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The Minister for Housing and the Central
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Date: 15 January 2014 **Appendices:** 3
Reference: RLI-2014/27
Cc: M.J. van Rijn,
State Secretary for
Health,Welfare and Sport
Subject: Advisory letter: Living independently for longer – a shared responsibility of the housing, health and welfare policy domains

This advisory letter has been produced in association with the Scientific Council for Government Policy (WRR)

Dear Minister,

In your letter of 11 June 2013, you – in conjunction with the State Secretary for Health, Welfare and Sport, Mr Van Rijn – request the Council for the Environment and Infrastructure (Rli) to advise you about the implications of the proposed reforms of long-term care for the housing market, public governance, and spatial patterns. You ask the Council to consider the relevant aspects in a broad context.

The Council notes that the primary objective of the reforms, as set out in the Letter to Parliament *Van systemen naar mensen*[1] (From Systems to People), is to enable people to live independently for longer, with appropriate care provided in the home setting (see Section 2.1). This aim is fully in keeping with the autonomous societal development whereby people do indeed wish to live independently and retain control of their own lives (see Section 1). The reforms seek to accelerate the ongoing development of small-scale housing forms within the local community for people with a disability or infirmity and to increase the provision of domiciliary care. The Council endorses the decision to adopt this policy. In the Council's view, the reforms will generally offer greater opportunity, in both the short and longer terms, to promote social integration of people with a disability or infirmity within their communities, to address the personal housing preferences of those with a care requirement, and to encourage the market to develop new housing and service concepts. In the short term, however, the Council foresees a number of difficulties further to the various policy amendments (Section 2) and their implementation within the housing, health and welfare domains.

[1] House of Representatives (2013), *Beleidsdoelstellingen op het gebied van Volksgezondheid, Welzijn en Sport*, letter from the Minister and State Secretary of Health, Welfare and Sport to the House of Representatives, 8 February 2013, Proceedings 2012-2013, 32620, No. 78

The Council identifies the following main issues.

- There is a worsening shortfall in the availability of places within 'assisted living' concepts (which vary in terms of the degree of medical or nursing care provided) for those with a disability or infirmity (see Section 3.1). The demand-supply imbalance can be seen in both quantity and quality. The proposed reforms provide for a process of 'extramuralisation'. This means that, over the next five years, an annual average of some ten thousand senior citizens, thirteen hundred disabled persons, and eight hundred psychiatric patients under the care of the mental healthcare services (GGZ departments) will become ineligible for residential care because they are assessed as having a 'lesser' care requirement. There is no guarantee that these people's current accommodation or its setting (the neighbourhood) will permit the desired degree of independence. It is the most vulnerable members of society who are likely to face the greatest difficulty in the years to come as affordable alternatives to remaining in their own homes (with appropriate care) are still few and far between.

- The spatial requirements for the combination of housing, healthcare and welfare differ greatly between and often within urban, suburban, and rural municipalities (see Section 3.2). It is necessary to conduct a local inventory of both the accommodation requirement and that for services and amenities on a regional basis, thereafter 'zooming in' to seek appropriate solutions at the local level.

- Under the current proposals, access to intramural care is to be restricted within a relatively short time span. It will not be possible to create suitable alternatives within that period, even where the buildings themselves are already in existence and require only modifications or a change of designated usage. The Council has calculated that over four million square metres of existing care sector real estate must be renovated or adapted (see Section 3.3). The organisations which own and manage these buildings may decide to close them altogether, which will inevitably have far-reaching consequences for residents and the local community. The demand for clustered accommodation with (nursing) care will increase again in future due to population ageing. Given more time, solutions other than closure can be explored, thus avoiding the write-off of valuable capital assets.

- The formation of coalitions should be encouraged, such as partnerships between housing associations, healthcare institutions, and welfare service providers: the stakeholders responsible for creating a link between the relevant policy areas for people in need of care. Given the aforementioned autonomous societal development and the objectives of the reforms, this approach would bring patient autonomy that much closer. However, the Council notes that the formation of such coalitions is sometimes hampered by overly restrictive policy. The combination of the proposed policy amendments (see Sections 2.1 and 2.2) and the uncertainty with regard to the content of the resultant legislation is likely to prompt organisations such as housing associations and healthcare institutions to focus on short-term survival and risk avoidance. They may also opt to discontinue some activities, passing their tasks and responsibilities to others.

Now more than ever there must be a long-term focus if the common objectives of the housing, healthcare and welfare policy domains are to be achieved.

Creating the desired opportunities for the housing, healthcare and welfare domains entails a complex investment strategy covering:

- The renovation and redesignation of existing care sector real estate
- The adaptation of existing dwellings to make them suitable for continued occupation by people with a disability or infirmity
- The development of new assisted living concepts
- More effective use of technology (such as 'domotics')
- The maintenance or improvement of local amenities to enhance the quality of the residential environment
- Innovation in care processes to enable tailor-made care, including the more intensive forms, to be provided in the home

In short, there are obstacles to overcome and investments to be made. The current economic climate and the nature of several policy amendments may discourage certain stakeholders from making such investments. At the same time, regulators are focusing more closely on the performance of a stakeholder's primary, core tasks. This stands in the way of achieving optimum synergy between the various stakeholders. That synergy is absolutely essential in the common domain of housing, healthcare, and welfare. Some policy proposals prompt stakeholders to focus on their own interests, while the short timeframe proposed for the implementation of the reforms is forcing them to make short-term decisions which may well lead to the loss of valuable capital assets in the longer term.

The Council views this situation as undesirable. Accordingly, we advise the government to formulate a clear vision on housing, healthcare and welfare covering the next ten to fifteen years. This vision should clearly state which chronic care indications are to be subject to the separation of housing and care costs (see Section 3.1), as well as the route by which this separation will be sought. This approach will create greater clarity for all stakeholders and will serve to alleviate current uncertainties. The parties involved will then be able to develop a long-term strategy for their real estate holdings as well as for housing in both the rental and owner-occupied sectors, whereupon appropriate investments can be made.

To overcome the obstacles outlined above, the Council makes the following recommendations, which are elaborated in Section 5.

- Stakeholders should be given greater room to create synergy between the domains. Seeking cooperation between the housing, healthcare and welfare sectors should be regarded as part of all parties' core task. This entails a further financial separation of housing and care costs, together with a clearer correlation between the responsibilities of the *Waarborgfonds Sociale*

Woningbouw (Social Housing Guarantee Fund; WSW) and those of the *Waarborgfonds voor de Zorgsector* (Guarantee Fund for the Health Care Sector; WFZ).

- Investment incentives should be created, including those encouraging stakeholders to invest in joint objectives. 'Split incentives' should be removed, while the members of the target group should be encouraged to devote timely thought to their desire to (continue) living independently and the measures they must take to allow them to do so.

- More time and greater flexibility should be allowed with regard to the transformation of care sector real estate, to include allowing real estate owners to devise and implement a phased transition plan which devotes due attention to the social-spatial context and the interests of the more vulnerable members of society.

The remainder of this advisory letter considers the obstacles and the Council's recommendations in further detail.

1. Autonomy and housing wishes

1.1 Independent living as the norm for people with (lesser) care requirements

The majority of people who require care or assistance wish to retain control of their own lives and live as independently as possible[2]. This applies equally to seniors with restricted mobility, adults with a physical or intellectual disability, and those under the care of the mental healthcare services[3]. Individual freedom (of choice) is a fundamental human need, and one which is respected and supported by government policy. Many people with a disability have already met that need: they live independently, perhaps with medical care or domestic help, or in a protected or 'sheltered' setting. Of all senior citizens with a care requirement, 74% live independently, as do 60% of persons with a disability and 87% of those under the care of mental healthcare services[4]. The trend whereby people who require care or assistance wish to retain personal control of as many aspects of their lives as possible is expected to continue over the coming decades.

