Key points
- Earlier studies assessed prevalence rates of abuse of older people in one country, but did not compare prevalence rates in different cities.
- Our study provides information of methods on conducting a multinational study on violence against older citizens.
- The findings identified different response behaviour among age groups in the study participants.
- The findings identified different response behaviour among the participating cities.

References

Good friends, high income or resilience? What matters most for elderly patients?

Vera-Christina Mertens1,2, Hans Bosma1, Danielle A.I. Groffen1, Jacques Th.M. van Eijk1

1 Department of Social Medicine, School for Public Health and Primary Care (CAPHRI), Maastricht University, The Netherlands
2 Department of General Practice, School for Public Health and Primary Care (CAPHRI), Maastricht University, The Netherlands

Correspondence: Vera-Christina Mertens, School for Public Health and Primary Care (CAPHRI), Department of Rehabilitation Medicine, Maastricht University, P.O. Box 616, 6200 MD Maastricht, the Netherlands, tel: +31 43 3882168, e-mail: vera.mertens@maastrichtuniversity.nl

Background: Chronically ill patients need to adapt to their impaired life condition. Social (e.g. social support), material (e.g. income) and personal (e.g. mastery) resources are needed to cope with this challenge. It is, however, less clear whether these factors also contribute to ‘relatively successful functioning’ and whether these effects are disease specific or generic across chronic diseases. Methods: Baseline data from 361 Dutch men and women aged ≥60 years who were mildly depressed and diagnosed with type 2 diabetes or chronic obstructive pulmonary disease (COPD) were used. These persons participated in the ‘Depression in Elderly with Long-Term Afflictions’ (DELTa) study. Logistic regression analyses were used to study the independent association of social support, income and mastery (independent variables) with physical, mental and social functioning (dependent variables). Results: A high level of mastery is significantly associated with physical, mental and social functioning in the total study population, as well as in subgroups of patients with COPD or diabetes. This relationship remained significant after controlling for confounding factors such as gender, age, educational level and the other remaining resources. In diabetes patients, high levels of social support and income also contributed significantly to successful social functioning. Conclusion: Our findings suggest that rather than having good friends and a high income, having a high level of mastery (resilience) might best help chronically ill patients in coping with and adapting to their often co-morbid condition. Further longitudinal research is necessary to unravel the long-term effects of mastery, income and social support on ‘relatively successful functioning’ in chronically ill patients.
Introduction

Due to demographic shifts, more people have and will have chronic diseases. Most chronic diseases can be seen as a chronic strain or stressor, especially among elderly people in whom chronic diseases are common. To adapt to the often deteriorating course of a chronic disease, a person's social, personal and material resources are constantly challenged. These resources can be defined as 'material, social, or personal characteristics that a person possesses that he or she can use to make progress towards his or her goals' (p. 926).

Social resources, such as social support, might help a person to adapt to the consequences of stressful events and ongoing strains associated with having a chronic disease. Emotional support is especially important during major life transitions which can occur frequently during the course of a chronic disease. Emotional support is a significant, independent predictor of less functional decline in people with chronic conditions and receipt of emotional support decreases the risk of death in elderly people. Furthermore, the amount of social support is positively related to social/family well-being and emotional well-being.

In the case of a chronic disease, material resources, such as money to compensate for increased health-care utilization, domestic care and other costs are needed to adapt to changing life circumstances. Income can also influence life satisfaction indirectly by mediating social participation (e.g. enjoying sports or recreation). Bosma et al. confirmed that lower income in a heterogeneous group of chronically ill persons was associated with lower social participation, even resulting in social exclusion. Others reported a significant relationship between the financial situation and life satisfaction in chronically ill persons and between low income and an increased risk of mobility decline.

