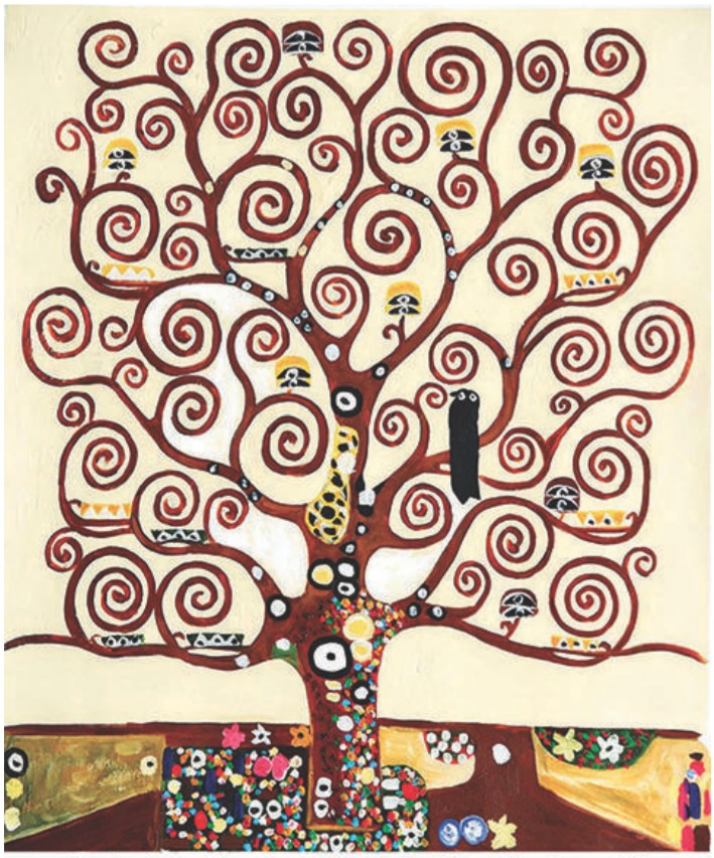
Saffier Residentie Group: Dementia Care Philosophies

Interview with Roland De Wolf



Based on Gustav Klimt, Tree of Life, Stoclet Frieze, Lebensbaum, 1905

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ACCESS Health Sweden

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Introduction

As part of my studies of good practice in elder care, I decided to spend a couple of weeks in The Netherlands. Many healthcare professionals in Sweden regard The Netherlands as a country that promotes innovation. I wanted to explore the innovative mindset that healthcare professionals in Sweden seem to associate with The Netherlands, learn about the Dutch healthcare system, and visit a few internationally recognized elder care groups.

I was amazed by what I saw in The Netherlands. I will try to communicate some of the strongest elements of the organizations that I visited, and of the Dutch elder care system at large. I think it is safe to say that we all are looking for inspiring examples that can help us shape the future of our elder care systems. In my view, some of the Dutch organizations that I visited already embody what I would like to see in all elder care organizations in the future, such as personal freedom, a focus on wellness and wellbeing, and an environment that feels just like home.

Background

The Dutch healthcare and elder care systems provide universal coverage through healthcare insurance. All Dutch citizens are required by the Health Insurance Act to pay for private health insurance. The cost for private insurance ranges from one hundred and thirty to one hundred and ninety US dollars per month. The insurance companies must accept every applicant who applies

for insurance. Companies also contribute toward healthcare insurance for their employees. There is a parallel insurance system for long term care, including nursing homes and exceptional medical expenses such as extended hospital stays.

The Netherlands spend about fifteen percent of gross national product on healthcare, including elder care. Elder care comprises around eighteen percent of total healthcare costs. There have been a number of recent reforms to the payment system. Among them, elder care is now the responsibility of local municipalities instead of the central government.

There are almost seventeen million Dutch citizens, and sixteen percent of the population is sixty five or older. This number is slightly lower than the European average, with comparable figures in Germany and Italy at around twenty one percent. The population over the age of eighty in the Netherlands is expected to increase to around ten percent by 2050. As such, The Netherlands, like Sweden and many other countries, will have to think carefully about how to care for its aging population.

In The Netherlands, life expectancy is eighty three years for women and seventy nine years for men, resulting in an average life expectancy of eighty one years. The Dutch elder care system has traditionally been ranked as one of the best in the world by international researchers and academics. The system is based on the principle of solidarity and universal coverage. However, there are concerns about the increasing cost of long term and chronic

care as the population ages. The Netherlands are looking abroad for inspiration.

