Deinstitutionalisation of Long-term Care for Older Adults

A Comparative Study Between Germany and the Netherlands

by

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Abstract

Unprecedented challenges are posed to European long-term care systems due to the ageing population. This thesis is involved in the topic of deinstitutionalisation of long-term care for older adults in two European countries: Germany and the Netherlands. The objective has been to gain insight into the relation between national long-term care policies and older adults' choices for long-term. Based on theories on choice processes, a theoretic framework is set up that helps to understand older adults' choices for long-term care alternatives. The choices for either institutional care, formal homecare, and informal homecare in Germany and the Netherlands are measured using data from national databanks. National long-term care policies are analysed to determine the favourability of alternatives. The main finding is that changes in long-term care policies strongly correlate to changes in choice processes. Especially policies directed at the accessibility and costs of alternatives appear to have effect. The greatest achievements towards deinstitutionalisation of long-term elder care, however, were reached by a combination of policies aimed at influencing multiple aspects of long-term care alternatives.

Table of Contents

List of Figures

List of Tables

List of Abbreviations

Abbreviation	Concept
AWBZ	Exceptional Medical Expenses Act (*Algemene Wet Bijzondere Ziektekosten*)
CIZ	Care Needs Assessment Centre (*Centrum Indicatiestelling Zorg*)
SGB XI	German Social Code, Book XI (*Sozialgesetzbuch XI* [SGB XI])
Wmo	Social Support Act (*Wet maatschappelijke ondersteuning*)
Wlz	Long-term care act (*Wet langdurige zorg*)
Zvw	Health Insurance Act (*Zorgverzekeringswet*)

Glossary

Concept	Explanation
Deinstitutionalisation	The replacement of institutional settings with community-based settings. Deinstitutionalisation is similar to extramuralisation (Da Roit, 2013).
Formal care	"Formal long-term care includes both in-kind care and cash benefits" (European Commission, 2018f, p. 136). In-kind care is provided by professionals or other contracted caregivers, either at home (formal homecare) or in an institution (institutional care). Cash benefits, or personal budgets, are payments that can be used to pay informal caregivers as income support, or to purchase formal homecare or institutional care (European Commission, 2018, p. 136).
Help-needing older adults	People aged 65 years or older who are dependent on either formal or informal care.
Informal homecare	The definition of the European Commission (2018f) is used: "informal care is in principle not paid and there is no formalised contract, even though an informal care giver may receive income transfers and, possibly, some payments from the person receiving care" (p. 136). Informal care is generally provided by a person with whom the help-needing person has a social relationship, such as a spouse, child, other relative, friend or neighbour. The provision of care takes place outside a professional or formal employment framework (European Commission, 2018a, p. 47). In addition, informal care can be provided by privately hired non-professions who are paid informally (Genet, Boerma, Kroneman, Hutchinson, & Saltman, 2012).
Institutional care	Institutional care takes place in institutional care facilities. Those can be nursing homes and residential care. The definitions for these are retrieved from Eurofound (2017), that adapted definitions corresponding to those from the OECD, Eurostat and WHO System of Health Accounts. Residential care is defined as "accommodation and support for people who cannot or who do not wish to live in their own home" (WHO, in Eurofound, 2017, p. 1). Services in residential care may include group activities, social care, personal care, medical care and help with performing daily tasks. Nursing homes are referred to as "high dependency care facilities primarily engaged in providing inpatient nursing and rehabilitative services to individuals requiring nursing care" (WHO, in Eurofound, 2017, p. 1). Inhabitants of nursing homes can also receive acute healthcare, assistance with day-to-day living tasks and assistance towards independent living (WHO, in Eurofound, 2017, p. 1).
Long-term care	Long-term care refers to "a range of services required by persons with a reduced degree of functional capacity, physical or cognitive, and who are consequently dependent for an extended period of time on help with basic activities of daily living" (OECD, in Willemse, Anthierens, Farfan-Portet, Schmitz, Macq, Bastiaens, Dilles & Remmen, 2016, p. 1). Long-term care includes both formal and informal care (Willemse et al., 2016).

1. Introduction

The ageing European population has received considerable attention in academic literature. The consequences of more and more elderly citizens are found to be widespread and pose unprecedented challenges to long-term care systems (European Commission, in Courtin, Jemiai, & Mossiales, 2018). Some of the most pressing issues appear to be a reducing labour force that results in declining labour productivity growth, increasing expenditure on health care, and a rising dependency of older adults on the employed population (European Commission, 2018f).

This thesis is involved in the topic of deinstitutionalisation of long-term care for the elderly in Germany and the Netherlands. The objective is to gain insight into the relation between national long-term care policies and choices for long-term care that older adults make. The research question for this study is posed after the following description of the development of Dutch and German long-term care policies.

The European Union desiderates to protect its elderly citizens and has developed multiple rights for them. In 2018, the European Commission, for instance, published its tri-annual report: the *2018 Ageing Report: Policy challenges for ageing societies*. The report addresses the decrease in the labour force and the increasing pressure on public spending (European Commission, 2017). Moreover, the European Union demonstrates the importance of ageing via the European Pillar of Social Rights; it states that "everyone in old age has the right to resources that ensure living in dignity", and that "everyone has the right to timely access to affordable, preventive and curative health care of good quality" (European Commission, n.d.b). Article 25 of the Charter of Fundamental Rights of the European Union also recognises and respects "the rights of the elderly to lead a life of dignity and independence and to participate in social and cultural life" (2000/C 364/01). In specific, the EU supports the concept of "active ageing", meaning that "people stay in charge of their own lives for as long as possible as they age and, where possible, to contribute to the economy and society" (European Commission, n.d.a). These rights point to the need for deinstitutionalisation of elder care and increased and improved care at home, especially in light of the forecasted accumulated ageing of the European population (see Appendix 2. Figure 19). Deinstitutionalisation is not only found to be less costly but also enhances the dignity of life of elderly citizens (Illinca, Leichsenring, & Rodrigues, 2015).

