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Guest editorial

The advantage of knowing on which side your bread is buttered!

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In The Netherlands the term *hangjongeren* is used to refer to young people who hang around shopping centres, street corners and other places in towns and cities, and who are seen as disruptive or annoying. A very similar term is now used in connection with those at the other end of the age spectrum. *Hangouderen* refers to small groups of coffee-drinking older people in shopping areas, blocking the way of other people and irritating shopkeepers and the shopping public. Last year the complaints about *hangouderen* were, for the first time, evident in the press and other media. 'Second cup (of coffee) free' was one of the headlines in a national paper, which however focused not on the free drink, but on complaints about this new phenomenon. The *hangouderen* were described as slow, miserable and blocking the economy. The article went further, arguing that *hangouderen* were taking from society, for example by using fuel resources to heat their homes and claiming a state pension that has been earned for them, not by them (*De Volkskrant* 17 November 2005).

What is going on? Surely this approach is unacceptable. People who have worked throughout their lives and now earned their rest are seen to be as much of a problem as those who, in England, are being given ASBOs (anti-social behaviour orders). A new discrimination is developing which goes beyond current trends towards ageism. If we are not careful, ideas about diversity in health and social care will soon be replaced by discrimination.

The numbers of older people in The Netherlands will continue to rise in the coming years as demographic changes lead to an increasingly older population, with comparatively fewer young people. In the year 2000, 13% of the population was aged over 65 years, but by 2030 it is predicted that this figure will rise to 22% (Ministerie van Volksgezondheid, Welzijn en Sport, 2005). Along with this trend, we are seeing two distinct and stereotyped groups emerge. There are the healthy 'well-to-do' pensioners who have the means and time to pursue what they wish. Glossy magazines such as *Plusmagazine* focus on a wealthy lifestyle for older people, promoting what appear to be non-stop holidays and travel that arouse jealousy among younger working people. Then there are the 'problem older people', those with poor health and sometimes few or no financial resources. They need ongoing care and support and are regarded with pity by the general public. The media and the policy makers continually focus on the rising public cost of this group, stressing the need for all responsible citizens to save and take responsibility for their own care. Both these stereotypes impact on the stability of society, damaging the relationships between young and old.

In the western world we live in an increasingly egocentric society encapsulated in the title *Me, Myself and the Selfish World* (Studium Generale, 2005). Tolerance and community spirit in this individualised society sit uncomfortably alongside collective responsibility. There must be care, but not by me (de Vries, 2000). Nice ideological phrases such as 'all of us have to do our part' cannot solve the dilemma of who should provide care. We have to realise that the basis of a safe and stable community is shared interest and reciprocity. Altruism, with its moral high ground, sounds attractive, but does not appear to be working in practice. In The Netherlands, the old welfare state is dead, seen as too expensive, too impersonal, too difficult to resource and in essence inhuman. It has left the individual in a world of regulation and bureaucracy which, while providing the illusion of choice, is in fact disempowering. We have allowed ourselves to become victims, losing sight of the importance of self-healing, and the recognition that only we can do it for ourselves.

Of course everyone wants to live in a civil society where care and support, safety and tolerance are integral parts of life. But such a caring, culturally safe society is only possible through acceptance of the need for mutual respect and the reciprocity that comes with shared interests. In Christian terms, people should treat others as they wish to be treated themselves. If we wish to create a vibrant and living community then we must build on that premise and have an attitude of commitment and involvement. The question for service providers is how, in modern society, to capture such

ideals and translate them into practice. Perhaps a good starting point would be for all individuals, whether healthcare professionals or clients, to consider their own needs and wants alongside what each can add and give to society. Clients must no longer be passive recipients. A more active attitude and interactive approach must be developed by both care-givers and care-receivers alike. Clients need to be invited and enabled to initiate a dialogue identifying their needs and wants from their own rather than the professionals' perspective. Informal carers also need to be involved in this dialogue. The aim has to be a move from *working for* and *doing to* towards *working with* and a recognition of how shared interests can be utilised to the benefit of all: recipients, their families, providers and the community. Saying and recognising this is much easier than doing it, it asks for a rethinking of the care we are giving and the empowerment of our patients and clients.

The time of the great ideologies seems to be over, but Vintgens (2003) argues that there is a new type of commitment arising which she calls 'the little commitment'. She suggests we are willing to become involved in small-scale projects but not in the greater scheme of things. We are prepared to participate if we can see some return, i.e. there is an element of self-interest here, and there is nothing wrong with that. However, a fully functioning society needs more. What is necessary is a transcendental change in the self and a true awareness that the highest level of individuality can only be realised when the self is subordinated to the whole. This principle applies equally to the sick and disadvantaged. We must recognise the contributions they can and want to make. We must accept without patronage their limits and enable them to achieve their full potential and citizenship. We can use the new engagement in society, taking small steps forward with one another, in the understanding that, from this, greater steps will come. Each individual contributes and makes a difference to their own and others' lives, but to do this in respect and reciprocity on a basis of shared interest, then in common parlance we would say they need to know on which side their bread is buttered.

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