Summary

Living with care

Exploratory study of privately funded residential care for older persons

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Summary and discussion

S.1 Study aim and methodology

Private residential care facilities are places where well-heeled older persons who have a care need, and who are no longer willing or able to live independently in the community, are able to live among like-minded peers in beautifully situated villas, enjoying a luxury diet, attending classical concerts and with access to care 24 hours a day. That at least is the stereotypical image of this sector.[1] But is that also the reality? And is it true that the number of private residential care facilities is growing in line with the number of well-to-do older persons and in response to government policy which promotes market forces and expects people to take responsibility for their own needs? Little is known from the scientific literature about private residential care in the Netherlands, even though it impinges on social issues such as the configuration of the care system and the dividing lines in society. In this study we attempt to shed more light on this topic: what is private residential elder care, who are the companies providing it, and who lives there? We also look at how private residential care differs from regular residential elder care, and investigate the potential consequences of the (further) development of private residential care. The aim is not to present an exhaustive picture of the private residential care sector, but rather to shed more light on what this sector entails and what issues are at stake.

For the purposes of the study, we conducted twelve interviews with a total of nineteen individuals. We spoke to ten key individuals from organisations with an overview of the private residential care sector: sector organisations, regulatory bodies (the Dutch Health and Youth Care Inspectorate (IGJ) and a care administration office) and expertise centres where members of the public and organisations can obtain information. We also spoke to nine operators and site or care managers from five private residential care organisations which offer long-term elder care, and visited a total of five of their facilities. We found these organisations (key organisations and private residential care organisations) through internet searches, publications and the key individuals. In selecting the subjects for the interviews, we tried to ensure a diversity of perspectives (operators, regulator, interest association) and characteristics (large-scale, small-scale). The private residential care organisations which took part in the study all provide care within the framework of the Dutch Long-term Care Act (Wlz). This means that we are not able to present information on types of residential care which offer only lighter forms of care or which do not provide care at all. We also did not speak to residents themselves, because our aim in this study was first to obtain a general impression of the field. The picture we present of residents is based on what key individuals, operators and site or care managers told us, as well as our impressions during our on-site visits. The emphasis in the selection of interviewees was on key individuals and operators from the private sector. The exploratory study consequently

provides no information on how those in the regular (public) care sector view the development of private residential care.

S.2 What picture can be painted of the supply and use of private residential care for older persons in the Netherlands?

The prevalent image of private residential care, of stately buildings with gourmet dinners for the wealthiest older residents, is only partially true. The range of facilities is more diverse, from new-build premises to converted school buildings and historical villas. Most of the facilities are small-scale. While there are indeed some facilities which are aimed explicitly at affluent older persons, others target older people with middle or higher middle incomes, and one or two also focus on older persons with a low income or living solely from the state pension. The accommodation and service charges can be as high as 8,500 euros per month, but there are also residents who pay only 500 euros per month, though this is uncommon. The costs of accommodation and services, such as meals, activities and the care infrastructure (regardless of whether it is used) generally lie between 2,000 and 3,000 euros per month. The costs of care come on top of this, and residents almost always pay for this using public funds (e.g. a personal budget or a full or modular home care package (VPT or MPT, respectively).[2] Any profits or gains for operators or investors come from letting the accommodation and providing supplementary services, not from the care provided.

The key individuals and operators in our study confirmed the strong growth in the private residential care sector in the Netherlands, especially over the last five years (see chapter 2). This growth is in line with government policy, which is based on people drawing on their own resources and taking responsibility for meeting their needs (first organising and paying for care oneself before being eligible to apply for publicly funded care and support) and the idea that people (wish to) continue living independently for longer. According to the interviewees, the policy of separating accommodation and care, the closure of residential care homes, the availability of the personal budget, the shift from supply-driven to more demand-led thinking and the increase in the number of older people with more financial resources have been significant factors in this trend. Precise figures are not known, but it is likely that there are at least 300 private residential care facilities for older persons in the Netherlands, providing accommodation for at least 5,400 older residents (see chapter 2). This means that the share of older people making use of these facilities is still very small: a total of around 108,000 over-65s live in residential care or nursing homes.[3]

