Care of Older People

History, other countries, the Dutch case, and what people already do themselves

J. Konstapel

Constable Research, Leiden, the Netherlands

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Abstract

This essay maps the care of older people. It starts with the oldest evidence of care and ends with the Netherlands in 2026. It compares the Dutch system with Denmark, Sweden, Norway, Japan, Germany, the United Kingdom and the United States.

Three findings stand out. First, the heavy care need is short. Severe limitation lasts about two years at the end of life. Before that lies a long period of chronic disease and light limitation. Second, the heaviest legal form of care is defined as presence, not as a medical act. Dementia and care without any diagnosis take 92% of the Dutch elderly-care budget. Third, many of the arguments that block care have no basis in fact. Older people are called "attached to their homes", but they move when suitable housing exists. Care at home is called cheaper, but at high need it is not.

People already organise much of the care themselves. Older people are often the helpers. What stops them is rarely the people. It is rules, money and land. The essay ends with six proposals and an annotated reference list.

Keywords: long-term care; ageing; dementia; loneliness; housing; mutual aid; the Netherlands; international comparison.

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1. Question and method

The question is simple. What is really going on in the care of older people? And what would solve it?

The research began with an article in NRC (Vriesema, 24 November 2026). It described how the word "nursing home" disappears from Dutch elderly care. That raised a wider question. Why do names, buildings and rules change so often, while the problem stays?

The research has one central theme. Some arguments block care without being true. This essay tests such arguments against data.

1.1 How the material was gathered

- Historical sources, from archaeology to Dutch parliamentary papers.
- Open data from Statistics Netherlands (CBS) and the National Institute for Public Health (RIVM), downloaded and recalculated in Python.
- Reports and reviews from the OECD, Eurostat, Cochrane and national institutes.
- Examples of initiatives by citizens in the Netherlands and abroad.

1.2 How bias was limited

The research used the Respondent–Judge protocol (Konstapel 2026). Separate "respondents" gathered claims with sources. Separate "judges" first gathered their own sources. Only then did they rate each claim. Twenty-five predictions were fixed and hashed before reading. Key numbers were recalculated with new code.

The round produced 153 claims. The judges rated 108 as verified and 45 as verified with corrections. None were refuted. The predictions scored 16 hits, 6 partial hits and 3 misses. Eleven of eleven recalculations matched.

The work was done with AI assistance (Claude, Anthropic). This brings a known risk. Respondents and judges were the same kind of model, so they may share blind spots. Zero refutations may also mean the judges were mild. The author acted as the human reviewer. Section 11 lists further limits.

2. A long history of care

Care of the old is older than our species. The forms change. The underlying patterns repeat.

2.1 Before writing

- **Dmanisi, Georgia, about 1.77 million years ago.** A *Homo erectus* man lost all but one of his teeth years before he died (Lordkipanidze et al. 2005). Some read this as group care. The authors are more careful. A toothless wild bonobo also survived for a long time (Surbeck et al. 2020).
- **Shanidar 1, Iraq, about 50,000 years ago.** A Neanderthal lacked a forearm, had a crushed eye socket and was nearly deaf. He still reached about 40 (Trinkaus & Villotte 2017).
- **Comparative anthropology.** Simmons (1945) studied 71 societies. Abandoning the old was most common in harsh climates, nomadic life and irregular food. Elsewhere, the old held knowledge, property and ritual roles.
- **The grandmother hypothesis.** Grandmothers who feed grandchildren may explain why humans live long after menopause (Hawkes; Kim, Coxworth & Hawkes 2012). Old age is then a contribution, not only a burden.