Personal resources, such as self-efficacy, sense of mastery or control beliefs, may be considered as components of psychological resilience and therefore important in the process of coping with a chronic disease. Luthar et al.'s advice is to use the term 'resilience' as an indication of a process or phenomenon of competence despite adversity (p. 15). In persons confronted with a chronic disease, this personal resource can be seen as competence in the face of adversity (i.e. a chronic disease). Control beliefs, as a marker of resilience, refer to the individual's belief regarding the subjective feeling of control about a certain life situation and the environment. Instead of falling into passivity and fatalism, high control beliefs might promote effective behavioural and cognitive strategies to buffer and lessen the detrimental effects of stress and to deal optimally with a chronic condition. Consequently, via lower stress hormone levels, high levels of control beliefs may reduce the risk of death and are critical in maintaining health-related quality of life in later—ageing.

Older people with a chronic disease and also with many good friends and acquaintances, a high income and a resilient and hardy personality, might deal more effectively with their disease in terms of their quality of life and health-related functioning. However, chronic diseases vary greatly in terms of onset, course and consequences. Therefore, adaptive processes and tasks for the patient may differ. Different resources are needed to deal optimally (given the circumstances) with the condition. For example, type 2 diabetes mellitus (DM) is characterized as a 'silent disease' initially with few complications and little impact on physical functioning. Its treatment requires lifestyle changes in terms of food intake, exercises and treatment adherence in order to prevent complications such as cardiovascular diseases. Chronic obstructive pulmonary disease (COPD), on the other hand, is an irreversible progressive disease which is characterized by systemic inflammation of airways and lungs in which exacerbations are recurrent. Even at onset, COPD has a strong influence on physical functioning.

To further elucidate the relative importance of social, material and personal resources for 'relatively successful functioning' in older age and whether adaptive tasks and the use of coping resources are different or comparable among patients with different chronic conditions, we used Dutch data from both COPD and DM patients. The approach in our study is both salutogenic, being aimed at 'relatively successful functioning' in social, material and personal factors and its contributing resources. It is also explorative, implying that our cross-sectional study aims foremost to generate further research hypotheses.

Methods

Design and study population

For our cross-sectional study, we used baseline data from the 'Depression in Elderly with Long-Term Afflictions' (DELTA) study. DELTA was an intervention study aimed at improving (mental and social) functioning in people with a chronic condition. A detailed description of the study protocol has been published elsewhere. Patients were ≥ 60 years, had either COPD or type 2 DM, and reported symptoms of depression. Patients were recruited between October 2003 and May 2005 in 89 primary care practices in the south of the Netherlands. Patients who had been diagnosed by their general practitioner (GP) with type 2 DM or COPD, who were aged ≥ 60 years, who were community dwelling and who did not meet exclusion criteria (treatment with anti-depressants for depression, major psychiatric problems such as bipolar depression, schizophrenia, alcohol or substance abuse, current psychosocial/psychiatric treatment, serious cognitive problems, on waiting list for nursing home, bedridden, loss of spouse within past 3 months and not being fluent in Dutch) were sent the patient health questionnaire (PHQ-9) to check for symptoms of depression (n = 8326). Patients were excluded, because they were either ineligible (n = 4192), refused to participate in PHQ-9 (n = 2747), or returned an incomplete PHQ-9 (n = 422). The overall response rate to the screening questionnaire was 67%.

The PHQ-9 questionnaire consists of nine questions with the four answer options 'Not at all', 'Several days', 'More than half the days' and 'Nearly every day' (4-point Likert scale). Patients scoring at least 2 depressive symptoms at least 'more than half the days' were invited for a structured diagnostic interview using the Mini International Neuropsychiatric Interview (MINI) (n = 965). Patients with minor depression, mild to moderate major depression or dysthymia were included in the study. Patients with suicidal risk and patients with severe major depression, according to the Hamilton Depression Rating Scale (HDRS ≥ 18) which was used to measure the severity of depression, were excluded and referred to their GP (n = 300 did not meet the inclusion criteria, n = 304 refused to participate in MINI or trial). After signing an informed consent form, 361 patients completed a baseline questionnaire (185 DM; 176 COPD, 53.5% males, mean age 70.7 years). Approval for the study protocol was obtained from the Medical Ethics Committee of Maastricht University/University Hospital Maastricht. For this study, only baseline data are used.