This trend of deinstitutionalisation is also visible in the Netherlands. Until the second half of the twentieth century, children were financially responsible for their parents. The focus

was on informal caregivers, such as daughters taking care of their parents. Over time, a professionalisation of elder care took place. An important incentive was the aim of the government to include the 'daughters' in the labour market. The introduction of the Exceptional Medical Expenses Act [AWBZ] has been a significant measure within this policy, which enabled both the use of intramural care as well as lighter forms of care (The Netherlands Institute for Social Research [SCP], 2015a). A change in policy took place in the eighties and nineties, when the Dutch government started to enhance informal care for the elderly from the network. Intramural care started to become increasingly extramural. The result was that a rising share of older adults lived at home independently and received care at home. The underlying objectives of the deinstitutionalisation were to enhance the participation in society of elderly with an impairment and to limit the care expenditures (SCP, 2015a). As the market could not solve both issues itself, the Dutch government had to implement laws and regulations.

The AWBZ, being the first Dutch long-term care act, was introduced in 1968. This long-term care insurance scheme constituted the core of the Dutch welfare state, together with family allowances and basic pensions. The introduction of the AWBZ resulted in the 'defamilisation' of care, as the Dutch state gained most of the financial and organisational responsibilities in supporting people in need of long-term care (Da Roit, 2013, p. 97). Since then, Dutch long-term care policies have developed around the AWBZ (Da Roit, 2013).[1] Everyone living in the Netherlands was ensured under the AWBZ; the act did not only cover care for the elderly, but for all chronic care in principle, both homecare and institutional care. The care services that the AWBZ provided include personal care, nursing, assistance, treatment, and stay in an institution. Domestic help was part of the AWBZ until 2007 when it was transferred to the Social Support Act (Mot, 2010).

Several changes have occurred at the end of the 20th century, but for this study, it is only relevant to discuss changes since 2004.[2] Figure 1 displays an overview of the shifts in Dutch long-term care acts. An overview of the sorts of care that are covered by the different acts is visible in Appendix A. Table 13. It is expected that the 2003 'modernisation' of the AWBZ has had an impact in 2004 and the years following as well. With the reduction of the distinction between different types of providers and different groups of AWBZ users, the Dutch government aimed at higher responsiveness of the long-term care system. This included a

[1] More information about the development of the AWBZ since the Second World War can be retrieved from Da Roit (2013).
[2] In the Research Methodology it is explained why a timespan was chosen ranging from 2004 to 2017.

greater role for personal budgets, and improved position of care-users, but also more difficulties in controlling costs, leading to higher co-payments (Mot, 2010).

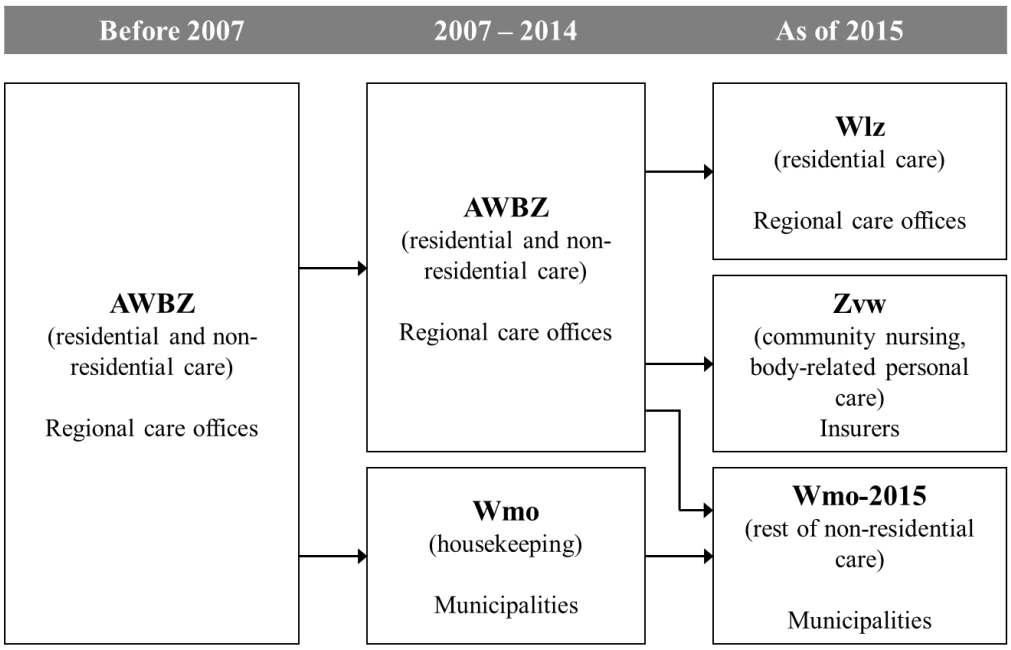

Figure 1. The old and new regulatory framework for long-term care in the Netherlands. The figure includes the service packages and implementing agencies. Adapted from "The policy and politics of the 2015 long-term care reform in the Netherlands" by Maarse, J.A.M. & Jeurissen, P.P., 2016, *Health Policy, 120*, p. 243.

In 2007, domestic help was transferred from the AWBZ to a new act, the Social Support Act [Wmo]. This new act constituted a major part of the transformation that the Dutch care system underwent. The aim of the reform was to reduce the long-term care budget by supporting individual responsibility within the community, informal care, and a decentralisation of care policies. The reform is described as a change from the 'welfare state' to a 'welfare society' (Da Roit, 2013, p. 102). In practical terms, it included a transfer of the task of organising support from the AWBZ to municipalities (Da Roit, 2013).[3] The covered services included transport, home help, meals on wheels, and home adjustments, which had to become more tailored to the need of individuals (Mot, 2010). An appeal was done on the self-reliance of help-needing people, and the availability of informal care became part of the assessments for care (Da Roit, 2016). Furthermore, the tasks that belonged to the Community welfare Law (*Welzijnswet*) and the Provisions for the handicapped Act (*Wet voorziening gehandicaption*), that both ended in

[3] The shift was implemented because it was expected that municipalities would organise care more efficiently due to their financial incentives (Mot, 2010). It accompanied an increase of discretionary power for municipalities (Da Roit, 2013).

2007, came to be covered by the Wmo (SCP, 2015b). Hence, where an integrated service existed before, consisting of health, social and household care, these were now separated into distinct provisions: health and social care on the one hand, and household care on the other (Da Roit, 2013).

