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RESHAPING THE TRADITIONAL SYSTEM

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Abstract

As in many other countries, in the Netherlands, too, the field of housing and care for the elderly has seen almost revolutionary changes over a period of less than twenty years. Key concepts are the prolonging of independence, upgrading of the housing function in institutional settings, and individualised care. By substituting residential care for home care and assisted living, the authorities try to reduce the number of people over 65 living in either a home for the elderly (6.8%) or a nursing home (2.9%) to an average of 5%. Home care is upgraded by improving the co-ordination of the care offered and the funds made available by recently introduced Acts of Parliament. Architectural measures in mass housing aim to improve its accessibility and useability for all age groups, including elderly people and people with physical disabilities. Institutional settings have widened their scope and offer now also so-called 'extramural' care to people living outside these institutions. These developments have cut across the lines separating four strictly defined segments, each with their own target groups and standardised provisions. This has resulted in a differentiated offering of combinations of housing and care for the elderly. The paper reviews how and why our traditional system has been reshaped and gives an impression of experiences with new combinations of housing and care.

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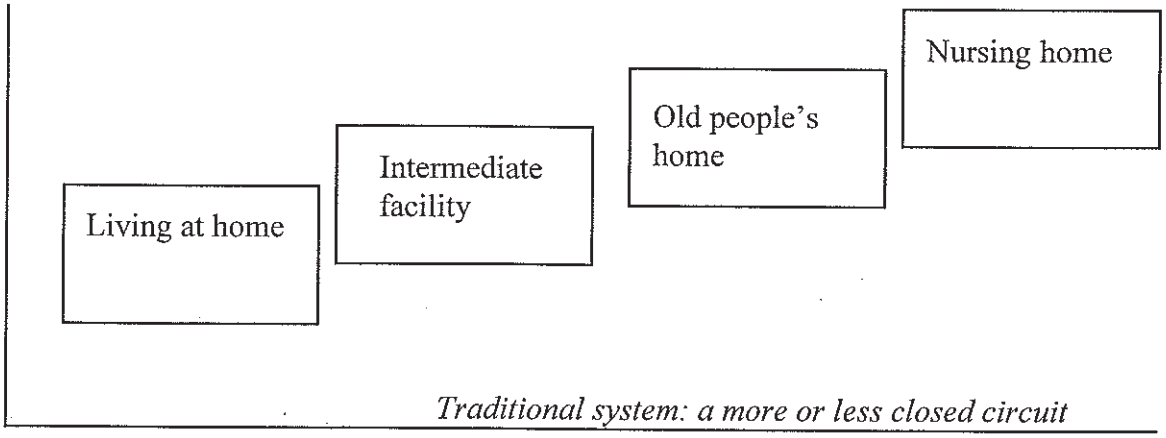
1. Segmentation and segregation of the vulnerable elderly

Until the eighties, the Dutch system of housing and care for the elderly was organised in a more or less closed circuit consisting of four steps: 1) living independently, with home care if needed; 2) living in an intermediate facility (assisted living for older people with a moderate need for care); 3) old people's homes, housing the elderly in serious need of care; 4) nursing homes mainly caring for fully dependent older people.



Traditional system: a more or less closed circuit

[1] This paper is a revised version of a paper called *Spatial Implications of Policy Trends and Changing Concepts of Housing and Care for the Elderly*, which is presented at the IAPS15-conference in Eindhoven, the Netherlands, July 14-16, 1998

This traditional system was well developed. But both policy makers and the elderly themselves plead for reshaping this traditional model. We can distinguish three main drives.

a. Reduction of forced movings

The traditional facilities focus on a particular level of care and a clearly defined (referred) target group. Changes in the level of care required may force people to move as often as four times: first, to a house more suitable to their physical abilities (no high thresholds, no steep stairs); then, to an intermediate facility such as a service flat; next, to a home for the elderly; the final stage is a nursing home. In practice, people will often arrive at a nursing home from their own private house, either directly (prompted by dementia) or after hospitalisation (prompted by physical disability). But a number of older people do indeed pass through the four different environmental settings mentioned above. One rung higher on the care ladder will mean higher costs, less independence and a more restricted housing.

