



Assisted Living Platform - The Long Term Care Revolution: A study of innovatory models to support older people with disabilities in the Netherlands

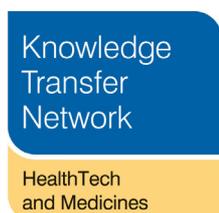
This study was undertaken to see what can be learned from the experience of the Netherlands about long term care in order to inform policy, research and practice in the UK.

The comprehensive analysis of the two countries has also been used to help the Technology Strategy Board's project - the Long Term Care Revolution – with examples of innovation and best practice in adult social care provision in a country similar to the UK in many ways.

Of particular interest is that while the two countries are very similar in demographic profile and the experiences of the older generation, it is notable that according to official statistics older individuals remain disability-free for nearly half a decade longer in the Netherlands than in the UK.

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Executive summary

The Netherlands, like the UK, has an ageing population; those aged 60+ are projected to increase from 23 to 30 per cent of the population, and the Age Support Ratio to decrease to below 4, by 2050. Despite having the same Life Expectancy as in UK, Healthy Life Expectancy in the Netherlands is over 4 years longer. If this is not a measurement artefact, it has important implications for long term care and suggests further research is needed to discover the reason for the difference. One possible factor is the lower poverty rate in the Netherlands among those aged 65+, which is about one fifth of the UK rate but there may be other factors such as the pro-cycling culture and a traditional culture that is more egalitarian and socially-cohesive. Furthermore:

1. Dutch older people are less likely than British to live with their children and informal care is low, formal home care high, relative to international levels.
 2. Spending on long term care falls less heavily on individuals in the Netherlands than the UK (7 compared with 36 percent of the total) due to a contributory social insurance scheme that covers home-based personal care and long term institutional care for all those with chronic conditions. Thus the risk of very heavy costs falling on vulnerable individuals is avoided by sharing the cost across the whole population.
- However, there has been a shift in recent years from collectively organised and funded long term care in the Netherlands, and also from residential to home-based care by family and private providers. Eligibility for care funded by social insurance has been tightened and co-payments based on income (but capped) have been introduced. Financial compensation to informal carers for their care work is now excluded as is most publicly funded help with housework. The latter may be supported by the Local Authority, depending on the user's income and circumstances. Personal Budgets have been ended for new users since 2010. These changes have been implemented mainly to save costs to the state-sponsored social insurance fund; but they might put more pressure on informal carers.
 - Technical innovations are evident in telehealth, telecare, and schemes to combat isolation through extending internet use, including the facility for video-conferencing with family members and wider community. However, these are not yet widespread and it is doubtful to what extent they can replace, especially for confused older people, the reassurance and comfort of helpful human care.
 - For older people with only light or moderate disability, age-proof housing, senior co-housing and local initiatives for neighbourhood-based care using volunteers demonstrate the viability of such innovations and their potential to delay entry to a residential institution. Co-housing tenancies for older people from several ethnic minorities has enabled them to live near to others from their own culture.
 - For those with more intensive care needs, innovations in accommodation-with-care, mostly set up by non-profit organisations, emphasise re-creating home-like small households within larger complexes. These aim to promote maximum autonomy within a 'normal', safe and familiar environment; they include provision for dementing residents.
 - Civil society organisations have pressed for a person-centred approach to care, one which gives voice and choice to disabled people while promoting re-ablement and preventing deterioration in health. Social relationships, allowing for frequent face-to-face interaction,

are recognized as vital to older people's health and well-being. Experts say more development on these lines is needed, especially reaching out to isolated individuals, and

- Opportunities exist for businesses to expand in the area of long term care. For example, as care providers in partnership with housing associations and also to invest in internet-based systems designed to promote social interception and combat loneliness.

The Long Term Care Revolution: A study of innovative models to support older people with disabilities in the Netherlands

Background

A Technology Strategy Board study, 'Assisted Living Platform - the Long Term Care Revolution' (Tinker, Kellaher, Ginn & Ribe, 2012 and published by King's College London and the Housing LIN, 2013) analysed a wide range of traditional and cutting edge initiatives to promote independence and well-being in later life, including a variety of evaluated initiatives in the UK and Europe. A particular focus was the role of housing in enabling older disabled people to delay or avoid admission to institutional care homes. It was clear that some countries were ahead of the UK in developing innovative and alternative approaches to long term care, with the Netherlands being the outstanding example. The country has a similar demographic profile to the UK and shares much recent history. It is therefore informative to understand the rationale underlying the Dutch long term care system, to learn how it was initiated and developed and to see how it operates. This case study by the Institute of Gerontology, King's College London, is based on a piece of research that looks more closely at the long-term care of older people in the Netherlands.

Aim of the study

To provide relevant information about the Netherlands on how support is provided to older adults in need of long term care in their own homes or alternative homes. The research aimed to explore not only how care for older people with modest needs is managed but also how those with intensive care needs can have a good quality of life; one that is more dignified, more autonomous and more enjoyable than is usual in UK residential homes. This case study on the Netherlands builds on the material in our earlier report to the Technology Strategy Board and includes:

- a) A comparison of the demographic and policy background in the Netherlands and UK, justifying the choice of the Netherlands as a comparator.
- b) A review of existing schemes in the Netherlands (updated from Tinker et al. 2012), some of which have been independently evaluated, and of housing-with-care schemes for older people with intensive care needs.
- c) An account of a visit to the Netherlands and what has been learnt, particularly about housing and innovative solutions. It includes, where possible, business models and use of technology and 'smart homes', with emphasis on housing and homes for older adults with high dependency. The visit included discussions with key academics, visits to a 'Smart Home', an advice-giving organisation and other promising initiatives such as the 'Dementia Village' DeHogeweyk in Weesp. It included discussions with providers of some innovative services in order to explore the potential for collaboration between industry and the public sector and information on how feedback from users is taken into account (please note that none of these have been independently evaluated).

This case study aims to inform the Technology Strategy Board's project - the Long Term Care Revolution – with examples of innovation and best practice in adult social care provision in a country similar to the UK in many ways. Where appropriate, messages have been targeted to industry and providers of housing and social care. The main goal is to inform the Technology Strategy Board in relation to their potential investment in revolutionary new approaches to care in the UK.

Research questions

The main question that informed this research is: What can be learned from the Netherlands about ways of revolutionising long term care for older disabled adults, focusing in particular on housing, innovative business models and use of technology? In particular:

- How are older people with modest care needs enabled to continue to live independently, preserving their health and well being for as long as possible?
- How can those with high dependency, needing ‘round the clock’ availability of care, be enabled to live with dignity and autonomy?

Organisation of the report

The case study is divided into 2 sections. The first section reviews demographic trends in the Netherlands and UK and reviews the changes in the Dutch long-term care system. Section 2 draws on the major topics of the interviews conducted in February-March 2013 in the Netherlands with key academics, policy-makers and consultants of long-term care services for older individuals.

SECTION 1: Policies

This section is based on an updated literature search and from information given in the interviews with experts. The researchers conducted 10 interviews covering a wide range of topics about the Dutch long-term care system, housing and care organisations, assistive technology, community living and other projects aimed at improving older individuals' well-being (see section 2).

a. A demographic comparison of the UK and the Netherlands

The United Kingdom (UK) and the Netherlands share many similar features, allowing us to learn from models of social care provision that could be introduced in the UK. Before looking at the demographic profile it is worth noting that both are sea-faring nations and they share a great deal of past history, including a baby boom after the Second World War and older people who share war time experiences.

Population ageing in Netherlands and UK. The population is ageing in both countries (see Table 1). In both countries the proportion of the population aged over 60 is projected to grow from 23 per cent in 2012 to over 30 per cent by 2050 and the number of older people is also projected to increase substantially. The Age Support Ratio (ratio of those aged 15-64 to those aged over 65) is projected to fall below 4 by 2050. The underlying determinants of population ageing are structural - sustained low and late fertility and increasing life expectancy (van Nimwegen, Esveltdt, & Beets, 2003). For example, average life expectancy at birth increased in the Netherlands from 51 at the start of the 20th century to 81 in 2012 compared with 46 and 81 years in England and Wales over the same period. The Total Fertility rate is lower in the Netherlands, 1.78, compared with 1.91 in the UK (Table 1). It is estimated that to keep the Age Support Ratio at the 2010 level by 2020, the UK needs 2.2 per cent migrants and the Netherlands 3 per cent (European Commission (EC), 2012). The UK is expected to have continued growth in the total population due to natural increase and immigration, but the Netherlands saw net emigration of over 35,000 in 2006, mainly non-Dutch. A rapid rise in average age is expected in the future in the Netherlands (van Nimwegen et al. 2003).

In 2012, two thirds of the population was aged 15-64 and 16 per cent were aged over 65, in both countries. The proportion aged over 80 in the UK was 4.6 per cent, slightly higher than in the Netherlands. Life expectancy in 2012 was the same in the two countries. However, Healthy Life Expectancy was longer in the Netherlands than in the UK at 3.7 and 5.4 for men and women respectively (Eurostat, 2012). Both the UK and the Netherlands are expected to see increases in total population, from net immigration as well as from increasing longevity. The Netherlands population is one quarter the size of the UK's and its population density is higher, 397 per sq km (Statline.cbs.nl, 2012) compared with 260 in the UK, but the Netherlands lacks the extensive mountainous areas in parts of the UK. The proportion of Dutch people aged over 65 who are at risk of poverty (if defined as less than half national median) is among the lowest in the OECD at only 2.1 per cent, compared with 10.3 per cent in the UK; in each country older women are more likely to be poor than older men, 2.4 and 12.6 per cent respectively (OECD, 2011).

