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Cohousing for elderly

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In 2015 a profound change in the financing of the Dutch health care system was initiated. Purpose of the reforms was also to enable elderly to live at home as long as possible. One of the consequences of the 2015 reforms was that care providers closed care homes. It was argued that care providers could use vacant care homes to house independent living elderly of lower and middle income groups seeking a break out from loneliness, and willing to live their life in the vicinity of other elderly without abolishing the independence, thus in a cohousing group for elderly.

This mixed methods study aims to gain insight into the conditions that influence the continuity of cohousing groups for elderly.

A survey was sent to 114 cohousing groups for elderly, yielding a net response of 52%. The outcomes were then used to select 6 cohousing groups who participated in in-depth interviewing.

Informal care is in all interviewed group provided by family caregivers and it was not the cohousing's responsibility to look after chronically ill members. For elderly, an important motive to live in cohousing was the social connection with others in the group. This also creates a feeling of safety. However, a main reason for cohousing groups in highly urbanized areas appears to be the possibility to bypass the regular waiting list for social housing. The continuity of cohousing groups seems to depend on the regular organization of activities, and therefore membership fees need to be included in the rental agreements.

Keywords: cohousing; independent living; aging, continuity of cohousing

1. Introduction

The ability to sustain long-term care systems lies at the heart of the policy debate in Western European countries. The growing number of older people in the population and the restricted economic development reinforce the need to devise a resilient care system. For decades, the Dutch government has been responsible for long-term care provision. Providing help for people with health impairments to enable them to continue participating in society continues to be high on the political agenda. However, as this gives rise to relatively high publicly funded costs, particularly for residential long-term care, in 2015 a profound change in the financing structure of the health care system was initiated. Like other European countries with a high proportion of publicly funded care, in the Netherlands there is a steering towards a larger share of informal care. Purpose of the reforms was also to enable elderly to live at home as long as possible. Necessary care will come from the local authority and care insurer (Verbeek-Oudijk, Woittiez, Eggink, & Putman, 2014).

The cohousing model is a residential typology consisting of individual residential dwellings with collectively owned facilities, with communities seeking to develop and maintain strong social bonds between residents through shared management (Hammond, 2018). It is exactly for this reason that the national committee 'Toekomst zorg thuiswonende ouderen' considers cohousing for elderly a means to reduce health care costs, and calls for another change in policy. The dictum is now changing from 'one has to age in place' (Tinker, 2013) into 'one has no right to age in place' (Commissie Toekomst zorg thuiswonende ouderen, 2020). Explicitly, the committee states that elderly have to relocate – which will be downsizing as most of them continued to live in the family house after their children moved out, and to use the money that will be freed to pay for the care themselves.

As there is a shortage in independent housing that is suitable for elderly, a possible solution might be to take advantage of existing vacancies of institutional care providers that have vacancies in former nursing homes. The challenge is how to motivate elderly to move into cohousing, and how to organize cohousing in such a way that it will be successful. An important element of successful cohousing groups, is that of continuity. Continuity requires a balance between community living and individual life. A too strong emphasis on the former might discourage (future) participants, whereas a too strong emphasis on individual life may attract (future) participants without a wish to interact with the group (Kesler, 1988).

Therefore, and given the advice of the national committee 'Toekomst zorg thuiswonende ouderen', the current study aims to gain insight into the conditions that influence the continuity of cohousing groups for elderly as a means to identify the most important lessons that can be learned from existing cohousing groups for organizing such a group.