b. Preference for prolonged independent housing

Most older people prefer to live independently in their own homes for as long as possible. Closely linked values such as autonomy, privacy and a familiar environment with valuable social contacts are not easily relinquished. Nursing homes are criticised for their lack of privacy and the one-sided emphasis on institutional health care. Until now many patients have to share a room with one, two, or even three other people. Old people's homes are criticised for the small rooms and regimented care. The homes for the elderly used to offer the ageing population a form of sheltered housing, but this function has increasingly been lost over the last decade. Stricter standards for admission have raised the average age of the residents, and their increasing care requirements have turned many old people's homes into nursing homes. Old people's homes are presently perceived primarily as care facilities instead of sheltered housing. This development is illustrated by the fact that, in the Netherlands, the responsibility for homes for the elderly was shifted from the Ministry of Housing to the Ministry of Health.

c. Cost control

A third drive for change can be found in the increasing costs of the present care system. In the next 25 years, the number of people over 65 years will have increased by one million people, bringing the number of older people in 2015 to 2.9 million (17% of the entire population). This increase is expected to reach its zenith in 2035, when 25% of the population will be over 65 years of age. The "double grey" group (people over 80 years old) will account for 5.4% of the population in 2030, almost doubling the figures of 1990. Institutional settings are very costly. Including cost of living, the daily cost in old people's homes amounts to some NLG 100, in nursing homes to NLG 255. Extramural care, on the other hand, averages NLG 10-35 per day. Continuation of widespread institutional care would lead to an ever-increasing burden on a decreasing number of younger shoulders.

2. Reshaping the traditional system

With a view to reducing the segmentation, segregation and institutionalisation of the vulnerable elderly, the Dutch government started a "substitution policy" to induce a shift from residential care to home care and, with it, to less expensive options. It is estimated that about 20% of all patients in nursing homes is substitutable to homes for the elderly, and 10% is substitutable to home care or different kinds of assisted living. About 60% of elderly people living in a home for the elderly might be able to live more independently in facilities for assisted living or even at home, provided that more/better home care is available and houses are accessible

for all age groups. A great number of financial and organisational measures and architectural and urban planning measures have been implemented to reshape our traditional system.

a. Financial measures

Regulations have been drawn up to extend the statutory financial base of *old people's homes* to cover the provision of meals, day care and short-term residential care. Key concepts are 'scope extension' (to assist older people living on their own but with a referral to an old people's home) and 'flanking policy' (to assist older people living on their own without a referral to a home). Old people's homes can also draw on municipal funding for services like chiropody, fitness exercises, bathing facilities and alarm systems for older people living outside the home. Funds established to implement the shift from residential care in *nursing homes* to external home care allow for services such as additional care in homes for the elderly, postponing or pre-empting the move to a nursing home; nursing care at home; support for older people living independently; the provision of temporary relief for volunteer aid (day and night care); a package of care options outside the hospital for older people with a referral to a nursing home who, without that extra care, would be forced to extend their hospital stay for want of space in the nursing home. One of the options is (permanently or temporarily) to transfer funds originally set aside for the approved construction of nursing home capacity to the financing of structural or temporary home care ("floating beds"). Authorities proceed on the assumption that the money to operate one floating bed suffices to offer supplementary nursing care to three people in a home for the elderly who, without that extra care, would have to be transferred to a nursing home. For nursing care at home this ratio is about 1:1.

b. Architectural and urban planning measures

To enable elderly people to cope on their own as long as possible, a programme was established to rebuild and construct *houses* for use by everyone, regardless of age or capability. Guidelines to this effect are included in manuals published by official bodies. Examples of implemented measures are:

- lifts fitted in flats and studio apartments;
- adaptation of individual houses through the Act on Provisions for the Handicapped;
- the promotion of an elderly-friendly housing environment, with special attention to universal access, safety, security, shops within walking distance, accessibility of public transport, supplementary adapted transport;
- the introduction of consumer quality marks, such as the Senior Citizen's Label ('Suitable for all age groups') and the Police Label for Secured Housing ('Secured by Design').