Table 1 Demographic comparison of UK and the Netherlands, with projections to 2050

	<u>UK</u>			<u>NL</u>		
	<u>2009</u>	<u>2012</u>	<u>2050</u>	<u>2009</u>	<u>2012</u>	<u>2050</u>
Total population (1000s)		63,182	-	-	16,656	-
Aged 15-64 (1000s)		41,700=66%	-	-	11,356=67%	
Aged 65+ (1000s)		10,381=16%	-	-	2,595=16%	
Aged 80+ (1000s)		2,890=4.6%	-	-	668=4.0%	
Aged 60+ (1000s)	13,813	14,436	21,568	3,548	3,803	5,470
% 60+ / total population	22	23	30	21	23	32
% 80+ / 60+	21	21	30	18	18	33
Age Support ratio (15-64:65+)	4	4	3	4	4	2
Fertility rate (births per woman)	-	1.91	-	-	1.78	-
Sex ratio 60+ %M / F	81	84	-	83	85	-
Sex ratio 80+ %M / F	54	60	-	50	54	-
Life expectancy at birth: M,F	-	79,83	-	-	79,83	-
Life expectancy at 60: M,F	20,24	22,25	-	21,24	22,25	-
% 60+ married (1): M,F	73,47	76,47		76,52	75,50	
% 60+ alone: M,F	22,45	-	-	17,42	-	-
% 60+ alone / spouse (2): M,F	-	84,83	-	-	90,94	-
% 60+ living with children	-	16	-	-	8	-
% 60+ in the labour force (3)	24,12	25,14	-	19,9	23,10	-
State Pension Age (SPA)	65,60	65,(4)	68,68	65,65	65,65	67

Sources: UN (2009, 2012); UK (2011); Statline.cbs.nl (2012)

1 "Currently married" includes those "living together".

2 Persons living alone or with spouse only.

3 Proportion aged 60+ economically active, as estimated and projected by the International Labour Office.

4 UK women's SPA is rising to 65 by 2018; NL SPA rises to 67 by 2025

Both countries have seen 'modernisation' of the household during the 20th century, with later marriage, a substantial increase in cohabitation, a rise in educational attainment, and an increase in working age women's employment (van Nimwegen et al. 2003). This reached nearly 70 per cent in the Netherlands compared with 65 per cent in the UK. However, women's full time employment is higher in the UK, 41 per cent compared with 32 per cent in the Netherlands (OECD, 2012). Employment over age 60 was lower in the Netherlands (23 and 10 per cent of men and women respectively) than in the UK in 2012 (Table 1). However, the employment rate of those aged 60-64 has risen rapidly in the Netherlands since 2001, for men from 20 to 47 per cent by 2011 and for women from 7 to 25 per cent over the same decade; longer working was associated with higher educational qualifications (International Longevity Centre, 2012). These changes in household formation and employment both reflect and reinforce the socio-cultural changes in the attitudes, norms and values of associated with modernisation. The ageing of the population challenges previous norms as to age of retirement, while increasing longevity of new cohorts, with longer years spent with disability, has made urgent a reassessment of long term care policy.

The two countries spend a comparable proportion of Gross Domestic Product (GDP) on long term care, but 36 per cent of the spending is from private individuals in the UK, compared with only 7 per cent in the Netherlands, where a social insurance scheme operates for long term care (see Table 2).

Table 2: Spending on long term care in UK and the Netherlands, as % Gross Domestic Product

	<u>UK</u>	<u>NL</u>
Public spending	0.9	1.35
Private spending	0.5	0.1
Total spent	1.4	1.45

Source: OECD (2005)

Indicators of long term care needs in the Netherlands. The proportion of individuals aged over 60 who were living alone, and therefore more vulnerable to loneliness and unmet care needs, was slightly lower in the Netherlands than the UK. For women, the proportion was 42 per cent, compared with 45 per cent in the UK in 2009 (see Table 1). Among women aged over 65, 44 per cent in the Netherlands lived alone and 47 per cent did so in the UK (not shown) (Soule, Baab, Evandrou, Balchin, & Zealey, 2005). Living with children indicates ready availability of informal care; the proportion living with their children was only 8 per cent in the Netherlands compared with 16 per cent in the UK (Table 1). We can infer that the proportion living in a couple-only household was probably higher in the Netherlands than in the UK.

At a recent Leiden conference on 'Integrated Care for the Elderly', it was reported that about 25 per cent of those aged over 65 were vulnerable but of these 85 per cent lived independently in the community and 15 per cent in a nursing home. This implies that 3.8 per cent of those aged over 65 lived in a nursing home, compared with over 5 per cent in the UK. However, among older people in the Netherlands who could not live alone without help, 25 per cent received care from their family (a low proportion by EU standards), 40 per cent from homecare services (a high proportion) and 35 per cent in a nursing home (also relatively high) (Schnabel, 2011). This implies that nearly 7 per cent of older people were cared for in a nursing home. Receipt of formal care was higher than usual in Europe and informal care lower (International Longevity Centre-NL (ILC-NL), 2011).

Dementia presents a formidable challenge to the aim of maximising an older person's choice and control and the efficacy of a person-centred approach is hard to assess (Argyle, 2012). Informal carers of an ageing parent with dementia may manage the situation while the condition is mild but struggle to do so as it becomes severe. A UK report shows the cost to informal carers of parents in terms of reduced earnings and stress, leading to ill-health and loss of family life and friendships (Carers UK, 2012). There is a lack of suitable alternatives to institutional care when UK family carers can no longer cope; 80 per cent of residents in institutional care homes have dementia. The estimated prevalence of dementia in the Netherlands is less than 1 per cent in the age group 55-9, a third among those aged over 85 and 43 per cent among those aged over 95. Overall, the rate is 6.3 per cent among all aged over 55. Alzheimer's Disease was the main cause recorded for dementia (72 per cent) followed by vascular impairment (16 per cent), Parkinson's Disease (6 per cent) and other causes (5 per cent) (Ott et al., 1995).

Another key policy element of long term care, as indicated in the first report, is housing. The main development recently in the UK has been of extra care housing. Research in the UK has shown its value and the overall conclusions of a recent large study were very positive (Netten, Darton, Baumker, & Callaghan, 2012). How to transform residential care homes and sheltered housing into extra care housing has shown both the advantages and the pitfalls. (Tinker et al., 2007).

b. Background to the Dutch long-term care system

Long term care provision for older individuals in the Netherlands has traditionally been publicly provided. Services for dependent and frail individuals were largely developed soon after the end of the Second World War. A national social insurance system was rapidly expanded during the 1950s and 1960s. In contrast to childcare services, where there was little public support due to a strong view that families should provide childcare, institutional care for older people was readily made accessible for individuals in later life (Bussemaker, 1998; Lyon & Glucksman, 2008).

The 1960s brought a series of important policy changes to guarantee wider access to care homes and assure a minimum quality of life. The Social Assistance Act (1965) provided financial support for individuals and the Long-term Care Insurance Act (1968) introduced personal care and support for individuals in nursing homes (Pavolini & Ranci, 2008; van Hooren & Becker, 2012). Public provision for the care of older people expanded during the 1970s, and there was widespread public acceptance of the need for collective provision of care for individuals with disabilities. Long term care provision was mainly in the form of residential care, as a substitute of family care. As a result, the Dutch long-term care system has largely been service-led, as the government supported individuals requiring care services (Pavolini and Ranci 2008). The Netherlands, as pointed out by Baldock and Evers (1991) is a good example of a nursing care system.

In the last two decades of the 20th Century, long term care in the Netherlands shifted from a publicly-subsidised institutional care system to a more privatised home-based care regime. The Dekker Report *Willingness to Change* (1987) made recommendations for a more prominent role of the family in the care for their older relatives. This shift towards a mixed model of provision was accompanied by the introduction of 'marketised' home care services. During the 1990s, financial support guaranteed by the long-term care system (AWBZ) was extended to individuals receiving personal care in their own home. The person-centred approach to care was encouraged through the introduction of Personal Budgets ('Persoonsgebonden Budget') in 1995; these were intended to promote choice and flexibility of care and to stimulate competition among private service providers. Individuals were offered a choice between a cash transfer or public services. Direct Payments allowed users to decide how to spend the money to meet their care needs, including the option to pay relatives to provide care. However, financial support for home-based care through Personal Budgets (PBs) brought a large increase in use of the budgets (Pavolini and Ranci 2008) and in the cost. This led the Ministry of Health to withdraw the right to personal budgets from 2010. However, people already receiving a PB continued to do so. The increasing costs were not the only reason for ending PBs. As van Ginneken, Groenewegen & McKee (2012) point out, reports of fraud opened a public debate about the rules for use of PBs.

The policy emphasis has shifted towards an expectation that older people will take more responsibility for their own health and wellbeing and that of their family (Moree, 2006). Service users are now required to contribute to the cost of their care services (co-payment) according to their means, as austerity cuts reduce the availability of public funding (Grootegoed & van Dijk, 2012). Eligibility criteria for care services have also become stricter.