Government policy which seeks to facilitate independent living by those with a care requirement is nothing new. In fact, only one decade (1963-75) saw a policy in which the construction of retirement homes was actively promoted and efforts were made to encourage seniors to take up residence. The government's 1975 Second Policy Document on Care for the Elderly[5] can be seen as a milestone in that it expressly stated that everyone should be permitted to live independently for as long as possible. 'Deinstitutionalisation' also became an important aim of care for persons with a physical or intellectual disability as residential care gave way to the concept now widely known as 'care in the community'.

The autonomous societal development and government policy have caused a significant change in intramural capacity. In 1980, there were 150 thousand residential care places. By 2010, this figure had fallen to 84 thousand despite a twofold increase in the number of people aged 80 or over in the meantime (see Appendix 2, Table 2). Today, some 688 thousand people receive domiciliary care, of whom 369 thousand require only general domestic assistance rather than any form of medical or nursing care (Appendix 2, Table 3).

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[2] PBL Netherlands Environmental Assessment Agency (2013), *Vergrijzing en woningmarkt,* The Hague; Trimbos Institute (2012), *Trendrapportage GGZ 2012 - Deel 1: Organisatie, structuur en financiering – Ambulantisering*, Utrecht; Netherlands Institute for Social Research (2005), *Zorg voor verstandelijk gehandicapten*, The Hague

[3] This advisory letter is confined to the impact of the proposed reforms of long-term care on the housing market for adult members of the target groups.

[4] CBS/Statistics Netherlands (2013), *Monitor Langdurige Zorg (*http://www.monitorlangdurigezorg.nl/kerncijfers/indicatie-gebruik/Paginas/default.aspx, retrieved 20 December 2013); Kwartel, A.J.J. van der (2013), *Brancherapport gehandicaptenzorg 2012,* Utrecht: Dutch Association of Healthcare Providers for People with Disabilities (VGN); Trimbos Institute (2012), *Trendrapportage GGZ 2012 – Deel 1: Organisatie, structuur en financiering Ambulantisering,* Utrecht

[5] House of Representatives (1975), *Nota bejaardenbeleid 1975*, Proceedings 1974-1975, 13463, No. 2

Between 1998 and 2008, the demand for care for persons with an intellectual disability grew by an average of 9% per annum. Almost half of this increase was in the long-term intramural sector, although demand for domiciliary care also showed a significant rise[6]. In the mental healthcare sector, the number of clinical places fell to below twenty thousand in 2002 but has since shown some increase. There has been extremely strong growth in assisted living and sheltered accommodation concepts, from just over four thousand places in 1993 to approximately thirteen thousand in 2009[7]. In 2012, an administrative agreement was entered into by the government (the Ministry of Health, Welfare and Sport), the mental healthcare providers, health insurance companies, and patient organisations, whereby the current clinical capacity of the mental healthcare sector will be reduced by a third by 2020 (compared to that in 2008).

1.2 Housing preferences and willingness to relocate

The majority of people who require care or assistance have the same housing wishes as anyone else: they wish to be able to live independently in an affordable property of their own choosing, in a pleasant neighbourhood with various amenities, and with a (diverse) social network[8]. Given the choice, most do not wish to relocate to another area, since doing so would sever links with their social network and severely disrupt the lives they have established[9]. Reluctance is even greater if the proposed new home fails to meet their main wishes and requirements: the proximity of the social network and the ability to receive appropriate care at home, with only a moderate increase (if any) in monthly expenses. By way of illustration, 65 in every one thousand senior citizens (aged 65 and over) moved to new accommodation in 1995. By 2011, this figure had fallen to just 48. Over two thirds of those who did relocate remained within the same municipality[10]. On top of that, homeowners wishing to relocate must first (be able to) sell their property, which is often an additional hurdle. The problem is at its most acute in areas which have a weaker housing market, such as those with a decreasing population or which are less in demand due to social problems. Properties which are poorly maintained or are not adequately insulated are also more difficult to sell.

A desire to live independently does not necessarily mean that the current home and its setting will permit doing so. In many cases, (temporary) physical modifications are necessary to allow the necessary care or assistance to be provided. Maintaining independence and autonomy may also

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[6] Ras, M., Woittiez, I., Kempen, H. van & Sadiraj, K. (2010), *Steeds meer verstandelijk gehandicapten? Ontwikkelingen in vraag en gebruik van zorg voor verstandelijk gehandicapten 1998-2008*, The Hague: Netherlands Institute for Social Research

[7] Trimbos Institute (2012), *Trendrapportage GGZ 2012 – Deel 1: Organisatie, structuur en financiering Ambulantisering,* Utrecht

[8] Netherlands Institute for Social Research (2004), *Met zorg gekozen? Woonvoorkeuren en woningmarktgedrag van ouderen en mensen met lichamelijke beperkingen,* The Hague: Ministry of Housing, Spatial Planning and the Environment (VROM); Kam, G. de, *et al*., (2012), *Kwetsbaar en zelfstandig. Een onderzoek naar de effecten van woonservicegebieden voor ouderen,* Nijmegen: Institute for Management Research

[9] In its work programme for 2014, the Dutch Council for Public Health and Health Care (RVZ) announces the intention of exploring the possibilities and limits of the extramuralisation of care for persons with severe learning disabilities and patients with a chronic psychiatric condition.

[10] Netherlands Environmental Assessment Agency (2013), *Vergrijzing en woningmarkt,* The Hague

demand a relocation to alternative accommodation where such care is possible and where the impact of any disability or infirmity is minimised.
The physical setting in which the home is located also does much to determine the level of independence and satisfaction that can be achieved. Social isolation must be avoided. The neighbourhood must therefore have an appropriate level of amenities (care, welfare, shops, and activities). It must be accessible, safe, and have a reasonable level of social welfare. Within such a vital setting, people with a disability or infirmity can not only live independently but can avoid social isolation and loneliness. People who require care or assistance therefore make a balanced consideration. Based on their wishes, preferences, and budget, they decide what will be the best combination of accommodation, residential environment, care, amenities, and overall welfare. The reforms in long-term care have prompted a societal discussion about the costs of housing and care, and about who should be responsible for those costs. The Council sees a development whereby a greater proportion of the total costs is apportioned to the housing domain; they are deemed 'accommodation costs', for which the individual is responsible. The costs of care, which are covered by health insurance and are therefore collectively funded, form an ever smaller proportion of the total.

2. Relevant policy amendments affecting housing, healthcare, and welfare

2.1 Reforms of long-term care: four main shifts

The reforms of long-term care place a focus on four shifts:

- Encouragement of independent living with care provided in the home (extramuralisation)
- More management responsibility to be devolved from central government to local authorities and health insurers
- No rise in collective costs despite greater demand for care (higher personal contributions)
- Less formal care (and hence more informal care)

As part of the reforms, access to intramural care is to be restricted for people with a lesser care requirement. In 2012, approximately 263 thousand people were referred to intramural care services further to the provisions of the *Algemene Wet Bijzondere Ziektekosten* (General Exceptional Medical Expenses Act, AWBZ). This figure has remained relatively constant for the past several years. The Ministry of Health, Welfare and Sport (VWS) expects the reforms to reduce the number qualifying for intramural care by approximately 78 thousand, being those with a lesser 'care indication' (see Table 4 in Appendix 2). This means that intramural facilities for the elderly, people with physical and intellectual disabilities, and psychiatric patients will see a 30% fall in patient numbers (Table 1). This represents a significant decrease in the required capacity, even allowing for the fact that the demand for places in nursing homes for seniors is likely to fall even without the proposed policy amendment due to the preference for independent living.