Many architectural measures have been taken in residential settings, too, particularly with a view to upgrading the housing function. In the not so distant past, each individual housing unit in *homes for the elderly* consisted of a 12 m^2 sitting room and a 6 m^2 bedroom, or perhaps a 15 m^2 bedsitter, plus a toilet. But the prime desire of the residents of these homes is to be allowed to adhere to their individual life styles, albeit within certain boundaries. With respect to autonomy, coping, privacy, comfort, social contacts and activities, heavy demands are made on the housing function. Under current regulations, standard measurements have been increased to 26 m^2 for a single unit and 40 m^2 for a double unit. A bedsitter, a kitchenette with sink and refrigerator, and a bath unit with washbasin, shower and toilet can thus be provided. When homes for the elderly are rebuilt, the housing function is often upgraded by joining two rooms into one more appropriate and larger housing unit, with some kind of separation between living and sleeping functions, an individual bathroom and kitchenette (Breuer et al,

1992; Houben and Van der Voordt, 1993). Newly constructed care home centres, which are focused on independent living with care to measure, can dispose of far more floor space per unit than do homes for the elderly. Authorities base their policy on a reference project with flats of 55 m² (excluding spaces for general use), which is still a far cry from the reference measures usually encountered in council housing (70 m²). In practice, 55 m² is considered the bare minimum to be let as an independent housing unit. Associations for the elderly argue in favour of a minimum of 65 m², allowing for a second bedroom/hobby room. A nice example is the Bergwegproject in Rotterdam, where "lifespan" housing units of 68 m² have been built.

From the start, *nursing homes* were strongly linked to health care (Van der Voordt and Terpstra, 1995). This type of home originated as a specialised general hospital, focusing on long-term somatic patients for whom no further treatment was available. They were often established by hospital organisations. The architectural design used to resemble a hospital setting: long straight corridors, no private sitting rooms, at most a private bedroom. But in many cases even the bedroom had to be shared with others. Over the years, the idea that more "homelike" surroundings would be of benefit to the patients gained ground. The shift from the medical care concept towards care concepts emphasising homelike surroundings is clearly reflected in the spatio-functional layout of modern facilities: smaller scale (subdivision of wards in smaller groups, annexes), fewer people to a room (privacy!) and more homely interior decorating (differently furnished sitting rooms, tables and chairs in corners, furniture brought from home). The standards for the allowed gross floor space for a ward of 30 beds has been raised from 30 m2 (1983) to 42 m2 per bed (1990). For a nursing home as a whole, all communal spaces and staff space included, the maximum gross floor space has been raised from 50-55 m2 per bed to 63-68 m2 per bed, depending on the capacity of the nursing home.

Ratio between 1-, 2- en 4-person-bedrooms in nursing homes

	1983		1990 PG*		1990 Som*		1997	
	number	m2	number	m2	number	m2	number	m2
1 bed	4-6	13	6	13	10	16	30	13-16
2 beds	3-4	19	6	19	4	22	-	
4 beds	5-4	34	3	38	3	44	-	
totaal	12-14		15		17		30	

*) PG = psychogeriatric; Som = somatic; in the building codes of 1983 and 1997 no difference is made between the allowed square meters per category.