Lifestyle and Wellbeing Matter

I visited a number of different care homes, homecare organizations, academic institutions, and eHealth providers, as well as the University Medical Center in Groningen. Throughout my time in The Netherlands, I noticed that innovative groups all shared fundamental ideas upon which they centered the delivery of care. The organizations I visited focused on wellbeing, wellness, and lifestyle choices. They focused less on the medical aspects of chronic and long term care. These groups did not consider themselves to be part of the curative branch of the healthcare system. These healthcare professionals wanted to focus on patients' individual capabilities, freedom, autonomy, and wellness.

For example, the care homes wanted to provide a nice home environment, with home cooked meals, small groups, interior design choices, and a personalized care routine. The care homes focused on providing tasty food, the freedom to go to bed and wake up at will, and an exterior environment that feels just like the environment in any city neighborhood. The homecare organizations strove to provide assistance, but only when individuals could not manage on their own. The nurses look first at a person's capability to care for him or herself. Next, the nurses look to the neighborhood and what help neighbors might provide. Then the nurses reach out to relatives to see if they can be of assistance. As a final step, the nurses provide care.

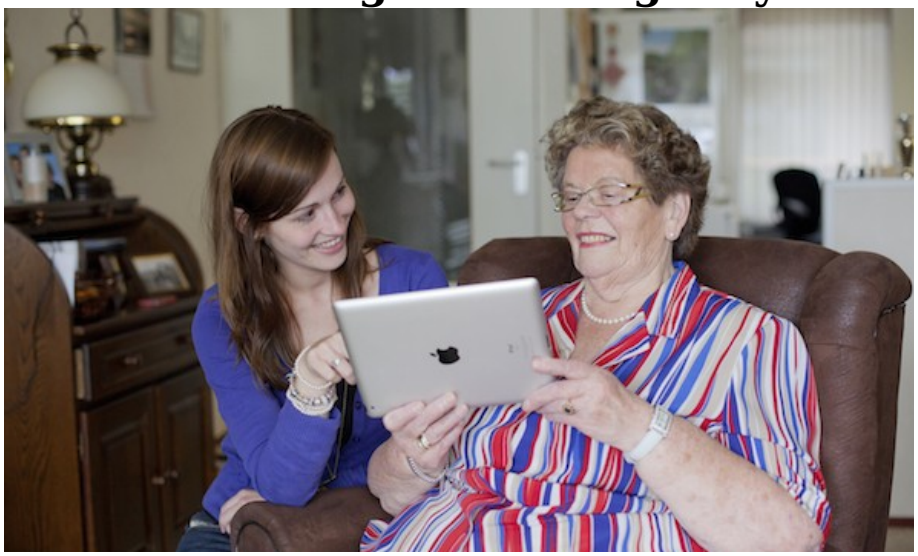
The nurses and assistant nurses in the organizations I visited were able to help individuals not only with the medical aspects of homecare, but also with personal hygiene and cleaning the house. Their goal is that the person who receives the care is happy and satisfied. As we all know, satisfaction and wellness can come from many different sources, not only by following a medical care routine rigorously. Satisfaction and wellness are also about how you feel in your home. For example, whether the flowers are watered or the garbage is taken out.

This boils down to is a different view of the role of nursing. Many times today, the most experienced and most senior nurses are promoted to managerial positions. The most experienced rarely see patients. The senior nurses manage assistant nurses and younger nurses. Some assistant nurses prefer to handle the more technical and medical aspects of homecare, such as treating wounds and distributing medication. Some nurses prefer to do this work to bathing patients, cleaning the house, and talking to relatives. In a way, the Dutch approach resembles what the district nurses did in the 1980s, when they assumed a holistic view of nursing.

