

5

Housing Policies

With the number of Americans over the age of 65 expected to more than double from 40 million to 81 million by 2040, it is paramount that policymakers, program managers, and researchers work to maintain and create housing options and communities that meet the needs of older adults and facilitate aging in place.

—AARP, *Strategies to Meet the Housing Needs of Older Adults*, n.d., p. 1

There is a very limited option for older adults housing in my locality. I am considering to move out of the house after my son marries, as the present area of my house is small. I may go in the vicinity of my native place, where I have some acquaintance.

—Mr. S., age 63, Mumbai, India

Comparisons of older people's living arrangements reveal substantial differences between developed and developing regions of the world (Kinsella & He, 2009). As shown in Table 5.1, older adults—and older women in particular—in developed countries often live alone, whereas living with family is more the norm in the developing world. That is not to say that multigenerational living arrangements do not occur elsewhere. Cultural norms of filial responsibility and the transfer of assets across generations, as well as availability of alternate living arrangements, influence where older adults live in their later years. In Spain, for example, about 66% of widowed older adults and 34% of married couples live with at least one child (Zunzunegui, Beland, & Otero, 2001). But in many countries, there has been a decline in multigenerational residence. Karagiannaki (2005) found that between 1974 and 1999, the proportion of unmarried older people in Greece living with a married child dropped from 23% to less than 9%, and the proportion of older couples residing with a married child declined from 14% to 5%. The decline of intergenerational co-residence has also occurred in Japan, where the extended family structure has historically been a prominent feature of society (Takagi, Silverstein, & Crimmins, 2007). Researchers speculate that factors contributing to a greater number of older adults living independently include an increase in

Table 5.1 Percentage Distribution of Population Aged 60 or Older by Household Composition and Sex: Average for Major Areas and the United States

<i>Major Areas</i>	<i>Alone</i>	<i>Couple Only</i>	<i>Child/ Grandchild</i>	<i>Other Relative</i>	<i>Nonrelative</i>
Male (M)					
Africa	6.1	10.6	75.6	6.3	1.4
Asia	2.8	14.9	78.1	2.9	1.3
Europe	14.7	54.6	24.5	3.8	2.5
Latin America and Caribbean	7.8	14.8	65.2	8.3	3.8
United States	14.9	60.1	16.8	4.3	3.9
Female (F)					
Africa	9.9	6.2	71.1	11.2	1.5
Asia	7.9	8.8	76.0	5.5	1.9
Europe	34.7	29.5	28.7	4.1	3.0
Latin America and Caribbean	8.7	10.6	65.6	11.2	4.0
United States	34.5	39.7	18.5	4.9	2.4
Sex differential (F-M)					
Africa	3.8	-4.4	-4.5	4.9	0.1
Asia	5.1	-6.1	-2.1	2.5	0.6
Europe	20.0	-25.1	4.2	0.4	0.5
Latin America and Caribbean	0.8	-4.3	0.3	2.9	0.2
United States	19.6	-20.4	1.7	0.6	-1.5

Source: United Nations (2005).

BOX 5.1 Policy to People Link: Supporting Elderly Population's Ability to Age in Place

Since 2000, Holland has seen the development of Green Day Care Farms that provide day care for older adults with dementia. More than 900 farms provide work such as gardening, meal preparation, and animal care for small groups of older people. Farms typically work with local health care agencies and are funded by the Dutch national insurance system (Bruin et al., 2009).

their personal resources and greater mobility and independence of their children (McGarry & Schoeni, 2000; Ruggles, 2007).

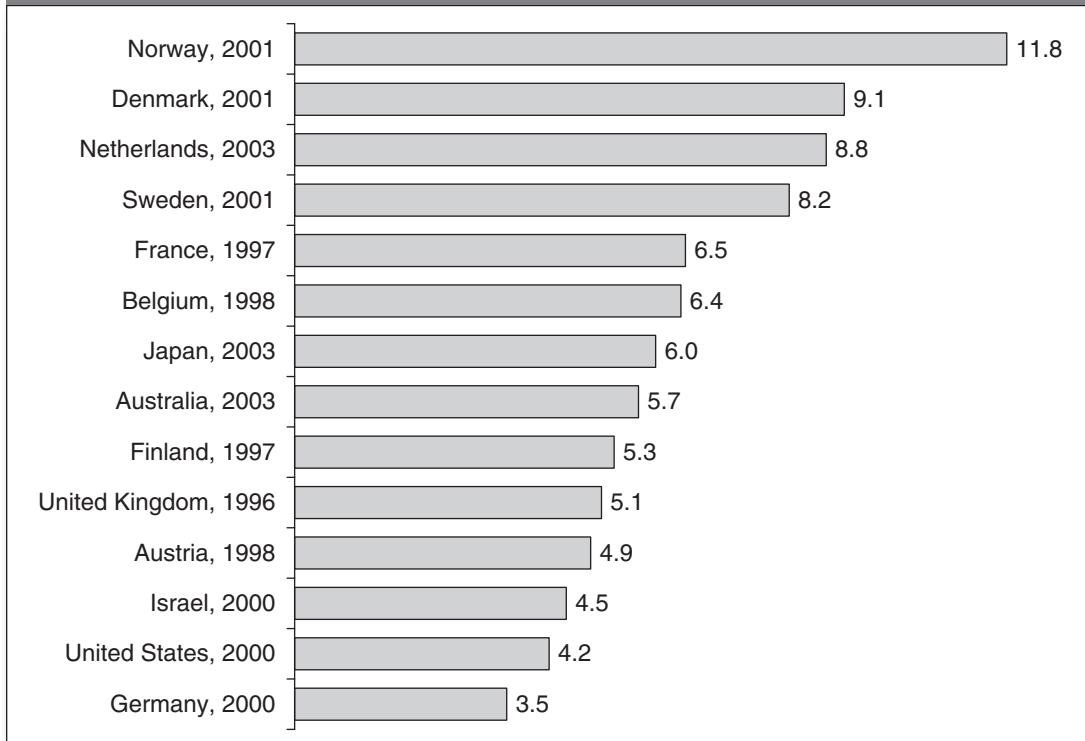
In general, housing policies supportive of older adults are prevalent only in countries with a strong individualistic or socially supported old-age system. For example, in countries with liberal economic policies, such as Switzerland and the United States, housing

