community services to support older people. Special procedures in which age is used as a differentiating characteristic (e.g., Dutch ICU-protocol) or specific for settings predominated by older adults (i.e., long-term care facilities)

Outdoor spaces, transportation and housing

In March 2020 the Netherlands introduced the so-called intelligent lockdown. The government advised the population to not use public spaces and transport unless this was necessary (Bendien & Abma, 2020). Two weeks later the (long-term) care facilities went in total lockdown: all visits were canceled, and during the first wave of the pandemic the residents were not allowed to go outside or receive visitors for several months.

The participants often mention outdoor spaces in two contexts: when they reflect on the general appeal to stay at home and when they describe how they try to stay safe in their neighborhoods and personal living accommodations. Most of the respondents comply with the advice to stay at home but do go out for the necessary groceries and a walk or bike ride. Their motives for doing so vary between being cautious and being afraid of infection:

> If there are too many people in the supermarket, I don't go in. . . . A neighbor had his birthday this week. I said to my husband: "We're not going there. Not even a 'hello'." We just don't do those things right now, just to be cautious. *(Female 68, married)*

The respondent who kept working during the pandemic, talks about her older clients who do not dare to go outside: "Especially those aged 65 + .When I call to ask how they are, they say: 'I am staying inside, I am afraid to go out, can I go shopping?" (Female 63, living alone).

Most of the respondents bring the lockdown in connection with feeling isolated, emphasizing that access to outdoor spaces means more than the possibility to exercise or enjoy entertainment. It touches upon their mental health: "And whether you could afford that [staying inside] mentally, all that time, that is the question, isn't it?" (Male 95, living alone).

The partial lockdown increases their awareness about the inequalities in housing. Roughly two third of them have spacious houses with gardens or apartments with balconies, where they spend time without feeling locked up: "I'm not complaining, because we have a nice house with a garden, we don't live in each other's pockets" (Female 67, married). All our interviewees seem to make use of the surroundings where they live, going for a walk or bicycling almost every day, even when they find such activities not exciting:

> When you are almost 93 there is not much more you can do. Of course, I go out every day. I have a park in the neighborhood, but in the end, it becomes a bit boring. But I am glad I still have that park. If you live between apartment buildings, that is completely worthless. *(Female 92, living alone)*

The last remark of the quote refers to another dimension of age-friendliness, namely the differences between neighborhoods regarding the quality of outdoor spaces. Living close to a park or a beach seems to make a positive difference to the respondents.

Interestingly, the issue of transportation, which is usually very important for the mobility of older people, becomes less relevant to most of our interviewees. Those mentioning public transport, follow the advice of the Dutch government and refrain from all unnecessary travel plans, especially in March-April 2021. Although it minimizes their sense of freedom, they acknowledge that it is not "smart" to use public transportation during the lockdowns. Bicycling is mentioned by many interviewees as an important way to stay mobile, to travel short distances and to get some exercise. More striking are the consequences of not using public transportation for their social contacts:

> Look, I really want to go there, one [child] lives in Germany and the other in [place] . . . I used to go by taxi. But given the situation now I don't want to do that. Let's hope it will be different by Christmas. *(Female 92, living alone)*

One topic the respondents are unanimous about is the negative impact of the measures on inhabitants of long-term care facilities. It overlaps with the areas of social participation and community and health services. Our respondents find that people living in care facilities are already cut off from many aspects of

life. They cannot see any added value in a personal lockdown, i.e., in not being allowed to receive visitors or to go outside:

> I think it's very sad that family cannot visit, and volunteers cannot come inside. Now those people have next to nothing, no distractions . . . They can end up in a kind of depression. I think that's very . . . sad. *(Female 73, living alone)*

The respondents who are living in long-term care facilities themselves confirm this:

> When everything was good, I used to read [outside]. Now I can't go to the cafe anymore. I don't read like I used to, for fun. I saw a lot of people whom I knew or didn't know. And here I don't know anyone. *(Male 74, married)*

People have various reasons for such critique. Those who have relatives living in a care facility, recognize the hardship of the consequences of isolation for the people involved. But a more profound point in outing critique about the measures, that overlaps with the WHO-area of respect and social inclusion, is distancing yourself from the phase in life when decisions are made for you, as happens with the clients of long-term care facilities in the Netherlands. To speak with one of the respondents: "In that case I would rather live happily for one week, than ten weeks put away in a kitchen cupboard" (Female 74, living alone).