The researchers and academics I met all considered autonomy and freedom to be critical elements of the elder care system. Throughout my conversations, the researchers focused on vitality, a word that they associated with the state of remaining alert and active, despite the bodily weakness that comes later in life. Vitality is not in inevitable opposition to aging, but accompanies aging when individuals alter their expectations and lead active lives based on

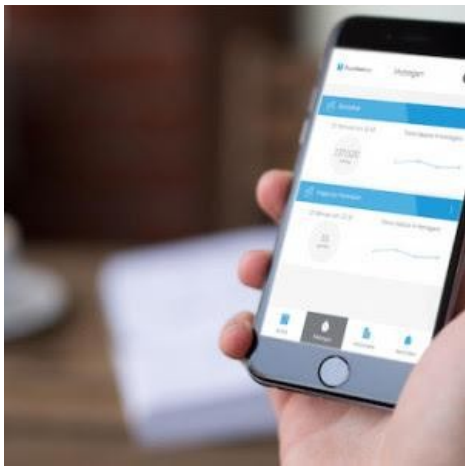
their physical and mental capabilities. Many aspects of elder care could benefit from more freedom, personal autonomy, and a focus on wellness and vitality.

Innovative Organizations: FocusCura and Dementia Village at de Hogeweyk



Learning to use the videoconferencing app on a tablet.

I visited FocusCura, an eHealth provider currently headquartered in the city of Utrecht. I met with Dr. Daan Dohmen, the founder and chief operating officer of FocusCura. Dr. Dohmen is a trained elder care nurse who completed his doctoral thesis on the adoption of technology among the elderly. He has built an eHealth technology company that currently provides two main software applications in elder care.



An app to monitor your healthcare at home.

The first is a video conferencing application that works with a tablet. The application allows individuals to Skype with their homecare providers, the doctors in the hospital, the general practitioner, any other healthcare provider, and relatives. The second application is a health monitoring device that helps patients manage illnesses such as chronic obstructive pulmonary disease, heart failure, and diabetes from their home. The application helps individuals collect their own health data and share it automatically with their providers. Both of these products have been rigorously evaluated and have received is a standardized European product certification. The software applications are classified as medical products.

Throughout my discussion with Dr. Dohmen, I was surprised to learn about the many different facets of technology adoption and the way that FocusCura has chosen to introduce technology into elder care. The company focuses on providing services to the elderly, but at the core of this work is personal autonomy and freedom. Many other organizations

provide standardized homecare with little room to choose what kind of services and what kind of assistance you want. With the help of the applications, individuals can choose with whom they want to videoconference and what type of care they want. For example, individuals can choose whether they want an in person visit with the doctor or a digital visit. Individuals pay the same price through their insurance policy for videoconferencing as they would for an in person visit to the doctor. Many choose to receive blended care, a combination of digital and in person care.

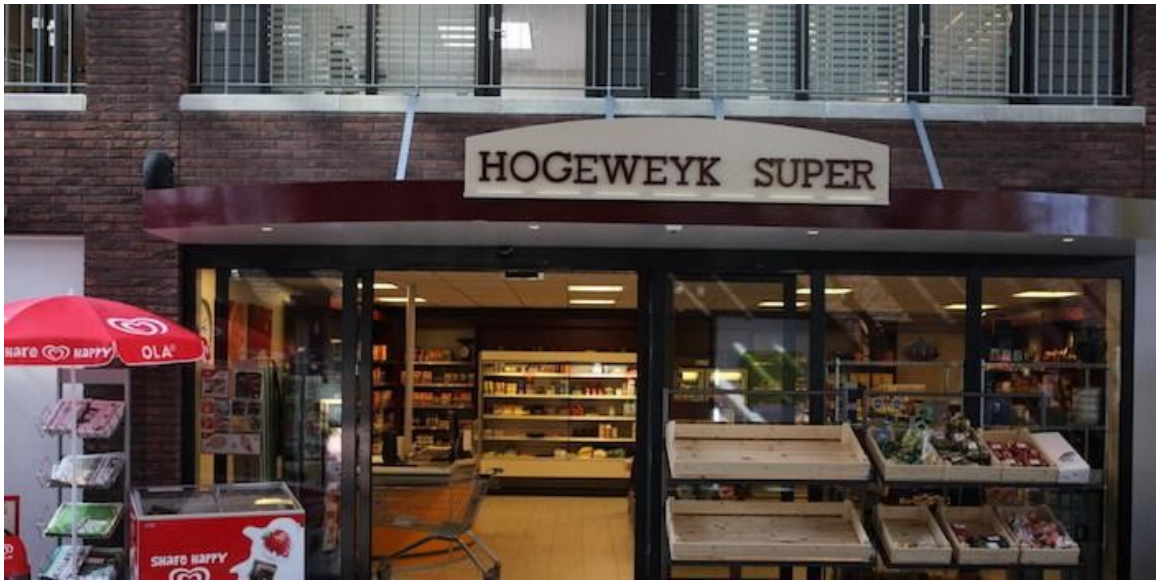
This application provides freedom for individuals who receive homecare. This is a flexible model: If you want to see your nursing provider, you can do so. If, for some reason, you do not want to see a doctor on a particular day, you can choose not to. Individuals can also add neighbors or relatives as videoconferencing contacts so they can videoconference with other people who matter to them. The Dutch insurance system reimburses videoconferencing, which is far from common in every country.