policies and the programs they support intersect with policies around aging or poverty. That is, the market economy determines housing for most people, but the government has developed policy to support populations with special needs. Even for countries such as Norway, with more universal government social welfare policies, the market approach is changing policy. In these countries, adequate housing for all has been a civil right throughout much of the 20th century. However, as these countries' economies become more market-based, there is a movement to allow the market to determine housing.

Older individuals are best able to remain in their homes and care for themselves when there is an appropriate “fit” between their level of competence (i.e., cognitive abilities, physical abilities) and the demands of their environment (Lawton, 1980; Lawton & Nahemow, 1973). Thus, the need for alternative living arrangements often is prompted by a need for greater physical, psychological, social, and financial security. Some countries have developed universal systems of residential or long-term care for their older populations that usually include assisted-living and nursing home facilities.

As shown in Figure 5.1, the highest use rates of long-term care facilities are in some of the world's demographically oldest countries (Kinsella & He, 2009). Policies directing the provision of long-term care typically are independent entities, except in

Figure 5.1 Percentage of People Aged 65 and Over in Institutions: Circa 2001



Note: Netherlands and the Nordic countries include people in service housing; Japan includes people in long-stay hospitals.
Source: Cited in Kinsella and He (2009).

countries with an integrated social services system, such as Sweden and the United Kingdom. In countries with more extensive social welfare policies, older adults with increasing needs enter the social services system and are assessed by a social worker or case manager who takes their needs and wishes for housing, as well as health care and other services, into consideration (see Chapter 8). A number of countries have recognized that even when families provide much of the care and support for their older members, changing demographics and socioeconomic conditions influence the feasibility of multigenerational living arrangements. Consequently, many countries have adopted new policies aimed at alleviating current and anticipated housing needs for their older citizens (United Nations Department of Economic and Social Affairs, 2007).

Facilitating older adults' ability to *age in place* (i.e., remain in their homes as long as possible) is increasingly recognized in most countries as being important for the well-being of society's elders and for society as a whole. In the United States, for example, there is recognition that institutional care is much more expensive than home care services for the majority of older adults. Thus, housing policy and related programs are often related to a country's approach to long-term care. In this chapter, we will review the housing policies of the United States, Brazil, Japan, Norway, Switzerland, and Spain. The countries selected represent a range of policies that support the housing and residential care needs of older adults.

United States

Housing policy in the United States is governed primarily by the Department of Housing and Urban Development (Haley & Gray, 2008), and states have jurisdiction over how policy is implemented. Public housing is the oldest and largest federal housing program in the United States, assisting individuals and families with low incomes. In 1956, Congress for the first time gave preference to seniors in public housing (Milbank Memorial Fund, 2006). Throughout the 1960s and 1970s, a large number of developments were built specifically for low-income seniors. With very few exceptions, these were traditional apartments. Local public housing authorities usually operate these housing units, and renters pay no more than 30% of their adjusted monthly income for rent. Older renters occupy an estimated 31% of public housing units (U.S. Government Accountability Office, 2005). They typically are older, poorer, and perhaps frailer than most elderly households. Almost one in five elderly public housing households is headed by someone aged 85 or older, compared with about one in nine households nationwide.

The Section 202 Supportive Housing for the Elderly Program is the only federally funded housing program designed specifically for older persons (Haley & Gray, 2008). The program makes low-cost federal loans to nonprofit sponsors for new construction or rehabilitation of existing structures to provide subsidized rental housing for low- and moderate-income elders 62 years and older. Since its inception in 1959, the program has supported the creation of approximately 6,200 housing facilities for older persons, accounting for approximately 250,000 residential units. Beginning in 2002, appropriations have included funding to convert a small number of projects to licensed assisted-living facilities. Tenants living in Section 202 units have incomes below 50% of their area's median income (Bright, 2005). These housing complexes usually offer supportive services, such as transportation, housekeeping, and home-delivered meals.

The Section 8 Housing Choice Vouchers Program gives rental subsidies to landlords who agree to rent to low-income individuals and families. Public housing authorities can allocate up to 20% of their allotted funds to landlords who make their properties available to low-income residents or who agree to renovate their properties to meet Housing and Urban Development quality standards. Typically, the subsidy covers the difference between the tenants' contribution—an amount that totals 30% of their adjusted income—and fair market rents. Older adults are heads of households in 48% of project-based Section 8 housing (U.S. Government Accountability Office, 2005).

In contrast to the Section 8 project-based vouchers, most participants in the housing choice voucher program find their own housing, including single-family homes, townhouses, and apartments. They are free to choose any housing that meets the requirements of the program (e.g., rent that is not higher than the fair market value) and are not limited to units located in subsidized housing projects. Tenants are responsible for paying 30% of their income for rent. If the rent is higher than the fair market value, the renters are responsible for the difference. Older adults are heads of households in 16% of tenant-based Section 8 housing (U.S. Government Accountability Office, 2005).