Table 1: Projected number of people 'living independently for longer' according to the scenario presented in the Letter to Parliament on the reform of long-term care

Indications which no longer qualify for intramural care	Absolute number of patients	Percentage of total intramural care capacity
All VV1, VV2 and VV3 indications; 50% of VV4	57,700	38%
All VG1 and VG2 indications; 50% of VG3 **All LG1, LG2 and LG3 indications** **All ZG1 indications**	15,100	19%
All GGZ1 and GGZ2 indications	5,100	18%
Total	77,900	30%

Source: House of Representatives (2013), *Hervorming van langdurige ondersteuning en zorg,* appendix to Letter to Parliament *Hervorming langdurige zorg: naar een waardevolle toekomst,* submitted to the House on 25 April 2013, Proceedings 2012-2013, 30 597, No. 296

Key: The 'indication' is a coding which represents the medical assessment of a patient's care requirement. The letters refer to the nature of the disability or infirmity, the figures to its severity.
GGZ = Psychiatric condition (often acquired, e.g. depression, addiction etc.)
LG = Physical disability
VG = Intellectual disability (learning difficulties, usually congenital)
VV = Nursing and care (e.g. age-related infirmity)
ZG = Sensory impairment (visual and auditory disability)

2.2 Other relevant policy amendments

This section briefly discusses other policy amendments insofar as they are relevant to the broader context of independent living and autonomy.

Separation of housing and care
By implementing a financial separation between housing and care, the government wishes to reduce the impact of accommodation costs on the collective care budget. Housing costs are an individual responsibility, while care is funded separately as a combination of collective and private responsibility. This separation will create greater transparency with regard to the relationship between the two types of cost. The financial separation is currently being implemented with regard to the lesser care requirement indications. The Ministry of VWS's briefing document of 1 June 2011 on long-term care states the intention of extending it to cover more intensive care indications by means of a phased process.

Normative Accommodation Component
The 'Normative Accommodation Component' (NHC) is being phased in as a means of establishing the amount of funding per intramural place. This process will be completed in 2017. The NHC is directly linked to the actual number of patients that an institution has at any one time rather than its total capacity. Unfilled capacity will therefore result in reduced income whereas previously, capital investments made were entirely reimbursed on the basis of post-calculation. The amount paid in respect of capital expenditure also took into account investments in communal areas, fire safety,

accessibility, and the care infrastructure. From 2018 onwards, healthcare organisations will bear the full risk of any unused capacity. If property currently used for intramural care is rented out on the rental market (perhaps as accommodation for independent or assisted living) in order to reduce the vacancy rate, it will be difficult to determine a rental price which will adequately recoup the capital investments (see Section 3.3).

Services of General Economic Interest
Towards the end of 2011, the European Commission adopted new regulations which apply to so-called 'Services of General Economic Interest' (SGEI)[11]. These regulations establish the conditions under which state aid may be provided, such as a loan guarantee on behalf of a housing association. One condition is that the association must allocate at least 90% of its social housing rental stock to households with a taxable income of less than EUR 34,678 per annum (the Dutch House of Representatives has recently passed a motion setting the upper income threshold for rented social housing at EUR 38,000). When making an SGEI investment, housing associations are able to call on a guarantee fund – the *Waarborgfonds Sociale Woningbouw* (WSW) – which enables them to obtain finance from commercial lenders at favourable rates of interest. Investments in activities other than 'Services of General Economic Interest' are not eligible for this guarantee. Housing associations can opt to apply either a legal or an administrative distinction between their SGEI and non-SGEI activities. An administrative distinction will entail closer supervision by the regulatory authorities, whereby associations will be permitted fewer non-SGEI activities even if they are of service to their core task.

Landlord levy
Landlords who rent more than ten properties in the social housing sector must pay a levy calculated according to the total value of their real estate holdings. This levy is expected to generate over 1.1 billion euros in state revenue in 2014, rising to approximately 1.7 billion in 2017. However, it also decreases housing associations' investment ability, and hence the part they can play in pursuing the common objectives of housing, healthcare and welfare policy.

Decentralisation to local authorities
Many areas of government responsibility are now being decentralised to local authority level: Youth Health and Welfare, the Participation Act, and the Planning and Environment Act, while some provisions of the General Exceptional Medical Expenses Act (AWBZ) are to be transferred to local authority responsibility as part of the *Wet maatschappelijke ondersteuning* (Social Support Act; WMO). It now falls to local authorities to assume a managerial role and to develop the necessary expertise, allowing for the uncertainty of future developments and diminishing budgets in these times of austerity.

[11] Services of General Economic Interest are services related to public interests in quality, accessibility and security of supply for large groups of citizens.

3. Consequences for the housing market and spatial patterns

3.1 Can the housing market accommodate the trend towards more autonomy?

Greater demand for sheltered accommodation and assisted living
The number of senior citizens in society is increasing, in both absolute and relative terms. In 2012, there were 2.7 million people aged 65 and over living in the Netherlands, representing 16% of the total population. By 2040, the number will have risen to 4.7 million (26%). The greatest increase will be seen in the group aged 80 and over, who will represent 44% of the population over 65 by 2050[12]. Changes will also be seen in terms of household composition, with increases in both dual-occupancy and single-occupancy households. By 2030, there will be some 1.4 million senior citizens living alone, compared with the current figure of 900 thousand[13].

Among seniors who are no longer eligible for intramural care, it is estimated that 80% will still opt to move into alternative accommodation as a result of their care requirement[14]. It is not clear what this number is for people with a disability or under the care of mental healthcare services. Extramuralisation therefore appears to have only a limited effect in terms of housing market through-flow. The number of relocations will decrease by no more than 22 thousand[15] in a six-year period compared to the current situation of 450 thousand 'movements' (changes of occupancy) each year in a total market of 7.26 million properties. However, the housing market itself has changed. Throughout the 1990s and the early 2000s, it was buoyant and dynamic, with rising prices and a high number of transactions. Today's market is more static, with lower prices and fewer relocations. In this type of market, every relocation can have a significant effect in setting off a chain of further relocations, whereupon the impact of the extramuralisation policy will be that much greater.

The demand for 'assisted living' continues to rise. Assisted living means that (medical) care and general help are available close at hand. Demand is already greater than supply, with a lasting shortfall of over 40 thousand units (30% of the 2012 stock level). The extramuralisation of the 'care and nursing' segment will serve to increase the shortfall by over 41 thousand units between 2013 and 2021, reaching a total of 81 thousand. Demand for 'accommodation with services' (a private room or rooms in a managed complex which offers additional services such as meals and communal areas) also outstrips supply, with a current shortfall of over 46 thousand places, or 26%[16]. As shown in Table 5 in Appendix 2, there is also a growing shortage in the category 'Seniors accommodation – other', which refers to units which are specifically designated for occupancy by seniors but which do

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[12] Huisman, C., Jong, A. de, Duin, C. van, Stoeldraijer, L. (2013), *Regionale prognose 2013-2040*. The Hague: PBL Netherlands Environmental Assessment Agency and Statistics Netherlands
[13] Campen, C. van (2011), *Kwetsbaar alleen*, The Hague: Netherlands Institute for Social Research
[14] Galen, J. van, Willems, J. & Poulus, C. (2013), *Monitor investeren voor de toekomst 2012*, Delft: ABF Research
[15] See Table 4 in Appendix 2. We base this projection on a maximum of 6,500 disabled persons, plus a maximum of 4,600 mental healthcare services patients, plus 11,100 seniors (20% of 55,700).
[16] Galen, J. van, Willems, J. & Poulus, C. (2013), *Monitor investeren voor de toekomst 2012,* Delft: ABF Research

not provide any additional care or services. These are, for example, apartment buildings which apply a minimum age of 55. The shortage of units in this category reached 63 thousand (31%) in 2012. The increase in demand for all three types of accommodation is primarily due to the demographic trend of population ageing.