In the last two decades, the introduction of market principles and individualisation has transformed the long term care system for older adults from a holistic universal public provision to a subsidiary model of care, in which care and costs are shared between public services and private households (Arksey & Moree, 2008). Neoliberal ideology, in which responsibility is devolved from the state to individuals, has prevailed over collective organisation and funding of care.

i) The Dutch long-term care insurance scheme

The Dutch National Social Security system provides insurance for the costs of treatment, support, nursing, personal care and residence in long term care institutions. In principle, all individuals living or working in the Netherlands regardless of their age or income are insured by the '*Algemene Wet Bijzondere Ziektekosten*' (AWBZ: The Exceptional Medical Expenses Act Law of 14 December 1968). Nonetheless, the AWBZ only covers some health care costs. Individuals must purchase (mandatory) private healthcare insurance from a private healthcare provider to cover short-term health care expenses; the minimum standard package must provide for medical care, short-term cure and medication at a pharmacy. The AWBZ is funded by social insurance contributions from earnings of employees or self-employed as well as from pensions and benefits of the retired or unemployed. For employees, 12.5% of earnings, capped at about 4,000 Euros per annum, is deducted at source, while the self-employed pay directly to the tax authorities. More recently, personal care services might also be partly funded by users through co-payments according to means. The standard private healthcare insurance is a flat-rate premium financed by individuals aged 18 and over regardless of their age or condition.

AWBZ covers the costs of exceptional and expensive care rather than cure, such as long-term nursing and personal home-based care. The system covers long-term healthcare services such as semi-permanent hospitalisation. However, it is not exclusively granted to older people, but also to individuals who have chronic care needs, where the costs are too great to be purchased in the private market. The philosophy of the Dutch long-term care system according to Mot (2010) is that "the state bears the responsibility for the elderly and others who are in need of long-term care" (ibid, p. iii). Although the AWBZ scheme is universal, applying as a legal right to all according to need, the Health and Long-term Care integrated budget approved by each new government for the following 4 years may be insufficient to meet the costs. In this case, the Ministry of Health must put in place measures to reduce costs or increase revenues (Mot 2010).

Individuals receiving AWBZ benefits are entitled to choose the care provider. In the Netherlands all care providers are private, whether they are for profit or non-for-profit organisations. The Dutch Healthcare Inspectorate (IGZ) is responsible for assessing the quality of care and for compliance with regulations. The Dutch Healthcare Authority (NZA) regulates services and ensures that non publicly provided care markets operate correctly.

Under the new Social Support Act, Wmo (Wet Maatschappelijke Ondersteuning; Law on Social Assistance) that came into force in 2007, local authorities were given responsibilities and powers over normal household work for older individuals. This includes cooking, cleaning, gardening, shopping and other related activities of daily living. Since the Social Support Act, financial support for housework is no longer financed under the Health and Medical Act (AWBZ) and is not a legal right. The Wmo has no ear-marked funds to support housework and depends on limited funds from national government and local taxes; Local Authorities are encouraged to use the budget efficiently and to target vulnerable groups.

ii) Care funded by the AWBZ system

The AWBZ funds long term social care, whether home-based or residential, plus a portion of health-related needs, while primary healthcare and short-stay hospital treatment costs (which account for two-thirds of healthcare costs) are funded from individuals' private health

insurance AWBZ-funded services, according to the Ministry of Health, Welfare and Sports¹, are as follows:

- *personal care: e.g. help with taking a shower, bed baths, dressing, shaving, skin care, going to the toilet, eating and drinking;*
- *nursing: e.g. dressing wounds, giving injections, advising on how to cope with illness, showing clients how to self-inject;*
- *guidance: activities to prevent neglect or admission into an residential institution. Guidance is focused on the preservation or improvement of the ability of the client to live as independently as possible. It is not intended for clients with mild limitations;*
- *treatment: e.g. care in connection with an ailment, such as serious absent mindedness;*
- *accommodation when a client's care requirements (such as need for round-the-clock care availability in the case of serious confusion) become too great to address in a home environment. Sheltered housing or admission to an institution may be necessary;*
- *temporary (short stay) accommodation: e.g. if it is necessary to relieve informal carers, an older person may be admitted temporarily into an institution. The maximum possible in a week is three periods of twenty-four hours.*

iii) Eligibility criteria and assessment

Individuals entitled to receive care under AWBZ include older people, physically or mentally disabled people with chronic problems and those who need long-term hospitalisation. Although all eligible individuals are entitled to receive care, cuts to the health and long-term care budget could necessitate higher social insurance contributions or higher co-payments for services (Mot 2010), but all eligible individuals are guaranteed a certain level of care and support.

An independent organisation, the Care Needs Assessment Centre ('Centrum Indicatiestelling Zorg', CIZ) is responsible for assessing the care needs of claimants and allocating the services and number of hours sufficient for claimants' needs, regardless of whether they claim cash transfers or services in kind. The assessment made by the CIZ is valid for a period of 5 years before an automatic review but if the beneficiary thinks his/her needs have increased, they may request re-assessment sooner. The CIZ examines the social circumstances of all potential clients. This is particularly important as others in the household are expected to provide a certain level of informal care; the latter is taken into account and thus tends to reduce the allocation of public resources.

Cash benefits and services are allocated according to the need for help and support. There are seven categories of assistance, namely personal care, nursing, supportive guidance, activating guidance, treatment and accommodation. As noted above, since 2007 help with housework has been excluded from the AWBZ system and is the responsibility of Local Authorities. The eligibility criteria for housework help varies among local authorities, due to differences in local budgets or priorities (Mot 2010).

All those assessed as needing long term care before 2010 were able to choose between cash transfers and services. However, cash transfers could not be used for institutional care or treatment. As noted above, once needs have been assessed, individuals used to be able to claim a Personal Budget that allowed them to purchase services from a professional care

¹ www.government.nl/issues/health-issues/exceptional-medical-expenses-act%5B2%5D last accessed 04/03/13

provider or to pay informal caregivers (including relatives) to provide help and support in the home. The amount received in cash transfers is lower than the value they would receive by using public services. According to Mot (2010) cash transfers could be 25 per cent lower in value than services. This is largely because those with cash transfers are expected to find cheaper services in the private market.

Benefits in kind include home care, care in day care centres or residential care. Individuals may choose the care provider from a list of profit and non-for-profit private organisations offering different care packages and conditions. Nonetheless, buying services for the user is still the responsibility of the regional care offices ('zorgkantoren') each of which is affiliated to a health insurer.

Before Personal Budgets were discontinued, informal caregivers could receive payment for the care they provided to a disabled relative, but there is now no financial compensation for the personal care they provide to their relative at home. However, informal caregivers may be directly supported by their Local Authority. For example, they are entitled to respite care for their relative funded through AWZB and receive information and advice through Wmo, which is responsibility of the Local Authorities that commission these services from local care organisations.

iv) How does the co-payment system work?

As a general rule, users of AWBZ and Wmo (Social Services) contribute to the costs of the services according to their income. The contribution also depends on the income and social conditions of the individual; income of other members of the household and assets are not included to calculate the level of individual contribution.

Adults in institutional care must also contribute to the cost of board and lodging, based on their taxable income. All users must be allowed to retain enough money for emergency expenses or clothes, at least 276.41 EUR a month for a single person and 430 EUR a month for a couple (Mot 2010). There are two levels of income-related contribution to institutional care costs according to the individual's level of dependency, the so-called 'high contribution', with a maximum of €2,081.60 a month and the 'low contribution', with a maximum of €758.60 a month.

c. Policies for long term care in the Netherlands: A review of schemes for the social care of older people

In the Netherlands, as in the UK, long term care for older people has been a pressing policy issue for some time, with a focus on preventing unnecessary admission to an institution for individuals with capacity to remain in the community. For policymakers, the cost of institutional care is a major concern, while for older people there is a strong preference to receive long-term social care in their own home in a familiar neighbourhood, rather than moving into a residential or nursing home (Freidland & Summer, 2005). This is partly because of the lack of privacy (van Hoof et al. 2011) and across most countries there are other worrying aspects of care in institutional settings, including poor social relationships, inadequate treatment of chronic pain and depression, bedsores or the inappropriate use of chemical or physical restraints (OECD, 2005).

Some radical thinking has aimed to promote development of a range of alternatives for older people and to ensure professionals had the tools and resources to promote independent living (Wiles, Leibing, Gubernman, Reeve, & Allen, 2012). Policies for delaying or avoiding

institutional care are supported by independent Dutch organizations such as the Independent Longevity Centre (ILC-NL) often in partnership with other NGOs. These include the Leyden Academy on Ageing and Vitality - a pioneer organization that educates masters students and managers to improve the quality of life of older people, Geron - a journal on ageing and society, Vereniging Het Zonnehuis - which increases knowledge about better institutional care, Rode Kruisvereniging - a regional association for care close to home, VerenigingAegon, Concert Communication, Fund RCOAK, Fund Sluyterman van Loo and Stichting Instituut. ILC-NL and other NGOs highlight the need for a new approach to long term care, one that encourages people to plan early for active and healthy ageing as employees and volunteers. To this end, they work with employers and trade unions to oppose age discrimination, organize media events, provide information and share expertise nationally and internationally. ILC-NL promotes arrangements for older people with care needs to remain living actively in their own neighbourhood, in supportive environments designed to maintain vitality and delay dependency. In 2009, ILC-NL published a study entitled 'Pioneering citizen's initiatives - Innovations in Housing and Care Schemes'. The aim was to inspire development of new kinds of residential care and services in which older users play an active role (International Longevity Centre Netherlands (ILC-NL), 2010). In the Netherlands, there is thus a common interest across government, NGOs and older people themselves in preventing institutionalisation for those who can remain living independently in the community – ageing 'in place'.