In 2015, the Dutch long-term care system was reformed again. The reform consisted of four interrelated pillars: "a normative reorientation, a shift from residential to non-residential care, decentralisation of non-residential care and expenditure cuts" (Maarse & Jeurissen, 2016, p. 241).

One of the developments was the replacement of the Wmo with the Wmo-2015. Under the Wmo-2015, municipalities received greater responsibility for the participation of people with a limitation or psychological problems in society. Local authorities became responsible for the provision of tailored services[4] to enable people to be self-reliant. Tailored services are an addition to what a person can contribute by him or herself. Before 2015, the Wmo postulated that municipalities had the obligation to compensate people that have reduced self-reliance. This plight to compensate formed the centre of the act. With the introduction of the Wmo-2015, the centre of the act became the plight to care, granting municipalities more freedom (Movisie, kennis en aanpak van sociale vraagstukken [Movisie], 2014). The interpretation of self-reliance of people changed from being able to function on a daily basis, such as fulfilling household work and participate in society, to having own control and asking and receiving support for the organisation of help (The Netherlands Institute for Social Research [Cpb], 2018). Moreover, since 2015, the concept 'usual care' is used as a directive to determine the amount of care that does not need to be covered. The Dutch government assumes that help-needing people enjoy a large amount of self-reliance and make use of informal networks to fulfil their care demands. Therefore, formal care is perceived as a solution to the shortage of personal and informal capacities (Da Roit, 2016).

Furthermore, during the 2015 reforms, the AWBZ was abolished and replaced by the Long-term Care Act [Wlz] and the Health Insurance Act [Zvw]. The Wlz exists for people who need permanent supervision or 24-hour care. It is however valid for a smaller group of people than the AWBZ was (Ministry of Health, Welfare and Sport [VWS], 2016). People that are eligible for Wlz-care can choose to receive care either at home or in an institution.[5] The types of care covered by the Wlz include residence in an institution, personal care, counselling,

[4] The Dutch term for 'tailored service' is '*maatwerkvoorziening'*.
[5] Both types of care are carried out by Wlz-executers, on behalf of the national government. Wlz-executers, on their behalf, appoint care offices for the factual provision of care (VWS, 2016).

nursing, Wlz-treatment and transport for day-care or a day-treatment (VWS, 2016).

Community nursing came to be covered under the Zvw in 2015. This act was already implemented in 2006, when it replaced several separate public and private health insurances (VWS, 2016). At that time, a unique compulsory scheme was implemented for all Dutch citizens, designed to be affordable for everyone. It mandated every citizen to purchase a basic package of healthcare benefits from a private insurer (Schut & Van de Ven, 2011). That way, the risk of needing healthcare came to be covered by private insurance companies, from which an insured person can freely choose (Da Roit, 2013). The basic insurance package can be upgraded with additional insurances for extra care, such as for glasses and dentist visits (VWS, 2016). With these measures, the Dutch government aimed to increase budget control (Da Roit, 2013, p. 101).

In Germany, a long-term care insurance scheme was implemented almost three decades later than in the Netherlands; in 1995, the German government introduced the long-term care insurance (*Pflegeversicherung*). Before that, mainly the family was responsible for the provision of care for Germany's elderly population, which was based on the principle of subsidiarity and universalism, and the sharing of care responsibility between family and society (Da Roit, 2010; Theobald, 2012). The long-term care insurance was introduced to insure all German citizens for their long-term care needs. It is a compulsory social insurance that is supplementary to healthcare funds (Longo & Notarnicola, 2018).

The cause for the implementation of the scheme was the increase in needs and the growing financial pressure on local authorities (Da Roit, 2010). Nevertheless, the family-oriented care tradition was maintained (Theobald, 2012). The German care regime is based on the premise that relatives care for older adults. What is more, a majority of the population socially rejects the placement of elderly in institutional care facilities (Lutz & Palenga-Möllenbeck, 2010). [6]

Between 2015 and 2017, the German government has modernised the long-term care insurance, by implementing three 'Long-term Care Strengthening Acts'. The introduction of a new definition of 'in need of care' has been the most significant amendment (Bavarian State Ministry of Labour and Social Welfare, Family Affairs, Women and Health & Federal Ministry of Health [Bavarian State Ministry & Federal Ministry of Health], 2010).

One research that is concerned with deinstitutionalisation is conducted by Illinca, Leichsenring, and Rodrigues (2015). The definition of deinstitutionalisation that the authors use

[6] More information on the developments in long-term care in Germany can be retrieved from Heinicke and Thomsen (2010, pp. 2-4).

is "the development of community-based services as an alternative for care provision in institutional settings" that has become "the hallmark strategy of social and care services for individuals with limited autonomy across European countries" (Illinca et al., 2015, p. 1). By analysing several cases, Illinca et al. (2015) track complexities and challenges of deinstitutionalisation and discuss the dos and don'ts in the context of long-term care for older adults. The typology that the scholars use for European long-term care regimes is based on three key dimensions: the demand for care, provision of informal care, and provision of formal care services (see Figure 2).[7]

	Demand for care	**Provision of informal care**	**Provision of formal care**	**Countries**
Standard care mix	High	Medium/low	Medium	Germany, Austria, France, United Kingdom
Universal-Nordic	Medium	Low	High	Sweden, Denmark, Netherlands
Family-based	High	High	Low	Spain, Italy, Portugal, Ireland, Greece
Transition	Medium	High	Medium/low	Latvia, Poland, Hungary, Romania, Slovakia, Czech Republic

Figure 2. A typology of European long-term care regimes. The scholars adapted the figure from Lamura (2007) and Nies, Leichsenring, and Mak (2013). Adapted from "From care in homes to care at home: European experiences with (de)institutionalisation in long-term care" by Illinca, S., Leichsenring, K., & Rodrigues, R., 2015, *European Centre for Welfare Policy and Research*, p. 2.

However, although this research is conducted only a few years ago, long-term care regimes have already changed. Furthermore, the model lacks preciseness and details, especially concerning the policy-aspect of ageing and care for the elderly. The authors recognise that "successful community-based care hinges on the availability of appropriate support services for informal carers and the implementation of quality control mechanisms with an emphasis on users satisfaction" (Illinca et al., 2015, p. 3). Moreover, alternative solutions to institutional care should be developed that can delay or avoid the development of intensive care needs. Illinca et al. (2015) state that strong governance structures are required to do so, although a detailed analysis of necessary structures is lacking in their article.