2.2 Ancient civilisations

- **Mesopotamia and Elam (about 2000–1700 BC).** Care was exchanged for inheritance. A childless person adopted an adult, or freed a slave on condition of lifelong service (Stol & Vleeming 1998).
- **Egypt.** The "staff of old age" was a son who took over his father's office. The father kept his title and income (Ptahhotep; Janssen & Janssen 1996). The first provision for old age was a role, not a place.
- **Athens (Solon, early 6th century BC).** Sons were legally bound to support their parents, unless the father had taught them no trade.
- **Rome.** Children were expected to care, but there was no enforceable legal duty (Parkin 2003). About 6–8% of the population was 60 or older.
- **Judaism.** The Mishnah made honouring parents a duty for sons and daughters. The Talmud describes Rav Assi, who cared for a mother with what reads as dementia, and later handed care to others. Maimonides allowed care to be delegated. This is an early precedent for outsourcing dementia care.
- **India.** In the *āśrama* system, the householder phase is followed by *vānaprastha*: handing over, advising, withdrawing. Old age is a change of role.
- **China, Han dynasty (206 BC – 220 AD).** People of 70 and older received an imperial dove-staff with privileges. At 60, tax and labour duties ended (Hulsewé 1987).

2.3 The first places for the old

- **Byzantium (4th–15th century).** The *gērokomeion* was an institution for the old. The name describes the act of tending. Constantinople had many; one founded under Emperor Maurice still existed in 1446 (Poulakou-Rebelakou et al. 2004).
- **Hippos-Sussita, Israel (late 4th – early 5th century).** A mosaic reading "Peace upon the elders" may be the first archaeological evidence of such an institution (Eisenberg et al. 2025).
- **The Islamic world.** Waqf foundations ran houses for the old and disabled (*dār al-ʿajaza*) next to hospitals. Seljuk deeds date from 1077–1308.

2.4 Europe and the Low Countries

- **Gasthuizen (13th century onward).** People bought a lifelong place with food and care: the *provende*. In effect it was a pension (Zuijderduijn 2015). The Bartholomeus Gasthuis in Utrecht (1367) is still in use as a care home.
- **Hofjes (almshouse courtyards, 14th–19th century).** The oldest is the Bakenesserkamer in Haarlem (1395). Leiden once had about 200, a quarter of all Dutch hofjes. Thirty-six remain.
- **England, Poor Relief Act 1601.** The parish cared for the old. Family was liable. The aim was to keep the old at home; few entered the workhouse.
- **The first Dutch nursing home.** Het Zonnehuis opened in Beekbergen on 24 April 1929, for chronically ill people who could not pay for care elsewhere.

2.5 Three forms that keep returning

Across continents and millennia, three forms of provision recur:

1. **Succession or role change.** The Egyptian staff of old age, the Indian *vānaprastha*, the Han pension at 60.
2. **Exchange or contract.** Mesopotamian adoption, the Athenian duty, the gasthuis provende, the modern pension premium.
3. **A place out of charity.** The gērokomeion, the gasthuis, the hofje, the nursing home.

Today's debate is almost only about the third form. The first two have largely disappeared from policy. They return, unnoticed, in what people do themselves (section 9).

A second pattern is a pendulum between home and institution. It is at least 400 years old. England 1601 favoured home. The 17th and 18th centuries built almshouses. The Netherlands built homes for the elderly from 1950 to 1975, then cut back, and closed residential homes in 2015.

3. The Netherlands, 1945–2026

Dutch elderly care went through eight periods. Each period has its own trend and its own cause.

Table 1. Eight periods of Dutch elderly care

Period	Trend	Main cause
1945–1965	From poor relief to a right to an old age; first homes for the elderly	Emergency pension 1947, state pension (AOW) 1957, housing shortage, end of the legal duty of children (1965)
1965–1975	Great building wave: 78,000 → 144,000 places	AWBZ 1968: the first collective long-term care insurance in the world
1974–1985	Growth stops	Policy note 1975: a 7% ceiling on places; cost control
1985–2000	Residential homes shrink, nursing homes grow	Substitution policy; Welschen Committee 1994; stricter assessment
2000–2012	Costs rise fast; housing and care separated	Budget ceilings lifted; care packages from 2010
2012–2016	Residential homes disappear as a category	Light care moved home (2013–2014); Long-term Care Act (Wlz) 2015
2016–2020	More money per resident; quality becomes a norm	Manifesto Borst & Gaemers 2016; Quality Framework 2017 (€2.1 billion)
2020–2026	From waiting lists to empty beds; staff becomes the limit	WOZO 2022; Main Agreement on Elderly Care 2025

Table 2. Institutional capacity, 1980–2005 (Ctg, Parliamentary paper 27 659-78)

Year	Residential homes	Nursing homes	Total	People 80+	Places per person 80+
1980	150,000	46,000	196,000	312,000	0.63
1990	140,000	52,000	192,000	428,000	0.45
2000	111,000	59,000	170,000	500,000	0.34
2005	105,000	65,000	170,000	548,000	0.31

Per person aged 80 or over, capacity halved between 1980 and 2005. The brake of 1975 is the hinge of the whole period. From then on, capacity no longer grew with ageing. Those who still got a place were older and sicker. The rest stayed at home.