More controversial has been the transformation of social care systems in some OECD countries to introduce economic and market criteria, with a shift from mainly public provision to a mixed economy of care. Baldock and Evers (1991) observed this pattern in the Netherlands, the UK and Sweden during the 1980s and 1990s. It is debatable whether the motivation for this development is improving older people's wellbeing, cost-cutting to divert public resources elsewhere, or an ideological preference to shrink the state and promote profitable opportunities for private businesses. A market-oriented approach to care provision and funding has stemmed from the ideas of New Public Management and from reports such as the Dekker Report, Willingness to Change, in the Netherlands (Dekker Commission, 1987) and the Griffiths report in the UK (1988). Despite the growing policy focus on market-led care provision, some of the most innovative and high quality 'housing-with-care' schemes for older people in both the UK and the Netherlands are set up and operated by not-for-profit organizations (described below).

The principle of personalisation in home care services, in which the older person is at the centre of their care management, has gained acceptance in both the UK and the Netherlands. The person-centred approach to social care demands a much greater involvement by older individuals, in which they become active agents co-producing their own care arrangements. Since needs for social care are complex and diverse, a variety of options are required so as to tailor care to meet individual's needs. In seeking to encourage active ageing and autonomy, greater responsibilities and risks are placed on individuals. Ideally, the self becomes empowered by the shift in responsibility from the state to individuals. Individuals have become part of a much larger system in which a combination of informal and formal resources are managed. In practical terms, the aim is to enable older people to choose among care providers and exercise control of the type and timing of formal care provided to complement any informal care.

However, the price of empowerment is the greater responsibility placed on the older person or their informal carers to co-produce care arrangements. This has not been universally welcome to older people already struggling with disabilities and poor health.

An important element of personalisation is the right to a Personal Budget, introduced in the Netherlands in 1995 and more recently in the UK (Tinker et al. 2012). Older people assessed as eligible for state support are allocated a budget judged sufficient to meet their care needs. The budget may be used in various ways, such as to employ a personal assistant as carer, for transport, or for aids and adaptations in the home. The older person may be willing and able to take on the management of their budget or may choose to delegate it to a family member (if available) or to a paid broker. In the UK, independent evaluations showed that Personal Budgets are not necessarily helpful to older people, partly due to the limited size of the budget, which constrains choices, and partly because of the extra work and worry entailed, compared with receiving a 'care package' from the Local Authority. There is mixed evidence as to their cost effectiveness in enhancing wellbeing (Tinker et al 2012). In the Netherlands, Personal Budgets are being withdrawn, with no new allocations made, due to excessive cost and to fraudulent use (van Ginneken et al., 2012).

For those who are confused or have been diagnosed with dementia, applying the concept of personalisation is particularly difficult. Identifying the person's wishes and preferences requires empathetic imagination as well as respect for the confused person's efforts to communicate. Given the prevalence of dementia with advancing age, this condition has been prominent in policy development in the Netherlands. A National Dementia Programme from 2004-8 involved the Ministry of Public Health, Welfare and Sport, the Netherlands Institute for Care and Welfare and Alzheimer Nederland. Together, these bodies coordinated a programme for regional providers of care, welfare and treatment of dementia with the aim of improving the experience of those with dementia. Over 200 improvement projects were evaluated and the best 50 used to show how better care for people with dementia and their carers could be achieved. Building on this work, the Dutch Dementia Care Plan was launched in 2008, to 'improve the quality of life of people with dementia and their carers and the provision of the right tools to professionals so they can deliver good quality dementia care' (Alzheimer Nederland, 2012). There are three main policy objectives: i) creating a coordinated range of care options to meet each client's needs and wishes; ii) providing guidance and support to dementia sufferers and their carers; iii) monitoring the quality of dementia care annually. More concretely, each policy objective includes:

- i) The needs of clients and carers, the care options available, their cost and examples of best practice, were established and The Ministry of Public Health, Welfare and Sport, with representatives of care insurance (Zorgverzekeraars Nederland) has developed a guide as to the coordinated dementia care options available in all regions of the country, and their cost. A set of best practice examples is also planned.
- ii) Improved diagnostic methods were developed to identify dementia more accurately and more quickly, so that early support can be provided to clients and their families. Municipalities have a legal obligation under the Social Support Act to support informal carers. A flexible case management system is used and has been found to increase client satisfaction, relieve informal carers, reduce admissions to residential care and to use resources more effectively. Each region seeks its own solutions, resulting in innovative approaches being used; however, case management must be provided in the client's own home and the case manager must be independent and knowledgeable about dementia.
- iii) Indicators have been developed to monitor quality of care, including the areas of communication, physical and mental wellbeing, safety, adequately skilled staff, life circumstances and coordination of care. It is intended that performing well on the indicators

will mean that clients can make choices, that insurers will be supported in their role, and that care quality will improve.

These objectives are not yet fully met, according to Alzheimer Nederland. Despite positive reviews of the best schemes by clients and informal carers, these are only available to a restricted number of older people and their families so far, due to limited resources from the national government.

d. Innovations for older people with modest long term care needs

Older disabled people tend to resist increased dependence on their personal networks and to avoid seeking alternative help despite need for it. They wish to preserve their autonomy and are also aware of policy rhetoric urging self-reliance (Grootegoed & van Dijk, 2012). Consistent with the aim to empower older people and to promote independence, a number of initiatives has developed in the Netherlands to help those with relatively modest care needs to continue living in their own homes as long as possible. These include telecare services, assistive technologies, Smart Homes, internet video links, Apartments for Life and co-housing and care villages.

- i) Telecare and telehealth offer remote monitoring of individuals' health and needs, avoiding the need for them to visit their doctors. Use has increased since the early 2000s (Botsis & Hartvigsen, 2008) and this technology is seen as cost effective in many countries. New devices and techniques may involve users only passively or as operators exchanging information with professionals. Yet in the Netherlands, telecare services are currently little used among individuals aged 65 and over, although public and private initiatives have been developing since 2000 and a series of pilot projects and programmes are now operating. Evidence as to positive outcomes for the health and wellbeing of older people through use of telecare is inconsistent (Tinker et al 2012).
- ii) Internet use helps older people to keep in contact with family and friends who do not live nearby, providing a vital connection with the world, especially for those with physical disabilities. The City of Almere took this further, investing in an extensive high-speed broadband network, the 'Versilvering' programme, in 2009. The aim is to overcome the constraints of location and mobility, so increasing the integration of the older population and also boosting economic growth. The project to provide video-enabled services was planned with the cooperation of the Internet Business Solutions Group, a community welfare group, a theatre with cultural centre, Almere Breed Community TV and service providers BT and UNET. Older people were involved in defining what would meet their preferences, which included live interaction with the theatre and musical fitness sessions 'at a distance'. Pilots were evaluated through interviews and observations. For Almere's citizens the facility 'brought joy to people's lives', less loneliness, increased learning and sharing of information. More than 95 per cent of participants reported increased social contact and 'mental and physical improvement'. For business, the pilot spread awareness of the potential of broadcast video and for Almere City the Mayor's video-conferencing stimulated interest in city projects and events (Cisco Internet Business Solutions, 2011: 5)
- iii) Smart Homes can meet a variety of needs, including through use of assistive technologies. The latter can be defined as 'any device or system that allows an individual to perform a task they would otherwise be unable to do or increases the ease and safety with which the task can be performed'. This can promote growing old in good health and maintaining independence. In the Netherlands, devices include alarms, grab rails, level thresholds,

raised seats on toilets, raised beds, height-adjustable work surfaces and stair lifts that cope even with winding staircases, something not yet achieved in the UK (Tinker, McCreadie, & Lansley, 2003). Smart technology may include a network of sensors and cameras distributed strategically in the house. Electronic and computer-controlled devices are integrated in the home. Funding arrangements are complex in the Netherlands, as in the UK. Agencies for housing, healthcare, social care and social security are involved and both public and private sectors. Eligibility for assistive technology depends on disability level and smart home systems are only funded where there is severe disability (Tinker et al., 2003). As early as 1994, a model house was built in Eindhoven, home of the Smart Homes Foundation (www.smart-homes.nl). It is debatable whether such a house would be comfortable for older people, given the space taken up by the control room and wiring. As Tinker et al (2003: 335) observed, assistive technology 'may be too sophisticated, complicated or impractical to address real issues'. Involving older Dutch people in designing user-friendly homes and other products has led to setting national standards. For assistive technology to be most useful, consultation with users, simplicity of devices, guidance as to use, and introduction before very old age are all important. Moreover, limitations must be recognised: human back-up to technology is essential (Tinker et al. 2003).