2. Theories and Methods

2.1. Theory

With a growing population of older people in the Netherlands, a housing supply and demand mismatch has developed where many homes are now too large for this group and/or unsuitably adapted to their needs. Because of the steering towards prolonged independent living, local authorities have been given responsibility for supporting other citizens with a long-term care need, through the Social Support Act (Wmo) (Verbeek-Oudijk et al., 2014). This includes home adaptations to support independent living. Because of constraint budgets, independent living older people need to adjust to declining physical and cognitive capacities by downsizing. The report of the committee 'Toekomst zorg thuiswonende ouderen' marks an impending turning point in the national health care policy. The dictum is now changing from 'one has to age in place' (Tinker et al., 2013) into 'one has no right to age in place' (Commissie Toekomst zorg thuiswonende ouderen, 2020). Explicitly, the committee states that elderly have to relocate – which will be downsizing as most of them continued to live in the family house after their children moved out, and to use the money that will be freed to pay for the care themselves. Currently, elderly who are entitled to be taken into a nursing home, are not willing to do so because they will be charged for the residential component when staying in a nursing home. The larger their wealth the more they are charged, so they will opt for home care, which places a load on the care providers due to low efficiency and long travel times (Li Ling Tjoa, 2018).

However, it is well known that in general elderly are reluctant to relocate (Bakker et al., 2018). Furthermore, if elderly are inclined to downsize, they will face further difficulties. Due to differences in past and current housing policies there is a shortage of nearby situated small scale suitable housing, or the available small scale housing is considered highly unattractive, while private retirement housing applies service charges challenging affordability.

2.1.1. Residential normalcy

Older people may be reluctant to downsize because of emotional bonds to their existing homes, and the distress involved in breaking these. They may also be concerned about the ability to develop emotional bonds with their new home. Following the Model of Residential Normalcy of Golant (2011), older people will apply accommodative (mind) strategies and/or assimilative (action strategies) to remain in their comfort and mastery zones (see also Figure 1). They will only voluntarily move when all of the following conditions are met:

1. other adaptive efforts have not been successful in maintaining such;

2. moving is considered a feasible option;
3. the individual believes that moving will improve his residential experiences;
4. the individual does not perceive the actual move as too strenuous.

According to Granbom et al. (2014) this model should be limited to voluntary moves within the ordinary housing stock. Since relocation then needs to improve one's residential experiences, this raises the question what motives elderly may have to relocate into a co-housing group.

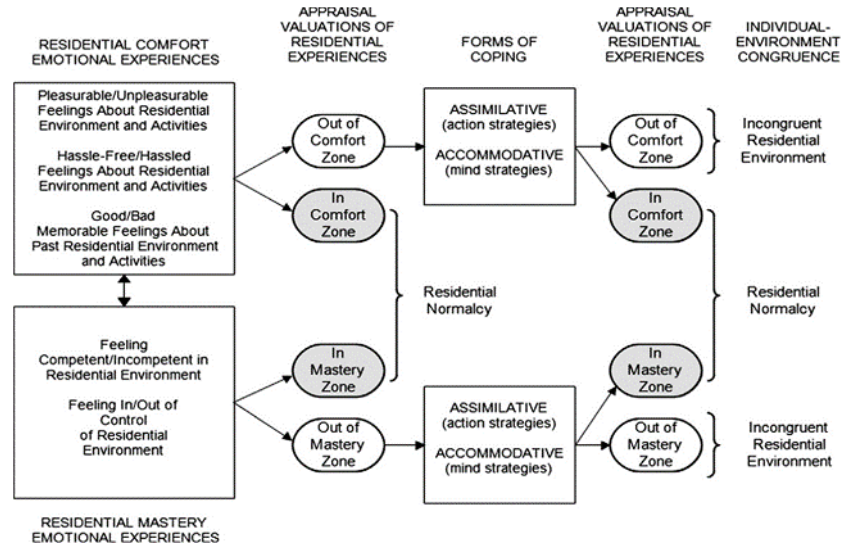


Figure 1 The model of residential normalcy as put forward by Golant (2011)

The model in Figure 1 highlights that the residential environment as perceived by the elderly not only requires the physical environment to be hassle-free, and offering positive feelings and memories. It also includes the need for an environment that support activities, and as elderly report strong feelings of loneliness with increasing age this may not only involve the nearby presences of amenities such as shops and (public) transport, but also the nearness of their social network. In former times, the social network might be more easy to sustain with people living at greater distance, but with increasing age this becomes more difficult. Not only will their social network become smaller as some members pass away, but both the persons in their social network and they themselves may increasingly experience difficulties because of impaired mobility, cognitive decline, etc.