Summarizing, the COVID-19 measures shift the emphasis from age-friendliness of outdoor spaces to a more basic question of being able to go outside at all. The decision to protect older citizens is made at the expense of their freedom to move around, and social inequalities among them become emphasized. The measures increase the need for personal means of transportation and make the differences between neighborhoods with and without friendly outdoor spaces even more pronounced. The strongest negative impact is perceived for people living in long-term care facilities.

Social participation, civic participation and employment

The COVID-19 measures include a general appeal for social distancing, which inherently undermines social participation as understood in the framework of age-friendliness. One of the participants calls it "a necessary evil" (female 76, married). During the first wave, the Netherlands saw many formal and informal efforts to create new forms of interaction, like special TV and radio programs, digital concerts via internet and other activities (Van Leeuwen et al., 2020). The measures demonstrate various attitudes toward the use of modern means of communication, including the readiness to learn new skills. The rates of digitalization among older Dutch adults are rather high (Google & ANBO, 2017). Most of the respondents possess basic digital skills. Yet, in a few cases

a lack of such skills and the internalized idea of being "too old" to learn new things hampers them to connect with people:

> What's that called again, Skype? No, I don't do that. A phone call is easy, you always get a reply immediately. . . So, no messages or anything like that. You need to be taught by someone, indeed, it's not that you suddenly know how to do it. People often say: you won't learn that. And it all goes so quickly. . . . So, the next time you try, something goes wrong again. So no, I find that difficult. *(Female 92, living alone)*

The respondents experience restrictions of social participation in various domains of their lives: contact with family, friends, club/sport activities, shopping and voluntary work:

> Bridge at the club has stopped. Physical exercises at the club have been converted into digital sport. I am happy with that. I still go outside every day. I also have a kind of studio, so I can do sculpturing on my own. I notice that I can make progress, but at some stage I need the support of my teacher, which is not available. Well, I can contact her digitally. Anyway, I haven't figured it all out yet. *(Female 72, living alone)*

This quote is representative of our participants. Many everyday activities are suspended. The participants show an impressive range of skills and coping strategies to compensate the many contacts that have fallen away. Some patterns about how the respondents talk about the lack of contact stand out, like the need for bodily contact and the spontaneity of social encounters. The sharp reduction of physical contact with family members, especially with the (grand-)children, makes our respondents realize how important a cuddle or a hug is in their lives:

> A simple touch on the shoulder. You don't have it anymore. Yesterday I couldn't resist the temptation. [The daughter] is having a difficult time now. So, I hugged her. I'd rather die with a hug, than I don't hug but die anyway. *(Female 73, living alone)*

The experiences with the pandemic demonstrate that having physical contact forms an important part of the feeling connected to others. Moreover, it makes people feel seen and valued, therefore adding meaning to their lives. Also, the way personal contact is initiated is mentioned, as the COVID-19 measures took away the spontaneity of an encounter.

A few of the respondents have a job or are involved in voluntary work. Those who continue working refer to the strategies like disinfecting places where they meet people or reinventing themselves as participants in the online working community. Some of them are driven by the content of the work, like the respondent who transfers a teaching course to an online seminar. Or another respondent, who is involved in social work:

> I supervise a lot of people. And now I think: where are they all? I kept working and I built it up again slowly. What I like is that I continue guiding people who really need it, who don't have a job or a roof over their heads, because they are doubly affected. That also

> gives you some strength and pride. I didn't hide into a corner until the pandemic was over but was able to do my work. *(Female 63, living alone)*

The pattern that emerges from the analysis shows that people who have been actively engaged in (volunteer)work before the pandemic, can lose that meaningful engagement and purpose in their lives due to the COVID-19 measures, which in turn can lead to feelings of idleness and depression. As one of the respondents tellingly puts it: "I miss the contact. The whole range of contacts. I mean your world becomes really small when you sit at home that long" (male 67, married). Most of them worry that they would be of less value to others.