Every change of name coincides with a change of funding. "Home for the elderly" belonged to the 1963 Act on Homes for the Elderly. "Residential home" came with the AWBZ in 1997. "Housing-with-care centre" came with the separation of housing and care after 2006. The word "nursing home" lasted only from about 1957 to 2010. In 2009 the nursing-home physician became the "specialist in elderly care medicine". The name follows the money.

On 1 January 2025, 131,096 people lived in a residential or nursing home (CBS). The number is rising again, as the baby boomers reach high ages.

4. Who grows old, and with what

4.1 How old people become

Table 3. Of 100 people who reach 65, how many are still alive at each age (CBS 37360ned, own calculation)

Year	Reaches 75	Reaches 80	Reaches 85	Reaches 90	Reaches 95
1975	73.7	54.1	32.4	13.8	3.6
2000	80.2	63.6	42.3	21.2	6.6
2025 (all)	86.9	74.9	56.7	33.1	11.5
2025 men	84.9	71.4	51.7	27.8	8.4
2025 women	88.9	78.4	61.4	37.9	14.1

In 1975, one in three 65-year-olds reached 85. Now more than half do. One in three reaches 90. Among women it is nearly four in ten. Being over 85 is now a normal old age, not an exception.

In 2025, 57% of all people who died were 80 or older (CBS). The Netherlands was the only EU country whose life expectancy in 2024 was below its 2019 level (−0.2 years; Eurostat).

4.2 How many years are healthy

The answer depends on the measure. That matters, because policy often uses the widest one.

Table 4. Healthy years from age 65 (CBS 71950ned, own calculation)

Measure, from age 65 (2025)	Women	Men
Remaining life expectancy	21.4	19.5
Years without moderate or severe physical limitation	14.6	15.3
Years with moderate or severe physical limitation	6.8 (1990: 9.7)	4.2 (1990: 4.5)
Years with severe limitation in daily activities	2.3	1.7

Three movements happen at once. Diagnoses expand: older people have a chronic disease for longer. Physical limitation is compressed, especially among women. And the period of severe limitation is short: about two years, at the end of life.

Those two years are close to the average stay in a nursing home: 853 days in 2022, about 2.3 years (ESB 2026). The heavy care need is a short final phase. Before it lies a long period in which people live with disease but function.

4.3 Disease by age

Table 5. Chronic conditions per 1,000 people (Nivel GP registry, 2015)

Age	≥1 chronic condition	≥2 chronic conditions	Mental condition
60–64	552	214	104
65–69	650	289	83
70–74	739	376	83
75–79	806	447	107
80–84	856	508	146
85+	890	533	223

Above 85, 89% have a chronic condition and 53% have two or more. Mental conditions rise sharply after 75. Multimorbidity is the rule. Care organised per disease does not fit old age.

4.4 What older people die of, and what limits them

Per single condition, dementia is the leading cause of death among people aged 65 and over: 17,841 deaths in 2024. That is twice the number two, stroke (8,820). Falls, mainly, caused about 7,300 deaths. In 2025 falls caused more than 7,800 deaths, three quarters among people of 80 and older.

What limits older people is something else. Years lived with disease are driven by kidney failure, COPD, back pain, heart disease, diabetes and arthritis. Worldwide, poor sight, poor hearing and pain weigh heavily (GBD 2019).