Dementia Village at de Hogeweyk.

I was also able to visit the famous Dementia Village at de Hogeweyk, in Weesp, about half an hour southeast of Amsterdam. This care home is constructed as a small, self contained village. Individuals who have been diagnosed with a later stage of dementia can live relatively normal lives here. The care home consists of smaller houses with six individuals in each house, a street with a shop, an activity center, a theater, and a grocery store. The village also includes restaurants, a bar, and many different gardens that surround the smaller houses. Inside the village, individuals are free to walk around. Staff dress in normal clothing. At the front end, the village is just a normal village. At the back end, de Hogeweyk is a nursing home with nurses and other healthcare professionals who deliver professionalized care.

I liked the atmosphere in the village. I sat down for a cup of coffee in the restaurant. I looked into the bar

and I saw the theater. The village attracts many volunteers from the city of Weesp. Many companies rent the theater for meetings and functions. Sometimes the village is full of people, just like a normal village. Other times, the village is quiet. This variation instills some normalcy into the everyday lives of the individuals who live there.



Grocery store at de Hogeweyk (Photo: Hans Erkelens)

Residents can stroll down the street and go into the grocery store to pick up whatever they like. There is no need to handle cash. At times, the lack of cash can be confusing, but it also simplifies matters for the residents. Each house has its own unique lifestyle. The lifestyle of the house can be city living, traditional living, or Indonesian living, for example. The small scale allows individualized care. Each nurse knows the residents quite well.

The nurse brings the residents to the grocery store to pick up ingredients for dinner. Later on, the nurse involves the residents in cooking. Such a simple

activity also ensures that life in the dementia care home still contains strong elements of normalcy. Residents walk outside and engage in activity when they go to the grocery store. Families testify that individuals who live in the village need less medical care and consume fewer medications.

The focus on activities is strong in the village. Each resident can sign up for one free activity, such as joining the classical music group. Many residents pay for additional activities. This approach cuts to the core of what de Hogeweyk is all about: maintaining your physical and mental strength by engaging in the normal everyday activities that you have enjoyed throughout your life. The managers of de Hogeweyk report that activities can reduce the need for rehabilitation services and prevent a range of medical illnesses, such as fall injuries. I was encouraged to see the amount of freedom, flexibility, and normalcy that the residents in the village could enjoy every day.

It is, of course, difficult to describe all of the impressions that I gathered while I was traveling around The Netherlands. I hope that I have been able to communicate some of the core principles and approaches that these groups have taken. Many elder care providers around the world work hard to provide person centered, individualized services. Far too often, resources are scarce, care needs are high, and staff turnover burdens care organizations. It is not easy to provide high quality elder care at an affordable price. I hope to communicate that achieving high quality and affordable elder care is possible, and that some of the organizations in The

Netherlands are doing just that. It will be my objective in the coming years to inspire others to look toward these innovative examples. I aim to help policymakers, practitioners, and community groups be inspired by these ideas and ultimately improve the quality of elder care. I hope that this research is the first step in that direction.

About Roland De Wolf

Roland De Wolf is chairman of the board of directors at the Saffier de Residentie Group. Since the 1990s, Mr. De Wolf has been focused on improving quality of life options in The Netherlands for elders and particularly the most vulnerable people, such as dementia care and brain damaged patients. The Saffier Residentie Group currently has eight homes where residents can live independent lives in the presence of trained elder care staff, as well as a medical rehabilitation center.

Interview

Sofia Widén (SW): How did you find your way into elder care?

Roland De Wolf (RD): After high school I started studying information technology. I am a very mathematical person, so I thought I had to go into information technology. I hated the work, so I started to study economics at Erasmus in Rotterdam. I first started working in healthcare when I took a job taking care of some disabled people. I realized I was not meant for economics. I had to do something in healthcare. I studied psychiatric nursing, then common healthcare and children's nursing. I also studied management. When I was twenty nine years old I wanted to work

as an interim manager in care centers in the Netherlands. Then I was asked to be the director of a care company here.