- iv) Apartments for Life were first built in Rotterdam in the 1990s by the non-profit Humanitas Foundation. They are designed as 'age proof' apartments that can be adapted as disabilities develop. Initially three complexes were built, with 350 apartments, but there are now 15 complexes with 1,700 apartments housing an estimated 2,500 individuals (Humanitas Foundation, 2012). The apartments are available to couples as well as individuals and residents can organise whatever care provision they need. Apartments may be purchased or rented and in the 195 apartments of Humanitas-Bergweg the rent is subsidised. The Humanitas Foundation stresses the value of enabling individuals to remain in control of their daily living as long as they can. In this, Apartments for Life resemble UK retirement villages, where individuals and couples often choose to live independently, having initially no or low care needs.
- v) Co-housing (*centraalwonen*). This movement started in the 1960s, mainly founded by young people, and the number of schemes has increased since then. Each household has the normal rooms but shares facilities such as laundries, meeting places, hobby rooms, workshops and garden space. Schemes usually have 30 to 70 households, sometimes in self-managing clusters. Most are rented from a housing cooperative but some are owner-occupied (Bakker, 2009). In the 1980s, communities for seniors, 'living groups of the elderly' were developed, to meet the needs of the growing proportion of the population aged over 50. These are supported by local government as they are expected to reduce care costs, but they are started by interested individuals and couples. The Dutch Federation of International Communities commissioned a study in 2008 into the level and quality of mutual caring experienced in co-housing communities (Bakker, 2009). This author notes that individuals need to be able to cope with the conflicts that sometimes arise in making democratic decisions and negotiating on the basis of equality, co-operation and a sense of responsibility; there are no leaders. The reward is a sense of belonging, reciprocity and learning from others. Members value this form of living for its warmth and companionability (*gezelligheid*), social interaction and mutual support. Shared meals are rare but members act as friendly neighbours. Some older people choose a mixed-age community, others an age-based one. An age range from 55 to over 90 years allows natural renewal to take place, with younger and more able members providing help for the

most disabled. Surinamese immigrants found a solution in Anand Joti, a 24-unit rented co-housing development. Surinamese people prefer the company and mutual support of their own ethnic group when they can no longer live alone. The group organises day care and other services, with a special focus of health education through drama, exercise classes, dancing and yoga (Fromm & de Jong, 2009).

- vi) Care Cooperative village - Hoogeloon. In 2005, residents built on a traditional model of the farm cooperative and organised a care cooperative – now with 200 members including volunteers, paid coordinators and professional healthcare staff. The aim was to meet older people's need for health and social care in their own village, instead of having to travel to a town. An ex-care home director provided necessary know-how and contacts. Volunteers take part in a rota to cook meals for older disabled residents, provide other domestic help required and transport when necessary. Start-up subsidies (under the Social Support Act) were used in 2008 to build 14 serviced homes and a Support Centre for older people. Day care is available twice a week, giving relief to informal carers. Wheelchairs and motorised scooters are lent out as needed. Staff are recruited locally so that they can provide a rapid response in emergencies. Garden maintenance is done by workers in sheltered employment. Running costs of services are met from Personal Budgets of users and from cooperative members' annual subscription of 20 Euros, the aim being to make the services entirely self-funding. This initiative demonstrates the viability of a small-scale approach to social care and the advantages of services being embedded in a community and thus able to build on the work of motivated volunteers (ILC Zorg voor Later, 2009).
- vii) 'City Village South' (StadsdorpZuid) a citizen's initiative near Amsterdam, inspired by the Village movement in the USA, was launched following ILC-NL's support work. The aim is to help older people remain active, healthy and safe in their own home and neighbourhood as long as possible. The importance of social interaction is emphasised, creating activities where people meet, to combat loneliness. Information is available on reasonably-priced services, restaurants and shops that deliver healthy food at a discount. There is a contract with a home care organization for providing personal home assistance. The project was funded by Van Bylandt Fund, Fund Sluyterman van Loo and Fund RCOAK from October 2011-December 2012 but financial contributions of the residents will enable the project to continue (ILC-NL 2010).

e. Innovations for people with intensive long term care needs

In the UK, residential care is widely dreaded by older people; seven out of ten said they were 'scared' at the thought of going into a care home, no doubt influenced by a number of recent scandals highlighting abuse and neglect. Aside from such horror stories, institutional care usually deprives residents of a 'normal' life – one in which they have choices, privacy, dignity and opportunities for social interaction with a wide range of people. For those with dementia, care in institutions is described as 'poor' by the UK Alzheimer's Society (Hunt, 2013). However, the Netherlands has examples of residential homes that are carefully designed to offer a more home-like, normal and enjoyable life. Innovative residential complexes designed to prolong independent living, while ensuring 24-hour care is available, are outlined below.

- i) WiekslagKrabbelaan. This scheme is described as a satellite nursing home, designed for dementia care in an environment that is familiar, enabling, 'home-like' and secure; the home is connected to its neighbourhood and promotes interaction with the wider community. Each household has its own front door, private bedrooms each of 25 square metres with a basin, one bathroom and a shared living area with kitchen, dining and sitting.

There is access to gardens, from where residents can see activities in the neighbourhood. The two households share large multipurpose areas for creative and cultural activities with staff or family members. The care organization (Zorgpalet/Barn-Soest) arranges welfare and support for the residents and for others in the neighbourhood from an office located on an upper floor.

Table 3 Examples of schemes accommodating those with intensive long term care needs

	<u>Wiekslag Krabbelaan</u>	<u>Weidevogelhof</u>	<u>De Hogeweyk</u>
Opened	2010	Some parts in 2010	2009
Organisation	Not-for-profit care organisation	Not-for-profit care	Not-for-profit care
Dementia places	13 in 2 households	60 in 10 households	152 in 23 households
Apartments	16 on upper floors (HA)	354 in 9 buildings	-
Housing type	Ground floor 'family' home	Flexible layout, 1-4 bedrooms	Homes, 6 bedrooms
Average age	87	Not known	82
Philosophy	Home-like, 'normal'	Complete neighbourhood / Affordable, age mix	Care, security
N Staff	11.35 FTE	Volunteers also used	Volunteers also used
Care services	Personal care, laundry, clean, shop, cook	Local health and welfare including meals on wheels	Healthcare in complex
Facilities	-	Private gardens and balconies	Accessible gardens
Cost of building	£650,000	£92,000,000	£16,186,000
Cost per place	£116,000	£260,000	£106,000

Source: Anderzhon, Hughes, Judd, Kiyota, & Wijnties (2012)

The 16 apartments on the upper floors are owned by a Housing Association and rented to people who can still live independently. The care provider assigns these apartments as they become available. Thus the complex as a whole allows for transition, when necessary, from modest to greater care needs; residents in the apartments can transfer to the ground floor of the same building. Dinner is cooked within the household and shared at a single large dining table, as in a family. Multitasking staff help residents to wash and dress, as well as doing the laundry and cleaning. Residents can help with these latter tasks if they wish. The small size of the home and location near to shops are intended to encourage residents to go out shopping with staff or family. Also, the neighbourhood activity can be seen from large windows, allowing residents to watch and feel part of it. The care focus is on 'adding life to the days' of residents. Schoolchildren aged 15-19 work with staff after school until 7pm; they may help prepare dinner, stay to eat with residents and get them ready for the evening, providing some intergenerational mingling. Family members of former residents often act as volunteers and more are being sought, to strengthen links with the neighbourhood. Care is provided through the Dutch national long term care insurance scheme. This provides a complete package (nursing care, housing, food and cleaning services) but residents are required to make contributions according to income, age and domestic circumstances.

The same care organisation also runs a nearby home for physically disabled older people, in WiekslagBoerenstreek. This has a similar philosophy of care – to maximize independent choices and integration with the neighbourhood. Each resident has a studio flat with ensuite bathroom and small kitchen. Residents share a dining area, large kitchen, laundry day care centre and gym on the ground floor, with all facilities wheelchair accessible. A café has sheltered terraces leading onto gardens with a pond and views of the neighbourhood (Anderzhon et al., 2012).

- ii) Weidervogelhof. This development consists of nine buildings scattered through the neighbourhood and is run by collaboration between housing associations and a care organization. The philosophy is to provide housing, at-home care and welfare services in close proximity, enabling people to live independently in their own home but with support available in the same neighbourhood when needed. This allows couples to be close when one partner needs care. Apartments are offered to older people with care needs but also to others needing shelter or care, some of the units being 'affordable'. Each apartment has its own garden or balcony. Weidervogelhof is a 'lifetime' neighbourhood, with 201 rented sheltered housing apartments (176 affordable); up to 82 of the sheltered housing units are reserved for people needing nursing home care. Thus the scheme allows for transitions in care needs. There are 41 one-bedroom assisted living apartments designed flexibly to enable reconfiguration into more households for dementia care in addition to the existing 10, each accommodating six people with dementia. A 'Care Hotel' has six rooms with ensuite bath and for rehabilitation and hospice care, allowing for transitions. One cluster of apartments is for severely physically disabled people, while another has 100 affordable apartments for people aged over 55. Weidervogelhof also has a range of primary care, dentistry, pharmacy, physiotherapy, speech therapy, welfare and other services. Although the development is high density, public green spaces are included (Andezhon et al. 2012).
- iii) Hogeweyk village in Weesp, near Amsterdam, is designed for individuals with dementia who can no longer live independently in their own home. Care is available 24 hours, seven days a week. The whole range of dementia is catered for, including the mildly impaired and largely autonomous, those who are moderately or severely cognitively impaired and need professional supervision on a daily basis and also those who are bed-bound. The aim is to replicate daily life in a village of households, thus making residents as comfortable as possible and enabling them 'to continue to live in the manner to which they were accustomed prior the onset of dementia' (Notter, Spijker, & Stomp, 2004, p. 449). To that end, they have created seven different life styles within the village as 'homes within homes'. Each home is planned so as to reflect a particular set of social circumstances: 'Het Gooi' for well-off residents attaching importance to etiquette and appearance; Culturel, for those with interests in art and other culture; Amsterdamse for city dwellers; Indische for those with an Indonesian background; Christelijke for practising Christians; Ambachtelijke for those who had a skilled trade; and Huiselijke for those whose focus had been family caring and domestic life. Individuals choose their preferred lifestyle and live with similar companions in one of the seven types of home. Each of the 23 homes is self-contained, with a budget for food, medicines and care supplies, its own front door and doorbell, 6 or 7 bedrooms and two bathrooms and kitchen. Meals are cooked and laundry done by a housekeeping team. Each home has a distinctive internal layout and exterior to aid residents in finding their way and identifying their own home. The design of the village promotes normal life and local residents may use the Hogeweyk facilities amenities and act as volunteers if they wish. The buildings enclose a spacious area with landscaped gardens, squares and streets where residents can walk and mingle safely around the ponds and benches. The village has a full range