4.5 Where the money goes

Table 6. Health costs per person and share of dementia and "not yet assignable" care, 2019 (RIVM Cost of Illness)

Age	Cost per person	Dementia	Not assignable	Together
65–69	€7,193	5.2%	14.3%	19.5%
75–79	€12,078	17.1%	19.8%	36.9%
80–84	€17,699	28.0%	25.4%	53.4%
85–89	€29,176	37.9%	31.5%	69.4%
90–94	€45,332	41.4%	37.3%	78.7%
95+	€63,958	38.4%	44.2%	82.6%

Within the elderly-care sector (€18.8 billion), dementia takes 49.2%. Care that cannot be linked to any diagnosis takes 42.5%. Together that is 92%. All known diseases together are almost nothing there.

This is a key finding. The heaviest care is not medical. It is care for frailty, old age and presence itself. That does not fit a diagnosis-based system. A caution: the split is an accounting allocation. Psychogeriatric care is booked as dementia.

5. The current situation in detail

5.1 In the nursing home

Access to the heaviest care is defined in law. A person needs "permanent supervision" or "24-hour care nearby" to prevent serious harm. The legal core is someone nearby who pays attention. That is not a medical act.

Table 7. Long-term care entitlements for nursing care, 1 April 2026 (Zorginstituut)

Profile	Description	Clients	Share
4VV	Sheltered living, intensive support and care	21,233	10.6%
5VV	Protected living with intensive dementia care	109,679	54.6%
6VV	Protected living with intensive care and nursing	50,182	25.0%
7VV	Very intensive care, emphasis on support	15,655	7.8%
8VV	Very intensive care, emphasis on nursing	2,902	1.4%
9VVb	Rehabilitation treatment	775	0.4%
Total		200,715	

More than half is dementia. Between 2018 and 2024, profile 4VV halved (23,000 → 12,000). Dementia (55,000 → 64,000) and severe physical limitation (24,000 → 35,000) grew.

The National Prevalence Measurement (2017–2024; n = 60,926) shows who lives there:

- Average age about 84; about 70% women.
- Residents on psychogeriatric wards: 45.7% in 2017, 53.3% in 2024.
- "Largely dependent": 32.6% → 43.9%.
- Pain: 34.2% → 42.7%. Urinary incontinence 20.5%. Malnutrition 16.2%. Falls 13.1%.
- Restraint fell from 30.3% to 17.1% after the Care and Compulsion Act (2020).

A resident receives about half an hour to an hour of hands-on care a day. Two thirds of that goes to washing, dressing, eating and the toilet. The other 23 hours are supervision, waiting and living. Little of that is measured.

What residents miss is life, not care (SCP 2017). Of those who could be interviewed, 54% felt lonely. About a third found it hard to find meaning. Thirty-six percent wanted to go outside more often. Two of the three barriers were not care problems: no transport (12%) and nobody to go with (12%). People with severe dementia could not be interviewed.

Eyesight is a hidden problem. In nursing homes, 41.3% have a visual impairment. Of that, 63% is avoidable (Sinoo et al. 2012). In a project near Den Bosch, only 17 of 210 referred residents were finally treated (Limburg et al. 2014). The bottleneck lies after screening.

5.2 At home

At home, the system runs on partners. Partners of people with dementia who live with them give 64 hours of care a week. The average across all carers is 39 hours (Nivel/Alzheimer Nederland 2022). Informal care precedes admission by 7.2 years on average (SCP).

Admission seldom happens because a medical act is needed. It happens when the partner breaks, or when behaviour becomes too hard to bear: wandering, night-time restlessness, aggression.

Older people are also carers themselves. Of people aged 75 and over, 15.5% give informal care, on average 24 hours a week. That is more hours than any younger group (CBS 2025). Of 65- to 75-year-olds, 54.7% do voluntary work.

Other parts of daily life:

- **Household help.** In the first half of 2023, more than 485,000 people received household help through their municipality. That is 27% more than in 2019. Many municipalities have waiting lists.
- **Mobility.** Four in ten people aged 75 and over did not go outside every day (2018). Of women over 75, 39% hold a driving licence, against 75% of men. About 151,000 people over 75 can hardly move about.
- **Fraud.** Incidents with fake police officers rose from 520 (2023) to 8,329 (2024), over 13,000 (2025) and 14,176 by October 2026. At least a quarter of those approached were defrauded. Victims stop opening the door, even to real police.
- **Digital life.** Daily internet use among people over 75 rose from 16% (2012) to 73% (2025). European targets for digital skills only measure people up to 75.
- **Loneliness.** Of people over 75, 7.6% are severely lonely and 33.9% somewhat lonely. Loneliness raises dementia risk by about 31% (Luchetti et al. 2024). It fragments sleep rather than shortening it (Kurina et al. 2011).