SW: Which care company was this?

RD: It was a very small house for elderly people. The Maison Gaspard de Coligny. It is connected to the church, the Wallonian Church, a French language church of the Huguenots, which is connected with the Kingdom of the Netherlands. My wife thought it would be good to work there because it was close to where we lived. I went there and it was half French speaking! I am a mathematics type, as you know, so languages are not my thing. Luckily, I had taken some French, so I managed it.

I started there with two projects in mind. One was to look at what happens to old people who do not live in nursing homes or service homes. The main problem is you are afraid to fall down, to break your hip. If you break your hip, that puts you in a nursing home. Many people also fear dementia. The worst fear of all is being allowed to die from neglect. We had to address the fears of elders and their families. I thought, “How do we resolve the fear?”

We started with what we call service packages. It means we offer services to people who live independently. For a small amount of money you receive several things. First, you can use the resources in the house. Second, there is a coordinator who knows you. Not a phone number, but a person who has visited you. She sends you a birthday card every year. You know who she is. She understands your situation. That is very important.

You can reach her seven days a week, twenty four hours a day. If something happens, you call. The third thing is insurance. If something happens and you cannot stay at home anymore, we have rooms here in this house. These rooms are always available. We guarantee that you will have a place in this house. That was the essence of the packages.

I always want to see if our projects are working, so we conducted an investigation with two universities, one in Utrecht and one in Amsterdam. We studied three hundred people who used our packages and three hundred people who did not. The results were remarkable. Over three years, the people who had the packages visited the doctor much less, almost thirty percent less, than the other group. They used less medicine. They even broke their hips less frequently. That was amazing. The system is all over the Netherlands now. It works.

The second thing I did was to make a difference in the way we subsidized care. In The Netherlands, care is subsidized as a total package, or it was at that time. You come in, you pay a variable amount of money to the government based on your income, and we receive an invariable amount of money as a care organization. It does not matter if you require a lot of care or not. The money is the same. I thought we needed a change. First, and this is very important, if something happens to you and you are unable to stay in your own home, where do you go: another house or a hospital with nursing care? There is a difference.

Fredrik Knoeff (FK): You do not necessarily know

who is taking you in and giving you a bed.

RD: It makes a big difference. What we did in this nursing home is we changed the system. We had to obtain permission from the government because our program did not fit into the law. So people started to pay rent and service costs. They had the choice of three packages at that time. That was 1993.

Next we said, “Your apartment is your apartment. Service is service. We have three levels of care packages. If you need help with this or that, you get fifty points to spend on extra services. Or one hundred points. Or one fifty. If you have medication and you have fifty points to spend, do you want us to bring it to you? Do you want us to clean your room? Do you want to call us?” The elders together with their families chose what they wanted for those points. If the care increased, it cost a little more.

We investigated the results over three years in this case as well. The results were equally impressive. The most important conclusion was that costs went down. If people are in charge of their own budget they spend less.

That was in the 1990s. Then we had a lot of mergers and finally became the Saffier Residentie Group. That was about nine years ago I think.

FK: How many organizations merged?

RD: The Saffier de Residentie Group now has ten locations. Eighty percent is nursing care, elderly care. We have some people with brain damage, young people suffering brain damage, and people

with Korsakoff Syndrome. We are number one in Korsakoff Syndrome treatment in the Hague. We do a lot of dementia as well. In fact, that is what we do most. We also do “intramural care,” as they call it now. I do not like the term.

SW: What does it mean?

RD: We have intramural and extramural care. Intramural is if you live in a care home. Extramural is if you live in your own house and we bring the care to you. There is a rift between the two in The Netherlands. The main question is always the same: How do you want to live? If you want to live somewhere else, you want to move to your own place, not to my institution where I take you on my grounds and my unit, where I am the doctor and you are my patient in my room. “And don’t worry,” I say to the family, “I will keep her alive.”

SW: Do you view the care home as a work place or a home?

RD: Exactly. That is an important distinction. So we made a change and we built houses with apartments. People rent an apartment. They have a high need for care, so normally those people would go to a nursing home. Here they rent an apartment and get subsidized extramural care. They use their insurance for the doctor, just like everyone else. That is something I need to explain a little bit. If you live in a nursing home in The Netherlands, your doctor is not your home doctor. It is the doctor of the institution, a specialist in elder care. So you only use your insurance if you go to the hospital or something. The rest—the doctor, the medicine, your

materials, treatment, physio, all the therapies—is all included in the nursing home package. It is the doctor and treatment stream of the institution where you are taken. What we did here is make the treatment extramural: you keep your own doctor. If there is a need for an elder care specialist, you can consult him. You use your insurance like everybody else. That is what we did in this house.