of amenities such as a supermarket, café and restaurant with outdoor terraces, clubroom, theatre and facilities for games such as boules. Meaningful activities are encouraged. Residents may visit their doctor, physiotherapist or hairdresser within the village and shop for groceries at the supermarket, accompanied if necessary. Meals are cooked within each home. The design and care programme is intended to promote residents' self-esteem, autonomy and independence, within a secure and familiar environment (Anderzhon et al. 2012). It is claimed that the cost per resident in Hogeweyk is no higher than in a Dutch nursing home but there has not been a thorough examination of the cost-effectiveness of the scheme nor studies assessing clinical outcomes (Hurley, 2012).

f. Conclusions

What emerges from the above innovative schemes in the Netherlands is that, although financially viable, the initiatives have been motivated mainly by the desire to enable active and enjoyable ageing 'in place' as long as possible, with care available when needed but without undue loss of autonomy. Planning and design followed the philosophy of providing normality, with as much independence as possible in a safe, home-like setting but with opportunities for interactions, activities, outdoor leisure and being part of a neighbourhood. A mix of accommodation types, care need levels and facilities allows for choice and change, as well as for maintaining connections with family and friends. The motive of maximising profit has been absent or secondary. This contrasts with some corporate-owned care home chains in the UK, which have treated the homes as assets for trading in international markets, to the detriment of the residents' security. Other UK housing-with-care schemes, such as those run by the Joseph Rowntree Foundation, have a more responsible and caring philosophy.

The potential is clear for local enterprises to provide caring services in the UK in a similar way to those in the Netherlands operating in partnership with a housing association or care cooperative village. Businesses can provide innovative technical services such as those at Almere City and in Smart Homes. There are opportunities for UK planners and architects to learn from the designs of Dutch care complexes; construction companies and many other skilled trades have also been partners in making these new developments possible.

Social insurance is used to finance long term care costs in the Netherlands, including personal care either at home or in a residential institution, as well as the cost of temporary accommodation for temporary respite or for long term institutional care. Unlike the UK, where social care funding is widely acknowledged to be unfit for purpose, social insurance shares the risk of heavy costs due to disabilities across the population and merits further examination as a viable alternative.

SECTION 2: The Netherlands case study visits

a. Introduction

This section provides more detailed information from interviews in the Netherlands, obtained from interviews with knowledgeable academic and others (see Appendix A) on the visit there in February and March 2013. As seen in Section 1, the researchers conducted 10 interviews covering a wide range of topics about the Dutch long-term care system, housing and care organisations, assistive technology, community living and other projects aimed at improving older individuals' well-being. See Appendix A for details of the visits and Appendix B for the topics covered and ethical approval for the interviews. They set out the development of policy, legislation and funding for social care. In this section, they also discuss major themes arising from the interviews.

b. Major themes from the interviews: Policy changes in long term care

Long-term care policy in the Netherlands is developing at a fast pace, with far-reaching changes in the funding and provision of long-term care services for older adults. Several trends were identified by interviewees. The first is the gradual closure of residential homes as they are seen by governments as too expensive, with rent and care both being fully paid by the state. A major shift in thinking about public residential support started in the 1980s, according to Dr Ad van Berlo. Residential care was not only seen as inadequate for meeting individuals' needs but also as being used by some individuals who had no need for such care. At the same time, citizens' attitudes and preferences were changing. Older people who considered residential homes as a right began to criticise the conditions, preferring larger rooms and communal spaces. The demand for better care environments became widespread.

There has been a shrinking of the state's role in adult social care since the 1990s, in parallel with the UK, since the 1990s. At that time in the Netherlands, regional authorities were responsible for providing and managing residential homes, the national state controlled nursing homes and the local authorities were responsible for assistive technology. Now, the state's role is limited to funding and to setting quality standards in institutional care, while services are provided by care organisations and housing associations. The number of residential and nursing care homes is about 2,200, with a capacity of 250,000 according to Dr Ad van Berlo. If all places were occupied, this would mean between 6-7 percent of individuals aged 65 and over living in institutional care. The aim of reducing use of institutional care has led to new rules as to who qualifies for residential care, with eight levels of care need being defined. From 2014, people with care needs assessed as level 2 or below will no longer have access to residential care homes and from 2015, individuals at level 3 (physical impairments) and 4 (mental health disabilities) will no longer qualify. These changes are intended to decrease the number of individuals in residential homes.

The second major policy trend is a consequence of the first: the promotion of care in older people's own homes for as long as possible. The promotion of home-based care can be seen as part of a general aim to enhance disabled older people's autonomy, choice and self-reliance. However there is no evidence of what is best for whom and it seems the main reason for governments' preference for home care is to reduce state spending.

There is a clear trend towards introducing measures to save costs at the national level. Eligibility rules for funded care services are being tightened and the focus is increasingly on re-activation and re-ablement of disabled individuals: cure rather than care. Domestic services (or housework) are no longer nationally-funded: instead, Local Authorities are now responsible for

assessing and funding these services for disabled individuals. This has clearly divided medical and personal care services (funded nationally) from domestic services (funded locally). Local Authorities now require co-payments for such services, depending on the disabled person's income. Personal care in the home remains free to the user but only for the hours assessed as necessary. The objective of the government is not only to reduce the numbers of older people in institutional care, where spending is considered to be very high, but also to limit the cost of funding personal care at home. Although accommodation and personal care costs in institutional care are both paid by the state, in future only personal care will be funded in this way. There is concern that a large number of individuals, especially lone men, live in residential care homes, despite having almost no particular need for care, according to Ms van der Waal. Because of this, the government plans to offer alternative assistance to these individuals. Considerations of cost have led to the discontinuation of Personal Budgets for new clients since 2010. According to some of the policy experts interviewed Personal Care Budgets were a major cause of increased social expenditure, partly due to fraudulent use. This experience in the Netherlands serves perhaps as a warning to England regarding the difficulties and problems in using Personal Health and Care Budgets, indicating they are not a cost-efficient way to allocate resources for care.

In sum, the Dutch long-term care system is undergoing a number of changes, with stricter eligibility rules so that fewer individuals have access to personal and domestic support.

c. Major themes from the interviews: The importance of social relationships

Technological devices are a means of facilitating networks and access to services in a more efficient fashion. Nonetheless, whether individuals' care needs are mild or severe, face-to-face human interaction and human touch remain important to individuals' social well-being. The majority of interviewed experts emphasised that human touch is crucial to ensure dignified care and treatment and that social relationships are very important for individuals' health and well-being. Social isolation and loneliness tend to exacerbate personal care needs, whereas socially-included individuals are more likely to participate in the activities that help promote active ageing and reduce care needs. Mental ill-health can create difficulties that prevent individual enjoying life to the full. Intervention must include the concept of re-ablement and restoring a person's life after a traumatic physical or emotional experience. A powerful example of the positive effects of continuous social relationships on individuals' wellbeing can be found in the Dementia Village 'De Hogeweyk' where, as Ms Yvonne van Amerongen points out, living arrangements have proved to work better if they are small clusters, promoting social interaction with a familiar group.

Another example of the value of social relationships was given by Mr Frans Stravers of Mextal (a company that offers technological solutions for care). He mentioned that one of the most successful projects has been the video conference platform which enables individuals to participate in a video conference with anyone in the world. This has been proved to work very well among individuals with children and grandchildren living abroad. The older person benefits from the feeling of being there, helping to ward off potential loneliness and reducing the sense of social isolation.

Other projects promoting social relationships in the community take the form of a collective activity. 'Garden', for instance, is a project where young and old meet and learn together how to do gardening. There are special initiatives designed to facilitate social life for migrants (mainly Turks, Surinamese, Indonesian or Moroccan). These include meeting centres where they can participate in various social activities, foster international networks or take part in

intercultural care projects. There are more than 300,000 older adults from ethnic minority groups participating in intercultural projects in the Netherlands.