Two government programs that help low-income older adults maintain their homes are the Department of Energy's Weatherization Assistance Program and the Low-Income Home Energy Assistance Program (LIHEAP). Under the Weatherization Assistance Program, low-income homeowners apply for funds to make energy-efficient changes to their homes, from installing new appliances and heating systems to adding weather-stripping or insulation. The federal government provides the funds, and governments manage them. Any household at or below 150% of the poverty level may be eligible for services. The program provides energy-efficiency services to approximately 100,000 homes every year and has weatherized more than 6.2 million families since its inception in 1976 (U.S. Department of Energy, 2010). In addition to reducing the utility costs for homeowners, the program helps improve health and safety by reducing carbon monoxide emissions and eliminating fire hazards, as well as creating jobs for those who provide the weatherizing services.

The U.S. Department of Health and Human Services began LIHEAP in 1981. LIHEAP provides heating and cooling assistance to low-income families, regardless of age, either directly through vendors or to landlords for home heating and cooling costs, energy crisis intervention, or low-cost weatherization. Particularly, households where at least one member receives Temporary Assistance for Needy Families, Supplemental Security Income, or Food Stamps qualify for LIHEAP. Applicants to LIHEAP services can apply for bill-paying assistance, energy crises assistance, or energy-related home repairs. Most LIHEAP funds are consumed during the winter months (U.S. Department of Health and Human Services, 2009). In 2003, about 36% of households receiving heating assistance and 47% of households receiving cooling assistance had at least one member 60 years of age or older (U.S. Department of Health and Human Services, 2006). There is wide variation in states' average household benefit levels for various types of fuel assistance.

Home repairs and maintenance are a considerable expense for many older adults, because they have likely lived in their homes for more than 3 decades. Besides needing specific repairs, many homes do not support frail older adults in conducting daily activities within the home. Older adults who are aging in place may need to modify their home's structure to accommodate their physical limitations. Modifications

in lighting, accessibility, mobility, and bathing facilities can improve functioning and enhance safety (Wardrip, 2010). In response to the increasing demand for assistance with housing upkeep and repairs, a number of home repair programs have emerged across the United States. Home repair programs provide assistance with home maintenance or minor repairs. The funding for many of these programs comes from community development block grants or Title III monies from the Older Americans Act (see Chapter 8 for details). Programs vary with regard to the type of repairs they subsidize but typically include emergency repairs for plumbing, electricity, heat, and leaking roofs; minor repairs; exterior painting; and the removal of debris.

BOX 5.2 Policy to People Link: Housing Assistance

The U.S. Department of Agriculture's Rural Development initiative provides help for housing in several ways. Residents of rural areas who are over 62 years old can apply for funds to help with weatherization, home repairs, and rental assistance. It is not uncommon for local Rural Development offices to partner with other governmental agencies, nonprofits, and community groups to help individual older adults maintain independent living. For example, a widow from Utah who applied for a weatherization grant was put in touch with her local Rural Development office when an assessment showed that her home was beyond repair. The Rural Development office teamed up with three other government agencies and local businesses to build the woman a new home that she could afford on her fixed income. Find more Rural Development success stories at www.rurdev.usda.gov/rd/stories/index.htm.

Residential Care

Long-term care facilities are group-living arrangements that provide a wide range of restorative, rehabilitative, and medical services. The growth of the long-term care industry parallels the passage of federal income (see Chapter 3) and health care policy (see Chapter 6). Prior to the enactment of Social Security, Medicare, and Medicaid, many older adults had few options if they needed medical and personal care. In the early part of the century, almshouses or "poor farms" cared for many frail older adults, persons with mental illnesses, and those who were chronically ill. An estimated 60% to 90% of the persons living in almshouses were over the age of 65 (Fischer, 1978). Older adults who were financially well-off had the option of living in old-age homes run by ethnic or religious groups. German and Scandinavian immigrants built Lutheran Homes, and Jews and Methodists built their own facilities (Waldman, 1985). The 1950 amendments to the Social Security Act of 1935, allowing residents of institutions to receive benefits and health providers to directly receive payments for services, helped expand the creation of nursing homes. But the real impetus to the creation of the nursing home industry came with the enactment of Medicare and Medicaid. Both Medicare and Medicaid provide payments to nursing homes—Medicare for acute care and Medicaid for long-term care for those with low incomes. Since the enactment of Medicare and Medicaid,

the percentage of adults aged 65 and older living in nursing homes increased from 2.5% in 1963 (Small, 1988) to 4.1% in 2008 (Administration on Aging, 2009e).

In 2004, there were about 16,100 nursing facilities in the country (Jones, Dwyer, Bercovitz, & Strahan, 2009). Nursing homes average around 108 beds, ranging from fewer than 50 to more than 200. Most nursing homes are certified by the Centers for Medicare and Medicaid Services and are eligible to receive reimbursement for their services to persons qualified for Medicaid and Medicare. Prior to federal legislation passed in 1987, nursing homes had two levels of care—skilled nursing and intermediate care—on which reimbursement was based. Skilled nursing facilities were designed to care for residents who needed care that was more medically oriented. Residents in intermediate-care facilities required custodial care. Because the two levels of classification did not accurately reflect the variations in the functional abilities of nursing home residents, the federal government replaced the dichotomous classification with one designation—the nursing facility. The Centers for Medicare and Medicaid Services designed a different classification system in 1998 called the Resource Utilization Groups: Version III. Instead of paying facilities retrospectively after services were delivered based on “reasonable costs,” facilities are now paid prospectively based on a patient’s care needs (e.g., rehabilitation, extensive services, special care, clinically complex care). This classification system (most recently updated in 2006) reflects the many types of older adults in need of nursing home care.