Therefore, if elderly experience loneliness, for instance after their partner passed away or their relationship broke up, or if they fear loneliness –for instance if their social network shrinks, elderly people may consider to opt for living in a cohousing group. One of the primary advantages of co-housing is that sharing space and activities facilitates social support (Hammond, 2018). Social support however, is but one of the aspects that elderly people will review before moving into a particular cohousing group. They will not only assess their current situation, but also evaluate aspects that concern the continuity of the cohousing group, alongside the evaluation of other coping strategies.

2.1.2. Main determinants of continuity in cohousing for elderly

As explained before, these cohousing initiatives that were developed in the last three decades of the former century all share an ideological common ground, i.e. these were rooted in the utopic, feminist and communitarian ideologies (Kesler, 1988; Nuesink, 2016). In this paper, the focus is however on a different kind of cohousing groups, i.e. not being rooted in ideology. Cohousing groups for elderly share a more pragmatic approach (Nuesink, 2016). Indeed, Nuesink is so far the only study investigating into the determinants of continuity of Dutch cohousing groups for elderly. All other studies either focused on cohousing groups with a shared ideology only (Kesler, 1988) or concerned cohousing groups for elderly in different countries as for instance the US (Glass, 2020). There are methodological concerns with using concepts from for instance the US and apply these in

the Dutch situation, as not only the health care system is fundamentally differently financed and further organized, but also because the studies in the US draw upon a different sample of particularly rather wealthy cohousing communities for retired people. As Kesler already reported, a large share of Dutch cohousing groups concerns social housing.

So far only Nuesink (2016) investigated cohousing for elderly, and a main lesson here is that important determinants of continuity in cohousing for elderly cannot be identified through quantitative study only, as particularly Trust and Dependency, Rules and Conditions and Involvement are not properly (validly) conceptualized in a survey. Also, as cohousing is put forward as a means to reduce the costs for care and combat loneliness, that means that motives of elderly people to move into a cohousing group need to be addressed as well.

Therefore, to be able to provide recommendations to Pieter van Foreest (thus the careprovider), this study was designed as a mixed method study. Through a general survey factual information on f.i. group size and average age as important determinants for the continuity will be assessed. Then the survey will be used to identify distinct cohousing groups to gain a deeper understanding of the motives new participants may have and to gain in-depth understanding of how ways of governance (Rules and Conditions), and other important lessons can be learned from existing cohousing groups for elderly. In this way, this study will find an answer to the main research question:

What are the most important lessons that can be learned from existing cohousing groups for organizing such a group?

2.2. Methods

In order to answer the main research question, a mixed method study was used. The first phase consists of a quantitative part in which a survey was developed. Then the survey was used to select distinct cases for in-depth interviewing and thus constituted the qualitative part of the study. In this paper, the results of the survey are presented and discussed using relevant data from the interviews.

2.2.1. Participants

To obtain an unselected sample for the survey, the database of the LVGO (Landelijke Vereniging Gemeenschappelijk wonen van Ouderen) was accessed and all 114 registered cohousing groups were included in the sample. Of these, 59 groups started the survey, yielding a net response of 52%. In further analysing the data, one respondent had misunderstood that the questions were asked to fill out for the whole group and this group was excluded from the dataset in further analyses. One group was in the initiative phase, so not all answers applied. Of the remaining, 42 cohousing groups had fully completed surveys.

2.2.2. Materials

In the survey only factual information was asked for, as it was argued that this would make the survey more easy to fill out. Information about motives for instance was on purpose therefore not included in the survey, as this was included in the in-depth interviews.