The shortages are largely of a qualitative nature. Many units within the current stock – both rental and owner-occupied – require modifications if they are to remain suitable for (continued) occupancy by persons with a disability or infirmity. The Council expects housing requirements and preferences to become even more diverse in future, and the senior citizen target group is no exception. Moreover, a greater number of people with some care requirement (such as people with a physical or intellectual handicap and psychiatric patients) will seek an appropriate home on the regular, 'mainstream' market. Accordingly, a much more diverse range of housing concepts must be made available, to include individual and clustered units, with rooms of varying sizes depending on tastes and intended usage, concepts which allow residents to determine the degree of assistance and support they require, the use of 'domotics', and a choice between the urban environment and a rural or semi-rural setting. Greater diversity will be made possible, in part, by the increased transparency of housing and care costs. Their separation will enhance the individual's freedom of choice based on the price-quality ratio represented by the various forms of housing-and-care concepts. To ensure a better match between the facilities available and the requirements of the target groups, the Council considers it essential that the costs of accommodation and those of care are charged separately in the intramural care sector as well. The current arrangements give rise to uniformity of accommodation, thus limiting freedom of choice. Separation of costs will also create more opportunities for civil initiatives and for innovation by the private sector. For this reason, the Council is in favour of introducing the further separation of accommodation and care costs for all chronic care indications, as previously endorsed by the Council for Public Health and Health Care (RVZ)[17] and the Social and Economic Council of the Netherlands (SER)[18] . To this end, the government must formulate a clear vision for the coming ten to fifteen years, clearly stating the chronic care indications to which the separation of accommodation and care costs is to apply and the manner in which this separation is to be introduced.

A vital setting is of great importance
As stated in Section 1.2, the residential environment is every bit as important as the dwelling itself in terms of independent and autonomous living. However, a vital setting may not be permanent: a retirement home might close, for example. Indeed, the first planned closures have already attracted some media attention. Retirement homes also play an important role in providing care and welfare for local residents, so closure would mean the discontinuation of such services. It also means the departure of the residents themselves who form the customer base for local shops and businesses

[17] Netherlands Council for Health and Health Care (2005), *Mensen met een beperking in Nederland. De AWBZ in perspectief*, Zoetermeer
[18] Social and Economic Council of the Netherlands (2012), *Naar een kwalitatief goede, toegankelijke en betaalbare zorg,* The Hague

and who are often mainstays of local community activities. In short, the closure of a retirement home affects not only its residents but the entire neighbourhood and its community.

Ideally, first-line healthcare centres and those which integrate some second-line (specialist) expertise should be located in areas which have a more senior population. People who require care can then continue to live in their own familiar surroundings, something they often attach great importance to (see Section 1.2). Research confirms that seniors who have access to a full range of services are able to live independently for longer than those in purely residential areas[19]. The 'targeted neighbourhood approach' – in which district nurses are on hand, there is an organised care structure (known as 'Buurtzorg'[20]), and effective use of IT resources – can also do much to facilitate independent living. A suitable home in a suitable setting is a 'prevention instrument', serving to reduce the demand for more intensive healthcare services.

The current stagnation on the housing market makes it more difficult for people who require care or assistance to relocate, and for housing associations to offer suitable alternative accommodation. Those units which do become available are often not the most desirable in terms of quality and location. The 'liveability' of a neighbourhood can be a very important factor in allowing certain members of the target groups, such as people with a physical or intellectual disability or psychiatric patients, to live independently. If their financial resources are limited, they are forced to seek low-rent accommodation, in which case they might be likely to find themselves living in areas in which safety and social issues are a concern.

3.2 Spatial patterns: a very diverse picture

In the shorter term, it is the urban areas which will see the greatest growth in the number of senior citizens in absolute terms, simply because the towns and cities have the highest population density. In relative terms, however, it is the rural areas in which population ageing has the most marked effect. The difference between the urban and rural areas will remain visible for many years to come[21]. At the regional level, it is the Randstad conurbation, Flevoland, the eastern region of Noord-Brabant, and West-Friesland which will see the greatest rise in the percentage of seniors (aged 65 and over)[22].
In the rural regions, it is not always practicable or economically viable to maintain a full range of social amenities and services in smaller residential areas. On top of that, in areas with a rapidly

[19] Kam, G. de, *et al*. (2012), *Kwetsbaar en zelfstandig. Een onderzoek naar de effecten van woonservicegebieden voor ouderen*, Nijmegen: Institute for Management Research
[20] www.buurtzorgnederland.com
[21] PBL Netherlands Environmental Assessment Agency (2013), *Vergrijzing en Ruimte. Gevolgen voor de woningmarkt, vrijetijdsbesteding, mobiliteit en regionale economie*, The Hague
[22] CBS/Statistics Netherlands (2012), *Gemeenten zien aantal 65-plussers tot 2040 toenemen*, article published 26 July 2012 (retrieved 20 December 2013 from http://www.cbs.nl/nl-NL/menu/themas/dossiers/vergrijzing/publicaties/artikelen/archief/2012/2012-bt-iag-65-plussers.htm)

ageing population the number of younger people (of working age) able to provide those services is dwindling[21]. One response to this situation is investment in technological and organisational solutions, such as e-health resources, domotics, care cooperatives, and home deliveries from (online) shops. This will enable people who require care or assistance to live (more) independently even in the smaller residential districts[23]. The Council also anticipates the emergence of civil initiatives in the form of cooperatives which establish small-scale housing concepts and care facilities in villages. It nevertheless remains essential to devote attention to regional public amenities, such as hospitals, libraries, and welfare centres. The current trend of scale expansion places accessibility at risk, not least because the mobility of the target group is declining[21].

It seems unlikely that we shall see any marked and deliberate spatial concentration of senior populations on a par with the large-scale 'retirement communities' of Florida and elsewhere. However, autonomous developments (especially where districts already have less diversity in age cohorts) may result in some concentration of senior populations at a lower level of scale: the retirement complex or seniors' apartment building. Some concentration may also result from a desire to live together on the part of a group of people requiring care or assistance, or on the part of their (informal) carers. This desire may be prompted by feelings of loneliness or a lack of safety, the wish to have "our sort of people" nearby, or to be close to carers. Where a number of (informal) carers and volunteers come together to provide assistance to a group of people with care requirements, a wider range of private housing-and-care concepts is likely to develop.

In the end, there will not only be marked differences between the urban, suburban and rural environments, but also within one and the same setting, even extending to individual neighbourhoods or residential districts. A local inventory of peoples' housing requirements and preferences is therefore required. Regional coordination is desirable because most housing associations and care organisations are themselves organised on a regional basis, and because people considering relocation usually search for suitable accommodation within a region. Moreover, some amenities demand a regional level of scale in order to be economically viable.