Quality of life for elderly people must not be confused with quantity of life. The older you get, the more risk there is. In Europe, we typically restrict your activities to alleviate that risk. If there is a risk of falling down and breaking your hip, you are given a walker. We do not question the quality of a life spent behind this walker. Quality of life brings risks. When we are young we accept risks. If you want to bungee jump, you know there is a risk. There is a risk every time you get in an airplane, but we do it.

What is the meaning of quality of life? If you go to an institution, what we typically do is take away those things that have quality for you. Homes usually take your big books, your pet, your social circle. We believe we should look at maintaining quality of life, and learn to accept some risks.

SW: How do you do that here?

RD: We have one group of twelve people in apartments upstairs. There are no treatment areas there, only the house. We have a group of dementia patients. We have a group for somatic diseases. We have a group of mentally disabled people, young people from eighteen to twenty five and a group of forty and older. We have a group of people with

brain damage, also younger. They all live together. They have their own houses. The houses are next to each other. Theoretically those houses are theirs, whereas the elderly residents can walk through the houses and floors to visit one another's apartments.

The house is full of information technology. It is not a problem for there to be only one night watchman. If someone leaves, there is a camera. You will see on your iPhone who is walking out of his apartment. We can even switch on the television in the room if we want. It has almost never happened. The doors are not locked. Anybody can walk away if they want, but nobody walks away. It has only happened once in the last eight years, when a person was lost.

So what we see is that if we put those people in normal houses with some security, their own houses, then they start to act differently. Families act differently. If you bring your mother to an apartment here, we say, "This is the apartment. You can rent it. It's yours." Then you start to put the bed in, the things in, what you want. We do not decorate your room. It is your house.

In the 2000s, the Netherlands started creating packages for living in a nursing home or an assisted living home. Now the lower service packages are not available anymore. You can only go to a nursing home or assisted living home if you have a certain level of care needs. We had ten packages. Now we have six. I think that was a good decision. People need to stay at home longer.

Do not build institutions. Never do it. Make homes for people who need care. Also, if you want the

market to invest in homes for elderly or disabled people then you must not subsidize it. That is the main thing. If the government subsidizes, then the market is uninterested.

SW: So what kind of subsidies would you take away in The Netherlands?

RD: I would take away two things: One thing is medical treatment in a special law for disabled or old people with comorbidity. I would take it away and replace it with the normal insurance packages. That will give you the opportunity to take only what you need. There is already a plan prepared for that. It will happen. Maybe not next year, because we have elections, but it will happen.

The second thing is living space. By law, institutional living is now paid for with a certain amount of money. The institutions in The Netherlands are very expensive. Their booking value is very high compared to their commercial value. So for instance, a room of thirty square meters in an assisted living home costs twelve hundred euros a month. That is not a social rent. Here in this building we maintain a social rent. Everybody can rent an apartment here because I do not build any treatment areas, physio areas, or offices.

My message is this: Never build institutions to be lived in. If you intend to treat there, like in hospitals or residential care centers, then just make sure the doctors are good because people want to go home as soon as possible. If people go somewhere to live for the rest of their lives, then it must be designed for living. It must be your apartment, your house where

you feel safe.

SW: You can stay there until you pass away.

RD: Yes.

SW: What kind of nurses and caregivers do you employ?

RD: That is a challenge too. When we started here the employees thought, “Okay we have two teams. One team takes care of the wellbeing of the house, housekeeping and things. They are in the house. The care comes like homecare to take care of you.”

SW: Was that outsourced?

RD: No. That was also a team of us from our company. Anyway, that was the system. It went wrong. After about six or eight months, the quality of care went down. Those people are welfare workers. They are very good at making you happy, but they do not notice if you have a fever or if something is going wrong with your health. You must understand that the people who live with us are elderly. It is not for nothing that they would have gone to a nursing home. So this is not good.

We decided the medical care team should be in charge in these houses. We put the medical care in charge, the nurses and the doctors. Within three months all the doors were opened. They made their own nursing office downstairs. They made a nursing home out of it. People started to complain. That was not the solution either.