Summarizing, our participants do not experience the rules of social distancing to be age-friendly in the areas of social and civic participation, even though they understand that those rules are necessary. The measures highlight the value of physical contact and the significance of spontaneity of interaction with others; many of them consider new forms of interaction, including learning new skills. Where possible and applicable, the participants aim to continue their work and during the second wave also their volunteer work, albeit in a different form, because that remains an important source of meaning and purpose for them.

Respect and inclusion, communication and information

In its communication about the various measures the government and the National Institute for Public Health and Environment (RIVM) addresses people who are 70 or over, as a homogeneous risk-group in need of protection (RIVM, 2021). Interviewees differ in opinion about the way the measures are communicated. Whereas some agree with the framing of older people as vulnerable, others reflect critically on the fact that older people are portrayed as being in need of help simply because of their age. Biological age and personal circumstances vary a lot, but they feel that this heterogeneity is not considered at all:

> I was so angry. Like when you're older – you're vulnerable. There is quite a difference between older people and frail older people. My friends said I shouldn't worry. I say you should, otherwise you are seen as vulnerable right away. No way. You are also vulnerable as a young person, only in a different way. *(Female 73, living alone)*

A larger part of the participants tells us that the communication about the measures was patronizing, without regard for the diversity of the group that the authorities address as "older people," and that the approach based exclusively on chronological age falls short of considering the other aspects of life. A small group of the respondents appreciate the fact that vulnerabilities of old age, like underlying health conditions, are explicitly addressed in public communication: "Well it makes sense to me, to put it that way, because after all, our defense systems are as old as the rest of the body" (Male 78, married). Nevertheless, even these respondents find that the image of older people that is

broadcasted by media is too homogeneous. The interviews contain many remarks that show how, because of a paternalistic approach and possibly due to their own prejudices about old age, the respondents distance themselves from the "at-risk" group, which they define as "old and vulnerable," thus reproducing stereotypes on the basis of age and health. In their view, when speaking of "older people" the government in fact addresses those who are older than 80 or 90, and the ones who live in long-term care facilities and are physically dependent on others. This can be seen as an intuitive self-protective reaction against homogenization and ageism:

> Well, I don't feel old yet. When I hear 'older people,' I think about being over 85. The calendar tells me I'm 76, so I fall into the group. But when I look at everything I do, I think that I should do something for older people, I am not one of them yet. Anyway, I do have limitations, but it doesn't feel that way at all yet. *(Female 76, married)*

People appreciate receiving detailed information about statistics and protective measures. At the same time the amount and the repetitiveness of the news about COVID-19 makes some of them feel frightened, others bored and eventually indifferent. The participants plead for a more balanced coverage, where apart from the figures and eerie things, one can also hear about the experiences of older people themselves, or simply about anything else than the pandemic: "People talk only about Corona, but there are many other things that we worry about, right? Like your own health" (Male 79, married).

Our participants plea for intergenerational solidarity instead of the polarization that many of them notice in the media coverage. They talk about similar experiences with the pandemic among young and old and do not appreciate the way young people are told off:

> That was emphasized too much at the press-conferences, where the Prime Minister talked about how the young people had to be careful because of the older people. As a young person you run a risk yourself, don't you? It would have been better to emphasize that they also have to be careful about themselves. *(Male 71, married)*

Concluding, the patterns in the responses of our respondents regard their (dis-) approval of how disrespectful or inclusive the tone and language of the information related to COVID-19 is. One of the patterns shows that due to the patronizing language of communication, some ageist views are eventually internalized and reproduced by older people themselves. At the same time the respondents show the ability to resist ageism and to come up with ideas about the value of their lives. The direct referral in public statements to older people as a vulnerable group is not experienced as age-friendly by most of the interviewees. In small number of cases it could lead to confusion, resulting in unnecessary confinement to their homes. Although the respondents appreciate the detailed information about COVID-19, they are disappointed about the lack of diversity regarding older adults.