3.3 Greater financial risks for the owners of care sector real estate

The developments on the property market and the policy amendments (see Section 2) place the equity position of owners of care-related real estate under pressure and increase the financial risks they face. Two thirds of care sector real estate is in the ownership of care providers, the remaining third is owned by housing associations[24]. The extramuralisation of senior care will have the greatest impact on the retirement and nursing homes. Housing associations own and manage over 50,000

[23] Mulder, H. (2013), *Meta-analyse Zorg op afstand,* Utrecht: In voor zorg!
[24] House of Representatives (2012), *Scheiden van wonen en zorg (SWZ)*, technical briefing by the Ministry of VWS of 7 March 2012, appended to *Antwoorden op vragen Leijten over een technische briefing over het scheiden van wonen en zorg in de AWBZ*, Proceedings 2011-2012, No. 2012Z06716

places within retirement homes: half the total number[25]. In broad terms, the owners of real estate designed and structured to provide care to people with lesser care indications face three types of risk:

- Operational risks will be exacerbated by the decreasing (certainty of) revenues (see Table 6 in Appendix 2) in the years to come which results from the extramuralisation policy and the adoption of the NHC.
- Book value (equity) risks will increase due to the decreased certainty of (rental) revenues, causing the book value of real estate as a capital asset to fall.
- (Re-)financing risks will be greater due to the decreasing certainty of revenues. Financiers (banks and investors) and guarantors (local authorities, the WSW, and the WFZ) will adjust the costs of (re-)financing accordingly.

The nature and level of risk may vary according to the type of owner. The interests of the stakeholders, which should be mutually reinforcing, may actually be conflicting. For example, a care provider concerned with short-term survival may opt to close the locations rented from a housing association, continuing operations only in those locations it owns outright. From the broader social perspective, this may not be ideal. The risks for housing associations which have a large number of retirement homes in their portfolio become that much greater, whereupon their investment capacity comes under even greater pressure.

Greater flexibility in care sector real estate is required, whereby one and the same location can be made suitable to accommodate members of various target groups, with multiple functions under the same roof. In order to reduce risks or avoid high vacancy rates, owners of care-related real estate have the following options.

- *Offering the more intensive forms of care provision*

The number of places in regular retirement homes rose from 46 thousand in 1980 to 74 thousand in 2010 (see Table 2 in Appendix 2). The average duration of occupancy is less than one year. The number of places required will continue to rise due to population ageing[26]. However, 'converting' retirement home places to nursing home places requires permission from the regional care office.

- *Direct rental of (independent living) apartments in combination with domiciliary care services*

This option is in keeping with the demand for more 'assisted living' and 'accommodation with services' provisions. The care provider must then be prepared to act as the managing agent of the relevant accommodation units, or to join forces with a housing association or private landlord. In the case of smaller units, it may be desirable to set a rent which is below the current threshold for social housing (i.e. EUR 699 per month) to ensure that these units remain affordable for those on lower incomes. However, if the service surcharge permitted by law is applied in full (35% of the basic

[25] ING Bank (2013), *Themavisie Scheiden wonen zorg in de AWBZ: Deel II – Woningcorporaties*
[26] ING Bank (2013), *Themavisie Scheiden wonen zorg in de AWBZ: Deel 1 – Ouderenzorginstellingen*

rent), it will often be impossible to apply a total rental charge below the threshold. Even in the case of more expensive 'free sector' rental accommodation, the service surcharge could price units out of the market altogether. This means that it will be difficult or impossible to derive a rental income from existing care sector real estate, built under past legislation, which is sufficient to recoup the capital investments. Moreover, depending on the age of the real estate in question, renovation may be necessary in order to meet the quality requirements of prospective tenants.

- *Renting to other groups*

Renting the property to groups other than those requiring care or assistance – such as students, starters, or higher-income households – entails an entirely different role for healthcare providers. It is a role more suited to housing associations and private landlords. The location, layout, and condition of the building will determine whether rental to other target groups is possible. Not every area has a student population, while people with higher incomes are likely to impose higher requirements in terms of quality and comfort.

- *Disposal or demolition*

In view of the impending overcapacity of regular retirement home places, the sometimes limited options for a (quick) redesignation of purpose, or simply due to the age of buildings, it may be necessary to sell or demolish care sector real estate. The Council is concerned by indications that some care providers are already disposing of their real estate with some degree of haste, based on a short-term strategy intended to serve their own immediate interests. While immediate closure of a care location in order to 'balance the books' may be the cheapest option for the organisation concerned, it may well prove a particularly expensive approach when viewed in the broader societal perspective. The sale of a care sector building and/or land must be approved by an official regulatory body, the *College Sanering Zorginstellingen* (CSZ). If permission for sale is conditional on a higher market price, the property will not be of interest to non-commercial buyers such as housing associations, since they will be unwilling or unable to make the additional investments required to develop some alternative social function.

The short time span in which the government wishes to implement the extramuralisation policy increases the likelihood of closures. A more gradual process would allow greater opportunity to make appropriate modifications to care sector real estate. The Council has calculated that the retirement homes, facilities for disabled care, and mental healthcare institutions which require renovation or change of usage have a total floorspace of over four million square metres[27]. The vacancy rate in other non-residential property is already extremely high: office space totalling over seven million square metres is currently standing empty, as are many retail premises. The introduction of care sector real estate onto this saturated market can only worsen the situation. Compared to much of the property on the market, however, the prime location of many care sector buildings makes them a more attractive proposition for conversion. If their owners were to opt for

[27] TNO 2009, *Investeringskosten per ZZP, basis voor een NHC voor de Care,* Utrecht. This calculation is based on 77,900 intramural care places (see Table 1), each assumed to be 60 m^2, giving a total of over 4.5 million m^2.

immediate closure and sale, it would have a major impact on both residents and the local community. Within a few years, however, it is possible that demand for residential care will recover due to population ageing. More time to consider options other than closure may reveal alternative solutions and will avoid the write-off of valuable capital assets. Given the longer average occupancy of their residents, facilities for disabled care have somewhat longer to adapt their property than those facilities which cater to seniors. For mental healthcare institutions, the reduction in the number of care places will mainly affect the 'lighter' forms of sheltered accommodation at the so-called RIBWs (regional institutes for sheltered accommodation). In addition, restricting the duration of admission to in-patient institutions will reduce the number of places required in the mental healthcare segment.

4. A complex challenge for all stakeholders: synergy is required

4.1 Complex investment requirement

In the Council's opinion, the desired changes in the domains of housing, care and welfare will require not only an effective real estate strategy, as outlined above, but also a complex investment programme covering:

- The adaptation of existing accommodation to render it suitable for people with a disability or infirmity
- The development of new housing-and-care concepts
- More effective use of technology to support independent living
- The maintenance or improvement of local amenities to enhance the 'liveability' of the neighbourhood
- Innovation in care processes to enable tailor-made care (including the more intensive forms) to be provided in the home setting

It is not possible to quantify the investment requirement precisely. In broad terms, the amount concerned will depend on factors such as: a) the level of comfort expected or demanded by prospective residents and the degree to which they are willing to pay for adaptations, facilities, and services; b) the vision of care providers with regard to the modification of amenities required to facilitate appropriate care; c) the balance between accessibility and affordability when considering the required level of scale; and: d) legislative requirements, such as those covering fire safety and accessibility.

Adapting existing accommodation for use by people with a disability or infirmity
Most of the Netherlands' housing stock is owner-occupied. Individual homeowners must take timely action to ensure that their property remains suitable for occupation should they become less mobile in future. However, not all homeowners are willing or able to make the necessary investments, and the level of investment can vary greatly depending on the nature of both the home itself and the required modifications. A new, higher lavatory would cost approximately three hundred euros, while

a monitoring and 'panic button' alarm system might cost a few thousand euros. More extensive structural modifications, such as widening doorways or enlarging a bathroom to provide wheelchair access, could cost as much as fifty thousand euros. Many homeowners' capital is tied up in the property itself, whereupon it is desirable for banks to devise some arrangement whereby equity can be released to finance this type of modification, for instance by remortgaging. A think-tank – the *Taskforce Verzilveren* – has made a number of recommendations in this regard[28].