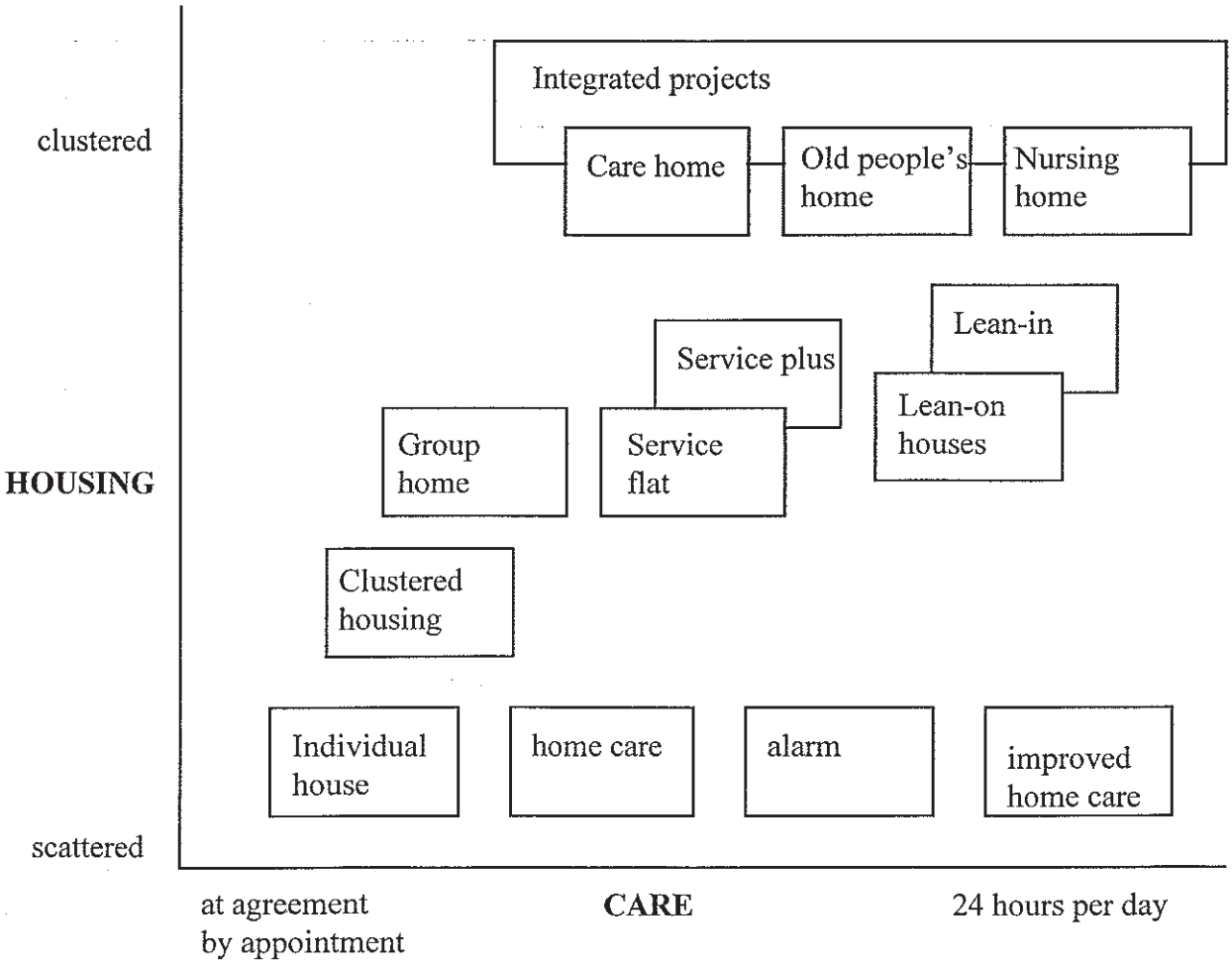
c. Provision of individualised care and services

People have different needs, abilities and limitations. That's why the standard package of care offered in residential settings until recently has been exchanged for differentiated packages based on individual care planning. This satisfies the need for cost control, but is also vital to maintaining a sense of physical, social and mental well-being in people. Insufficient care results in a lower performance level. Too much care results in an inadequate challenge of the capabilities and skills still present, and may lead to a deterioration in performance ('use it or lose it'). The care-to-measure concept entails a shift from a supply-oriented organisation to a demand-oriented one. Of particular importance is the shift from a facility-oriented approach towards a function-directed approach. Until recently the demands for care were translated into

facilities: after referral, people had a right to receive home care or to be placed in a home for the elderly or a nursing home. The present function-directed approach means that people's requirements, which they may expect to be met under the terms of their insurance, are translated into functions, for example professional assistance at daily living activities, day care, temporary residential care, long-term care, terminal care. A function-directed approach makes it easier to disconnect the care from the place where it is being supplied, and to offer care both in a residential context and elsewhere, for example (also) at home.

3. New combinations of housing and care

The substitution policy, the function-directed approach and leeway to experiment with new combinations of housing and care have increasingly loosened the traditional link between four types of housing and care (independent housing, intermediate housing, homes for the elderly, nursing homes) and their target groups. Experiments have been started to offer 'nursing home care' at home, with additional volunteer help. Nursing home units are built within old people's homes, in order to prevent or postpone movings to a nursing home. Modern care home combinations often accommodate a heterogeneous group of people, whose needs vary from little care to the high care level of a nursing home. When the entire scope of care is covered only a single move will be required: from independent housing in a housing area to a care home combination supplying the entire range from no care to round-the-clock care.