In the late 1970s, long-term care insurance became available to help cover the costs of long-term nursing home care. Such insurance policies are indemnity policies that pay a fixed amount for each day of care received once the individual reaches specified disability levels. Policies generally limit benefits to a maximum dollar amount or days of care, and some pay benefits for a limited number of years. In 2006, Congress passed legislation giving states the permission to coordinate the purchase and payment of long-term care insurance with Medicaid. The law permits Medicaid to cover long-term care needs beyond the terms of the policy, and policyholders are not required to “spend down” their assets to meet the Medicaid eligibility guidelines (Capretta, 2007b). Although long-term care insurance policy sales have steadily risen since being introduced into the market, older adults have been slow to purchase such policies because of the availability, the cost, the limited benefits, and a belief that Medicare or Medicaid will cover long-term care costs.

Insurance companies are increasingly allowing holders of long-term care policies to use their benefits for assisted living if the services are cost-effective. Although definitions of assisted living vary across states, the term is generally defined as a residential setting that provides or coordinates personal care services, 24-hour supervision, scheduled and unscheduled assistance, social activities, and some health-related services (Wright, 2004). These settings may include personal care boarding homes with additional services, residential care units owned by and adjacent to nursing homes, congregate housing settings that have added services, purpose-built assisted-living programs, or the middle level of continuing care retirement communities. Nationwide, there are about 39,500 assisted-living facilities accommodating more than a million residents (MetLife Mature Market Institute, 2009). Public payment for assisted living includes supplemental payments to the facility for housing for services for residents receiving Supplemental Security Income (see Chapter 3), reimbursement in Medicaid, Medicaid waiver, state long-term care programs, or some combination of these sources.

Brazil

Brazil is a country with many discrepancies in the distribution of income and wealth and acute problems of poverty. As such, there is great disparity among the lifestyles of its citizens, including housing options available to older adults. Only about 9% of Brazilians aged 60 and older live alone; 18% live independently with their spouse, while 61% live with adult children, grandchildren, or other relatives (United Nations, 2005). Co-residence often is beneficial for both generations. For many new families (i.e., young adult children) and working-class families, economic conditions make independent living difficult. In joint households, older adults can get the care and support they need while sharing both property and the benefits of their government old-age pension (e.g., purchasing food, clothes) with their family members (VanWey & Cebulko, 2007).

In describing housing policy in Brazil, da Piedade Morais and de Oliveira Cruz (2010) noted that until the 1930s, access to housing for middle- and low-income families was gained predominantly through the rental markets, which were privately supplied by the upper classes because there was no official housing financial system. This started to change when the principle of “self-owned housing” gained momentum. The 1942 Tenants Law provided incentives for the construction of housing to sell for owner occupation. The development of self-owned housing was closely related to the increasing construction of high-rise buildings in central areas, self-help construction in the periphery areas, and the emergence of slums and peripheral settlements in the main metropolitan areas of the country (cited in da Piedade Morais & de Oliveira Cruz, 2010). In 1964, the federal government created the Housing Financial System (SFH) and the National Housing Bank (BNH), under the military regime. BNH was the first effective initiative of the government to promote a national housing policy (cited in da Piedade Morais & de Oliveira Cruz, 2010). It also made the promotion of self-owned housing one of the main objectives of its national housing policy. The SFH/BNH System divided the housing market into three income segments: popular (up to three minimum wages), affordable (three to six minimum wages), and medium (above six minimum wages). Despite generating a real-estate boom, the BNH subsidized medium- to high-income households and was incapable of reaching the low-income population, therefore increasing slum formation and horizontal expansion toward the peripheral areas.

Although Brazil still lacks a comprehensive housing policy that would enhance housing conditions for all people throughout the country, much has improved in the housing sector since the end of the military government in 1986, including the development of a number of housing programs and supporting legislation (Valença & Bonates, 2010). Government leaders have sought to consolidate financial instruments in line with global markets and restructure the way private interests operate within the system. Such reforms and modernization have tended toward benefiting market solutions to housing policies (Valença & Bonates, 2010).

Following market-based economic policies means that class matters for older Brazilians’ living arrangements. For example, independent living among older adults rose from about 27% in 1980 to 32% in 2000 (De Vos & Andrade, 2005). The largest

increase by race showed that White Brazilians, who are also the wealthiest group of elders, accounted for the most change. There was little or no change among Brown or Black elders. Thus, increased financial resources may help facilitate independent living among some groups of elders (e.g., Whites) and multigenerational living among others (e.g., Browns and Blacks).

Residential Care

Brazil reflects the roots of colonialization, as it shares the common European system of charitable poor homes taking care of the poor and disabled (Garcez-Leme, Leme, & Espino, 2005). Nursing homes are rare in Brazil; most are privately run religious institutions and are primarily found in urban areas (Garcez-Leme et al., 2005). They typically serve the most frail and vulnerable elders and have a heterogeneous structure, with some providing medical care via a professional nursing staff and others providing social support.

Japan

Traditionally, pre– World War II, the eldest son in a Japanese family took care of his parents and inherited family property when the parents died. Government reforms after World War II deinstitutionalized this system, though many families continued to practice it (Izuhara, 2002, p. 69). Indeed, the 1950 National Assistance Act stated that public assistance should be considered as a supplement to family care (Izuhara, 2002). Thus, although the oldest son no longer had exclusive inheritance rights and care responsibilities, families were still expected to provide care for aging members. Older people can expect not only their spouses and children to provide care but also siblings and grandchildren (Izuhara, 2002). This state policy with explicitly stated expectations for familial care resulted in uneven public assistance, so Japan provides universal pensions and health insurance but very little if any other social services (Izuhara, 2002). Moreover, while it used to be typical for adult children and parents to co-reside throughout the parents' old age, older adults are increasingly living by themselves in couple or single households until they need care (25% in 1998; Izuhara, 2002; Takagi et al., 2007).