5.3 Housing

Single people over 70 have on average 81 m² per person. The national average is 55 m². An owner aged 85 or over has 97 m². Seventy percent of people aged 65–74 live in a family house. The growth in one-person households comes entirely from older people.

Half of people over 55 consider moving within two years, mostly to something smaller. More than seven in ten expect such a home to be hard to find (De Hypotheker 2024). Seniors do move when suitable new housing exists (Kadaster 2026). One in five people over 65 would rather live in a residential home now, but has no entitlement.

Supply falls short. The national target is 290,000 suitable homes for older people by 2030. In 2024, only 11% of the planned 36,250 homes for older people were built. For clustered and care-suitable homes, plans cover only 40–50% of the target. The government is now studying the reintroduction of residential homes.

5.4 The workforce

- Nursing, care and home care employ about 476,000–480,000 people. Of them, 31% are older than 55.
- The expected shortage in this sector is about 108,000 in 2034.
- Seventy-four percent of Dutch care workers work part-time (OECD 2025). That is a hidden labour reserve.
- Almost a third of working time goes to administration (CBS 2025).
- The mix shifts: level 3 carers fell from 41.5% to 34.0% of hours between 2019 and 2023. Levels 1 and 2 grew.

The law does not require a diploma for most of this work. Under the Dutch Act on Professions in Individual Health Care (BIG), anyone may perform care acts. Only 14 reserved acts, such as injections and catheterisation, need authorisation. Supervision, washing, feeding, company and noticing pain are not reserved.

5.5 Money

The Netherlands spends the most on long-term care of all OECD countries: 4.1% of GDP (2023). It long had the most long-term care beds: over 70 per 1,000 people aged 65 and over, against an OECD average of 46 (2019). At the margin of a nursing-home entitlement, admission is roughly cost-neutral (Bakx et al. 2020).

6. Arguments that block care without being true

This is the core of the research. Each argument below is used in policy or practice. Each is tested against data.

Table 8. Blocking arguments tested

Argument	What the data show	Status
"Older people are attached to their homes and do not want to move."	Half of people over 55 consider moving. They move when suitable housing exists. Only 11% of planned homes for older people were built in 2024.	Not true. The behaviour is forced by lack of supply.
"Care at home is cheaper."	At high need, institutions are cheaper in 12 of 22 OECD countries. In the Netherlands, admission at the margin is cost-neutral (Bakx et al. 2020). Reviews from Denmark and Sweden found no saving either.	Not true at high need.
"Care demand doubles; care workers do not grow with it."	This compares people with workers. The core demand is presence with dementia. Presence needs no diploma.	Compares unlike things.
"45% of dementia can be prevented."	This is a calculated upper bound that assumes causality. Mendelian randomisation finds no robust causal evidence for most factors. LDL reaches 7% through a broad cut-off that classes 76.5% of people as at risk.	A model result, not a measurement.
"Dementia is rising."	The number rises because more people grow old. The risk per age group fell 20–40% in thirty years. Part of that fall has no known cause.	Half true.
"Technology will save labour."	Telecare showed no fall in care use in a trial with 2,600 people. Robots go together with more staff.	Not shown.
"Loneliness is solved with activities."	Activities reduce social loneliness, not emotional or existential loneliness.	Partly true.
"Older people need care."	Older people are also the helpers: 15.5% of people over 75 give informal care, 24 hours a week on average.	One-sided.

A pattern appears. Many arguments measure what people say or do in a market without alternatives. They then read that as preference. Or they compare two different things, such as patients and diplomas. Or they present a model as a measurement.

7. Other countries and cultures

7.1 Denmark

Denmark stopped building nursing homes with its Act on Housing for the Elderly in 1987. Places fell from about 50,000 to about 5,000 (sources differ; one gives 15,400 in 2006). Housing and care were separated. Older people gained a right to a self-contained home and free home care according to need.