There are also circumstances in which rented accommodation must be adapted. Responsibility is shared by the tenant, landlord, and local authority (social services department). Minor modifications can be made by the tenants themselves. In consultation with their housing association or landlord, more extensive modifications may be implemented, whereupon any investment could be compensated by means of a rent adjustment. Where modifications which the tenant simply cannot afford are required, a subsidy application can be made to the local authority under the provisions of the Social Support Act (WMO). Some local authorities have already entered into agreements with housing associations under the WMO, setting out the modifications which are possible and permissible, and who is responsible for their costs. Such agreements reduce the time that tenants have to wait for a decision and ensure more efficient use of the available budget.

Development of new housing-and-care concepts
Demand for housing-and-care concepts is becoming ever more diverse[29], which means that the supply must also be diversified. There are many examples of innovation. The established providers are already developing new concepts. Housing associations, for example, have introduced 'kangaroo homes' (two independent but interconnected units) and temporary units which can be erected in a garden in order to enable friends or family member to act as informal carers. Housing associations are also involved in various third-party initiatives, such as projects launched by the parents of children with a disability who wish to establish their own communal home, or initiatives devised by *Stichting Thuis in Welzijn*, a foundation which is working to create small-scale accommodation for single seniors, some of whom may have dementia. There are also several groups who are meeting their own housing-and-care requirements by joining forces to contract the necessary services directly. Similarly, several private sector organisations are now offering new housing-and-care concepts or new forms of service provision. The logistics company TNT not only delivers products but will assemble and install them as required. Some supermarkets have introduced a door-to-door taxi service for their less mobile customers.

Alongside the new accommodation concepts, new forms of care provision are both possible and desirable. Various care cooperatives have now been established, primarily in the rural areas. They contract professional care services and coordinate the volunteers who provide care and companionship to local residents in need. This enables people with a disability or infirmity to

[28] Taskforce Verzilveren (2013), *Eigen haard is zilver waard*
[29] Castelijns, E., Kollenburg, A. van, Meerman, W. te (2013), *De vergrijzing voorbij*, Utrecht: Berenschot

continue living in their familiar surroundings, even in the smaller residential cores. The 'Personal Care Budget' system also offers many opportunities to organise care provision differently. One example is the 'Thomas Houses' project: small scale accommodation for groups of six to eight people with an intellectual disability, with constant supervision by two resident carers.

More effective use of technology
A meta-analysis of seventeen pilot projects concludes that technology such as remote monitoring systems will make long-term care more 'future-proof'. The use of 'domotics' and effective follow-up of any unusual situation reported by the automated sensors can enable people with a care requirement to live independently in their own homes for longer. According to the meta-analysis, this type of technology reduces the workload of care professionals by as much as 20%[30]. Both carers and clients report a higher degree of satisfaction. Nevertheless, other pilot projects have raised some concerns: expectations are too high, projects are slow to come off the ground unless incentive subsidies are available, and the technology bears little or no relation to the organisations' standard care processes[31]. It is difficult to establish a firm business case, while care professionals may be reluctant to adopt the new technology. In some instances, the individual user is overlooked. This suggests a 'technology push' rather than a desire to meet actual needs. It is important to ensure that the technology is user-friendly, and equally important to consult and involve the end user in its implementation.

Assuming that (informal) carers and patients will gradually become more *au fait* with technology, the demand for technological aids can only increase. The urgency of introducing new technology will become more acute in the years ahead, not least because local authority budgets will come under even greater strain. The demand for care will rise while the number of staff able to provide that care will fall. This means that – policy amendments and the resultant budget reductions notwithstanding – there must be adequate incentives for the further implementation of technological solutions. In the longer term, innovations such as care robots, driverless cars, gaming technology, and exoskeletons[32] will all play a part in increasing people's autonomy.

Maintaining or improving local amenities in order to maintain or enhance the 'liveability' of the residential environment
Amenities such as shops, transport services, daycare activities and care centres are not always available or not always located where they are needed most. Moreover, the desired location for such amenities can change over time. Local authorities must plan ahead to ensure that proper amenities are indeed in the right place at the right time. In doing so, they must be aware that population

[30] Mulder, H., (2013), *Meta-analyse Zorg op afstand,* Utrecht: In voor zorg!
[31] Zorg voor de Toekomst Noord- en Oost-Groningen (2013), *Zorg dichtbij. Resultaten van de actielijn zorg dichtbij in een notendop*
[32] An exoskeleton is an external frame or 'wearable robot', with motorised segments corresponding to the limbs and joints of the human body, providing assistance in mobility or rehabilitation.

ageing can 'shift' from one district to another. Today's new housing developments have a high concentration of young families. In forty or fifty years' time, such areas are likely to have a high concentration of elderly residents. By the same token, today's 'ageing' neighbourhoods may eventually have a much younger population.

Innovation in care processes to make tailor-made care (including the more intensive forms) possible in the home setting
If appropriate care is to be provided in the home, existing care processes must be modified and updated. This demands a 'cultural shift' within the long-term care sector, whereupon the focus is no longer on the system but on people, their possibilities, and their restrictions. Wherever possible, care should be organised around the lives of the care recipients rather than expecting them to organise their lives around care.

4.2 Roles and responsibilities

As noted above, investments must be made by homeowners, landlords, housing associations, civil initiatives, healthcare organisations, welfare departments, project developers, health insurers, private sector organisations, local authorities, and the government. Coalitions between these parties, bringing together the domains of housing, care and welfare for the benefit of the target groups, will help to achieve the desired situation sooner. There is, after all, a shared and integrated objective. All three domains are important in enabling people to live independently and autonomously for longer despite disability or infirmity. Research shows that a sense of 'well-being', which extends beyond physical health to include mental and social aspects, reduces the demand for care. However, the Council notes that the formation of such coalitions is being hampered by overly restrictive policy. A combination of factors has prompted many stakeholder organisations to focus on short-term survival, risk avoidance, and divestment of tasks. In this context, we can cite the autonomous social development of wishing to live independently for as long as possible, policy amendments such as the introduction of the 'landlord levy' and the NHC (see Section 2.2), stricter regulation of the primary tasks, decentralisation, as well as uncertainty with regard to the form and content of future legislation as a result of those policy amendments. A longer-term focus is essential if the common objectives of the housing, healthcare and welfare domains are to be achieved.

In the Council's opinion, deferring investments until the economy has recovered would be imprudent. Rather, the Council sees opportunities in allowing people with a care requirement, as well as creative private sector parties, to assume a more prominent role in addressing the joint objectives. If they are allowed to develop their ideas, it will be possible to achieve a closer match between the care requirements and the new 'smart' provisions which will emerge. Stakeholders such as housing associations, healthcare providers and health insurers should be encouraged to contribute to this process and to cooperate with each other in the interests of synergy. We must find a good 'mix' which mobilises the investment capacity of individual residents, private sector organisations, care providers, housing associations and other landlords, and government itself. By adopting a broader framework in which all interests are taken into account, the various stakeholders

will be able to arrive at a long-term strategy based on people's actual requirements and their possibilities.