The interviewees stated that private residential care is currently mostly used by older persons with higher middle incomes. Children are often the decisive factor: they feel it is no longer feasible for their parent to continue living at home, but have a negative perception of regular nursing homes. A private facility feels 'right'. In most cases, the older persons living in the facilities visited for this study already had a reasonable care need – often based

on a Wlz indication – when they moved into residential care. There appears to be a lower limit on the care intensity, but also an upper limit.[4] Residents with a high care intensity and complex care needs appear to be more at home in regular nursing homes, where the expertise and facilities needed to provide complex care are more readily available. Some private organisations focus on specific groups, such as older persons with dementia. People who do not (yet) have a care need, or require only mild care, can sometimes also move into private residential care homes, but only a small proportion of residents have no care need. These are often married couples, with one partner having a care need and the other not.

Those behind the private residential care initiative are a mix of enthusiastic care professionals and people from the business world with a passion or with (negative) experience of family members in a care institution. They are often keen to show that things can be done differently and 'better', and seek to place greater emphasis on accommodation and well-being. There are also some whose main aim is profit, though this does not mean that they do not offer good-quality care – like other providers, the care they provide has to meet legal quality standards.
Financing a private residential care facility requires adequate revenues from the rent and services provided. Being able to provide adequate (24-hour) care profitably requires a minimum number of residents (around twenty) with an indication for Wlz-funded care.[5] When a new care company begins operations, the owners often ask residents to purchase the care from them using their personal budget. However, among the companies interviewed in this study, which have been in existence for several years, there appears to be a trend towards switching to full home care packages, which require a contract with a care administration office. This may mean that residents lose some control, but also reduces the administrative burden because they no longer have to claim the care costs themselves from the care administration office – that is done for them by the care company. For the care company, a contract with the care administration office means recognition and often greater financial security. It also enables the care administration office to keep a closer eye on the organisation.

S.3 How does private residential elder care differ from regular (publicly funded) residential care?

Although virtually all interviewees recognised and used the term 'private residential care', it proved difficult to distinguish private from regular residential care for older persons with a Wlz care need (chapter 2), and to define the two terms. Separation of accommodation and care does however appear to be a key characteristic of private residential care: clients pay rent for their apartment and the costs of additional services are separate from the costs of care. However, many regular care organisations now also offer variants which can be paid for with a personal budget or full/modular home care package, so that separation of accommodation and care is not (or no longer) a unique feature of the private sector. The

care provided in the private residential care sector is almost always funded from public budgets (usually Wlz: personal budget, full/modular home care package) and, as mentioned above, private organisations are increasingly taking out contracts with care administration offices. The full range of Wlz-funded care with accommodation, in which both the care and the accommodation are funded, as well as medical treatments, is only obtainable from regular institutions. The different care culture with innovative principles which the private residential care sector ascribes to itself – small-scale, more client-focused and more personal – is also no longer an exclusive characteristic, but is also being developed (further) by providers in the regular sector.

Small-scale private residential care requires different competencies from staff compared to regular residential care: employees must be able to work independently and perform more all-round tasks. The same quality standards are applied to the care in both sectors, but if the care is funded only from personal budgets, there is less scope for supervision (see chapter 4). The main area where a difference in quality can be discerned is where there are highly complex care needs: according to some key individuals from regulatory bodies, private providers currently often fall short in this area (see chapter 3). Care administration offices therefore mainly take out contracts for highly complex care with 'regular' providers of traditional nursing home care. Private care providers often state that residents requiring very complex care and with severe behavioural or other problems can no longer continue to stay in the facility.

In conclusion, we may observe that the commonly used terms 'private' and 'regular' residential elder care are actually not a very good fit. In reality, the two forms of residential care cannot be clearly separated, partially overlap and are becoming more similar. We would note that we are referring here to residential care which is accessible to older persons with an indication for Wlz-funded care; the study offers no information relating to a private sector for older persons with no care need.