Ms Yvonne Witter focussed on two successful projects to avoid loneliness. The first encouraged residents in a nursing home to share coffee together and to interact with others. The second project also had a social purpose, but the interaction with others was through internet chats. It is significant that as soon as the programme finished all the positive effects from reducing loneliness disappeared. This highlights the need for interventions tackling loneliness and social exclusion to be sustained rather than temporary. However, reaching out to individuals suffering social isolation is difficult, as they tend to avoid social and communal gatherings.

d. Major themes from the interviews: Environment and community belonging

A closely connected aspect of social relationships is the feeling of belonging in a community. This is particularly important for individuals with severe dementia. The Small Scale Living project tested 13 different initiatives in small scale housing (up to 8 individuals sharing a common space, but everyone with his/her apartment). Three initiatives were particularly successful in improving individuals' well-being. Their common component is the degree of social contact between individuals and their community. As Professor Helianthe Kort explained, individuals need opportunities for activities outside the confines of their home, so as to feel part of the community. For example, they might be encouraged to walk to the post office with a member of staff.

The living environment is gaining increasing recognition as of value in the delivery of care. Although there is growing pressure to maintain individuals in the home, there is less attention to the spaces outside the home and in institutions. We find a very good example of the need and importance of maintaining a link in the local community as Mr Frans Stravers from Mextal pointed out. He found that social interaction is one of the most highly regarded activities among older adults and that the sense of belonging in a community is fundamental to the well-being of individuals. A project that has proved very successful is designating a place to collect groceries that have been ordered online. This communal space gives opportunities to encounter other people, places to sit and drink a coffee and most importantly it is used to monitor individuals and make sure they are fine. Mr Stravers remarked on the social value of a communal welfare organisation, saying it should be the centre of any technological development.

The previous example applies to individuals with mild to moderate impairments. However, the importance of the community and the sense of belonging have been also found crucial for individuals with severe dementia. The dementia village De Hogeweyk was built to reconstruct the same environments and patterns of life as exist in the outside world. Unlike other nursing homes that lack social context, De Hogeweyk has introduced elements such as a pub, supermarket, streets, theatre and a restaurant to recreate common practices and places in the outside world. The continuation of old habits (sometimes with the help of a carer or the family) is crucial to the philosophy of care and well-being in this care project. Individuals have to feel included and that they are in control of their life.

Co-housing projects are often initiated from the bottom. However, co-housing projects for people from minority ethnic groups (Turks and Surinamese) are usually started by an organisation. Rental co-housing provided by not-for-profit organisations has served the interests of a diverse group of migrant individuals who are not used to Dutch food, and language. According to Ms Els de Jong, an independent consultant in Dutch co-housing, senior co-housing projects for migrant individuals have a positive effect on their daily life. As is usual in co-housing; the projects have a common space where tenants can gather and participate in social activities.

Ms Els de Jong pointed out that individuals in co-housing schemes are usually active and not in need of care. In the event that they do need some care, this might be formal and provided within the home. Members of a co-housing project are typically couples or singles (more often women). Although the majority of co-housing projects are intended for active and healthy people, there is currently one project 'Thuishuis' (Feeling at home) that is designed for frail older adults with no 'self-starting' capacity. There are notable differences from traditional Dutch co-housing. Each resident has only a bedroom instead of a whole apartment. The care component is more important in this scheme. There are professionals in charge of providing care, with volunteers to help.

e. Major themes from the interviews: Listening to users: designing for choice, control and flexibility

Most recent policy changes in long-term care have emphasised the need for increasing choice and flexibility for disabled older people. However, there has been little attention to designing services according to users' needs. This is particularly important for the members of the community in Son en Bruegel, they consider it fundamental to be 'in the driving seat'. Mr Pieter den Hamer, chairman of the cooperative association ThuisVerbonden, also stressed the idea of constantly learning from users, adapting and adjusting technologies to changing demands. He pointed out the value of designing technologies that can adapt to individuals' daily circumstances and their changing activities during the day. Alarms, for example, can be adapted to fit daily schedules (i.e. day, afternoon, evening and night). A better understanding of individuals' daily practices would reduce the number of false alarms and would create less disturbances to the individual. Although they have considerably reduced the number of false alarms, the percentage of false alarms is currently about 20%.

f. Major themes from the interviews: Opportunities for business

A theme that occurred in all the interviews is that social care businesses (profit or non-for-profit) could be expanded, increasing their participation in care and housing and promoting a better quality of care. Growing numbers of older people with disabilities extends the opportunities for business research and development (R&D) to improve provision of healthcare and social care. As interviewees stressed, the Netherlands is still far from finding perfect solutions but the large variety of individuals and their specific preferences and circumstances open the door for business competition to provide services tailor-made for their needs.

Interviewees noted that innovation must be led by collaborative partnerships. The private sector of business cannot on its own initiate innovations for the present and future consumers of care and leisure. Research and development need the support and cooperation of municipal, regional and national authorities, research centres and businesses. Such partnerships are being developed in the province of Brabant (e.g. Tilburg and Eindhoven) where care and health needs have helped to drive technological developments.

Partnerships do not always guarantee success. An example of an unsuccessful partnership can be found in Son en Bruegel at Eindhoven (see below). The ZDA proposed to develop an online care service led by the preferences of the clients. However, difficulties with care providers and local business rendered the project unfeasible. The conclusions were that the local authority and care providers were insufficiently developed to match individuals' multiple and changing preferences.

Tackling social isolation and loneliness presents significant challenges for both social and business innovation in the future. Social communications have experienced a great boom in recent years. Local communities can be strengthened with innovative schemes such as the virtual community village Son en Bruegel. This self-starting project has established partnerships with the Local Authority and business providers to install broadband in the village, where 85 per cent of houses have an internet connection. At present, they are seeking a business provider to install a series of devices that will integrate services for communication, care, emergency, leisure and entertainment. An important feature of the project is the control that individuals will have in choosing their service package, including the ability to adapt it to their changing care needs. Such virtual communities are increasingly common and are most successful where ICT technologies and devices are adaptable and inclusive so as to address a wide diversity of needs.

Assistive technologies also provide scope for more business involvement. These technologies have helped disabled individuals and their caregivers to manage in their own home. So far, few initiatives have focussed on improving informal carers' wellbeing and, most importantly, providing them with practical help and information. One such innovation, called 'd'mentia', was described by Dr Jan Rietsema, a consultant at the research and consultancy agency Minease. The aim is to improve awareness and understanding of dementia among carers and thus to reduce their frustration and depression. 'Into d'mentia' is a simulation space that allows individuals without dementia to experience the range of symptoms (confusion, detachment, fear, aggression, impassiveness, etc.). This initiative is very relevant, as increasing numbers of older people with dementia live in their home with an informal carer, typically their spouse, providing the bulk of the care. According to one interviewee a better understanding of the condition should improve the carer's quality of life and help them provide care at home for longer. This practical and informational tool might have business applications in formal care service development. Both formal and informal carers are increasingly in need for help and support.

The housing sector is still underdeveloped in terms of age-proofed design that allows individuals with disabilities to stay longer in the home. Smart homes are few at present but beginning to expand, providing opportunities for partnerships and research.

In conclusion, many kinds of businesses have potential for expansion and innovation in care, cure and leisure in later life. Crucially, civil society, local authorities, research centres and businesses have to listen to each other and cooperate to create innovative business models that tackle the needs of society or specific social groups.

g. Major themes from the interviews: Understanding of disability and the need for care

Understanding of long-term care conditions among the public can be helpful to both disabled people and their informal carers, by reducing stigma and stimulating assistance. According to Ms van der Waal, a change of attitudes is necessary, with a new discourse that focuses on re-ablement interventions to improve the physical or mental health of individuals; mindsets need to change among both older adults and care professionals. The current expectation among individuals is that the state will and should provide care when they become disabled. One interviewee suggested the government should promote a change in individuals' views and be more oriented towards re-ablement. Some initiatives to increase understanding of disabling conditions are very promising, such as 'Into d'mentia' described above. Less sophisticated tools such as books for children may be used to create understanding of dementia; these include Yvonne Witter's book 'The right chord' published in September 2012.

h. Conclusions from the interviews

- a. Many technologies are already in service for computing and simulating experiences for gaming purposes that could be applied to care and leisure in later life. The task for business is to develop these for people with care and social needs. Technologies that facilitate social interaction (such as internet chats and Skype) are regarded as solving the problem of isolation and loneliness. Yet not all older people can cope with such technologies; nor are all connected to the internet or owners of a computer.
- b. Social relationships are vital to individuals' wellbeing and pre-exist the onset of need for care. Any innovative device or practice must take both social and care needs into consideration. Technology, however well-designed, cannot replace the human need for face-to-face interaction, understanding and help.
- c. Active ageing initiatives are effective for people who are already active, helping to extend their healthy life expectancy. Yet it is proving difficult to reach isolated individuals whose social, health and care needs at a mild stage are likely to be undetected and who will thus lack the interventions that could improve their health and wellbeing.
- d. Policies towards long term care have been implemented to reduce the costs to the state-sponsored social insurance scheme and to Local Authority budgets. This is likely to increase the pressure on informal carers.
- e. Informal caregivers, since they provide the bulk of home-based care, need support from the local authorities and care organisations to enable them to guarantee adequate care to their disabled relative. However, payments for informal carers must be avoided as otherwise would institutionalise care in the family.

CONCLUSIONS

This study was undertaken to see what can be learned from the experience of the Netherlands about long term care in order to inform policy, research and practice in the UK. It is a modest piece of research involving desk work and a week-long visit to the Netherlands to see schemes and to talk to key individuals.