Although most older adults (85%) in Japan live in homes that they own, it is possible for two generations to purchase a home together with an extended mortgage period (Izuhara, 2002). Also, a new type of public housing, the three-generation home, features two living rooms (Izuhara, 2002). In 1984, Japan began giving a tax credit for intergenerational households and gave special “tax concessions” (p. 68) for building or remodeling because of intergenerational needs. The practice is changing somewhat, but the tradition of the family home makes it the least likely used asset to finance elder care (Izuhara, 2002).

As of 2001, in Japan, 58% of adults over 60 co-reside with their children (Takagi et al., 2007). Researchers examined determinants of three patterns of residency of older adults in relation to their adult children: non-co-residence, lifelong co-residence, and boomerang co-residence (parents moving in with children, or vice versa, after a period of non-co-residence); however, because their subsample was nonrepresentative

and was generally healthier than the representative sample from which it had been taken, the experiences and prevalence of the non-co-resident (including those who were institutionalized) may have been underrepresented (Takagi et al., 2007). Those who were boomerang families (12.7%) tended to move in together again after a critical event, such as widowhood or acute illness, and were more likely to be found in regions with strong cultural norms of traditionalism. Surprisingly, those who were lifelong co-residents (44.7%) tended to be less traditional in their attitudes. The authors speculate that this may be because they had been living traditionally and the issue may be less salient than for those who may feel that they transgressed traditional norms and thus need to espouse them more strongly. Forty-two percent of the sample did not co-reside with children. Homeownership by older adults, availability of larger homes, and stronger local economies predicted co-residence among both co-residing groups, suggesting how structural factors and related policy influence family practices.

Residential Care

Municipalities cover 90% of the cost of long-term care insurance for everyone in Japan over the age of 40. Persons aged 65 and older needing care, or their providers, can apply for subsidies that support home-based or institutional care (OECD, 2005b). Individuals are assessed according to six levels of need, which determine the amount of funding. The majority of older adults who applied for long-term care provisions (over 73%) received home care services. One option that municipalities may incorporate as a feature of care is a cash allowance for family caregivers who do not use community long-term care services and provide higher levels of care (i.e., fourth level or above out of the six levels).

There is an increasing number of public and private large-scale nursing homes throughout Japan, as well as group homes and assisted-living complexes (Jenike, 2003). However, the availability of subsidized residential care facilities and services varies depending on the tax resources of an area and the foresight of local social welfare administrators. Typically, demand is higher than supply, particularly in high-density areas such as Tokyo. According to Jenike, in every district in Tokyo, the age of the caregiver, health status of the older care recipient as judged by the social welfare office, and household structure are taken into account in allocating these scarce resources. If an elder is accepted into the social welfare program, there are often 2- to 4-year waits for nursing homes within Tokyo wards and cities. In more sparsely populated rural areas, placements within federally subsidized nursing homes are more readily available.

Norway

Housing policy in Norway has changed since the 1980s from social-democratic to a “liberal welfare regime [featuring] market economics, low public expenditure, and subsidies for small, targeted groups” (Stamso, 2009, p. 194). Welfare states are supported by four pillars—health care, education, pensions, and housing—but housing is the most susceptible to the market because people buy and sell housing rather than the state providing it (Stamso, 2009). Prior to 1985, the Norwegian government actively

sought to replace market conditions with state intervention (Stamso, 2009). Moves from an increasingly conservative government in 1984 and 1985 led to the deregulation of credit institutions and housing markets (Stamso, 2009). Unlike many other European countries, homeownership has historically been the norm, because Norway has been characteristically rural and without an aristocratic culture (Stamso, 2009). The Norwegian State Housing Bank began in 1946 and has financed up to three-fourths of housing construction. The Concession Act of 1974 has influenced the character of communities in Norway. For example, it established residency requirements so that homeowners in rural areas either must live in the home or rent the home. This was meant to stop people from purchasing a second home in the country and in effect creating urban bedroom communities.

Norway has the goal of homeownership for most people with three policy strategies: keep interest rates low and stable to promote a healthy housing market, ensure housing access for disadvantaged peoples, and encourage the development of environmentally sound and universally accessible housing and neighborhoods (Norwegian Ministry of Local Government and Regional Development, 2004). In anticipation of the aging population, the Norwegian State Housing Bank encourages universal design by adding these design criteria for loan applications. It also makes home modification loans to promote aging in place.

Residential Care

Norway follows the so-called Nordic model—as do Finland, Sweden, and Denmark—in which public services strongly promote aging in place and independence by providing in-home formal services when needed (Meeks, Nickols, & Sweaney, 1999). Moreover, Norway is known for its efficient and affordable public housing (Meeks et al., 1999). Family care is less prominent in Norway than in some other countries, but publicly supported programs such as adult day care and respite care help the many families that do provide informal care (Meeks et al., 1999). In Norway, there was a growth in assisted-living-type housing during the 1980s and 1990s (Meeks et al., 1999).

In Norway, approximately 50% of older people with dementia live in the community, mostly with family members (Norwegian Ministry of Health and Care Services [NMHCS], 2008). In 2007, the government declared that municipalities needed to prioritize day programs and home services to help independent living and provide respite to families involved in caregiving. Day programs may be offered at the homes of community-dwelling elders, at nursing homes, and at day care facilities. Moreover, there is increasing focus on making nursing homes and assisted-living facilities more amendable to the needs of those with dementia. The Norwegian State Housing Bank provides grants to such facilities to make living spaces smaller and more communal, with easy access to outdoor spaces (NMHCS, 2008). The primary aim is to change institutional housing to meet the needs of those with dementia, who compose around 80% of residents, as suggested by research findings. Some of these findings suggest that people with dementia have a higher quality of life when they do not change facilities, when they are in smaller spaces, and when they are served by professional staff members who understand dementia.