The survey covered the following topics:

- Outline of the cohousing group: information on the number of households, number of persons, shared activities, age range of its members, etc.
- Descriptive information on the dwellings, e.g. information about ownership, the floor plan including information on private facilities such as bathroom, kitchen, storage, etc.
- Descriptive information on the cohousing building, and particularly on the shared outdoor and indoor spaces, building year, etc.
- Amenities in the neighborhood
- Governance covering whether formal arrangements were made or not, and how decision regarding the waiting list were made, etc.

- Care, since this was a main topic questions on the number of residents with care demands were asked as well as to what extent the cohousing group took care of those in need of care.

3.2.3. Procedure

Statistical analyses included descriptives and logistic regression modeling. These were conducted in SPSS version 26, and a significance level of $p \leq 0.05$ was used as a threshold in analyses.

3.3 In-depth Interviews

3.3.1 Interview protocol

Ethical clearance has been obtained from the Human Ethical Research Committee of TU Delft.

To prepare for the interview, each time a general description of the cohousing group was made using the outcomes of the survey. Open in-depth interviewing was used with probing to encourage interviewees to explain their perspective and the meaning they assigned to the examples we asked them to provide (Moerman, 2010).

The main topic were

- Who is the interviewee, and since when is (s)he involved in the cohousing group.
- What makes this a cohousing group? (Motives to participate)
- How is the relation between the co-housing group and the housing association / investor (adapted accordingly)
- Housing and Care
- Lessons learned

3.3.2 Interview analyses

Interviewees were asked to consent with audio recording. Afterwards, they received a small present without such being mentioned upfront.

The audio recording was used to make a full transcript. These transcripts were anonymized. They were then coded using motives, governance, and care demands as deductive codes. Rent harmonisation and the motive to bypass the social housing association waiting list were used as an inductive code.

3. Results

In total, 55 groups started the survey, whereas 42 cohousing groups completed the survey. There was one group that was discarded from further analyses, because it appears that the survey was only describing the situation of the individual who filled out the survey instead of describing the whole group as was asked for. Here only a brief summary is made, describing the mean number of residents per cohousing group, whether housing was social or private tenancy, or occupant owned, how long the co-housing group exists (continuity) and how many residents the cohousing groups had with care demands. The latter is an important feature, as the main idea behind the renewed interest for cohousing for elderly of the committee 'Toekomst zorg thuiswonende ouderen' (2020) is that the cohousing group is willing to provide informal care to co-residents with care demands.

It was further argued that co-housing groups that were more similar might be different from socially diverse co-housing groups, and forward logistic regression modeling was used to explore what characteristics distinguished between both groups.

3.1. Descriptives

On average, as summarized in Table 1, groups have about 25 members. There are no groups without women; 4 groups had only women.

Table 1 Overview of group size of cohousing groups

	N of groups	Minimum	Maximum	Mean	Std. deviation
Number of residents in CH with only women	4	8	22	13	6.2
Number of residents in CH with only Men	0				
Number of residents in CH (all groups together)	41	8	67	24.4	12.3

Table 2 describes whether cohousing groups had only social or private tenants, or were occupant owners, or whether there was a mixture of both. Most were social rent only. Since this also reflects differences in socio-economic status, and since it might be possible that there is a difference in continuity in socially homogeneous groups and socially mixed groups, the groups were further combined into groups without social mix (so only social tenants (n=26), or only occupant owners (n=4), or only private rent (n=1)) versus cohousing groups with a mix of social economic status. So in total, there were 31 socially homogeneous cohousing groups, and 9 socially mixed groups.

Table 2 Overview of ownership of cohousing groups.