Measures

'Relatively successful functioning'

Given the underlying co-morbid condition of the study population (COPD/DM and mild to moderate depression), we added the term 'relatively' to our health-related outcome 'relatively successful functioning'. The outcome was measured using above-median function in either physical, or mental or social functioning. The short-form 36 (SF-36) general health survey includes eight health concepts which can be aggregated to a general measure for 'physical' and 'mental functioning'.

The SF-36 has been extensively tested for validity in various countries, disease groups and settings. Higher scores indicate better health status. For 'social functioning', we used the Autonomy Outdoors domain of the ‘Impact on Participation and Autonomy’ (IPA) questionnaire. This domain includes five questions about the ability to attend social activities. Scores range from 5 to 25, where higher scores reflect less social participation. The IPA has good psychometric qualities. One of the items is 'My chances of using leisure time the way I want to are very good/good/fair/poor/very poor' (5-point Likert scale). Missing values were imputed in patients for whom at least 50% of items were available. The individual mean score of items that were not missing was used for the imputation (see manual of the SF-36). The sum scores...
were dichotomized using the median where ‘1’ represents ‘relatively successful functioning’ and ‘0’ indicates ‘less successful functioning’.

**Resources**

The patients’ social, material and personal resources were measured. Received social support (‘social resource’) in terms of emotional, informative and instrumental support was measured by the Social Support List of Interactions questionnaire (SSL-I-12). The questionnaire consists of 12 items. Two examples of items are ‘Does it ever happen to you that people who are around you a) emphasise your strong points? and b) visit you at home?’. Items are rated on a 4-point Likert scale ranging from ‘very often’ to ‘seldom or never’. Items were summed with a range of 25–100, where higher scores indicate more social support. Cronbach’s α was 0.91.

Monthly net household income (‘material resource’) was measured by self-report at baseline using eight ordinal categories ranging from <750€ to >3000€. To adjust for the number of people who had to live from the income, we divided household income by an equivalence factor. To calculate this equivalence factor, we used the following formula: 1 (the first adult) + 0.5 * the number of extra adults living from the income + 0.3 * the number of children below the age of 18 years. Mastery was chosen as a marker of resilience (‘personal resource’) and measured using the Personal Mastery Scale developed by Pearlin and Schooler. Respondents described their feelings about seven items such as ‘I have little control over the things that happen to me’ on a 5-point Likert scale ranging from 1 (strongly agree) to 5 (strongly disagree). Higher (total) scores represent higher mastery. Cronbach’s α was 0.83. The total scores of the three resources of income, social support and mastery were subsequently divided into thirds using tertiles in order to define the low, medium and high level of each resource, where a higher level represents a more favourable situation.

**Covariates**

Covariates were level of education, age, sex and disease. Level of education was measured using an 8-point scale that hierarchically ranks the Dutch educational levels. We also controlled for type of disease (diabetes vs. COPD) in the total population.

**Statistical analyses**

All analyses were performed using SPSS, version 16. Chi-square and t-tests were used to test differences between diseases regarding background characteristics. Logistic regression analyses were used to examine the relative contribution of the three categorical resources. Additional linear regression analyses were performed to test the robustness of findings. In all analyses, the association of the resource with the outcomes was adjusted for sex, age, education, underlying disease and the two other resources. All analyses were performed in the total study population and in the COPD and diabetes population separately.