The family bond did not erode. Three quarters of Danish older people see their children at least weekly (Stuart & Hansen 2006). Since 1987, about 250–300 senior co-housing communities have been founded. Reablement began in Fredericia in 2007 and spread to almost all municipalities. Reviews on reablement are mixed.

7.2 Sweden and Norway

Sweden reduced admission to institutions by 34% between 1970 and 1985. Norway kept its nursing homes. Several Nordic countries cut 15 or more beds per 1,000 people aged 65 and over in ten years (OECD 2021).

7.3 Japan

Japan introduced long-term care insurance in 2000. Unlike cash-for-care schemes, this raised the paid work of family carers. Since 2015, Japan's main strategy against disability is the *kayoi-no-ba*: community salons run by residents. In Taketoyo, more than 10% of older residents attended (875 of 8,062). Observational studies link participation to less disability, about a third less dementia and more happiness.

Japan also developed *Fureai Kippu*, a time bank for care. Helpers earn credits they can save or transfer to a parent elsewhere. Older people preferred helpers paid in credits over helpers paid in yen. Growth slowed after 2000, and evaluation is hard (Hayashi 2012).

7.4 Germany

The Seniorengenossenschaft Riedlingen was founded on 9 April 1991 by 111 citizens. It later had about 800–900 members and around 450 people receiving help. It offers 68 small flats and runs day care. Helpers can save their hours and receive help later. Its own principle: voluntary work with a small payment, because unpaid goodwill alone gives no certainty.

7.5 United Kingdom

In Shared Lives, a person lives with or stays with a family that supports them. In England it served about 12,800 people in 2020, about 10% of them older people. The regulator rates 97% of schemes good or outstanding, against 83% for the whole sector. Evidence on outcomes for older people is limited. In Homeshare, a young person lives cheaply with an older person and helps in return. Both report benefits: less loneliness, cheaper rent.

7.6 United States

Beacon Hill Village in Boston was founded by older people themselves. Villages grew from 35 in 2010 to about 190 in 2016. About 40% of members help other members. The strongest effect is more confidence to age at home. Villages remain small: 35% have 50 members or fewer. PACE, a professional programme, showed higher nursing-home use and higher cost than comparators.

7.7 Australia and beyond

Men's Sheds began in Australia. Older men work together on crafts and repairs. Evaluations report less loneliness, better mood and more activity. The evidence is mostly qualitative.

Table 9. Selected models abroad and at home

Country	Model	Who carries it	Evidence
Denmark	No new nursing homes since 1987; right to own home; senior co-housing	State + residents	Policy outcome clear; cost saving not shown
Japan	Insurance 2000; kayoi-no-ba salons; Fureai Kippu	Residents, with municipal support	Observational, consistent
Germany	Seniorengenossenschaft (saved hours)	Members	Case reports
United Kingdom	Shared Lives; Homeshare	Families; young people	High inspection ratings; limited outcome data
United States	Villages; PACE	Members; professionals	Villages: confidence. PACE: higher cost
Netherlands	Care cooperatives; Knarrenhof; AutoMaatje	Residents	Case reports; no trials

8. What works: the evidence

The Respondent–Judge round sorted interventions by level of evidence.

Table 10. Proven interventions

Intervention	Effect	Source
Balance and functional exercise, tai chi	Falls −23% (RaR 0.77), high certainty	Cochrane 2019
Geriatric assessment at hospital admission	Nursing-home admission −20% (RR 0.80)	Cochrane 2017
Hospital care at home	Living in an institution after 6 months RR 0.53	Cochrane
Home modification, only at high fall risk	Falls −38%; no effect in unselected people	Cochrane 2023
Intensive support of dementia carers	Admission OR 0.66; effect fades	Spijker 2008; Mittelman 2006
Cataract surgery	Fall rate RaR 0.66	UK trial, n = 306
Person-centred care in nursing homes (WHELD)	Less agitation, better quality of life, lower cost	Cluster trial, 69 homes
Withdrawing antipsychotics	Little or no worsening of behaviour	Cochrane
Group interventions against loneliness	SMD about −0.25, moderate certainty	Meta-analysis 2024

Several popular interventions did not work on the stated outcome:

- Preventive home visits and proactive screening (including ISCOPE in Leiden and Embrace).
- Multifactorial fall prevention beyond fall advice (Cochrane 2026, RaR 1.09).
- Vitamin D in healthy older people.
- New glasses after eye tests in frail people: more falls (RaR 1.57).
- Telecare, respite care and day care: no delay of admission.
- Light therapy and melatonin in dementia.
- Sedatives and Z-drugs: harm outweighs benefit.