5. Recommendations: room for cooperation; incentives; flexibility and time

The transformation of housing-and-care provision is one of the major social issues of today. As in other domains (economic, social, and ecological), a quest for new standards and for new social and economic values has begun. New definitions are being sought for concepts such as 'earnings and payback models', 'sustainability', 'equality', and 'governance responsibility'. As this quest continues, there may be occasions on which the traditional arrangements are at odds with the new, as yet incomplete arrangements. The various stakeholders must grow into their new roles. The government's role will be far less prominent: rather than controlling the entire process in a 'top-down' manner, it will become more of a facilitator.
According to the level of scale, the tasks and challenges for districts, municipalities, regions, and provinces will differ. Bespoke, 'tailor-made' solutions are required at each level. It will only be possible to arrive at such solutions if the overall objective is fully clear to all stakeholders, who must consistently act in a way which addresses the common interests. This demands greater opportunity for cooperation (Section 5.1), investment incentives (Section 5.2), as well as flexibility and time in which to bring the transition to a successful and measured conclusion (Section 5.3). The Council has formulated recommendations in each of these three areas, and has incorporated those recommendations into the stakeholder agendas presented in Appendix 1.

5.1 Create room for cooperation

1. *Regard cooperation between the stakeholders as part of their core task*
   In principle, it is appropriate for stakeholders – whether private or public – to concentrate on their core tasks. At the same time, there must be opportunity in both financial and policy terms to cooperate with others in order to meet the requirements of the target group. After all, the demand for care and assistance is not confined to any one domain. Both housing associations and healthcare providers should be given budgetary discretion to jointly create, for example, a meeting area or a local medical centre, perhaps with financial support from the local authority. Establish a link with care funding, so that there is room to contribute to an integral product which addresses both the requirements of the target group and the need to reduce healthcare costs, rather than demanding performance in only one of the three domains.

2. *Introduce further separation of accommodation and care costs*
   Have the providers of intramural care set out clearly which costs are related to accommodation and which to care relating to chronic health conditions. This does not mean that there should be two separate invoices from one and the same provider. However, it is important to make transparent which costs are incurred in the domain of housing, and which in that of healthcare.

This will also enable people to opt for a different standard of accommodation (be it of higher or lower quality), which is in the interests of personal freedom of choice. The Council regards this as the first step in the separation of accommodation and care costs relating to chronic care indications.

3. *Ensure adequate synergy between the WSW and WFZ guarantee funds*
   There are indications that the Social Housing Guarantee Fund (WSW) and the Guarantee Fund for the Health Care Sector (WFZ) are starting to focus exclusively on their respective, separate domains as well. This puts investments in the combination of housing and care at risk. Both guarantee funds should be requested to facilitate (innovative) investments which straddle the boundaries between the domains, such as those relating to assisted living, sheltered accommodation, and 'accommodation with services'.

5.2 Create incentives for investment and for patient autonomy

4. *Encourage stakeholders to invest in pursuing the joint longer-term objectives*
   - The government's long-term vision on housing, healthcare and welfare should be explicated by means of a concrete and consistent policy which precludes potential uncertainties for potential investors.
   - Encourage investment on the part of homeowners and landlords by means of temporary (fiscal) measures which make expenditure on 'future-proofing' a property more attractive. Investigate ways in which tenants who invest in modifications can be compensated, e.g. by means of reduced rents.
   - Within budgetary planning, seek means which will encourage investment in the housing and care domains while also stimulating the national economy. This might, for example, entail removing legislative obstacles, introducing fiscal measures ('tax breaks'), reducing or abolishing certain current levies, or implementing subsidy arrangements.

5. *Identify and resolve 'split incentives'*
   Stakeholders are not inclined to make investments if doing so reduces another party's costs rather than their own. For example, a housing association might invest in domotics but it will be the care provider which gains the greatest benefit in terms of cost reductions. Similarly, a care provider which invests in cost reduction measures for its patients might see revenues fall as a result. Creative solutions to such 'split incentives' should be sought. For instance: if a health insurer invests in prevention measures which are successful in reducing health system costs, a percentage of the amount saved could be paid directly to that insurer.

6. *Encourage people to devote timely consideration to their future independent living needs*
   Homeowners should be encouraged to think about whether their property and its setting will continue to be suitable should they require (greater) care in future. If not, they will then be able to take appropriate action. Invite tenants to do likewise so that timely measures can be taken in consultation with their landlords.

5.3 Create time and flexibility for 'smarter' solutions with lower societal costs

7. *Create more time and flexibility within the care real estate transformation process*
   Greater flexibility is required in the transition and transformation of care sector real estate to allow appropriate solutions to be found at the local level and to avoid the write-off of valuable capital assets. The Council suggests an arrangement whereby owners are given two years in which to formulate and present a 'transition plan' which sets out the timeframe for the transformation itself, in keeping with the specific local conditions and context. This transition plan should then be assessed and approved by the relevant care agencies and regulators (including the CSZ where necessary). If the societal costs of the transition can be reduced by adopting a more gradual process, the opportunity to do so must be allowed. This will overcome some of the obstacles inherent in the reforms and mitigate their negative impact. Although this proposal will have implications in terms of the short-term financial objectives, the Council believes that it is essential to accomplish the structural reform of the sector at lower societal costs and with less risk of unforeseen costs due to hasty decision-making.

8. *Devote attention to short-term solutions for the more vulnerable groups*
   Over the next five years, an annual average of some ten thousand senior citizens, thirteen hundred disabled persons, and eight hundred psychiatric patients will become ineligible for intramural care due to the reforms. The accommodation currently available is not able to meet their requirements, nor those of the healthcare providers. Alternative short-term solutions must therefore be found. The patients concerned must be clearly identified at the local level, and creative solutions must be implemented. Failure to do so will seriously undermine societal support for the policy reforms. Particular attention must be devoted to the affordability of the solutions for those with a lower income.

Concluding remarks

The Council concludes that there is significant problem-solving ability available within society, alongside the capacity to create the synergy required to address the joint objectives of the housing, care and welfare policy domains. It now falls to stakeholders other than the government itself to take action. However, the government is uniquely placed to ensure the cohesion and long-term success of the policy, and indeed has a responsibility to do so. Government must encourage the stakeholders to commence the transition; it must facilitate the process and must resolve the conflicts and frictions which the policy amendments will inevitably bring. The transition process will be enabled by further separating accommodation and care costs and by managing on the basis of mutual interests and flexibility. It is possible that new questions and issues will arise. The Council is of course willing to assist in answering those questions. In its work programme for 2014, the Council for Public Health and Health Care (RVZ) announces the intention of examining in detail the interrelationship between health, welfare and care on the one hand, and the human environment on the other. This study will be undertaken in close cooperation with the Council for the Environment and Infrastructure.

Raad
voor de leefomgeving
en infrastructuur

Yours sincerely,

The Council for the Environment and Infrastructure

Henry M. Meijdam
Chair

Ron Hillebrand
General Secretary

APPENDIX 1: THE HOUSING, CARE AND WELFARE AGENDAS OF THE VARIOUS STAKEHOLDERS

Homeowners (owner-occupiers) are to take a proactive approach in considering their desire to live independently and how this can best be achieved. They will make timely modifications to their property or take their future (care) requirements into account when relocating to a new home. Homeowners must acknowledge their own responsibility for funding any necessary modifications, setting money aside or borrowing against the equity in their property.

Tenants may also be expected to take a proactive approach, devoting timely consideration to modifications to their home or a move to alternative accommodation. It is essential to explicate future (care) requirements. There are already many examples of projects in which tenants are taking a more prominent role in self-management and in the maintenance and improvement of neighbourhoods. It is hoped that such projects will inspire emulation.

Various **collectives and civil initiatives** are developing new housing-and-care concepts. Their projects are promising but in many cases fragile, whereby attention must be devoted to continuity and imbedding.

Private sector organisations, both the established parties and new entrants to the housing-and-care sector, are developing new technologies and concepts.

Care providers which own real estate must engage in closer consultation and cooperation with other stakeholders such as local authorities and housing associations. They must devote due consideration to the wider social impact of any decision to close locations or change their usage. They will enter into coalitions (including those with other property owners) with a view to developing new housing-and-care concepts based on a long-term strategy.