This thesis aims to fill in this gap. While building on studies such as from Illinca et al.

[7] Not all typologies of long-term care regimes place Germany and the Netherlands in the same type, as is for instance visible in Appendix B. Figure 20.

(2015), it aims to focus more in detail on deinstitutionalisation of long-term care for older adults in relation to changes on the policy-level. Only a few studies are conducted on this topic, such as by Alders, Costa-Font, De Klerk & Frank (2015)[8], Bakx, De Meijer, Schut, and Van Doorslaer (2015)[9], Plaisier, Verbeek-Oudijk, and De Klerk (2017)[10], and by Heger & Korfhage (2018)[11]. The ultimate objective is to obtain more pieces to the puzzle of what successful policies are to let older adults live at home the longest as possible, and as dignified as possible. To serve this purpose, this study focusses on two countries: Germany and the Netherlands.

The long-term care systems from Germany and the Netherlands are selected because of their relevance for analysis: they are located next to each other, they are both West-European, and they belong to the same cultural region (Stevens & Westerhof, 2006). In terms of care, both countries deal with the same issue: a growing ageing population and increasing care expenditures. The objective of both countries is that older adults live at home longer, to ensure a dignified life for them and to minimise expenditures. Likewise, the two countries have a similar system of financing and organising universal coverage for long-term care (Bakx et al., 2015). These similarities make the Dutch and German long-term care systems for the elderly comparable cases.

Nevertheless, there is a noteworthy dissimilarity between both countries. Although belonging to the same cultural region, the Dutch and German culture and societal systems differ to some extent. One of the most important differences to note in this thesis relates to the welfare-state system that the Netherlands has, which gives priority to social services for a range of support. The German system, on the other hand, makes adult children legally responsible for their older parents and prioritises financial transfers by the state (Stevens & Westerhof, 2006). Bakx et al. (2015) specifically found that cross-country differences in eligibility rules and coverage generosity can influence differences in the choice between formal and informal care. These are some aspects of the Dutch and German public long-term care insurance that Bakx et

[8] Alders et al. (2015) found that a key in the success of a reform is a behavioural change in the long-term care system. They highlight the importance of a sequence of policies, as no single factor can lead to deinstitutionalisation.

[9] Bakx et al. (2015) examined how institutional differences relate to differences in the choice for formal and informal long-term care. The scholars found that system features influence the choice between the two forms of long-term care, such as eligibility rules and coverage generosity.

[10] Plaisier et al. (2017) examined changes in the use of community-based care between 2004 and 2011 and changes in the explanatory effects of its determinants (health, personal and facilitating factors) that may be influenced by these reforms. The main finding is that the role of household and income composition has changed the most, which could be linked to changes in eligibility for care.

[11] Heger & Korfhage (2018) explored how individuals choose between different forms of long-term care, to gain understanding in the influences of long-term care policies or changes in population composition on utilisation patterns of different types of care. Their results show that differences between Germany and the Netherlands can be explained by differences in impacts, as a result of different incentives that the long-term care systems provide.

al. (2015) discussed; this thesis, on the other hand, is concerned with the systematic differences between long-term care policies that result in differences in choice processes and use of care.

The objective in this thesis is to explain differences in choice processes between Dutch and German help-needing elderly citizens by cross-country long-term care policy-differences on the national level. Research will therefore be conducted according to the following question:

> *How can cross-country long-term care policy-differences between Germany and the Netherlands explain differences in the degree of deinstitutionalisation of care for help-needing older adults?*

To answer this question, three sub-questions will be answered after a discussion of the theoretic framework and the research methodology. In the theoretic framework, rational choice processes of alder adults are modelled for choosing a long-term care alternative. It also discusses favourable aspects of alternatives and sets out which characteristics of policies enhance these aspects. The sub-questions are as following:

1. What are the differences in the deinstitutionalisation of long-term care for older adults between Germany and the Netherlands?
2. What are policy-differences between Germany and the Netherlands regarding long-term care for help-needing elderly?
3. What is the relation between long-term care policies and choice processes of help-needing elderly?

The thesis is ended with a conclusion and a discussion.

2. Theoretic Framework

Individuals make choices based on an underlying choice process (Viney, Lancsar, & Louviere, 2002). Choices for healthcare can depend on numerous factors. Examples are frames, costs, sociodemographic factors and a person's health situation (Kemper, 1992). The same is true for older adults' choice processes when choosing between long-term care alternatives. In general, an older person can choose to receive care at home – both formal or informal – or care at an institutional care facility. This section starts with a discussion on theories on choice processes; a model is created based on these theories, which maps the choice processes of older adults when choosing a long-term care alternative (either institutional care, formal homecare, or informal homecare). Moreover, the factors influencing choice processes are established, based on theories on choice processes. Likewise, favourable aspects of each form of care are determined. With that information, it is possible to determine which policy-aspects, and especially which differences between policy-aspects, relate to the choices of help-needing older adults to move to an institutional care facility or to receive either formal or informal care at home.

2.1 Theories on Choice Processes

Multiple scholars have theorised choice processes of individuals; the theories do not only describe processes for general individual choices, but they also concern choices of health services use. The most relevant ones in this thesis are discussed hereafter.

2.1.1 Rational choice theory. Rational choice theory is probably the most well-known theory concerned with individual choices. This theory is based on the assumption that individuals act according to choices that they make, rather than that they act based on their intentions or attitudes. Rational choice theory states that everyone is rational and strives for equilibrium, meaning that all individuals adopt their best strategy at the least amount of costs (Ostrom, 1991). Individuals are, according to the value assumption of the theory, motivated to attain private and instrumental goods, such as wealth, power and prestige (Hechter, 1994). They search for an optimum for achieving an objective or for solving a problem (Hechter et al., in Owumi, 2013), and thus maximise benefits and minimise costs (Brown & Ainley, 2005). In doing so, individuals make trade-offs between alternative choices. Individuals are assumed to make feasible choices, in the sense that they are not constrained, resulting in the highest possible value (Owumi, 2013). This is dependent on how much value an individual attains to a certain cost or benefit. Hence, a rational choice theory can be perceived as a "theory of advice", as

Ostrom (1991, p. 238) describes it, "that informs individuals or, potentially, collectivities of individuals, about how best to achieve objectives – whatever these may be" (Ostrom, 1991, p. 238). Rational choice theory thus explains how processes of choice emerge and postulates that individuals make choices that best help them to achieve their goals, given all relevant factors that are beyond control.