The new system: a range of different combinations of housing and care

4. Examples

Examples of the range 'slight need of care' to 'serious need of care' (connected with a referral to a home for the elderly) are the *'living-plus' projects*, such as the *Jan van der Ploeghuis* in Rotterdam (Regnier, 1994). This complex consists of 79 two-room and three-room council houses for 84 older people as well as a recreation room, a small shop, a launderette, and a physical therapy room, all situated around an atrium. The complex accommodates a mixture of 30% elderly people requiring little or no care and 70% elderly people requiring care to the maximum level traditionally provided by a home for the elderly. The organisation is centred around the concept of "independent housing with care" and emphasises the housing function. Round-the-clock long-term nursing care is not available. Volunteer aid has a distinct place within the project. Contrary to the home care dispensed to older people in private houses nearby, the home care in Jan van der Ploeg is delivered by permanent teams who also provide care outside office hours. A geriatric attendant is employed by the project to supplement the primary health care. Alarm systems are overseen by a nursing home, which communicates with neighbours or relatives if need be. Housing and care are separate financial issues.

Examples of a combination of elderly with a slight, medium, serious and high need of care are the so-called *integrated care projects*, such as the *Bergwegproject* in Rotterdam. This project contains 84 two-room, 109 three-room and 2 four-room flats. Of these 195 flats, 66 are designated for people over 55 with a service-plus referral, 60 for people with a referral to a home for the elderly, 60 for people with a referral to a nursing home, and 9 for group housing of older people of foreign extraction. There is no need for people to move when they require more care. The care centre offers the services of care and nursing facilities, physical therapy, speech therapy, a dietician, dentist, social worker, doctor, and hairdresser, and has shops, day care facilities and a restaurant. These facilities are also open to older people living in the neighbourhood. Here, too, the finances of housing and care are managed separately.

Examples of a combination of people with a serious need of care (connected with a referral to a home for the elderly) and a high need of care (connected with a referral to a nursing home) are group care for older people suffering from dementia and supplementary care for physically disabled residents in a home for the elderly, under the responsibility of a nursing home and financed through the Health Act. Other examples are the so-called satellite projects in Krimpenerwaard (Wiewel and Fahrenfort, 1993; Houben and Van der Voordt, 1993). Here, 15 older people with referral to a home for the elderly and 15 people with referral to a nursing home are mixed. Single rooms consist of a private 24 m^2 bedsitter with 5 m^2 bathroom; double bedsitters are over 40 m^2. In these residential settings the finances of housing and care are coupled: clients pay a fixed price for a combined package of housing and (individualised) care.

Examples of upgrading the housing function within nursing homes are the so-called 'normalised housing projects' for psycho-geriatric elderly. An example is *Anton Pieck-hoffe* in Haarlem (Plaisier et al, 1992; Van der Voordt and Terpstra, 1995). This project was established in 1989. The point of departure was housing with professional basic care, supplemented by primary health care, in a small-scale setting resembling a private housing situation. The project consists of six houses grouped around a patio. Six older people, who suffer from dementia, live in each house. The residents have small private bedsitters (11 m^2 each) and share a communal sitting room with an open kitchen. At project level, the communal facilities consist of a multi-functional room, an indoor corridor with a sun lounge, and the patio. The grounds also

contain apartments for older people living independently, which are basically meant for the partners of the Anton Pieck-residents. Daily life in the units revolves around the household chores. Within this structure, care is offered flexibly and to measure by a core team of five to six helpers in each unit. Supplementary care is provided by a home care organisation. The prevailing attitude is non-medical, directed towards diminishing the feelings of anxiety and insecurity rather than towards rehabilitation or therapeutic objectives. The building was designed according to current standards for council housing. The project is financed through contributions from the residents for rent, service and household expenses, the standard budget of the home care organisation, and funding obtained through the Health Act.

The Haarlem concept has been followed in several places, sometimes with units on an even smaller scale. One such example is *De Mussengang* in Groningen. This project dating from 1986 consists of two linked houses with a total of six psycho-geriatric residents. They have private bedrooms and a communal sitting room, with a few supporting rooms (sanitary facilities, office cubicle). A nearby nursing home is responsible for the organisation. Daily care is dispensed by four part-timers and one full-time co-ordinator. No special brief was drawn up for the double unit. It was constructed according to council housing regulations. But the houses were slightly adapted for the use by six people suffering from dementia (bedroom replaced by kitchen-diner, serving hatch between sitting room and kitchen, raised toilet and handles, fire alarm system). The house is financed through rents plus monthly contributions from residents towards care and household expenses, supplemented by Health Act funds.