FK: That is against your philosophy.

RD: Completely. Nursing people are used to efficiency. “We must be faster. We can run through the halls. We keep all the doors open.” So it was a nursing home. That was wrong. We made a competencies profile for ideal employees, then we started testing people on these competencies. About one third, almost half of the people we had could not work here. They were intramural persons, persons who need to work in an institution. They are good people, but not appropriate for this situation. We took them out, put them in other places, and put new people in.

SW: What were the competencies?

RD: There is a nice example I can give you. There is a lady who is ninety two. She is in a wheelchair. One morning she was downstairs and she said to one of the care people, “I would like to have cake with my coffee.” So the care person says to her, “Okay, there is the kitchen. We can bake a cake if you want.” The lady says, “Bake a cake? I am ninety two. You think I am going to bake a cake?” The employee says the right thing. She says, “Okay, then there is no cake.” That is it exactly. Everybody else would say, “Okay, I will bake a cake for you. You are ninety two. Stay there.” No. She says no cake, I’m sorry. Then the lady says, “Okay, I will help you.” She starts to bake the cake together with the employee. In the afternoon there was cake with tea with the other residents. The lady’s daughter was there. She complained to her daughter that she had pain in her arm because she had to make the cake, but the compliments of the other residents made her day.

Quality of life is connected with such worries. If I cannot complain about anything anymore because everything is okay and everything is nice and I am lying on my back in Hawaii on the beach, that might be nice for one week, maybe two. But then . . .

SW: You are bored.

RD: Exactly. You start to understand that complaining, having worries, is part of quality of life. When you take all the worries from someone's life there is no reason to live anymore. If you are older and you are depending on other people for care it is already difficult. To be unnecessary for society is one thing. Being unnecessary for your children or your family, or even worse being a problem for them, imagine how that feels.

SW: I think a lot of this is driven by fear of the media. In Sweden, if you have an incident, even if it is one person in ten years getting lost or spending two hours walking on the road, then the homes have a big media scandal on their hands.

RD: Us too. If one of the residents from this house runs in front of a train, you know what it will say in the newspapers: "Mr. De Wolf does not take care of his people."

SW: How do you communicate this to policy makers and the public?

RD: I give a lot of speeches about my vision for quality of life. Everybody my age says, "Absolutely, you are right." But if it is your mother who lives in my house and falls down the stairs and breaks her

hip or something, how do you feel?

SW: You are scared. You are angry.

RD: So what happens? Who is to blame? “My mother, why did you not put her in a chair? Why did you not lock the door to keep her from running away? Why?” That is the discussion about risk and quality of life that we need to have. We need a big attitude change toward accepting risks.

SW: Do you think we talk about this enough?

RD: No, not enough. I am trying. The Ministry has a program called Dignity and Pride. We are one of the members of that program. Our goal is to show that we can make this cultural change. It is a change of mind about disabled people and elderly people.

There is another important fact that we must keep in mind: in ten years, more than fifty percent of the people in The Netherlands will not be working anymore because of their age. That does not mean that this group has no economic potential. If you have your pension, you can do whatever. That is why there are so many older volunteers. There are many more possibilities for them. That improves life quality. If I say to one of the people here, “You have to bake a cake every week for the other elders,” that gives some meaning to that person’s life.

SW: So people need expectations.

RD: Yes. It makes use of the potential you have. Do not be afraid. Do not find an excuse. Someone is ninety two or someone does not know everything . . . We have a project here with children. After school

they come to the garden to grow vegetables and things together with our residents. The people with dementia in the electric wheelchairs have children saying, “Can we ride on your wheelchair?” “Yes, sure you can ride.” That is quality of life, but it also brings risks that we must learn to accept.

SW: How can you show through research that you provide a higher quality of life?

RD: We did three years of investigations and research with a research institute. We investigated three things. One thing was what happens to residents who live here compared to people who live in a typical care institution. What we saw is that quality of life is higher based on what they feel. They have more worries. “To be here, I have to take care of my money.” There was more complaining, but quality was higher. That was interesting.

SW: How do you measure quality?

RD: There are lists. Focus groups get together every three months to identify quality. We got together with groups from the other houses over three years. You need to measure quality over longer periods, otherwise you do not obtain accurate values. Only forty two people live here, which is too few for evidence based proof.

Professionally, it turned out to be no more or less work than working in a nursing home. A resident is not washed better or treated better by a doctor here than in a nursing home. It is the same. For the employees who work here, the quality of work is no better or worse.