Though Norway has a reputation for its aging-related services, such as home care, the reality is that much of home care still depends on help from informal carers (Fjelltun, Henriksen, Norberg, Gilje, & Normann, 2009). Moreover, if an elder or his or her family decides to make the transition to a nursing facility, the elder must pay between 75% and 85% of his or her income for these institutional services. The transition process begins with a home nurse or family member requesting nursing home placement. Then, an assessment of the elder's care needs is made, and the result should be that the person gains admittance to a nursing facility. However, in most instances, older people are placed on a waiting list before entering the nursing home.

Switzerland

Most people (65%) in Switzerland live in rental housing dominated by the private market (Lawson, 2009; Van Wezemaal & Gilroy, 2007). Although older persons in their 60s and 70s who wish to move into care homes can afford them, the oldest old (over 85) are at risk for poverty and often cannot afford the care they need (Van Wezemaal & Gilroy, 2007). The three-pillar retirement system (state responsibility, individual responsibility, and employer responsibility) went into full effect in the 1980s and is based on a liberal market economy; however, the oldest old in Switzerland may be vulnerable, since they did not plan for the three-pillar organization of benefits that depends on employer contributions (Lawson, 2009; Van Wezemaal & Gilroy, 2007). Medical and social services, collectively called "Spitex," are increasingly merging in Switzerland and are organized at canton (the regional) level and facilitate aging in place. Forty-four percent of Spitex customers are 80 years old or older (Van Wezemaal & Gilroy, 2007). Services are a mix of public and private and are paid for by private insurance or out of pocket. Older adults occupy cooperative housing at a higher rate than other forms of housing because they typically facilitate aging in place, unlike tenants who live in flats that are ill-equipped for an aging population. Van Wezemaal and Gilroy (2007) contend that landlords who are participating in the market economy do not see profitability in producing age-friendly flats, and therefore, there are few.

Public support for nonprofit housing has been intermittent in Switzerland, peaking at affecting 20% of households in 1992 to 1993 (Lawson, 2009). Cooperative began in the 19th century as a result of social housing policy arising from the labor movement response to deplorable living conditions during the Industrial Revolution. Instead of being managed by the state, however, most cooperative housing was run by particular labor enterprises (including public utilities) for their workers, such as the Swiss National Railway (Lawson, 2009). Cooperative policy attracts families and older people, and some places feature medical consultation rooms, day care facilities, fitness rooms, and studio space (Lawson, 2009).

Residential Care

Long-term care in Switzerland generally refers to home care. About 93% of home care organizations are nonprofit and private, which meets the conditions to receive government subsidies (OECD, 2005b). Historically, long-term care was a part of

post-hospitalization and rehabilitation policy and has only recently emerged as an issue in its own right (OECD, 2005b). All citizens have health insurance, but the costs of long-term care are supplemented by public financing. Depending on municipality, sometimes clients receive tax breaks; other times, there are direct payments to the care provider or client. Private long-term care insurance is risk-based and therefore cost prohibitive, especially for aging women.

Spain

Housing policy in Spain is governed at the national level, the regional level (Autonomous Communities), the provincial level, and the municipal level (Gomez Jimenez & Koebel, 2007). Essentially, the national level provides money and general policy under the Spanish Housing Ministry, which was established in 2004, while the Autonomous Communities and their municipalities coordinate and implement policy on a local level. For example, all Spaniards have the right to “decent and adequate housing” (p. 27), though individuals cannot enforce this right; rather, it is a goal of the state. One plan that the Spanish government has to meet this goal is to subsidize homeownership rather than rental property. For example, the goal of the Spanish Housing Project (2005–2008) was to provide housing funding for disadvantaged groups, such as older people and those with disabilities; how it was implemented depended on the Autonomous Communities. Implementation included housing development for first-time buyers, renovating to facilitate accessibility, and redeveloping urban centers. But too often, services that affect housing, such as home help or other long-term care services, are not well-incorporated—or incorporated at all—into housing policy. Moreover, because the government is decentralized, the opportunities available from policy enactment in one region may be different from those in another region. Another type of policy that affects older persons is policy directed toward people with disabilities, which often makes explicit references to aging, such as the Spanish Disability Act and the National Plan for Accessibility (2004–2012). Such plans recognize that most people want to age in place or be cared for by family members and stress using funds to improve accessibility.

In the 1990s, 95% of older adults in Spain were community-dwelling, living in their own homes or in the homes of family (Rojo Perez, Fernandez-Mayoralas, Pozo Rivera, & Rojo Abuin, 2001). In 2001, 84% of all households were owned, with or without a mortgage (Population and Housing Census, 2001). Older women were more likely to live in their children’s homes or alone, highlighting women’s longer life expectancy; the age composition of homes where older men were present tended to be younger (Rojo Perez et al., 2001). In 1994, the Urban Letting Act affected the 13% of older adults in Madrid who rented homes (Rojo Perez et al., 2001). Until this Act, rents were fixed and contracts were automatically renewed and extended even to adult children; now, landlords can ask tenants to sign revised leases, which often ask for increased rent (Rojo Perez et al., 2001). Since this time, rentals have decreased by 3% from 1991 to 2001, though this follows a general pattern in Europe—and Spain in particular—of increasing homeownership (Population and Housing Census, 2001; see

also Pareja Eastaway & San Martin Varo, 2002). Before the 1994 Act, there were similar measures in 1964 and 1985 (e.g., the Boyer Decree), but it wasn't until the 1990s that the deregulation of rental properties was clearly spelled out (Pareja Eastaway & San Martin Varo, 2002). However, rental contracts signed before 1964 still feature controlled rents and compulsory renewal for landlords, which means that older adults who have lived in the same rental home for decades may have very low rents based on their income (Pareja Eastaway & San Martin Varo, 2002). Gomez Jimenez and Koebel (2007) point out that these rental properties are notorious for their poor conditions and for the land the buildings rest on being far more valuable than the buildings themselves. Of the 14% of available rental property, only 8% was subsidized public housing (Pareja Eastaway & San Martin Varo, 2002).