Some promising areas have not been tested well:

- Housing forms such as hofjes, the Knarrenhof, co-housing and Homeshare.
- Whether better sleep delays admission or dementia. Cataract surgery is linked to 29% less dementia (HR 0.71), while glaucoma surgery is not (HR 1.08) (Lee et al. 2022). This points to light and sleep, but it is observational.
- The work older people do themselves.

The NYU Caregiver Intervention deserves a note. Six counselling sessions, a support group and a telephone line delayed nursing-home admission (HR 0.717; Mittelman et al. 2006). It needs no nursing diploma. The median difference of 557 days is a model estimate.

9. What people do themselves

The evidence above is mostly about what institutions offer. Yet much care is organised by people themselves. Older people are often the helpers.

9.1 In the Netherlands

- **Care cooperatives.** Hoogeloon founded the first in 2005. It has 245 members, about one in ten villagers. Some sixty volunteers run it. Fourteen people with dementia live in its care villa. Austerlitz built its own care homes, and later rental homes when a housing corporation dropped out.
- **City villages.** Amsterdam has more than twenty *stadsdorpen*. Members offer computer help and lists of trusted handymen, and form clusters of 25–40 nearby neighbours. The municipality hardly knew them.
- **AutoMaatje.** Since 2015, volunteers drive less mobile neighbours. In September 2026 the two-millionth ride took place. More than 6,000 drivers serve about 60,000 people. Some drivers are 80 themselves.
- **Thuisgekookt.** About 24,000 home cooks prepare an extra portion for a neighbour, at the cost of ingredients.
- **Knarrenhof.** A modern hofje where residents help each other. Seventy thousand older people are on its waiting list.

9.2 What stops them

The obstacles are rarely the people. They are rules, money and land.

- **The partner rule in the state pension.** Older people who live together receive a lower pension per person. A cost–benefit study for the Ministry of Social Affairs found this blocks living together and giving care. Simplifying it would free 2,000–3,500 homes a year, and bring more informal care and less loneliness.
- **Land.** Municipalities must sell land publicly. The highest bidder wins. A Knarrenhof wants to sell homes as cheaply as possible. Projects took three years in Loosdrecht, eight in Groningen, and five to eight in the IJmond without a single pile driven. Zeist found a way: it sold directly to Knarrenhof as "the only serious candidate".
- **Subsidies and tenders.** Subsidy rules raise needless hurdles. Tenders hardly count social value (Driessen, Leiden University).
- **The cap on volunteer payments.** In 2026 the tax-free maximum is €5.75 an hour, €220 a month and €2,200 a year. One euro above it makes the whole amount taxable. This also applies to volunteer drivers.
- **Professional boundaries.** Volunteers in a cooperative "search the limits of the law". What a neighbour may do is not always clear.

9.3 The recurring pattern

Where self-organisation works, there is reciprocity. Riedlingen saves hours. Fureai Kippu gives credits. Homeshare lowers rent. Hoogeloon gives the idea that help will come back. This is the second historical form, exchange, returning in a new shape.

10. Solutions

The main advice is to remove blockades, not to add programmes. People can invent their own solutions. Policy should stop standing in their way.