**Results**

Table 1 shows the baseline characteristics of the study population by type of disease (DM vs. COPD) and in the total population. Both groups differed significantly in gender, level of education, income and physical functioning. Significantly more COPD patients were male compared with the diabetes patients (59.1 vs. 48.1%). Comparing educational level, significantly more COPD patients had a low educational level compared with the DM patients (36.9 vs. 31.9%). Furthermore, COPD patients had significantly more missing values for income (35.2 vs. 29.2%). With respect to physical functioning, significantly more COPD patients scored below the median of the total group (51.1%) compared with 35.7% of the DM patients. To summarize, COPD patients were significantly more likely to be male, have a low educational level and to have more missing data on income compared to DM patients. With respect to physical functioning, significantly more COPD patients scored below the median of the total group compared with the DM patients.

Table 2 shows that people reporting a high level of mastery had higher odds of relatively successful functioning in all domains compared with persons who did not report high levels of mastery in the total study population. This holds for physical functioning (OR 1.84; 95% CI 1.05–3.2), mental functioning (OR 3.85, 95% CI 2.15–6.89) and social functioning (OR 2.62; 95% CI 1.52–4.51). This also holds for both patient groups separately. In COPD patients, odds ratios ranged from 1.52 (95% CI 0.68–3.41) to 5.12 (95% CI 2.10–12.3) for physical and mental functioning. Except for physical functioning in COPD and DM patients, mastery was significantly related to all outcomes. Except for social functioning in DM patients, mastery was the strongest correlate of health-related functioning. In diabetes patients, social support (ORDM 4.1; 95% CI 1.75–9.62) and a high income (ORDM 3.97; 95% CI 1.35–11.6) were more strongly related to social functioning than high mastery.

Analyses in the group that had complete cases for all three outcomes demonstrated similar findings. Additional linear regression analyses were done using both the resources and the outcomes in a continuous format. The pattern of findings was again highly similar. Furthermore, changing the cut-off for the different outcomes, e.g. using the best functioning 25% (instead of 50%), did not modify the pattern of findings. The general pattern of findings was similar whether or not educational level was controlled for and whether or not the three resources were mutually adjusted.

**Discussion**

In elderly people with depression and two distinct chronic diseases (type 2 diabetes and COPD), we found that high control beliefs (mastery) contributed most strongly and consistently to different areas of ‘relatively successful functioning’ in both groups of patients. In diabetic patients, a high level of social support and a high level of income
Table 2 Odds ratios (OR) (95% confidence interval) of ‘relatively successful functioning’ by social support, income and mastery of the total population and separated by subgroups a

<table>
<thead>
<tr>
<th>Social support</th>
<th>Mental functioning</th>
<th>Social functioning</th>
<th>Physical functioning</th>
<th>Mental functioning</th>
<th>Social functioning</th>
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<td><strong>Total population</strong></td>
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<tr>
<td>High</td>
<td>0.86 (0.66–1.13)</td>
<td>2.57** (1.45–4.55)</td>
<td>0.69 (0.60–0.80)</td>
<td>2.48 (1.86–3.31)</td>
<td>0.94 (0.80–1.11)</td>
<td>3.97** (2.15–7.34)</td>
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<td>Middle</td>
<td>1.71 (0.94–3.13)</td>
<td>1.54 (0.99–2.38)</td>
<td>0.77 (0.66–0.90)</td>
<td>1.26 (0.92–1.73)</td>
<td>1.00 (0.85–1.18)</td>
<td>2.68* (1.05–6.89)</td>
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<td>Low</td>
<td>2.04 (0.91–4.55)</td>
<td>1.34 (0.79–2.28)</td>
<td>0.62 (0.51–0.77)</td>
<td>1.02 (0.83–1.24)</td>
<td>0.96 (0.82–1.12)</td>
<td>2.35* (1.03–5.40)</td>
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<td><strong>Diabetes sub-population</strong></td>
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<td><strong>COPD sub-population</strong></td>
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<td>2.35* (1.03–5.40)</td>
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</table>

a: Adjusted for sex, age, education, and other resources. Although included in the analyses, odds ratios for the category indicating missing income data are not tabulated.

b: Although included in the analyses, odds ratios for the category indicating missing income data are not tabulated.