Spain has a history of legislation that discourages rental development and encourages homeownership. The average number of bedrooms in family dwellings is five, with only about 12% of homes having three bedrooms or fewer (Population and Housing Census, 2001). There are three times as many women over 65 living alone than men over 65 living alone. Of the European Union countries, Spain and Portugal are the countries with the highest average number of persons per household; however, for those who are 90 years or older, 10% live in institutions, more than 25% live alone, about 44% live with someone of another generation, and 20% live with someone their own age (Population and Housing Census, 2001).

Residential Care

Although most elderly people in Spain live independently, those who are dependent typically live with a family caregiver; only 3% of elderly people rely on institutional or nursing home care (Rodríguez Cabrero, 2002). Older adults' reliance solely on family care is likely to decline with current demographic shifts. Specifically, Spain is experiencing

- a. a decline in the number of women available to provide care at the same time as there is a growing number of elderly dependents,
- b. a dramatic change in the traditional model of family because of growing rates of divorce, and
- c. a change in the social role of women related to increased labor force participation that decreases their availability and the amount of time available to provide care (Rodríguez Cabrero, 2002).

The Spanish long-term care system is highly decentralized and can be characterized as a system of regional long-term care services (Costa-Font & Patxot, 2005). It is financed mainly through taxes and, to a lesser extent, copayments and charges (Comas-Herrera et al., 2006). In 2007, a marked change in Spain's long-term care policy began with the implementation of a national long-term care system. Changes will be implemented gradually, with full operation expected to be reached in 2015 (Costa-Font & Rovira-Forns, 2008). Previous to this system, long-term care was means tested and only the poorest

people were able to get support for home services or institutional care. One of the chief characteristics of the “modern” Spanish state is its decentralized political structure (Costa-Font & Rovira-Forns, 2008, p. 22). There are 17 Autonomous Communities in Spain that will design their own specific policies to address perceived priorities while maintaining a basic long-term care system for the whole country.

Summary

Housing and long-term care policies are inextricably intertwined with overall governmental edicts and cultural values regarding who is ultimately responsible for the safety and care of older adults. Countries offer very different late-life housing options and support depending on whether tradition dictates that the national government, states/municipalities, or family members should shoulder primary responsibility for the long-term well-being of aging citizens. Political governmental leanings and societal belief systems also influence which older adults are deemed eligible for assistance in maintaining their homes, alternative housing, and long-term residential care. In some locations, a range of supports are available to all older adults, while other countries have policies and programs that target only the most vulnerable of aging citizens (i.e., those living in poverty, the oldest old, the sick and frail). What became apparent as we reviewed existing systems, however, is that most nations, regardless of ideological framework, are faced with the reality that their traditional systems of support are breaking down under the weight of population aging. Systems dependent on values of filial responsibility and care are seeing both demographic and cultural shifts that undermine the stability of family safety nets. Conversely, systems that rely heavily on public funding may potentially collapse under the financial burden of an expanded older population.

There is agreement across many nations on one particular issue of residential support and care in late life: It is crucial to find creative ways to support adults *aging in place* whenever possible. That is, for older adults, staying in their own homes and communities is the best option—economically, socially, physically, and emotionally. Even in countries with strong public systems of support, the large majority of late-life care is provided by informal family caregivers. Thus, the question remains—what’s the best pathway for stabilizing lives of older adults in the community, and who is most responsible for ensuring the success of this process? The countries discussed in this chapter have developed a wide range of initiatives to support affordable housing and feasible in-home care in late life, including public and subsidized housing options, assisted-living options, and insurance schemes for long-term residential care. Although support programs differ considerably across countries, they all face two key challenges when trying to implement their unique systems of residential support—severe within-country discrepancies in regional programming and resources and generational decline in family support systems. Other factors that must be considered in any discussion of housing policies designed to support older adults include socioeconomic and class differences, rural/urban divisions, and the tensions between traditional and current societal values and norms.

For More Information

1. Assisted Living Federation of America (ALFA)
<http://www.alfa.org/alfa/Default.asp>

ALFA is the largest national association exclusively dedicated to professionally operated assisted-living communities for seniors. It works to influence public policy by advocating for informed choice, quality care, and accessibility for all Americans.

2. Australian Housing Urban Research Institute (AHURI)
<http://www.ahuri.edu.au/>

This institute is dedicated to drawing together researchers, policymakers, the industry, and the community to achieve better housing market outcomes, to achieve an effective and efficient housing assistance program, and to build viable communities. One of its primary research themes examines how to integrate housing assistance with other care and support programs to improve overall outcomes for older adults.

3. Communities and Local Governments Ministers
<http://www.communities.gov.uk/corporate/>

*This government entity in the United Kingdom works to create thriving, sustainable, vibrant communities that improve everyone's quality of life. Among its publications is *Lifetime Homes, Lifetime Neighbourhoods: A National Strategy for Housing in an Ageing Society*, available at http://www.communities.gov.uk/publications/housing/lifetimehome_sneighbourhoods.*

4. The European Center for Social Welfare Policy and Research
http://www.euro.centre.org/broschuere_engl.pdf

The European Centre provides expertise in the fields of welfare and social policy development, particularly in areas that require multi- or interdisciplinary approaches, integrated policies, and intersectoral action. Long-term care and personal social services is one of their primary research areas.