	Frequency	Percentage
Social rent only	26	65.0%
Social and private rent	1	2.5%
Social rent and owner-occupied	8	20.0%
Private rent only	1	2.5%
Owner-occupied only	4	10.0%
Total	40	100.0%

On average cohousing groups were existent for 17.8 years (s.d.=8.8 years). There were no significant differences in how long the cohousing groups were existing between groups that were classified as social mix or not ($p=0.64$); or between groups with only social tenants and all other groups ($p=0.64$).

However, there was a significant difference in the size of the group, but this was only true between groups that had a social mix or not (social mix $T=-2.49$, $p=0.02$; social rent vs other: $T=-1.09$, $p=0.29$). Social mix cohousing groups had significantly more members (mean=35, sd=16.4) than had cohousing groups without social mix (mean=23.4, sd=9.81).

4.2 Members with care demands

As of 2015, the change in law urges elderly to age in place. Table 3 shows that 14 cohousing groups did not have any members with care demands. There were no significant differences between the number of members with care demands according to social mix, or between social rent versus others types of ownership. On average, per cohousing group there were 2.5 members with care demands.

Table 3 Number of residents per cohousing group with care demands

Number of residents with care demands	Frequency	Percentage
0	14	33.3%
1	2	4.8%
2	7	16.7%

3	3	7.1%
4	8	19.0%
5	3	7.1
6	2	4.8%
7	2	4.8%
9	1	2.4%
Total	42	100.0%

4.3 Final model: distinguishing between cohousing

The number of members with care demands were then used to classify cohousing groups into those without members with care demands, and those with members with care demands (this is the variable CareDemand2).

Together with the variable CareDemand2, several other variables were included in a logistic regression analysis to investigate what distinguished cohousing groups with social mix from those without social mix. A forward selection of the following variables was used to obtain the final logistic regression model as summarized in Table 4: in addition to CareDemand2, these were AgeCH# (age –or continuity- of the cohousing group), CH_nrWomenAndMen# (total number of members), CultureMix (whether or not the CH group had a cultural mix or only existed of Dutch), CH_nrRation75plus (% members aged 75+), CH_nrRation80plus (% members aged 80+), CH_nrRation85plus (% members aged 85+), pp1HH_Total (number of single persons households). All these variables were found in crosstab analyses to have at least a weak ($p \leq 0.25$) relationship with whether or not the cohousing group was homogeneous or not, as recommended by Hosmer et al (2013).

It turns out that social mixed groups were larger and were less likely to have members with care demands than were the socially homogeneous cohousing groups. By including CareDemand2 the model fit significantly improved (-2LL changed from 27.38 to 23.43), and the Nagelkerke R square, reflecting the explained variance changed from 24% to 40%. The Hosmer and Lemeshow Test, reflecting the goodness of fit of the model, improved from $\chi^2=13.19$, $df=7$, $p=0.068$ to $\chi^2=7.52$, $df=8$, $p=0.48$.

Table 4 Final model describing the factors distinguishing a homogeneous social group from a mixed social group

Step		B	S.E.	Wald	df	Sig.	Exp(B)	95% CI
1a	CH_nrWomenAndMen	0,089	0,046	3,660	1	0,056	1,093	0.998-1.197
	Constant	-3,675	1,432	6,583	1	0,010	0,025	
2b	CareDemand2(1)	2,112	1,151	3,366	1	0,067	8,263	0.866-78,88
	CH_nrWomenAndMen	0,116	0,052	4,855	1	0,028	1,122	1.013-1.244
	Constant	-5,385	1,924	7,837	1	0,005	0,005	

4.4 Results on Care demands from the interview

Informal care is in all interviewed group provided by family caregivers and it was very clear that it was not considered the cohousing's responsibility to look after chronically ill members. Some groups have accommodation for family members who provide informal care, or set up a committee for this. Members look after each other, and provide assistance, but up to a certain level. As one interviewee explained, since they are of higher age themselves, this places a too high burden on them. Formal care is provided by professional organisations. Often there are several care organisations in one group fulfilling this task.