The most important outcome was that the cost and the number of employees we need is twenty percent less than in a nursing home. That was really remarkable. At only forty two residents, we thought it must be more expensive. It is twenty one percent less expensive than a normal nursing home. Why is that? We think volunteers and the families are willing to provide much more here. Expectations for what you get if you rent an apartment here are different than what you expect if you go to a nursing home.

SW: The patients' social surroundings.

RD: Yes. People are coming much more often, taking care, and supporting their relatives because they do not have the expectation that we will do it for them. In a nursing home you bring your mother and the home does everything.

SW: Do the family members like it here?

RD: Yes. It is a very popular house. It is always full. Everybody wants to live here. When you see it, you understand. Do you want to bring your mother here or to an institution? The costs are low. Your living can be subsidized if your income is inadequate, so everybody can live here. It is not just for people with money. That is also important.

SW: You are improving the quality of care and you are lowering costs while you do it.

RD: Yes. That was important. It is called a government resistant program. No matter what the government does, it will always be useful. It has

value.

FK: Did you foresee that you would lower costs?

RD: No. We did not expect that. We thought it would be maybe a little bit more expensive than a normal nursing home, but with better quality. We increase quality of life. People are better off. The rest is equal to a nursing home. The staff is no better or worse, but the costs are much lower.

SW: I have heard this place described as a learning center. Can you explain that term?

RD: Of course. Basically, we learn from the mistakes we make or the things we did not think about. We write it all down and make a complete book from it. It becomes a toolbox containing three years of learning. What are the problems we are encountering? What have we changed? Do our changes work or not? That is what we call our learning evaluation. As a result, we are now making the same change in a classical nursing home and have thirty people from three different groups switched back to their home doctors: the Korsakoff Syndrome group, which is quite a heavy group, a group of younger brain damaged people, and a somatical group. Over the next three years, the whole institution will make this change. Here too, the whole change is followed and described by science.

SW: So the idea is to spread your concept.

RD: Exactly.

SW: What is your biggest challenge?

RD: To change people's attitudes about care. That is the biggest challenge. I spoke about it in Sweden one or two years ago. I tried to explain what I knew. The problem in Sweden is that everything is based on government, yet there are now commercial foundations. They see everything commercially. They see my company here as a commercial company. It isn't. It is subsidized. I explained that. They still do not believe it. They say, "No, you need profit."

FK: The Dutch system is special.

SW: You are a nonprofit.

RD: Nonprofit. Our profit is in quality of life, not money.

SW: You travel and give speeches, not only in The Netherlands but elsewhere.

RD: I try to. There is not much time for it now. Something else has happened, a mindset change in the United States. In the United States, you always have to be young, you always have to be beautiful. That is the culture. Luckily, there was recently a best selling book by Atul Gawande. Do you know the book?

SW: Yes. *Being Mortal*.

RD: It was great. In that book he describes the meaning of life exactly.

FK: There is another new book called *Disrupt Aging*. It is also contributing to the discussion of how to grow old and how we should view growing old as enriching instead of just a passing away.

RD: I think that is one of the challenges here. The other challenge is thinking about the countries who are far behind us and are now considering their elderly. If they start to build nursing homes, they are making the wrong decision. We should teach them what we have learned: Do not build institutions. Build homes where people can live with the problems they have.

SW: Is there a difference between individuals who suffer from dementia and those who suffer from a somatic disease?

RD: In fact there is not a difference. I will tell you why. With dementia you need to look at what you need. If you lose your ability to communicate or to live independently, then you need a secure area. You feel better if you are together with people who help you. My mother has dementia. She still lives at her home. I pick her up every day. She knows that. I come inside, she plays piano, and so it goes. It has worked for five years. She needs a steady, safe situation. That is her home, including her music room with the piano where she still plays everyday for at least four hours. It drastically improves her quality of life. But her short term memory is gone and she needs help too. Of course, there is a risk that she will fall or get lost, but going to a nursing home will take away her piano and musical life for the most part, which is so important to her. So I accept the risks. That applies to everybody. A safe situation is important, but always in relation to the quality of life and its risks. Let’s not lock up the elderly in a hospital and keep them alive as long as possible to let them suffer forever. Focus on quality

of life as experienced by the person and except the risks.

FK: You should not feel locked up.

RD: Exactly.

SW: Thank you for your time.