5. WHO Age-Friendly Environments Program
http://www.who.int/ageing/age_friendly_cities/en/index.html

The Age-Friendly Environments Program is an international effort by WHO to address the environmental and social factors that contribute to active and healthy ageing in societies.

Mrs. C., age 96
Greeley, Colorado, United States

I was born in Mystic, Iowa, in 1914. My grandfather was a Methodist minister. My dad served in WWI, and when he came home from the war, he worked in a coal mine office; he also had a small office where he edited a newspaper. He also worked in the oil business in Wyoming and worked in Utah as a deputy sheriff. My mother was a clerk and post mistress for the post office, did laundry and ironing for different companies. I had two brothers, one born in 1926 and one in 1920. I graduated from high school as a Salutatorian. I wanted to go to college, but I wasn't able to. But even though I didn't go to college, I feel like I got a lot out of life by just living it.

I've been married twice, once in Cleveland, Ohio, when I was 19. We kept it secret for a year because we didn't have the resources to set up a house, because this was during the Depression; so he lived at the YMCA, and I lived at the YWCA. We had a son, who is now 70 years old. I divorced in 1939. People didn't get divorces then, and so that was kind of a stigma. . . . I felt very bad about that. I met my second husband, who was a school teacher, and within 6 weeks after I married him, he was off to a WWII boot camp! That was a fast romance, but it lasted 53 years. I have a daughter from that marriage, who lives here in Greeley. I have grandchildren and great grandchildren. I see them all quite often.

My typical day? I live here in an independent living apartment, but they serve three meals a day. You don't have to be there for the meals, but it is an important part of the day for people who don't take part in activities. I participate in a drawing class, spelling bee practice and contests, exercise classes 5 days a week, and we have walks. I belong to PEO [a nationwide organization that promotes education], and we have meetings twice a month. I have been doing some dancing, too. For our talent contest, I learned how to do the River Dance. I won the talent contest! We have a nurse that comes and does pedicures and nurses that come and take our BP. We have a beauty shop and a bus that goes Monday through Thursdays that will take you to your doctors. On Thursdays, we go to Wal-Mart, and that is an expedition! They are always providing some kind of musical program. If people would just go to them, they would be busy every day. Some people come here and shut themselves up in their rooms, and that is too bad. I thrive on people and just have to be around people. I go to church every Sunday. My faith has been a help to me—a great source of strength to me. It has helped me through a lot of bad spots. The church has been a very important part of my life.

My daughter, who is a wonderful help, helps me if there is anything I need to do. I just moved here not too long ago, and it was very difficult. I lived in my house in Nebraska for 35 years. I really dug my heels in several times. . . . Finally, my children told me that "Mother, you have a decision to make because you can't move back into your house all by yourself." I knew they were right, but I didn't want to admit it. But I finally said okay, I will go, and I will be happy, but I don't want to go. It was like pulling a big tree out of the yard by its roots!

My health is pretty good. I have macular degeneration, and my hearing isn't great, but I have hearing aids that help. I have some aches and pains, but when I went to the doctor, he told me, "For 96 years, I think you are doing remarkably well!" I have rheumatism and congestive heart failure. I take five pills a day, and three are vitamins.

I do receive a Social Security check every month, which is based on one's working income. I get a small pension because my husband, who was a teacher, wasn't paid very well. I paid into Social Security when

I was working in Cleveland at a department store, and when I was in Wyoming, I worked at a feed mill in the office. My pension isn't adequate for my needs. It's \$1,065 a month. Out of that, they take your insurance. What I am living on here is what we accumulated over a lifetime—my savings. I also have a small farm that my husband inherited from his grandfather in Kansas. I would say the income from that varies depending on the crop, and it is about \$6,000 a year, but in some years it is nothing.

Medicare pays for my health care, and I have supplemental insurance that helps pay for the doctors. My supplemental insurance costs \$207 per month. I am grateful for that because I can go to the doctor and I don't feel like I have to scrape to pay for it. None of my insurance covers my glasses, dental care, or my hearing aids. I pay for all of this by myself, and my insurance doesn't cover it. I have another insurance program, Well Care, and it costs me \$30 a month, and that covers my prescription. It cuts the cost of each pill to \$4 a month.

I have someone that works here that comes in and does light housekeeping for me. I do have a Long-Term Care insurance that I pay for every month, but it doesn't help with the costs of this place because it is independent living. I don't know if it would cover any costs if I needed additional nursing care while I was living here.

How do I feel about growing older? Well, I don't know. I got to 96 just day by day. . . . I don't know how I got here! I know I can't do the things I did when I was 16, but I do what I can. Some people say growing old is hell, but it really isn't. It is all in how you look at it. I just do it day by day. People are very nice to me, . . . my friends here, the people that work here. What I dislike about my age is that my eyes and ears are not like I would like for them to be. But there is nothing I can do about it. So I might as well accept it, as there are some things that are inevitable. So I try to work around them. I look forward to seeing my grandchildren and participating in their lives. I got to thinking about what I would like to leave for the kids, and I wrote a kind of legacy for each grandchild, which I hope they will appreciate when they get older. I had to do something. I am so privileged to know my grandchildren, because many people never get to know their grandchildren.

My advice about growing older is something I have been doing all my life—do exercise; keep those muscle and joints active, even if you are working. It is so important. I have always done that. At age 7 or 8, I found a magazine called *Physical Culture*—it was all poses, stretching. I have always done that. The body was made to move; you have to keep going. I was fortunate that I found that magazine. But all my life I have done that. Just keep active and keep your mind active.



Duilio, age 88, Italy



Mrs. U., age 82, Netherlands