Community and health services

The COVID-19 measures have placed the community and health services under a lot of pressure. Our respondents recognize this and talk with gratitude about the dedication of the medical and nursing staff in the hospitals and long-term care facilities. The supermarket personnel are also mentioned in several interviews, because they quickly reorganized their schedules to allow for an extra shopping hour in the mornings for people with fragile health and older people. At first this measure led to contradictory reactions. The point of criticism was that the early shopping hour would rather stigmatize than help older people, but the data point out that most of our respondents do not see it this way and appreciate the option. In the end, none of the respondents in our sample makes use of it though, because shopping at regular hours is fine with them and for others the time is way too early (7AM):

> There isn't much reason for me to go to that hour for older people. . . . But I do find it admirable. Just think of all those shelf stackers and the cashier, all the personnel walking around; they have to be there by seven o'clock! *(Female 72, living alone)*

During the pandemic the Dutch healthcare services remain available for everybody. In May 2020 though it becomes clear that if the infection rates would not decrease, the intensive care units (ICU) would not be able to accommodate all COVID-19 patients any longer. Therefore, the Royal Dutch Medical Association develops and publishes an ICU-protocol (FMS, 2020), i.e., a guide for triage based on non-medical considerations for ICU-admission. The most controversial part of the protocol refers to the "fair innings"-argument, that states that everybody should have equal chances to live through the various stages in life (Bognar, 2015). This principle would be applied in the unlikely case ICUs would be full and choices would have to be made between persons with similar health conditions. Since older people have already had more opportunities in life, younger people could have a stronger claim on an ICU-bed than an older person. The publication caused a public outrage, the echo of which we hear in the interviews. Two major topics emerge: anti-ageist statements, in which our participants argue that they themselves have the right to decide whether they should be treated or not, and end-of-life issues. The question that one of the respondents asks is emblematic: "Are we still welcome at intensive care?" (Female 74, living alone). The following statement reflects feelings that many people have about prioritization based on age:

> To be honest I didn't even want to listen to that because I think it's outrageous. Older people have also worked in the past, for the younger generation, so I don't think they can reason like that: you have the right, and you don't. *(Female 63, living alone)*

The participants feel vulnerable in the discussion that addresses issues of life and death. They look for more nuanced procedures, that respect their

autonomy and value their life, especially where decisions about health services and particularly the end-of-life are concerned:

> Older people have just as much the need for a continued life as the young. It's not that simple, like the older people have lived their lives and the young have yet to live it. I read a piece titled: 'When doctors have to decide between life and death.' This is not right. The doctors cannot decide about life and death. They have to follow the law, according to which they have promised to help people, not to decide whether you are going to die or to live. That was a very strange formulation. *(Male 95, living alone)*

The quote is illustrative for the majority of our interviewees, who want to make that type of decision themselves, and preferably not in a moment of crisis. Some of them find it intrusive when they were phoned by their General Practitioner at the beginning of the pandemic with the question whether they want to be admitted to the ICU if it would come to that. Although these phone calls stimulate some people to think about their options, the implicit ageism of the action is also painful to them:

> If I'm very sick, then I think that's [ICU-bed] really not necessary for me. I've had a wonderful life, so give me something so I can die in peace. But now people with underlying conditions are being approached, and I am sure that people who do not have any health condition are also being approached [to decide whether they want to be admitted to ICU]. I find that scary. *(Female 73, living alone)*

Bringing age and fair-innings-arguments as indicators into the ICU-protocol is explicitly marked by the interviewees as an age-unfriendly measure during the pandemic.