2.1.3 Cross-country policy-differences. Policy is one of the factors that can have an influence on rational choices. If policies enhance aspects of forms of care that older adults find more favourable, more older adults tend to choose that certain form of care. Policies can (partly) regulate the availability, the accessibility, the costs, and the quality of (public) care. Besides public care, older adults can also choose to purchase private care. This study only engages in long-term care, either public or private, that is (partly) publicly covered, because analysing choices for private institutional or homecare without any public support would not display much information on the impact of policies on choices. Besides that, there is no data available on this topic. Policies can differ between countries because of different governmental decisions on long-term care. Although policies and their implementation may also differ between regional and local governments, this thesis engages in broader, national policies.

Policies are a way for governments to influence choice processes. A policy is a strive to achieve an objective, including the belonging activities and notions about its feasibility and desirability. These objectives and means constitute the base of a policy. In other words, a policy is a solution to a problem. The base of a policy is its objectives, its instruments and its time choices. Instruments, in this case, refer to anything that can be used to enhance the achievement of one or more policy objectives (Bressers & Klok, 2014). In the case of long-term care policies, it can be assumed that governments aim for improved care and well-being of the population, while managing expenditures.

This thesis is concerned with policy instruments that are meant to influence the behaviour of citizens. Behavioural policy instruments can be separated in judicial instructions, financial stimulations and transfers of information; in other words, these are judicial, economic and communicative steering models. Physical instruments are also included in this typology of instruments, referring to government services that are meant to influence behaviour as well (Fenger & Klok, 2014).

In terms of long-term care policies, there are multiple instruments that policymakers can use to achieve an objective. Policymakers can implement judicial instructions, for instance in terms of eligibility criteria that regulate accessibility to care. Financial stimulations can also be employed, in terms of financial structures that support the existence of care, and allowances

that enable older adults to purchase care. These allowances can be a general instrument, being similar for a whole group, or to an individual instrument, meaning that the allowance is tailored to an individual's situation. Furthermore, a communicative steering model can be used, for instance in the form of television commercials to inform citizens about care, or to frame informal care as the norm. These are general instruments, that are similar for a group (Fenger & Klok, 2014). Lastly, governments can enact upon physical instruments; they can, for instance, decide to close down a publicly funded nursing home.

2.1.4 Theory of planned behaviour, theory of perceived behavioural control and the reasoned action approach. Besides rational choice theory, the theory of planned behaviour is concerned with human behaviour as well (see Figure 3). This theory was developed by Ajzen and Fishbein (1975) and is one of the most popular conceptual frameworks for studying human action. The theory is derived from the theory of reasoned action, the counterpart of rational action (Ajzen, Albarracín, & Hornik, 2007). According to the reasoned action approach, "changes in behaviour can be brought about by changing people's intentions to perform the behaviour in question" (Ajzen et al., 2007, p. 13).

The main proposition of the theory of planned behaviour is that people act in accordance with their intentions and perceptions of control over the behaviour (Ajzen, 2001). Intentions, as a determinant of behaviour, are described as constructs that "capture the goal-oriented nature of human behaviour" (Ajzen & Fishbein, 1980, p. 736). These intentions are influenced by attitudes toward the behaviour, subjective norms, and perceptions of behavioural control (Ajzen, 2001). Hence, individual behaviour is guided by "beliefs about the likely consequences of other attributes of behaviour (behavioural beliefs), beliefs about the normative expectations of other people (normative beliefs), and beliefs about the presence of factors that may further or hinder performance of the behaviour (control beliefs)" (Ajzen, 2002, p. 665). Behavioural beliefs can produce favourable or unfavourable attitudes toward a certain behaviour; normative beliefs can result in a perceived social pressure or subjective norm; and control beliefs can establish a perceived behavioural control, which is the perceived ease or difficulty of performing a certain behaviour. These three sorts of beliefs combined, result in the formation of a behavioural intention.

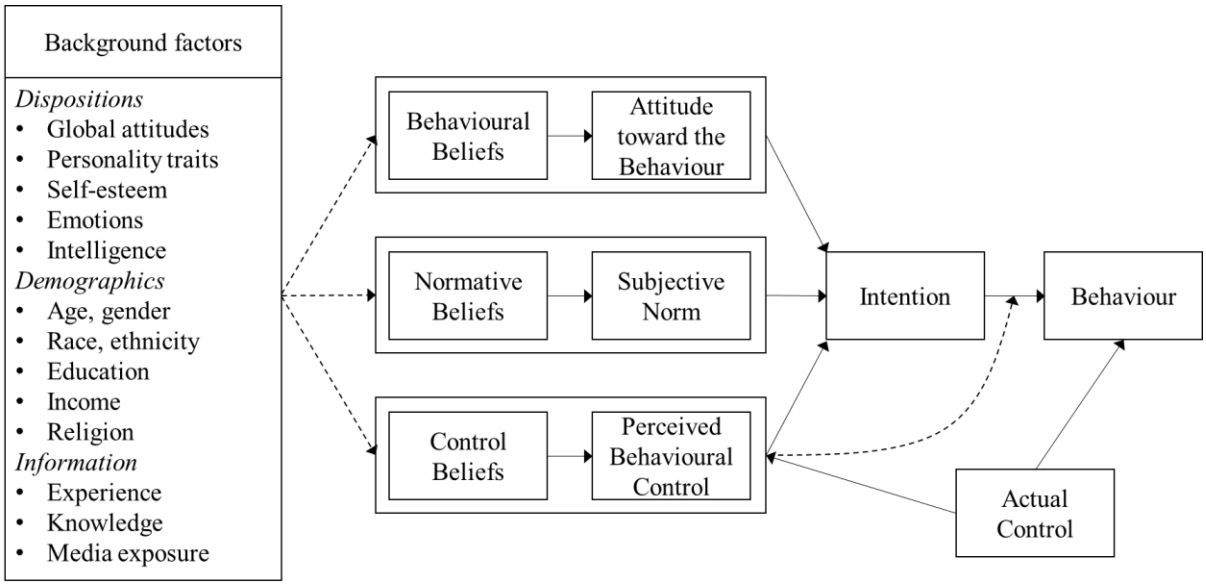

Figure 3. The theory of planned behaviour. Adapted from "Prediction and Change of Health Behavior: Applying the Reasoned Action Approach" by Ajzen, I., Albarracín, D., & Hornik, R., 2007, p. 6.