*P < 0.05, **P < 0.01.

Our findings corroborate previous studies and fit very well with Antonovsky’s salutogenic theory. By exploring the origins of good health, Antonovsky postulated three types of coherence: meaningfulness, comprehensibility and manageability. Meaningfulness refers to pleasure and satisfaction and an understanding of things and events. Comprehensibility refers to a certain predictability of events and people’s recognition that they can control these events. Manageability refers to people’s resources (skills) to control events which are also experienced in their area of control. Using the sense of coherence concept, Antonovsky’s salutogenic perspective on health, rather than underlining the extra-individual material and social resources, underlines the importance of personal resources for positive health outcomes. Other studies confirmed the importance of personal resources, such as control beliefs. The other individual resources of income and social support were also important, but only in diabetes patients and only for social functioning. The impairments resulting from COPD might be so substantial and interfering that these cannot be outweighed by a high income and much social support. This speculation, however, merits further examination.

Another aspect needing further clarification is the question of whether mastery can be seen as a modifiable state or a dispositional trait and what that might imply for intervention purposes.

We used mastery as a personal resource which more or less suggests an interpretation in terms of a dispositional trait. From such a perspective, interventions should probably focus on the early life roots of this trait. Beliefs of high control might originate in positive socio-economic circumstances during upbringing; adverse childhood circumstances might thus be the subject of interventions to improve control beliefs. The educational level of our participants might be considered a proxy of these childhood circumstances; education, however, did not confound our findings. Also for intervention purposes, further research should thus explore which circumstances in childhood exactly promote the development of high control beliefs and mastery. Finally, a genetic basis of personality and mastery in particular probably can neither be neglected. Depending upon the genetic influence, mastery might be difficult to modify leaving restricted room for interventions. Viewing mastery as a modifiable state, intervention might focus on skills to improve mastery. Cognitive behaviour therapy (CBT) and other behavioural interventions, e.g. in the field of lifestyle aim to improve skills, such as self-efficacy; self-efficacy might conceptually be closely related to mastery. In the DELTA study from which we have used baseline data, a nurse-led minimal psychological intervention was provided which aimed to educate patients in self-management for their illness and its emotional and cognitive consequences. It was shown, that this intervention resulted in a significant reduction of depressive symptoms in both patient groups and a better quality of life in COPD patients (Jonkers, Lamers, Bosma et al., submitted). In another DELTA substudy, we found that a likely mechanism might be through elevating self-efficacy. Hence, tailor-made self-management interventions that also address the emotional and cognitive consequences of chronic disease might promote beliefs of control in chronic disease patients and empower them to more adaptively face their disease.

Our study also has several limitations. First, the cross-sectional design excludes causal interpretations of the association between resources and outcomes. The study therefore is explorative and primarily aimed at generating hypotheses to be tested further in longitudinal research. Furthermore, all data were self-reports leading to the possibility of reporting bias. Negative affectivity might have influenced both reports of the resources and the outcomes resulting in overestimated associations.

Second, the DELTA sample was also quite specific in terms of its co-morbidity (having either type 2 diabetes or COPD in combination with a mild to moderate depression); it remains to be tested whether our findings can be generalized to patients with other chronic conditions.
with and without depressive complaints. Third, we used only a restricted set of measurements of material, social and personal resources. Perhaps it would be useful to examine additional measurements, such as social networks (size, composition), material housing and neighbourhood characteristics and other indicators of psychological resilience and hardiness.12 Finally, our measurement of 'relatively successful functioning' with above-median scores on either physical, or mental, or social functioning was rather simple. This probably deserves further refinement and validation.

Conclusion
In chronically ill patients with a co-morbid depression, more than having good friends and a high income, having a high level of mastery (resilience) is most strongly related to coping with and adapting to the co-morbid condition. Empowering older ill people by strengthening their control beliefs might improve their health-related quality of life. To enable causal inference, further longitudinal research is necessary to unravel the long-term effects of mastery, income and social support on 'relatively successful functioning' in chronically ill patients.