Care providers which do not own real estate must establish a new relationship with the target group (including more demanding clients and those who avoid seeking assistance), in which the focus is on the care requirement rather than the intervention. This new relationship may form the basis of new coalitions with care sector property owners.

Private landlords and investors enjoy opportunities to invest in newbuild and renovation in the middle segment of the rental market, i.e. properties with a monthly rent of 699 to 900 euros (just above the threshold for rent subsidy).

Housing associations should (continue to) invest in newbuild property and renovations in order to create an adequate stock of affordable housing for people with a care requirement. They play an important role in connecting the domains of housing, care and welfare, and contribute to the liveability of the human environment.

Health insurers should (continue to) organise care services in a manner which creates new connections between the domains of housing, care and welfare, introducing greater emphasis on prevention and the longer term. For example, the expansion of social networks has been shown to increase patient autonomy and to decrease reliance on medication.

Banks and financial institutions must introduce new mortgage and savings products with which care services and home modifications can be financed.

Local authorities are to take the role of process director, but will also act as a consultation partner and (co-)financier. They must adopt a regional perspective, since not all issues and potential solutions are confined to the municipal boundaries. They must promote and support initiatives on the part of informal carers and other volunteers.

Central government must remove obstacles to investment for all stakeholders. It must also ensure that a cohesive policy is in place within all relevant policy domains, addressing the future of housing, care, and welfare, both as separate domains and, more especially, in combination. The government must set out a clear vision of that future which encourages stakeholders – including the public – to acknowledge their own responsibilities with regard to independent living. Central government will facilitate the stakeholders in pursuit of the desired future situation. It must also monitor whether the anticipated increased reliance on volunteers and informal carers remains realistic[33].

[33] Bijl, R., Boelhouwer, J., Pommer, E., Sonck, N. (2013), *De sociale staat van Nederland 2013*, The Hague, Netherlands Institute for Social Research

APPENDIX 2: STATISTICS

Table 2: Development of intramural care capacity

Year	Residential care places (with no permanent medical care) (x 1,000)	Residential care places (with permanent medical care) (x 1,000)	Total capacity (x 1,000)	Population aged 80 and over (x 1,000)	Capacity per person aged 80+
1980	150	46	196	312	0.63
1990	140	52	192	428	0.45
2000	111	59	170	500	0.34
2010	84	74	158	648	0.24

Source: House of Representatives (2012), *Scheiden van wonen en zorg (SWZ)*, technical briefing by the Ministry of VWS of 7 March 2012, appended to *Antwoorden op vragen Leijten over een technische briefing over het scheiden van wonen en zorg in de AWBZ*, Proceedings 2011-2012, No. 2012Z06716

Table 3: Provision of domiciliary care services (AWBZ and WMO), 2012

Client age	Domestic assistance only (WMO)	Medical/nursing care (AWBZ)	Indication for medical/nursing care requirement (AWBZ)
18-65	61,305	98,065	159,680
65-79	129,290	79,240	102,060
80+	178,775	141,595	140,575
Total	**369,370**	**318,900**	**402,315**

Source: CBS/Statistics Netherlands, *Monitor langdurige zorg* and Statline

Table 4: Estimated cumulative number of clients designated 'living independently for longer' according to the scenario contained in the Letter to Parliament on the reform of long-term care

ZZP	2013	2014	2015	2016	2017	2018	Estimated overall effect of independent living proposals	Total intramural capacity for sector
VV1	1,100	3,500	5,800	7,000	7,900	7,900	7,900	
VV2	3,000	9,000	15,100	18,100	19,900	19,900	19,900	
VV3		3,000	9,400	15,600	18,600	18,900	18,900	
VV4 (50%)				2,000	6,000	9,000	11,000	
Total VV	**4,100**	**15,500**	**30,300**	**42,700**	**52,400**	**55,700**	**57,700**	**150,000**
VG1	100	200	400	600	700	900	1,500	
VG2	200	700	1,200	1,600	2,100	2,600	5,500	
VG3 (50%)			300	900	1,600	2,200	6,600	
LG1 + LG3 and ZG1		100	200	300	500	800	1,500	
Total GHZ	**300**	**1,000**	**2,100**	**3,400**	**4,900**	**6,500**	**15,100**	**78,000**
GGZ1	100	300	400	600	800	800	1,100	
GGZ2	400	1,100	1,900	2,600	3,400	3,800	4,000	
Total GGZ	**500**	**1,400**	**2,300**	**3,200**	**4,200**	**4,600**	**5,100**	**28,000**
Total for all sectors	**4,900**	**17,900**	**34,700**	**49,300**	**61,500**	**66,800**	**77,900**	**255,000**

Source: House of Representatives (2013), *Hervorming van langdurige ondersteuning en zorg,* appendix to Letter to Parliament *Hervorming langdurige zorg: naar een waardevolle toekomst,* submitted to the House on 25 April 2013, Proceedings 2012-2013, 30 597, No. 296

Key: The 'indication' is a coding which represents the medical assessment of a patient's care requirement. The letters refer to the nature of the disability or infirmity, the figures to its severity.
GGZ = Psychiatric condition (often acquired, e.g. depression, addiction etc.)
GHZ = Patients with an intellectual or physical disability or sensory impairment
LG = Physical disability
VG = Intellectual disability (learning difficulties, usually congenital)
VV = Nursing and care (e.g. age-related infirmity)
ZG = Sensory impairment (visual and auditory disability)
ZZP = Care intensity package

Table 5: Shortage of suitable accommodation (absolute numbers and percentage of total stock)

		2009 (number of places/units x 1,000)	2012 (number of places/units x 1,000)
1 Residential care / assisted living		40 (29%)	40 (30%)
2 Other accommodation, by type	Accommodation with services	41 (22%)	46 (26%)
	Seniors accommodation – other	43 (18%)	63 (31%)
	Accommodation with extensive modifications	0 (0%)	0 (0%)
	Single-storey units	Surplus of 36	Surplus of 64
		47 (3%)	**45 (2%)**
Total shortage of suitable accommodation (1 + 2)		**87 (5%)**	**84 (4%)**

Source: Galen, J. van, Willems, J. & Poulus, C. (2013), *Monitor investeren voor de toekomst 2012*. Delft: ABF Research

Table 6: Number of care providers achieving reduction in (acceptable) costs*

Projected maximum reduction in acceptable costs	0-2.5%	2.5-5%	5-7.5%	7.5-10%	10-12.5%	12.5-15%	15-17.5%	20-22.5%	22.5-25%	>25%
2013	379	273	157	58	17	2				
2014	163	127	161	124	75	63	67	50	30	21

* 'Acceptable costs' refers to the care provider's total budget allocated under the provisions of the General Exceptional Medical Expenses Act (AWBZ) in accordance with current policy regulations.
Source: Dutch Health Care Authority (2012), Advisory report: *Scheiden van wonen en zorg in de AWBZ*

Raad voor de leefomgeving en infrastructuur

APPENDIX 3: BACKGROUND TO THE ADVISORY LETTER

About the Council for the Environment and Infrastructure
The Council for the Environment and Infrastructure (*Raad voor de leefomgeving en infrastructuur*, Rli) advises the Dutch government and Parliament on strategic issues concerning the physical environment and infrastructure. The Council is independent, and offers solicited and unsolicited advice on long-term issues of strategic importance to the Netherlands. Through its integrated approach and strategic advice, the Council strives to provide greater depth and breadth to the political and social debate, and to improve the quality of decision-making processes.

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Raad voor de leefomgeving en infrastructuur

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