Perceived behavioural control is useful to consider; when individuals have a sufficient degree of actual control over the behaviour, they are expected to carry out their intentions when the opportunity arises (Ajzen, 2002). This theory is an extension of Ajzen's and Fishbein's theory and was established to deal with situations in which individuals may lack volitional control over the behaviour of interest (Ajzen, 2002). In other words, this construct was added to deal with behaviour that a person does not perform because of a lack of requisite ability, resources, or opportunity (Sheeran, Trafimow, & Armitage, 2003). The theory posits that perceived behavioural control is formed because individuals take into account factors that may further or hinder their ability to perform a certain behaviour (Ajzen & Fishbein, 1980).

Hence, the theory of planned behaviour is relevant for two reasons. Firstly, it demonstrates that perceived social pressure, as a result of normative beliefs, can impact human behaviour. In other words, external pressure plays a role in the formation of intentions and behaviour. Secondly, it can explain the extent to which external factors may facilitate or hinder the performance of behaviour. In this study, however, only external factors in the form of policy measures are relevant to consider. Policies are most likely to influence control beliefs; policies can establish factors that may hinder or facilitate certain behaviour. An example is the implementation of higher co-payments for institutional care, which may hinder the choice of older adults for institutional care. In this case, policy is an intervention directed at influencing attitudes and thus beliefs. Changes in attitudes are likely to correlate with changes in intentions

and actions (Ajzen, 2007). An intervention, such as a policy-measure, can change people's intentions to perform a behaviour (Ajzen et al., 2007). In this way, policy can influence external factors, which on their turn may influence attitudes. Yet, policies cannot influence all external factors.

Behavioural beliefs and normative beliefs are to a lesser extent relevant, but do demonstrate interesting features of human behaviour.

2.1.5 Choice processes for healthcare preferences and healthcare services use. Viney, Lancsar and Louviere (2002) are also involved in choice processes of individuals, and specifically researched the individuals' preferences for healthcare. The scholars (2002) state that, in order to conceptualise the choice process, several aspects must be considered. These are "the decision-making context for the individual making the choice, the alternatives that are likely to be available, how the choice alternatives will be presented, and which factors are likely to be important in choosing between them" (Viney et al., 2002, p. 322). Besides that, it is necessary to consider the policy-context and how the choices are framed (Viney et al., 2002).

Victoor et al., in Groenewoud, Van Exel, Bobinac, Berg, Huijsman, and Stolk (2015) make this more concrete with regard to healthcare choices and posit that patients' choices are influenced by (infra)structural aspects of healthcare quality, as well as by process and by outcomes. The aspects of healthcare quality are dependent on "the availability of providers, the accessibility of the providers, the type and size of the providers, the availability/experience/ quality of the staff, the organization of health care, the cost of treatment, and sociodemographic factors of the individual doctors" (Victoor et al., 2015, p. 1942). Process, in this case, includes interpersonal factors, availability of information, continuity of treatment, waiting time, and the quality of treatment (Victoor et al., 2015). Hence, it is likely that older adults make choices for long-term care based on the abovementioned factors, and for instance are more prone to choose an option when the cost of treatment is favourable. Lehnert, Günther, Hajek, Riedel-Heller, and König (2018) enhance this statement and found that German citizens prefer more time for care, but at lower costs. Based on Viney et al. (2002), Groenewoud et al. (2015), and Lehnert et al. (2018), the following conclusions can thus be drawn: decisions depend on the availability of care, the quality of care, the costs of care, the decision-making context, the policy context, and the (presentation of the) alternatives.

2.1.6 Behavioural Model of Health Service Use. Furthermore, Andersen's Behavioural Model of Health Service Use (see Figure 4) highlights both the individual and contextual determinants of the use of health services (Babitsch, Gohl, & Von Lengerke, 2012). It is one of the most well-known models of healthcare utilisation (Baker, 2009), and was

developed in the late 1960s (Andersen, 1995) to understand the social, individual and system factors that influence the use of health services (Baker, 2009).

The model identifies three factors that explain why individuals are more likely to use certain health services. These are predisposing factors, enabling factors, and need factors. Predisposing factors refer to age, gender, demographics, social structure, and health beliefs that represent the likelihood that people will need health services. Enabling factors refer to community and personal enabling resources that must be present for use. Measures for these factors can be income, health insurance, travel, and waiting times. Need factors refer to the perception of people of their general health and functional state, as well as a professional judgement about people's health status and their need for medical care (Andersen, 1995).

Although the model has been criticised for being too broad and nonspecific and has been adapted over the years (Andersen, 1995), the initial behavioural model does give insight into why certain individuals are more likely to use certain health services than others (Baker, 2009). This is relevant as especially the enabling factors explain the influence that policy-measures, such as restrictive eligibility criteria, can have on the choice of people to make use of care. The factors with regard to the perceived need of healthcare are not relevant here, as this thesis is only concerned with people of which it is already determined that they are in need of care.

