

# CO-CREATING INTEGRATED HEALTH-HOSPITALITY HYBRIDS FOR ACROSS THE LIFESPAN

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## ABSTRACT

Salutogenesis ensures that physical environments promote wellbeing across people's lifespan. Although this has influenced medical architecture, it has not yet penetrated into the domain of urban development. Despite the gradual decrease of medicalization of healthcare facilities, a conceptual gap remains between hospitality and healthcare facilities. This paper explores the possibilities of synergistic domains between healthcare and hospitality facilities. Using the architectural typology interpretation of a dementia village as a case study this paper explores how to create hybrids between healthcare and hospitality facilities that contribute to the silver economy while providing the ageing population with better built environments.

## INTRODUCTION

In Europe, the 15-20 year difference between life expectancy and healthy life years led to setting up a target of adding two more healthy life years by 2020 (Lagiewka 2012). A key framework for achieving this has been the European Innovation Partnership on Active and Healthy Ageing known as EIP on AHA (EIP on AHA 2016). It aims to address barriers that might prevent this target from being reached (European Commission 2016). It promotes synergies, bringing together disciplines right from the conceptualization of a project. Part of its actions has been the 2016 Call for Commitments, a project aiming at bringing together stakeholders across industries, i.e, finance, built environment, healthcare provision, tourism etc, including the entire decision making spectrum, i.e., from end-users to governance, and across geographical regions. Due to its experimental, innovative and bottom up nature it displays a higher degree of flexibility and freedom compared to most European Actions.

In line with the synergetic spirit of EIP on AHA, this paper constitutes one of the collaborative, multidisciplinary activities generated by an approved

Commitment running from 26/09/2016 until 01/08/2019. The Commitment falls into the broader area of 'Innovation Age-Friendly Buildings Cities & Environments' and more specifically in the Action Group D4 and is called '[Inclusive Urban and Rural Communities](#)' (Inclusive Urban and Rural Communities 2016). The Commitment explores the interaction of health and wellbeing with the physical environment. One of its areas of focus is hospitality. More specifically, it brings together three main axes related to wellbeing and AHA and in particular the interface between health, tourism and the built environment. It is in agreement with the conclusions of our targeted review on multidisciplinary and user-inclusive approaches to inform architectural research and education, at least at post-graduate level, on the need for environments that are inclusive for people across the lifespan (Chryssikou et al 2016). This is in agreement with an increasing discussion on the limits of universal design to accommodate the needs of several vulnerable groups and especially the least represented, as research on fall prevention and AHA indicates (Herman 2016, Gutman 2016). It also complements the work on hotel industry opportunities to cater for the needs of people at early stages of Dementia and their partners, which has been conducted by our commitment partners (Blanas et al 2016). This paper builds on the above actions and evidence based research, uses as Case Study the first and most internationally acknowledged village-type accommodation for dementia, De Hogeweyk (CNN 2013, BBC News 2012, The Guardian 2012).

From the architectural perspective, there are several parallel, mainly overlapping theoretical approaches that focus on the research and implementation of evidence based Eco-psychosocial interventions aiming to support the mechanisms that generate health or help combat disease. These are known as medical or therapeutic architecture, generative space or salutogenic design, a term that initially derived from the theory of Salutogenesis originated the field of Medical Sociology (Antonovsky 1979, Antonovsky 1987). This term refers to the possible impact of environmental interventions to increase wellbeing and sense of social coherence. These models do not claim to substitute medical intervention or treatment. On the contrary, their aim is to support staff, carers and patients by decreasing the amount of effort needed to overcome stressful situations as well as by providing complimentary support. This ecopsychosocial support is more important in conditions that Christensen (2009) describes as having low diagnostic and interventional accuracy such as the umbrella of mental health, including Alzheimer's (Zeisel 2010). In the case of Dementia, Zeisel proposed the manipulation of the physical environment through elements of positive and negative distraction as a way to promote cognition. The importance of the physical environment, its spatial configuration and quality of construction in the

context of the urban scale, is well document by Marmot (The Marmot Review 2010, Marmot 2015).