The two countries are very similar in demographic profile and the experiences of the older generation, although it is notable that according to official statistics older individuals remain disability-free for nearly half a decade longer in the Netherlands than in the UK. It was also evident that social care policies are moving in the same direction, seeking both to delay admission to residential care and to create more acceptable and home-like settings. Also there have been similar reforms to limit costs to the public purse. The emphasis, at least in theory, on expanding choice for individuals was another common factor. Where the UK can learn from the Netherlands can be summarised in these areas. Although one would not necessarily want to emulate the Netherlands in all respects, some salutary lessons are offered.

First, the greater use and attention paid to technology. The Netherlands was in the forefront of the development of, for example, smart homes, and much industry was based there.

The second is the early development of co-housing. That is where a group of people decide to live together. Most schemes have started with younger people but a few have now been pioneered for older people. There are some schemes in the UK too but again they are in the main for younger people (with a few exceptions e.g. a scheme will soon be operational for older women in North London). Co-housing group projects tend to emerge naturally, in response to people's wish for company and mutual support. The challenge for both countries is to encourage and support such initiatives in planning and funding their projects. Communities where people grow old together may have the potential for mutual support in later life. The experience of extra care housing is that where older people have lived together for a period they are more accepting of frailty and unusual behaviour than when a new group move in.

Third, is the development of schemes specially designed to include people with dementia and the care taken to make these as like a real life community as possible, avoiding ghettoisation and educating the public about dementia to reduce the stigma. These schemes are beginning to develop in the UK too. In the Netherlands there are some promising initiatives in planning and design for residential care followed the philosophy of providing normality, with as much independence as possible in a safe, home-like setting but with opportunities for interactions, activities, outdoor leisure and being part of a neighbourhood. A mix of accommodation types, care need levels and facilities allows for choice and change, as well as for maintaining connections with family and friends. The motive of maximising profit has been absent or secondary. This contrasts with some corporate-owned care home chains in the UK, which have treated care homes as assets for trading in international markets, to the detriment of the residents' security.

Fourth, is the salutary experience of the Netherlands with Personal Budgets (PBs) where not only was the cost found to be higher than expected but there appeared to be a substantial element of fraud. UK research on pilot PB schemes has shown them to be of doubtful value for older people but the principle is being extended from social care to health.

Fifth, is the way that funding for social care and for health is split between different budgets in the Netherlands. Acute health care costs are funded by individuals' (mandatory) insurance contributions to private healthcare providers, while long term social care and long-term

hospitalisation for health treatment are both funded by public (mandatory) social insurance contributions. This contrasts with the UK where the split is between tax-funded healthcare and privately-funded social care (except where income and assets are very low). In the UK, the logic of bringing the two systems together has been recognised; it would treat individuals' health and social care needs holistically. If the criterion for fairness and effectiveness is a seamless health and social care system, then a single mandatory social insurance scheme with contributions from the whole population (in effect tax-funding) could be considered for the UK.

Sixth, is the example of the housing scheme (a village in this case) where people are allowed to choose the group of people to live with on e.g. cultural, ethnic or other grounds. In the UK there are separate schemes for groups such as actors and licensed victuallers but we do not know anywhere such a choice is made within a scheme.

Seventh, is the recognition in all schemes and services of the importance of facilitating social relationships and a sense of community belonging. Promoting greater understanding of disability and listening to users are also seen as valuable.

Eighth, are the opportunities for business. A theme of all the interviews was the need to expand care businesses whether these were in technology or in social care provision.

Perhaps one of the unexpected findings, although this was hinted at in our first report (Tinker et al, 2012), was that the UK can offer viable ideas to other countries. There are two specific areas where the UK has an outstanding record. These are extra care housing and help with aids and adaptations. There is clearly much to be learnt by studying policy and practice differences between countries.

APPENDIX A: DETAILS OF THE VISITS IN 2013

27th February

Eindhoven:

Dr. Ad van Berlo: Smart Homes organisation: national expertise centre on Home Automation and Smart Living.

Mr. Pieter den Hamer: Chairman of the cooperative association Thuis Verbonden Son en Breugel.

Dr. Jan Rietsema: Dr. Rietsema is a consultant at the research and consultancy agency Minease; this agency does research in collaborative innovation and provides advisory services about the design and control of these collaborations such as business clustering, open innovation, supply chain management or economic stimulation. Jan is mainly involved in the Dementia experience project, which provides informal carers and their social network, and professional carers with more knowledge and understanding about the experience of a person with dementia. Dr. Rietsema is also a programme manager of 'Care Avenue' in Tilburg. Care Avenue works as a centre for Social Innovation in the healthcare sector. It develops care projects aimed at improving and delivering cost-effective care to elderly and chronically ill people.

Mr. Roger Jongen: Programme manager at Careyn Netherlands. Careyn is one of the biggest care organisations in the Netherlands.

28th February

Eindhoven:

Mr. Frans Stravers MSc: Frans Stravers works at TKH Care Solutions, a leading company offering care technology solutions.

Professor Helianthe Kort: Meeting with Pr. Helianthe Kort, leading academic on Ambient and Assistive Technology at TUE (Eindhoven).

4th March

Leyden:

Ms. Marieke van der Waal MSc: Marieke van der Waal is director of the Leyden Academy. The meeting took place at the Leyden Academy on vitality and ageing. The Academy is a knowledge centre aimed at promoting and improving the quality of life of elderly people. Leyden Academy is also project leader for the VITALITY! Programme within the Medical Delta, a co-operation of Dutch medical universities comprised of the LUMC, Leiden University, TU Delft, Erasmus University and Erasmus MC. Furthermore, Leyden Academy works closely with the Netherlands Consortium for Healthy Ageing, ILC Zorg Later/ILC Global Alliance, Max Planck Institute for Demographic Research (Rostock) and Biology of Ageing (Cologne), and since June 2012 with *Vereniging Het Zonnehuis*.

Weesp:

Ms. Yvonne van Amerongen: Yvonne is one of the six founders of the dementia village De Hogeweyk and head of Quality and Innovation in the small-scale village.

5th March

Rotterdam:

Ms. Els de Jong: Els de Jong is an independent researcher specialising in co-housing in the Netherlands.

The Hague:

Dr. Yvonne Witter: Advisor at Aedes-Actiz Knowledge Centre of Housing and Care.

APPENDIX B: METHODOLOGY

The research has been a mixture of a literature search building on the existing materials together with field work. The latter involved a visit of 7 days for one researcher in the Netherlands accompanied by Jackie Marshall-Cyrus of the Technology Strategy Board for two of those days.

Ethical approval was sought and gained from the King's College Research Committee before the interviews took place.

The choice of schemes and experts to visit was partly governed by the timing. They were arranged at very short notice and we were fortunate that some of the key informants were available. The main gap was the lack of a policy maker from the Department of Health whom we were unable to contact in the time available. We are most grateful to all our informants.

The topics covered in the interviews were:

1. Description of the scheme/innovation including physical features, funding
2. Has it been evaluated?
3. Where the impetus came from to develop this scheme/initiative?
4. What helped develop this initiative?
5. What hindered it and what lessons can be learnt?
6. How were the views of users taken into account?
7. How does this fit into long term care policies in the Netherlands?
8. What does the future hold for long term care and what is the next innovation/scheme/policy direction?
9. In particular what are the lessons for industry?

Please note that the literature follow up is mainly of evaluated schemes whereas the visits are not.

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Note

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About the Institute of Gerontology, Department of Social Science, Health and Medicine, King's College London

The Institute of Gerontology at King's College London is one of the leading gerontological research and teaching centres world-wide. Founded in 1986, the Institute is at the vanguard of multi-disciplinary research and teaching, acting as a bridge between the social and clinical sciences. The Institute has many long-standing research and teaching collaborations including the Institute of Psychiatry, the School of Medicine, the School of Nursing and Midwifery and the School of Biomedical Sciences.

The objectives of the Institute are to;

- Engage in state of the art research in the demographic, sociological, psychological, financial and institutional processes of ageing.
- Provide multidisciplinary research led education and research training for both clinical and social scientists, including practitioners in health, social care, government and the voluntary sector.
- Engage critically with social policy issues for the benefit of older people both internationally and nationally.

The Institute's interdisciplinary nature is reflected in its broad research sponsorship base; it has received funding from UK Research Councils (i.e. ESRC, MRC, EPSRC and AHRC), from

numerous charities concerned with the welfare of older people, and from government (including the Department of Health, the Department of Communities and Local Government and the Department of Work and Pensions). The Institute's recent research has included a study of elder abuse; pensions and poverty; housing and technology; the health and social concerns of 'new' ageing population, end of life care and bereavement; the demography of informal care; and the biology of natural ageing. Current research is focussed on three core areas: (i) ageing policy, health and healthcare; (ii) ageing policy and family life; and (iii) global ageing.

About the Housing LIN

Previously responsible for managing the Department of Health's Extra Care Housing Fund, the Housing Learning and Improvement Network (LIN) is the leading 'learning lab' for a growing network of housing, health and social care professionals in England involved in planning, commissioning, designing, funding, building and managing housing, care and support services for older people and vulnerable adults with long term conditions.

For further information about the Housing LIN's comprehensive list of online resources and shared learning and service improvement networking opportunities, including site visits and network meetings in your region, visit www.housinglin.org.uk

The Housing LIN welcomes contributions on a range of issues pertinent to housing with care for older and vulnerable adults. If there is a subject that you feel should be addressed, please contact us.

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