5. Appraisal of new combinations of housing and care

When these projects were developed they were really in the front-line. But since the late eighties the number of innovative projects is rapidly increasing. Many old peoples homes have been remodelled to modern care homes with nice apartments and individualised care. About 300 far-reaching renovations are in preparation. Residential settings are opening up their boundaries and co-operate with other organisations in order to widen their scope. As the housing function in homes for the elderly is more developed than in nursing homes and old peoples homes are less expensive than nursing homes, the planned extension of nursing home beds by 4000 places is mainly implemented by realising nursing units in existing homes for the elderly. Older people themselves generally adopt a very favourable attitude towards the changes implemented so far (see for instance Plaisier et al, 1992; Pepels et al; 1993; Fahrenfort et al, 1993; Wiewel and Fahrenfort, 1993). The growing opportunities for independent living, at home and in assisted living facilities, and the shift within residential settings from a medically oriented model towards a housing model, are considered a giant step forward. The concept of care to measure stimulates an attitude of coping in the older people involved.

In spite of widespread satisfaction there are still many problems to be solved. It is true that the policy of substitution requires relatively less expensive residential facilities compared to a continuation of the old policy. Evaluation studies showed that, compared to traditional solutions, the costs of the Krimpenerwaard projects and the Anton Pieckhofje are slightly lower. Savings were found in lower spending on general support rooms and medical provisions. Up to a certain level extra home care is cheaper than institutional care. However, funding remains a worrying issue. The growing demand for independent housing increases the pressure on the housing market and is accompanied by higher expenses in individual rent subsidies. The latter conflicts with the wish of the Ministry of Housing to cut down on public expenditure. More

single and double rooms in nursing homes demand extra floor space. Although the building standards have been improved, no extra money for yearly exploitation costs will be available.

An even more important problem is the increased work load in residential settings, as a `consequence of a higher average age and level of care needed. The same holds true for home care. The financial means do not keep pace with the increasing number of elderly people in need for home care. Furthermore, the policy of substitution of institutional care to home care and extramural care in facilities for assisted living has led to a reduction of beds in old people's homes and a reduced increase of nursing home beds. Now it turns out that policy makers were too optimistic. This is reflected in longer waiting lists for residential settings and increasing waiting times. This, too, leads to an increasing work load for home care employees.

Another point of contention is the desired scale of the facilities. The advantage of a more residential character for small-scale facilities seems to be offset by the disadvantage of less funding made available for facilities in general. The opportunities to vary activities are decreasing with it. Some older people feel that the Anton Pieck-hofje is a rather dull environment, where the aspect of well-being needs to be addressed. The small scale of projects such as De Mussengang allows them to be established in the residents' former neighbourhood, making it easier for them to maintain their social network. Residents and staff are in close daily contact, and the extensive social control does not tolerate much escapist behaviour. But social control can be felt to be oppressive, and the small scale puts a heavy burden on the staff members. Furthermore, such projects can only succeed if adequately supported by external (para)medical and other facilities (hairdresser, shop, etceteras).

It is important to recognise that not all solutions are suitable to everyone. Nursing care at home can only function satisfactorily with the support of adequate volunteer aid and in the absence of very serious psycho-geriatric disorders. Many of the examples discussed here cover only part of the present nursing home population. In De Mussengang only psycho-geriatric people in need of continuous guidance were selected. It is assumed that this category, in particular, will benefit from small-scale facilities. In view of the accommodation and staff capacity available, as well as the desire to avoid moves disturbing to the group, several supplementary criteria were used. Residents had to require nursing by no more than one nurse, be reasonably mobile and not dependent on a wheelchair, possess adequate communication skills and be stabilised in their dementia. Should they come to require extensive (para)medical care, demonstrate restless wandering behaviour or a rapid and progressive deterioration, they may have to be moved elsewhere. Therefore, this housing project suits only some of the older people who are referred to a PG nursing home, whereas the more traditional nursing homes can offer older people all kinds of care whenever needed. Opinions on the most desirable and feasible forms of housing for various target groups appear to be highly divergent. In the eyes of some, the possibilities of (independent) housing with small-scale nursing care are far greater than in the opinion of others. There is a definite need for more detailed studies on feasibility and the preferences of older people themselves.

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