S.4 What is the significance (positive and negative) of private residential elder care for residents, the care sector and society?

The respondents see added value in private residential care for older people themselves, for the care sector and for society, but also highlight a number of risks and problem areas (see chapter 4).

For residents

According to the key individuals and operators, the added value of private residential care for residents lies mainly in the smallness of scale, the client focus and the prominence given to accommodation and well-being. A further benefit is the increased choice for potential residents, making it easier for them to find a home which matches their personal

wishes, for example homes for people with a particular cultural background, or the ability for couples to live together, something that is often not possible in regular homes.[6]

However, there are also limits to what small-scale private residential care providers can offer. It is not possible to predict in advance how residents' health will develop, except for the high likelihood that their care need will increase. According to the key individuals in our study, operators are not always aware of this when starting a residential care home. In addition, according to staff of regulatory bodies, they sometimes fail to identify medical developments affecting residents because they generally do not have the requisite expertise – in geriatric medicine – in-house. If a resident's care need is very complex, for example requiring a closed setting, or if they need specialist medical care, private providers of small-scale residential facilities can generally not offer this. Not only do they often lack the specialist expertise needed for this, the accommodation is also not always suitable for providing highly complex care, according to staff of regulatory bodies. In such cases, residents are forced to move to a regular nursing home. A few operators reported that they make agreements on this in advance with new residents. Several key individuals regard it as undesirable that older people have to move again. The question of what small-scale private care providers need to be able to offer complex care was cited as a challenge for follow-up research.
There is another issue in relation to couples: following the death of one partner, if the remaining partner does not have a care need they are not always able to remain living in the residential care facility. A number of key individuals also warned that where care is funded through a personal budget, there is a risk that this can affect the quality of care because the care administration office has less oversight. Staff of regulatory bodies also cite the risk that the importance attached by a resident to the residential setting can distort their judgement, potentially leading them to accept care of lesser quality.

For the care sector

The private sector, with its often new care or organisational concepts, may have an innovative impact on regular care providers, prompting the sector to mobilise and, for example, respond better to the wishes of older persons or develop cheaper organisational structures. Respondents cited the problem that residents of private residential care facilities are generally forced to refer to their general practitioner for medical matters, because they are regarded as 'living independently'. This means that GPs are more often confronted with complex care needs, which may cause them to feel under increased pressure. To be able to offer specialist care to residents with complex care needs, many private residential care providers make agreements allowing them to consult geriatric specialists with regular care providers which do offer this specialism. A few respondents accordingly feel that more thought should be given to embedding the private residential care sector in a regional and local care infrastructure within which they too can make use of specialist elderly care and which enables them to respond better to the growing and often complex care needs of their residents.

A further issue is the (tight) labour market in the care sector. The private care sector appeals to a certain type of care worker (for example those with a need for autonomy), potentially at the expense of regular care providers. On the other hand, a private provider with a small-scale organisation may be extra-sensitive to changes in the number of residents and staff turnover: one resident fewer means less money to fund the care, and because there is less scope than in a large organisation to 'rotate' staff, an unfilled vacancy has a major impact on capacity. Some private care companies therefore prefer to work with flexible staff, for example self-employed/freelancers. It is unclear whether this will lead to an increase in the number of self-employed people working in the care sector, and whether this is a desirable development.

The developments in the private residential care sector also create a need for greater steering from local authorities and care administration offices when a private residential care provider wishes to set up in a particular locality: what is the local market like, and what impact would a new private facility have on other providers?

For society

Although not investigated in this exploratory study,[7] it is possible that private residential care meets a need in society, specifically for people with relatively mild care needs who are not yet (or do not wish to be) eligible for a nursing home but do need to live in a sheltered setting. However, small-scale private residential care appears less easy to achieve for older people with limited financial means, who are accordingly less well served by this sector and have much less choice than their peers with higher incomes. There are a number of initiatives for older persons with a low income, but these generally entail just a few rooms being made available in a residential care facility. It is therefore unclear what the consequences will be of the rise in private residential care facilities on any social dividing lines in the care sector (we shall return to this below).