## SALUTOGENESIS AND HEALTHCARE ARCHITECTURE

Employing design for health benefits is an established practice in healthcare architecture since the 80's (Verderber 1986, Zeisel et al 2003, Shepley 2009). Key findings, especially on the use of daylight (Joarder et al 2003) views and nature (Ulrich et al 1991, Alvarsson et al 2010, Verderber 1986) effects of art (Upali 2012), may prove useful in other forms of the built environment such as hospitality, malls, social housing among other. However, we do not support overgeneralisations from one area to another, as research on the transfer of normalization from autism to acute mental health has indicated that such loans should be subject to critical review and further research before any application (Chryssikou 2014). Yet, a growing body of knowledge on design for vulnerable populations, on perception and neuroscience, combined to the increased tendency for people to receive care in the community and closer to home indicates that the impact of the field could be much larger than just hospital design.

Similarly, work conducted on other forms of the built environment such as the work of space syntax on social housing (Hanson 2001, Hillier and Hanson 1998) could shed more light on the way we design for healthcare. Finally, all of these work streams could find in the area of hospitality a new place for implementation and research.

Until recently there has been limited exchange of information between these sectors of nonresidential architecture, yet for reasons that are beyond the scope of this publication, this appears to change. This is the case of healthcare architecture, especially in the UK, that after the functionalistic, capital-expenditure friendly Nucleus hospital typology (Francis et al 1999), was influenced by the salutogenic theory, patient friendly perspective of the Plane Tree hospital and consumer oriented approaches of the US private healthcare sector and started introducing "hotel-like" aesthetics and design solutions, such as the single en-suite patient bedroom or the use of carpet and art, even in public hospital design or, alternatively, residential references driven by the homelike approach of normalization theory for developmental disabilities. Yet, we hardly ever noticed hotel architecture claiming to be physically restorative, hospital-like or clinical.

Despite this relative, cross-disciplinary rigidity in aesthetics, morphology and typology and taking into account the current demographic change, we strongly support that these areas of architectural research and

practice, instead of progressing in parallel, could be enriched if allowed evidence base, and in our case salutogenic principles, to penetrate through their design and even create hybrids and innovative building concepts. Places for AHA as well as places for neurodiversity could benefit from more fluidity as the collaborative and entrepreneurial approach of EIP on AHA is advocating. This trend is still at early stages, yet we already see research by design products at concept level such as the dementia friendly supermarket till (Lab4 Living 2015) or materialized innovation, such as the case of De Hogeweyk.

## THE HOGWEY DEMENTIA VILLAGE (OR DE HOGWEYK)

The Hogewey Dementia Village derived from the replacement of a care home and was aimed to introduce a non-institutional, patient-friendly approach to the concept of care home. As the name demonstrates, it was conceptualized as a village, generating a brand name for dementia accommodation that has been since transferred to other parts in the world, including the UK and Italy. According to one of the founders it aimed to recreate a neighbourhood (CNN 2013). In fact, salutogenesis was the key principle of this first dementia village, as one the founders considered a normative, institutional care home as a place that her “father luckily would never need”, and from this stemmed their motivation to demolish the existing care home and replace it by a village. Under that influence, they introduced normalization theory principles aiming to improve patients’ quality of life in a homelike environment.

After a detailed study of the architectural plans and visits that resulted in a qualitative architectural auditing, triangulating between two architectural methodologies: a) salutogenics to detect therapeutic elements and b) spatial analysis to detect spatial hierarchies and host vs inhabitant relations. These involved the public and semi-public areas of the village. The village develops inwards of a continuous-fence-like-building, which doubles as clear boundary between the village and the outskirts of actual village of Weesp (figure 1), where Hogewey sits geographically and a means providing balance between privacy and anti-ligature. This is in agreement between the initial objectives of De Hogeweyk: a non-institutional, i.e., providing qualities such as privacy, interpretation of a care home, i.e, providing safety and security. Also, under the umbrella of salutogenesis, the concept used spatial elements as therapeutic means, such as the village concept from the normalization stream of the salutogenic umbrella, as opposed to a clinical model. In this village they incorporated thematic aesthetics and employed perception clues through art, which is not an element of normalization, yet derives from the salutogenic negative/positive distraction design principles developed by Zeisel (2010).

Architectural morphology-wise Hogeweyk chrematistics include the following:

- accessibility through a single entry point as opposed to a multiple network of possible entry and exit points that is even the case in medieval castle-type villages, which tend to have a more controlled entry point network compared to most urban structures.
- lacks the organic growth and flexibility of a village, as villages (as opposed to urban developments) are normally built piece by piece over the years according to individual needs, family growth etc.
- places the inhabitant as the guest rather than the host, despite the fact that (s)he remains a resident of the village for the rest of the lifespan.
- is organized according to seven distinct aesthetic themes, which have been preselected by the planning team rather than a more flexible, user-led approach.
- follows a core and cluster model of a centralized multi-functional, public core with satellite accommodation clusters that is a not-uncommon form of nonresidential architecture typologies.
- the house residents do not share family bonds but follow the norms of strangers house-sharing, similar to student accommodation.