Acknowledgements
The authors thank Kitty Daemen, Henny Geelen, Francine Hendriks and Micke Witte, for administering the intervention with dedication and enthusiasm; Wendy Engering for her contribution to the patient recruitment; and Dorien Mintjes for her contribution to the data entry, as well as MEMIC (Centre for Data and Information Management, Maastricht University) for providing us with a data management system.

Funding
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Conflicts of interest: None declared.

Key points
- Few studies have focused on the relative importance of having good friends, high income or a resilient personality for relatively successful functioning with chronic disease in older age.
- The current Dutch cross-sectional data of type 2 diabetes and COPD patients with a mild depression suggests the relative importance of resilience, as indicated by having high control beliefs (mastery), for health-related physical, mental and social functioning.
- Helping older people cope with their disease by strengthening their beliefs of control should probably have a stronger emphasis in intervention efforts aimed at heightening quality of life and 'relatively successful functioning'.

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Health-care and home-care utilization among frail elderly persons in Belgium

Sarah Hoeck1, Guido François1, Joanna Geerts2,3, Johan Van der Heyden4, Maurits Vandewoude5,6, Guido Van Hal1

1 Department of Epidemiology and Social Medicine, University of Antwerp, Antwerp, Belgium
2 Federal Planning Bureau, Belgium
3 Department of Sociology, University of Antwerp, Belgium
4 Scientific Institute of Public Health, Brussels, Belgium
5 Hospital Network Antwerp, Belgium
6 University Geriatrics Center, University of Antwerp, Belgium

Correspondence: Sarah Hoeck, Department of Epidemiology and Social Medicine, Campus Drie Eiken, University of Antwerp, Universiteitsplein 1, BE-2610 Antwerp, Belgium, tel +32 3 265 28 70, fax +32 3 265 28 75, e-mail: sarah.hoeck@ua.ac.be

Background: The patterns of health- and home-care utilization among Belgian frail elderly persons living at home with varying socio-economic status are currently unknown. Methods: In this cross-sectional study based on a representative sample of 4777 elderly participants (≥65 years) in the Belgian Health Interview Survey the prevalence of frailty, as determined by items referring to the Fried phenotype, was estimated according to age, gender, comorbidity, place of residence, survey year, living situation and socio-economic status. Differing health-care utilization [contacts with a general practitioner (GP), specialist and emergency department; and hospital admission] and home-care utilization (home nursing, home help and meals-on-wheels] patterns among the frail, prefrail and robust subpopulations were examined. Results: Overall, 9.3% respondents (426) were classified as frail, 30.7% (1636) as prefrail and 60.0% (2715) as robust. Frailty was associated with age, gender, comorbidity, place of residence, survey year and socio-economic status. The frail and prefrail groups were more likely than the robust to contact a GP, a specialist or an emergency department and were more likely to be admitted to hospital, independent of age, gender, comorbidity, survey year, living situation, region and socio-economic status. They were also more likely to appeal to home nursing, home help and meals-on-wheels than the robust participants. Conclusion: Even after adjustment for potential confounders, including age, gender and comorbidity, frailty among Belgian elderly persons is associated with their socio-economic status and is strongly associated with their health- and home-care utilization.

Introduction

Frailty is an emerging concept in current medicine, especially in the fields of general practice and geriatrics. As it increases with age, it is to be considered an important notion in societies with a rapidly ageing population. It is assumed that the total number of frail elderly living at home in European countries will drastically increase in the near future, which will supposedly lead to a significantly higher need for health-care services. In 2020 for example, persons aged ≥65 years will make up 19.2% of the Belgian population and this proportion will have risen to 26.3% by 2060. There is, however, no general consensus on the definition of frailty. The concept can be described in different ways, but practicable definitions should in all cases be clear-cut and preferably not to be confused...