S.5 Discussion

Blurring boundaries within long-term care

In reality, genuine private residential elder care which is paid for entirely by the residents themselves does not exist in the Netherlands. In the form of residential care that is the focus of this exploratory study, the care is almost always paid for from public funds (through the Long-term Care Act (Wlz)). Funding models such as the personal budget and full home care package make this possible. At the same time, regular providers are increasingly separating the accommodation and care components, increasingly organising the care provision on a smaller scale (especially for people with dementia) and deriving increasing revenues from providing services and meals. The private and regular residential care sectors are thus becoming more similar, with only the full package of 'care with accommodation' in kind and highly complex care currently being the sole preserve of regu-

lar care providers. This means that older persons with the most complex care needs currently have no alternative to regular care providers.
Is it still useful then to speak of private versus regular residential elderly care? Might it perhaps be better to draw a distinction between 'newcomers' and 'traditional providers', with the focus primarily on differences in experience and innovation? Or perhaps between 'small-scale facilities with separate residential and care provision' and 'nursing home care providing the full package', in which the difference lies mainly between 'living with care' and 'care with accommodation'? Even then, however, it is likely that the dividing lines will ultimately prove to be vague.

Our findings illustrate the many dynamic developments taking place in long-term care in the Netherlands. New accommodation and funding models are removing the 'hard' distinction between independent and institutional living, private and regular and small-scale and large-scale (see also Zantinge et al. 2011). Older persons who receive Wlz-funded care in a private residential home based on an indication for care and a personal budget or full home care package are regarded within the public finance system as living independently; however, is this an accurate description if they are clustered together in a single building where they all receive the care from the same organisation?
Policymakers will need to recognise this as a sector which is becoming increasingly diverse and diffuse. It is not always easy to predict how new policy will affect all groups. Training programmes and in-service training for care staff also need to take (even) better account of these developments.

Input for the debate on a 'divide' in the care landscape

The fears of a divide between rich and poor in elder care provision is a recurrent theme in the political and public debate in the Netherlands (see Bannenberg & Boekholdt 2000; Kant 2000; Duk 2008; Landeweer & Kraaijeveld 2013; Leupen 2014). Does private residential care really create a divide in relation to Wlz-funded elder care, and if so does this pose a risk for society? A number of points emerged from our study which can serve as input for the political and public debate on this topic.
Participants in that debate express fears that the proliferation of private residential care facilities could threaten the mutual solidarity within Dutch society (*de Volkskrant* 2000; Kant 2000), suggesting for example that people with a high income would no longer be willing to pay contributions for a social insurance scheme which they subsequently do not use. We found this not to be true for private residential care: virtually all residents of private residential care homes pay for the Wlz care they receive from public funds (personal budget or full home care package) and therefore do make use of national insurance schemes. It is thus not the case that an increase in the number of private clients receiving Wlz-funded care leads to a (substantial) increase in the public funds available to support less well-off older persons.[8] There may also be people who fear that solidarity is actually coming under pressure precisely because the government helps pay for (luxurious) care for affluent older people. However, the government budgets for private Wlz-care are the usual budgets for

care to which everyone is entitled and for which they are required to make a (partially means-tested) co-payment. The costs of accommodation and additional services are paid for by the residents themselves.
At present, private residential care does offer more options for older people with higher incomes. Moreover, more expensive private residential care homes are more attractive and better located, offer more high-end services or more expensive meals and may more often be smaller in scale than regular residential care centres. The people we interviewed (including key individuals) generally do not see this as a major problem, arguing that differences in life circumstances also exist among younger people, with some people living in a rented home in a working class neighbourhood, for example, and others in their own detached villa surrounded by nature. Other research has also shown that most people do not have much difficulty with the idea that older people with more disposable income should also receive more luxurious care, as long as the basic care is of adequate quality and is accessible to everyone (Kooiker et al. 2012). As Bannenberg and Boekholdt (2000) put it: 'Division is really only division if the regular care is perceived in society as inadequate.'