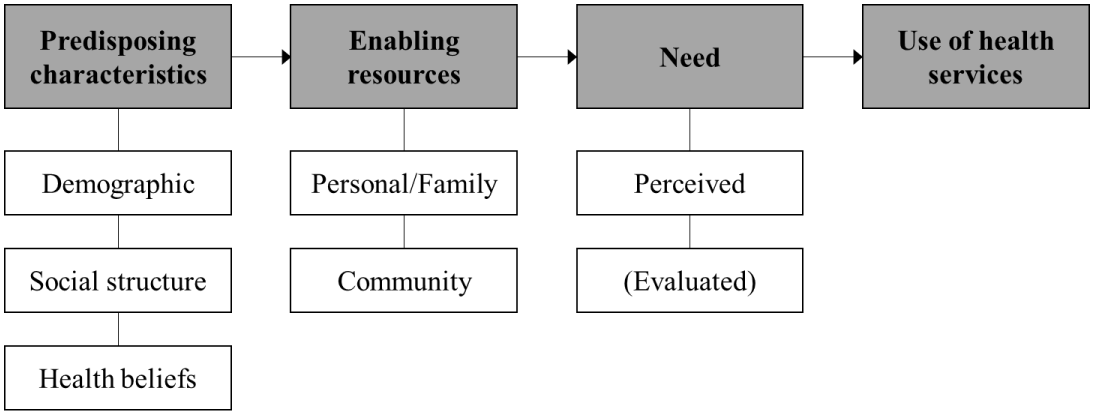

Figure 4. The initial behavioural model (1960s). Adapted from "Revisiting the Behavioral Model and Access to Medical Care: Does it Matter?" by Andersen, R.M. (1995), *Journal of Health and Social Behavior, 36*(1), p. 2.

In conclusion, as appeared from the abovementioned theories, a significant part of individual choice processes is concerned with the homo economicus model that is forwarded by rational choice theory; rational choice theory draws a large part of its strength from the discipline of Economics, in which rational choice assumptions constitute the fundament (Brown & Ainley, 2005, p. 40). However, the importance of non-rational behaviour of individuals

should also be highlighted. This behaviour can differ per person and can depend on the care user's personality, state of health, values and respective healthcare decisions to face. All aspects can impact the choice-making process (Ewert, 2013). Moreover, it is recognised that long-term care preferences are not entirely static but can vary between people and between periods of time (Wolff, Kaspers, & Shore, 2008). Nevertheless, rational choice theory forms the starting point for the model on choice processes in this thesis; choices for a long-term care alternative are often important choices in an older adult's life and are not represented by an attitudinal model as Ajzen and Fishbein (1975) put forward. They are made for the long-term and are expected to have a significant impact on a person's life. As studies have found, the following factors influence an individual's choice process when choosing a form of care: policies, information about the different forms of care, societal factors and external pressure (see Figure 5). Factors such as personal experiences are not included in the analysis, as the aim is to create a general picture of choice processes instead of focussing on individual choice processes.

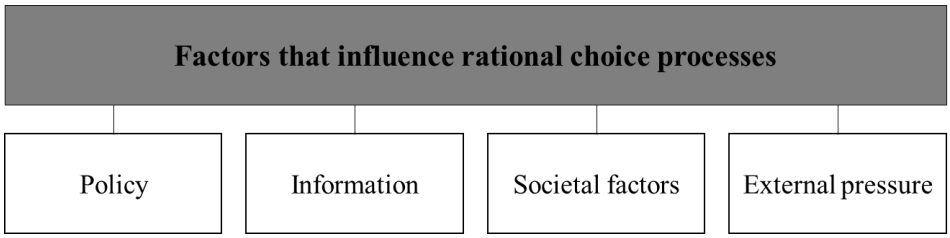

Figure 5. Factors that influence rational choice processes.

As is also found in the literature, people tend to find certain aspects more appealing, which gives them a reason to choose a certain long-term care alternative. These are especially presented in Andersen's Behavioral Model of Health Care Use and in the articles from Viney et al. (2002), Groenewoud et al. (2015), and Lehnert et al. (2018). The aspects include good availability of care, good accessibility of care, low costs of care, and high quality of care (see Figure 6). Availability is the primary aspect and even a prerequisite; when an alternative is not available, it cannot be chosen, and an individual is left with the other two alternatives. Good accessibility, in this study, is concerned with the conditions that someone has to meet to be eligible for care, or for coverage for care; the eligibility criteria constitute the framework for access. Costs refer to the co-payments that care-users have to pay out of their pocket. High quality of care refers especially to the difference between informal care and professional care, but also to the actual quality of for instance care-workers and institutional care facilities. In certain situations, informal care provided by caregivers is not sufficient to fulfil the care-needs of an older person.

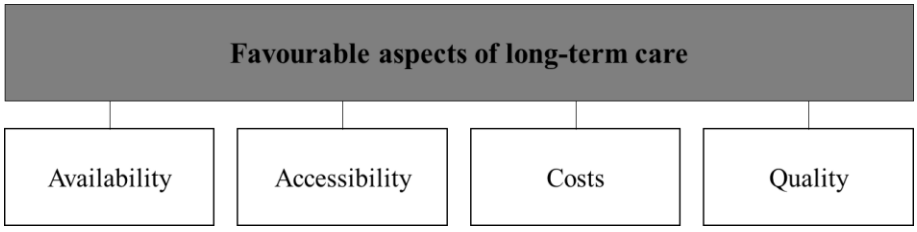

Figure 6. Favourable aspects of long-term care.

2.2 Favourable Aspects of Institutional Care, Formal Homecare and Informal Homecare

For each alternative – institutional care, formal homecare and informal homecare – the interpretation of the favourable aspects is different. This section discusses what the favourable aspects – availability, accessibility, low costs, and quality – include for each alternative. It is necessary to specifically address these aspects per alternative, since differences between alternatives mean that for each form of care, different policy-aspects need to be analysed.

Institutional care. Firstly, the choice for institutional care depends on several factors. These are the availability of facilities, the accessibility, the costs for living in an institution, and the quality of institutional care. The availability or existence of facilities depends on whether national, regional or local governments enable the establishment and maintenance of facilities such as nursing homes, for instance via policies and finance structures.

The accessibility to an institutional care facility also plays a role. People need to fulfil certain requirements in order to get access to the institution. The eligibility criteria constitute a framework for access to institutional care. If the criteria are favourable, an older adult might be more likely to decide to move to a facility.

Furthermore, certain conditions can make living in an institution more appealing. These conditions can be acceptable prices and/or allowances or a support system for living in a facility, that decrease the costs. Governments can thus regulate the costs for living in an institution, via finance structures such as support systems. The quality of care in institutional care facilities is assumed to be professional, but national measures can improve the quality standards.