All interviewed cohousing groups were clear that if an aspiring member would develop a serious, chronic health condition, that they be rejected as a potential member to be placed on the waiting list. Indeed, interviewees made clear that if a member for instance developed dementia, in the end this would mean that such a member needs to move out, unless there is a partner able to address all care demands.

In this sense age is relative. Age does not always go hand in hand with health. There are healthy people in their eighties and less healthy people in their sixties.

4.5 Other motives to join cohousing groups from the interviews

An important motive for older people to live in cohousing is the social connection with other residents. Residents know each other and together ensure that there is supervision at the immediate surroundings. This creates a feeling of safety. They also ensure that the living environment remains clean and tidy.

Residents further indicate that they've chosen for this type of housing because they can live here independently for longer. Although cohousing groups are largely inhabited by single elderly people, this motive also applies to couples. If one of the two becomes less mobile or is mentally in decline, the other has the support of other residents and the familiarity of the known living environment.

However, particularly the cohousing groups in the highly urbanized areas mentioned that another main reason was that it was in their view the only way to bypass the regular waiting list for social housing in these cities. Clearly the waiting list of cohousing groups in these areas are much longer than they are in areas of lower density. Waiting lists might even not exist in the latter. Such a motive might be a threat to the continuity of these cohousing groups, as these new members might withdraw themselves from the community once they got in. Noticeably, in many of the interviewed cases there were former members who quit the cohousing. Depending on the further (rental) agreements, this may further challenge the continuity of these cohousing groups. This may be particularly true for those groups where the housing association had not included the membership fees in the rental contract, but required the cohousing group to collect the fees themselves. Indeed, one of the cases had serious problems regarding the continuity of the cohousing group as this leaves the remaining members with (unaffordable) costs for the common room.

4. Discussion

The cohousing model is a residential typology consisting of individual residential dwellings with collectively owned facilities, with communities seeking to develop and maintain strong social bonds between residents through shared management (Hammond, 2018). It is exactly for this reason that the national committee 'Toekomst zorg thuiswonende ouderen' considers cohousing for elderly a means to reduce health care costs, and calls for another change in policy. The dictum is now changing from 'one has to age in place' (Tinker, 2013) into 'one has no right to age in place' (Commissie Toekomst zorg thuiswonende ouderen, 2020).

The first lesson from this study is to use a waiting list and require all aspiring members of cohousing for elderly to actively participate with shared activities to distinguish between aspiring members that have motives that are incongruent with the social dimension of cohousing. This also allows the current members to get acquainted with future members. The person who fits best with the group members should be chosen. Secondly the formal admission procedure should not (only) be depending on length of time on the waiting list. This gives the group the possibility (again) to choose the person they think is best for their group. Thirdly, a large mixture in age will ensure that new (young) elderly are willing to get involved, particularly if they are willing to take part in governance. Groups with ages from one generation age together while a mix of ages ensures continuity. The fourth recommendation is to include membership fees in the rental agreement to avoid the financial burden in case members do not longer take part in the cohousing group. Especially the rent for the common room should be part of the rent. Fifth, rent harmonization need to be avoided as this negatively impacts the social cohesion. Mem-

bers from the same cohousing group should have a rent that is similar to avoid discussions. Last, restrict access to the waiting list to those without compelling care demands? The latter is an issue for further debate. In most of the researched cohousing group informal care is not given by members. Informal care is mainly given by family or professionals. Couples are an exception as they do give informal care to each other in cohousing.

5. Conclusions

Although cohousing is advocated as a means to increase independent living and to decrease healthcare costs, this mixed methods study shows that cohousing group are not to be considered a way to reduce healthcare costs once an elderly person can no longer deal with independent living.

Data Availability Statement (if applicable)

All data are available through the authors

Contributor statement

All authors were involved in the conceptualization of the project. Data curation and analyses were done by Waling Bergsma and Clarine van Oel. All authors were involved in writing.

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