It is not necessarily the case that private care is of better quality than regular care, nor that smallness of scale is always better. In our study we found no clear indications that the care provided in private residential care homes is better or worse than that in regular nursing homes. What we did find is that private residential care organisations are often not able to provide complex, intensive care, which means that an older person with steadily growing care needs will ultimately have to relocate to a regular nursing home.

In addition to the condition that the basic level of care must be of sufficient quality, there may also be other conditions which make private residential care for affluent older people acceptable to the general public. One of the key individuals we interviewed referred to this: 'is there still a sufficient range of facilities, and sufficient variation in those facilities for people with lower incomes?' (S5: expertise centre employee, chapter 4). Sufficient availability of residential care facilities can mean among other things that older persons with a lower income are not faced with longer waiting times than their affluent peers, regardless of whether they opt for regular or private residential care. Older people who have to rely on the regular sector should also be offered some variety and choice, in order to avoid a divide on this aspect. This is also in line with expectations that the older population in the future will be more diverse than it is today (De Klerk et al. 2019).

Finally, we see two aspects to which our study provides no answer but which do warrant attention and could perhaps be subject to further research. The first relates to well-being and quality of life. As stated, there are no indications of differences in quality of care between the private and regular residential care sector, but in this study we did not look at possible differences in well-being and quality of life. It may be that there are differences in people's experiences and the degree to which the care meets the wishes and needs of individual residents, or there may be differences in how residents perceive their quality of life.

However, well-being is also a relative concept; an older person who previously lived in a large home with a nice view may for example regard a one-bedroom apartment in a town-house as a retrograde step. Research on residents' experiences of care and their perceived quality of life and well-being could contribute to the knowledge on this topic. It may be that residents of private residential care facilities are less well represented in existing research on older people living in institutions,[9] given that they are officially regarded as 'living at home' because they are renting a home from their own funds. In short, the perspective of older residents of private residential care facilities definitely warrants attention in research.

A second area for attention concerns older people who are not (yet) eligible for an indication for Wlz-care, but who do need to live in a more sheltered setting. The trend towards community-based care is leading to the disappearance of the former residential care homes and the sheltered housing units attached to them. Several parties, including private operators, are developing new residential forms, but in the cheaper segment in particular the choice is limited (Van Klaveren et al. 2018; De Klerk et al. 2019). The risk of a divide between the lower and higher income groups, with not everyone having access to a suitable home, could be a more pressing issue here than among older persons who are eligible for a referral to Wlz-care.

More knowledge needed about preferences of potential residents

The perspective of current and potential residents received too little attention in our study, because we did not speak to older persons themselves. The study does, however, make clear that the client population is increasingly diverse: there are not only facilities for affluent older persons, but also residential care organisations which target older people with a middle or even low income, albeit to a limited extent. It is plausible that care companies have more difficulty making facilities for this group profitable, but we did not investigate this aspect in this study; it is possible that there may be a gap in the knowledge about the scope for providing services for older people with a middle or low income. The extent to which the needs of older persons with higher and lower incomes differ from each other is also an important question in this regard.

As well as income diversity, one private residential care sector organisation believes that there is a trend towards creating residential care facilities based on residents' cultural background, for example people with an Indonesian, Surinamese, Turkish or Moroccan background. The underlying idea is that, if they are no longer able to live independently, older people prefer to live with like-minded people. This aspect was not covered in our study; we did not visit any residential care organisations which focus on any specific group of like-minded people.

We gained the impression in our study that older people who already have a care need are most likely to want to move to a private residential care facility, but our impression could be distorted because we selected residential care organisations where Wlz-funded care was available. It is also possible that there are forms of residential care which focus more

on older persons with mild or no care needs. Do such facilities exist, and if so who lives in them? Could private residential care offer an alternative to the former residential care homes? How many, or what proportion of older persons would want to move to a residential care complex if it were available in their familiar setting, and under what conditions? Do older people want to live among people of their own age even if they themselves do not need care, but where care can be provided if necessary? These are questions for (further) research.

Policy questions

Private residential care has become an integral part of the care system in the Netherlands, which is (currently) used by a modest proportion of older people with a care need; that calls for structural attention in government policy. We will mention a number of policy focus areas here.