10.1 Six proposals

1. **Remove the penalty on living together.** Make the partner rule in the state pension objective, or individualise the pension. Only national government can do this. Expected effect: 2,000–3,500 homes a year, more informal care, less loneliness.
2. **Give land to people who want to build their own housing form.** Reserve part of municipal land for housing forms set up by residents. Use social criteria, not only price. Zeist shows it is possible.
3. **Allow reciprocity.** Treat saved hours and time credits separately from the volunteer-payment cap, as long as they are not paid out in euros. The tax and pension status of such credits must first be clarified.
4. **Give money directly to the village or neighbourhood.** A fixed budget for a cooperative founded by residents, without a tender, with accountability to its members.
5. **Let professionals do what needs a profession.** Fund what is proven: exercise against falls, cataract surgery without waiting, assessment at hospital admission, hospital care at home, withdrawing antipsychotics. Stop what did not work, such as preventive home visits.
6. **Start small and count.** Start where people are already active. Count how many people act and how many wait. Publish the counts. Make no forecasts. Study initiatives that stop, and ask why.

10.2 An infrastructure for work between people

Self-organisation needs a way to bring people and work together. The Maze-Guild is one such design (Konstapel 2026; version 8, not yet online). It is a tool, not an institution. A person reports work. The tool proposes nearby people who can do it, if possible together with a learner. People choose and accept. The tool never invents a match. Where nobody fits, it reports a gap, with the step where matching failed. It gives counts, not forecasts.

Several features match the findings of this essay:

- **Reciprocity.** Members can exchange work in a circle of credits. There is no interest and no conversion. The members set the rules. This resembles Riedlingen and Fureai Kippu.
- **Choice of reward.** The worker chooses: exchange, voluntary, or paid in euros.
- **Learning on the job.** An experienced worker and a learner work as a pair. Only someone who can do the work independently confirms another person's level.
- **Safety.** Work in homes and in care requires a certificate of conduct. Work that legally requires a qualification goes only to people with that qualification.
- **No age criterion.** Age counts only where the law forbids work under 18.

Such a tool does not remove the outside blockades. The pension rule, land policy and the tax status of credits remain for government. Whether a retired neighbour can be a learner in personal care is still an open point.

10.3 Comparison with successful implementations abroad

Table 11. Proposals and foreign examples

Proposal	Foreign example	What it shows
1. No penalty on living together	Denmark: right to a self-contained home, care follows need	Housing and care can be separated without losing family ties
2. Land for own housing forms	Denmark: 250–300 senior co-housing communities since 1987	Residents build and run communities when space is given
3. Reciprocity	Riedlingen (saved hours); Fureai Kippu (credits); Homeshare (rent)	Reciprocity sustains help over decades
4. Money to the community	Japan: kayoi-no-ba run by residents with municipal support	Light public support scales resident-run activity nationally
5. Professional work where needed	Cochrane-level evidence across countries	A small set of interventions works; many popular ones do not
6. Count, do not forecast	US Villages: small, measured, honest about scale	Initiatives stay small unless barriers are removed

11. Limitations

- The evidence for what people do themselves is observational or self-reported. There are no trials, because nobody tests such initiatives as interventions.
- Failed initiatives were not studied. The examples therefore show survivorship bias.
- Respondents and judges in the evidence round were the same kind of AI model. They may share blind spots. The research question itself was set by the coordinator and was not tested independently.
- Many medical sources could only be read as abstracts.
- Most sources are from high-income, English-speaking or European countries.
- Some figures come from weaker sources. Examples are the net pension difference for cohabiting pensioners (about €500 a month) and the number of Knarrenhof courts. They must be checked against primary data.
- Cost allocations to dementia are accounting choices, not clinical measurements.

12. Conclusion

Care of the old is as old as humanity. For most of history, it rested on role change and exchange between generations. Only later did places of charity appear. The modern system focuses almost entirely on that third form.

In the Netherlands, the heavy care need is short and is mostly presence. Dementia and care without diagnosis take 92% of the elderly-care budget. Before that phase lies a long period in which people function, help others and live with disease.

Several arguments that shape policy do not hold. Older people are not attached to their homes; they lack alternatives. Home is not cheaper at high need. A shortage of diplomas is not a shortage of people.

People already do much themselves. Older people are often the helpers. They drive, cook, care and organise. What stops them is a pension rule, land policy, a tax cap and tenders. The most effective step is to remove those blockades, and to let professionals do what needs a profession.

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The references are grouped by theme. Each note says what the source offers and how far it can be trusted.

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