An important element of the age-friendly environment is accessibility and the quality of care in long-term care facilities. Examples have already been presented in the section about outdoor spaces. The reactions of our independently living respondents to the way measures may affect older people living in long-term facilities during the pandemic are unanimous: pity, compassion, disbelief and indignation. In the eyes of our participants the lockdown, that is introduced in all the facilities top-down, does not take into consideration the wishes of their inhabitants, especially their dependence on the visits of their friends and family. The lockdown of the facilities puts all voluntary work on hold. For that reason too, the respondents see the lockdown in long-term care facilities as an ill-judged measure.

To sum up, the COVID-19 measures expose age-unfriendliness in health services, which becomes explicit in the protocol for ICU-admission. Our respondents experience them as lacking respect for their autonomy and dignity. Yet, those issues have stimulated self-reflection among our participants, resulting in placing a value on their lives and strengthening their wish to remain autonomous and in control of their lives and end-of-life decisions.

Discussion

Based on the experience of our respondents, the Dutch COVID-19 measures have not considered age-friendliness as understood in the WHO's conceptual framework. The available literature provides us with a very limited number of examples where COVID-19 measures have been structurally introduced in conformance with the WHO framework (Dabelko-Schoeny et al., 2022). The negative effect of the mitigating measures in the Netherlands is felt most in the areas of social participation, respect and inclusion, which is similar to the findings in other countries (Falvo et al., 2021). Communication and information, community and health services, are explicitly criticized as being age-unfriendly. Comparing our results with international reporting, we find that that the assessment of these last areas varies by country. For example, a Japanese study emphasizes the effectiveness of the existing communication channels (Estévez-Abe & Ide, 2021), while a Canadian study focuses on the tragic events in Quebec, exposing the shortcomings of the community and health service for older people and advocating improvement (Béland & Marier, 2020). Similarities and differences regarding the impact of the COVID-19 policies in various areas of the framework, depend on the interplay of several relevant national contexts. In their comparative study Yan et al. (2021) provide an analytical explanation of how culture and institutional and political structures within countries influence the type of the policies that their governments select, linking them to the anticipated responses of the population. For example, the Netherlands has a so-called "loose cultural orientation," just like Belgium, Australia and several other countries, where compliance to social norms can be questioned and acceptance of atypical behavior is high. This can explain why the COVID-19 policies in these countries are introduced less expediently. They are called "reactive," i.e., following instead of anticipating high deaths rates of older people, which is why they become highly unpopular when they are introduced (Yan et al., 2021).

The overarching criticism of the Dutch respondents can be summarized as a lack of attention to diversity. This resulted in homogenization and stigmatization of all older people as vulnerable and needy (Ikani et al., 2021). This rhetoric is often not endorsed by older people themselves, since many of them do not identify themselves with the image of vulnerability and dependency (Berridge & Hooyman, 2020). These findings are supported by international research on ageism and recent publications as a reaction to the upsurge of ageist sentiments during the pandemic worldwide (Falvo et al., 2021; Meisner, 2021). A noteworthy pattern in the interviews is the critique that the government measures singled out older people as an at-risk group based on their chronological age (Ayalon et al., 2020). The suggestions from several interviews point at creating an alternative approach, where not age but the analysis of an individual's unique situation should facilitate the decision about support.

This implies that age always intersects with other relevant characteristics, such as social economic status or digital literacy (Schroyer, 2021), and that a broader context of people's lives needs to be taken into account when developing policies, as the framework of age-friendliness suggests. If policies suggest treating all older people in the same way, then the inequalities between them can be strengthened. More in general, according to our interviewees, the issues of autonomy and being in control of your own life must be respected, even when tailoring services to needs (Abma & Bendien, 2019). Loss of control of one's own life can decrease one's feelings of self-efficacy or even one's wellbeing (Ngo, 2012).