New private residential care providers are often insufficiently aware that older people can develop highly complex care needs over time. This requires sufficient expertise, for example from geriatric specialists and specialist nursing staff, and the accommodation also needs to be suitable. Start-up companies could be better prepared for this, so that they can make allowances from the start. Some steering from local authorities could be helpful in this context when a new operator develops plans for existing or new premises. Consideration could also be given to the question of what help could be given to existing residential care providers who are encountering this problem, so that they continue to be able to offer their residents a good quality of life and high-quality care.

A recommendation from a number of key individuals interviewed in this study is to give careful consideration to the regional coordination of supply and demand and to consider whether regular and private providers are not crowding each other out. Local authorities and care administration offices need to be more alert to this. If a new provider arranges with a care administration office to provide a certain number of Wlz-funded care places, this could mean fewer places – and therefore less funding – for another organisation, for example a large regular residential care provider. That could detract from the specialist care available, which can often only be provided in large, regular care settings.

Older people living in a private residential care facility are regarded by the government as 'living at home' and are forced to consult their general practitioner when they need medical help. GPs are not always able to deal with the complex care needs of these older persons, so there is a need for more availability of geriatric specialists who can also be accessed by residents of private residential care facilities. This is also in the interests of older persons who are still living entirely independently and who – as older people remain living at home for longer – may have more complex care needs. A review of care for older persons living at home cited this as one of the issues in the present elder care system (De Klerk et al. 2019). This also calls for proper embedding in the local care chain.

At the same time, private facilities could meet regional needs where there is a lack of facilities, for example in contracting regions and regions with an ageing population. Some of the operators in this study argue that their smallness of scale and innovative organisation

means they are able to offer the same or even better care for less money than regular organisations. If that is true, these organisations would be of great benefit to the elder care system. Attention therefore needs to be given to the cost-effectiveness of private residential care, for example in a study of the desirability and feasibility of small-scale residential care.

Notes

1 See e.g. the following newspaper articles (in Dutch): https://www.volkskrant.nl/nieuws-achtergrond/ouderen-wonen-heerlijk-in-een-zorghuis-maar-de-huisarts-is-er-maar-druk-mee~bcfaabff/ and https://www.nrc.nl/nieuws/2013/09/21/hier-gaan-de-gesprekken-ergens-over-1295760-a547117.

2 A personal budget is a budget that can be used by the holder to pay for the care they need. The care recipient enters into a contract with the care organisation and submits expense claims for the care costs (via the Sociale Verzekeringsbank (SVB)) to a care administration office. A full (VPT) or modular (MPT) home care package covers the provision of care by an organisation in the recipient's home setting rather than in an institution. The organisation providing the care enters into a contract with a care administration office for this purpose. The care recipient does not have to claim the costs from the care administration office; the care organisation does this on their behalf.

3 Data from CBS StatLine, May 2019.

4 The lower limit appears to be 'sheltered living with intensive support and extensive care' (*VV Beschut wonen met intensieve begeleiding en uitgebreide verzorging*) (previously Care Intensity Package VV 4 (*ZZP VV 4*)), while the upper limit is 'sheltered living with intensive support and nursing care' (*VV Beschermd wonen met intensieve begeleiding en verpleging*) (previously Care Intensity Package VV6 (*ZZP VV 6*)).

5 According to an employee at an expertise centre, at least eighteen residents with a Wlz indication are needed in order to fund night-time care. See also Thaens 2015.

6 While in principle a partner who does not require (Wlz-funded) care has the right to move into a regular care home with their partner, in practice this does not happen often.

7 This study concentrates on private residential care for people with (or who are eligible for) an indication for Wlz-funded care.

8 The tariffs for care purchased with a personal budget and the full home care package are, however, lower than those for 'care with accommodation' in kind, though this also applies for the required co-payments.

9 E.g. the 'Older people in institutions' survey (*Ouderen in instellingen* (OII)), which is conducted jointly by SCP and Statistics Netherlands (CBS).