Figure 1: A general bird's-eye view of Hogeweyk



These traits and in particular the controlled access, the power of the host, who does not stay 24/h even if the facility is staffed around the clock, over the inhabitant, who does, the predetermined form and capacity, and the thematic classification of the accommodation provision, indicate a pre-programmed, rather structured typology. This

structure is softened by ecopsychosocial features to increase the inhabitants' control and sense of control. For instance, De Hogeweyk demonstrates extensive use of art and visual clues to ease self-orientation (figure 2), inclusion of elements of normality such as a high street with commercial and social functions, the use of normal –as

opposed to uniforms- clothing from staff, without compromising the safety or the clinical outcome. Via architectural traits such as the visual permeability of public spaces and lack of physical barriers of movement, it cultivates the enabling of free access. This is achieved mainly through the extensive use of glazing and the extensive use of automatic doors in both horizontal and vertical communications.

Figure 2: Visual clue for better self-orientation of the users



The core and cluster typology bears references to a common typology of current hospital campuses (MARU 1996), yet medical architecture is not the only area that the core and cluster model has been applied. The emphasis on the areas that are accessible to residents vs support and staff areas, including offices, differs from most healthcare typologies, where medical or staff offices and support areas play key role for spatial hierarchies. The staff-only accessible areas in this case are visually obscured, even though they are located close to the entrance and lack direct connectivity to patient areas. This transfers the message, in an ecopsychosocial manner, that staff is there to support but patients come first. This diversification from the medical model and in combination to the use of visual clues, either through the theme houses or the almost theatrical set of the “high street”, bears similarities to a more hedonic type of accommodation, i.e, the holiday resort. The core and cluster model, of a central communal core and satellite accommodation clusters is a typology that fits that model too.

Indeed, Hogewey employed salutogenics but not as much normalization as the term village implies. The typology, as our auditing shows is nonresidential, contradicting the village and the normalization concepts. Still, it does not contradict the salutogenic element. So, we observe already a hybrid of hospitality typology and residential function and we propose to extend the argument and combine the hospitality typology with the dementia patient group, the salutogenic concept and the hospitality function and create something new --as the existing hospitality for dementia comprises normative, asylum-like “accessible” hotels with some training to staff but ignore the therapeutic aspects of space.

## CONCLUSIONS

We revisited the spatial planning of a dementia village in an effort to understand if the innovative so-called village typology was indeed a new multidisciplinary approach of designing for dementia, a village-type hybrid

offering a new approach to the design for AHA in general, including facilities for tourism. Yet, the model was in fact closer to typologies already established in the hospitality industry and more specifically the resort typology. It is important to clarify that this discussion referred to the typology in terms of spatial planning and not to the actual function, which remained a care home. Yet, this innovative spatial planning paved the ground for the revisiting of care settings and the use of space to soften institutional structures through spatial planning and design. A more elaborate analysis, using space syntax could indicate if this resort-like typology ran deeper in the social structure of that particular care home.

From this realization we came up with two research ideas that we plan to explore as part of our Commitment actions. The first refers to the initial hypothesis of the village. What if there were a village to cater for the short or longer term needs of people with dementia, or at least at some stages of it? One incorporating the socio-friendliness of organically developed town centres, with walking-distance facilities such as the corner-shop and social meeting points, such as the café in the central square, could be created in an existing almost deserted village. This concept is worth exploring and potentially experimenting at rural areas of Europe. The second refers to taking this protected, neurodiversity informed, resort type of accommodation and adapting it for hospitality accommodation for people with dementia. It practically means building on the existing idea of hotels for dementia but in a manner that incorporates space to the concept, together with employing specially trained staff and universal accessibility devices that the existing literature and practice suggests.

Finally, regarding healthcare and hospitality, more synergies could promote the wellbeing and the physical and mental restoration of people. Having an example of a care home resembling a resort, we reverse the question: How a dementia friendly resort would look like? In line to our Commitment we are designing our next steps to combine medical architecture, tourism and gerontology to create new short or longer term staying models, utilizing the silver economy to build safe environments where people interact and live to the fullest possible that their condition would allow. The built environment could assist in an integrating way.

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