Using age-friendliness as a lens to appraise the mitigating measures, allows us to look critically at the framework itself and to identify points of attention within the existing areas. For example, the importance of age-friendly outdoor spaces becomes dependent on the possibility to be outside. The participants connect the accessibility of the environment where they live, with the consequences for their mental and physical health and autonomy, which broadens our understanding of age-friendly spaces and policies (Lindenberg & Westendorp, 2015). Another area with a new focus is the community and health services. The COVID-19 measures objectify the inhabitants of long-term care facilities as subjects that are to be protected. In the future, the framework should be more explicit about the freedom of choice for this group, apart from the availability and quality of care.

We conclude that the recent Dutch policies, related to the COVID-19 pandemic, did not consider age-friendliness as a basic starting point. In face of this conclusion there are several lessons to learn. Firstly, in times of crises we would do well by using all the knowledge that has been accumulated so far. The WHO's conceptual framework offers a multifaceted tool for appraisal of policies involving older people, *ex ante* and *ex post* (Abma, 2019; Zhang et al., 2020). During COVID-19 much of the existing academic and experiential knowledge has not been used, quite likely because neither older people themselves nor the experts who are familiar with the framework, were among those whom the governments consulted in first instance. Secondly, policies that consider personal autonomy insufficiently, usually fail. The issues concerning the possible shortage of ICU-beds and the resulting ICU-protocol are good illustrations of this. The Dutch ICU-protocol that is developed in cooperation with medical professionals and ethicists, is felt to be age-unfriendly, not so much because in certain cases the treatment of younger people could be prioritized over older ones, but because the decision would be taken top-down, without consulting the patients themselves. Even those persons who would be satisfied with the notion of a fulfilled life, emphasize the importance of being able to make their own decisions, of simply *having* a choice. In that respect the policy in question fails to respect the role and wishes of the patient and does not live up to the bioethical principle of autonomy and human rights

of bodily integrity (UN, 1966). Not being acknowledged as able to make your own decision as an older person is a form of ageism. Several studies point out that exposure to ageism can negatively influence the mental and other forms of health of older people (Hu et al., 2021; Levy et al., 2021). Therefore, government policies must also consider the views of the people whose lives are at stake during the decision-making processes.

Limitations

The study has several limitations. The data has not been collected with the explicit aim to investigate whether the mitigating measures against COVID-19 are experienced as age-friendly, therefore other policy issues could also have been identified as age-(un-)friendly. The data is acquired through telephone interviews, therefore observation of the participants, that could have provided additional information about the respondents, is absent. Also, this study has been unable to reach out to large numbers of residents at long-term care facilities, and although we have tried to pay attention to their diverse perspectives, given the quite stringent and exceptional situation for these respondents, it would be worthwhile to explore these perspectives with more interviews. Finally, given the continuous, and at times quite rapid, changes in COVID-19 measures during the past two years, it would have been beneficial to hold recurring interviews with a selected sample of this study, to allow for a more processual and longitudinal view. Time and resources have not allowed us to do so.

Conclusion

This study uses the framework of age-friendliness to evaluate the policy measures, taken to protect older people from infection with the COVID-19 virus. Given the purpose of the measures, one could expect that the notion of age-friendliness would underlie the entire policy, or at least form an integral part of it. The COVID-19 pandemic can be seen as a checkpoint on the road toward an age-friendly world, showing how deep the idea of age-friendliness has developed its roots in society. On the basis of this framework and comparing this to the experiences of Dutch older adults during this pandemic, we conclude that many measures to protect older people are in fact not experienced by them as age-friendly. Older people feel negatively affected in the areas of social participation, respect and social inclusion. An important underlying issue of the COVID-19 measures is limitation of individual autonomy. While viewing the measures through the lens of the framework proves to be useful for analysis of various policies worldwide, the framework itself needs critical reflection and development. The new focal points within the established areas are promising departure points for such a conceptual development.

Key points

- A crisis such as a pandemic requires policies, based on interdisciplinary and experiential knowledge.
- Policies directed at older people can be experienced as ageist if the heterogeneity of that group is not considered.
- Policies directed at older people will benefit from examination within the WHO conceptual framework of age-friendliness ex ante and ex post.

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