Formal homecare. When choosing to receive formal homecare, there are similar factors as for institutional care facilities that influence the decision-making process. To start, formal homecare is only an option for receiving care when the government or other actors enable the existence of it; older adults can only choose this alternative if it is available. As Illinca et al. (2015) state, “the primary driver of deinstitutionalisation is the development of community-based alternatives” (p. 3), such as flexible services and support that are provided in a person’s home. For instance, Kemper (1992) provides evidence that the use of formal homecare is greater

in urban areas than in rural areas, because there is greater availability of homecare in urban areas. Moreover, a correlation exists between the non-availability of caretakers and admission to nursing homes (Wingard, Williams Jones, & Kaplan, 1987, p. 6). Governments can establish finance structures that support the existence of homecare in light of the national or regional health policy (European Commission, 2018b). Hence, the availability of formal homecare is not only an appealing aspect, but also a necessary aspect.

In addition, easy access to homecare is a favourable aspect. When a care organisation has to set less strict requirements for access, people may rather choose this alternative. The national or local authorities may set standards for eligibility criteria, and thus influence the favourability of formal homecare.[12]

Moreover, older adults will sooner choose formal homecare when the costs for receiving homecare are relatively low. For instance higher income leads to greater use of formal care and lower use of informal care. Governments can play a role in the height of elderly's income, via for instance state programmes that (partly) pay for homecare. Moreover, when people have to pay a higher price for formal homecare, the use of this type of care is likely to decrease, whereas the use of informal homecare increases (Kemper, 1992). Professional quality of homecare is also a favourable aspect; it can be expected that people choose to receive formal homecare when informal care does not suffice the care-needs anymore. Nationally set quality standards can impact the quality of care.

Informal homecare. The choice for informal homecare depends on its availability, the costs, and the quality of care. The availability of formal homecare is dependent on informal caregivers. Caregivers, in this case, are sometimes referred to as a social support, and can be a spouse, child, other relative, friend, neighbour, or anyone else with whom the older adult has a social relationship (Genet, Boerma, Kroneman, Hutchinson, & Saltman, 2012). When these kinds of people are available to a help-needing older adult and provide care, it is associated with a lower risk of nursing home admission (Chiswick, 1987; Wingard et al., 1987), as well as a lower use of formal homecare (Kemper, 1992; Lehnert et al., 2018). For instance, when job opportunities improve for adult women, demand for institutional care increases, as these women are less able to provide informal care (Chiswick, 1995; De Jong, Plöthner, Stahmeyer, Eberhard, Zeidler, & Damm, 2018). Availability of caregivers can thus be publicly regulated via for

[12] As Kroneman, Cardol, and Friele (2012) state, governments have two options to control formal care. They can either implement a model of equal access, implying that all citizens have the same right to support based on levels of disability, or governments can provide tailored solutions for citizens, implying that the situation of the individual is leading in granting support.

instance finance structures that ensure that caregivers can temporarily leave their job with greater ease. This is also related to the costs of informal homecare; for a family, taking care-leave from work becomes more costly when the caregiver does not receive any financial compensation. In addition, some countries grant cash benefits to help-needing elderly to compensate informal caregivers. Besides finance structures, governments can implement eligibility criteria for formal care that demand the provision of informal care; care that can be provided by the social network is not covered, meaning that informal caregivers are 'forced' to step in (SCP, 2014b).

The quality of this alternative depends on the qualification of the caregiver that provides informal homecare. It can be expected that professional employees of homecare organisations or nursing homes provide care of higher quality, and can for instance execute nursing tasks, such as inserting a catheter or measuring blood pressure. Nevertheless, authorities can use measures to improve the quality of informal care, such as training for informal caregivers and the provision of information.

The accessibility of informal homecare is not listed as a favourable aspect, since there are no eligibility criteria that need to be fulfilled to be eligible for receiving informal homecare.

Policies influence favourable aspects of long-term care alternatives. Figure 7 summarises the favourable aspects of each long-term care alternative, as found in the previous section. These aspects can be influenced by policies; policies can make them more or less appealing. For instance, when a government implements a policy that provides high allowances for institutional care, this alternative becomes more appealing, which makes it more likely for older adults to choose for. In this regard, policies thus also influence the macro-outcomes; policies have an influence on how many people choose for a certain alternative.

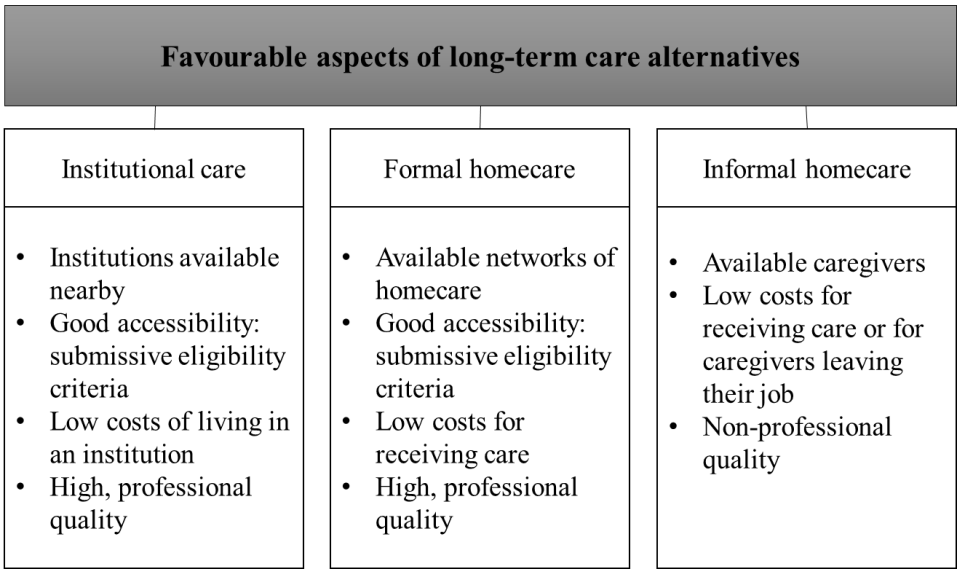

Figure 7. Favourable aspects of long-term care alternatives.

Based on the favourable aspect of each long-term care alternative, Figure 8 is set up. This figure links aspects of policy to the result that it achieves in terms of favourable aspects of long-term care.

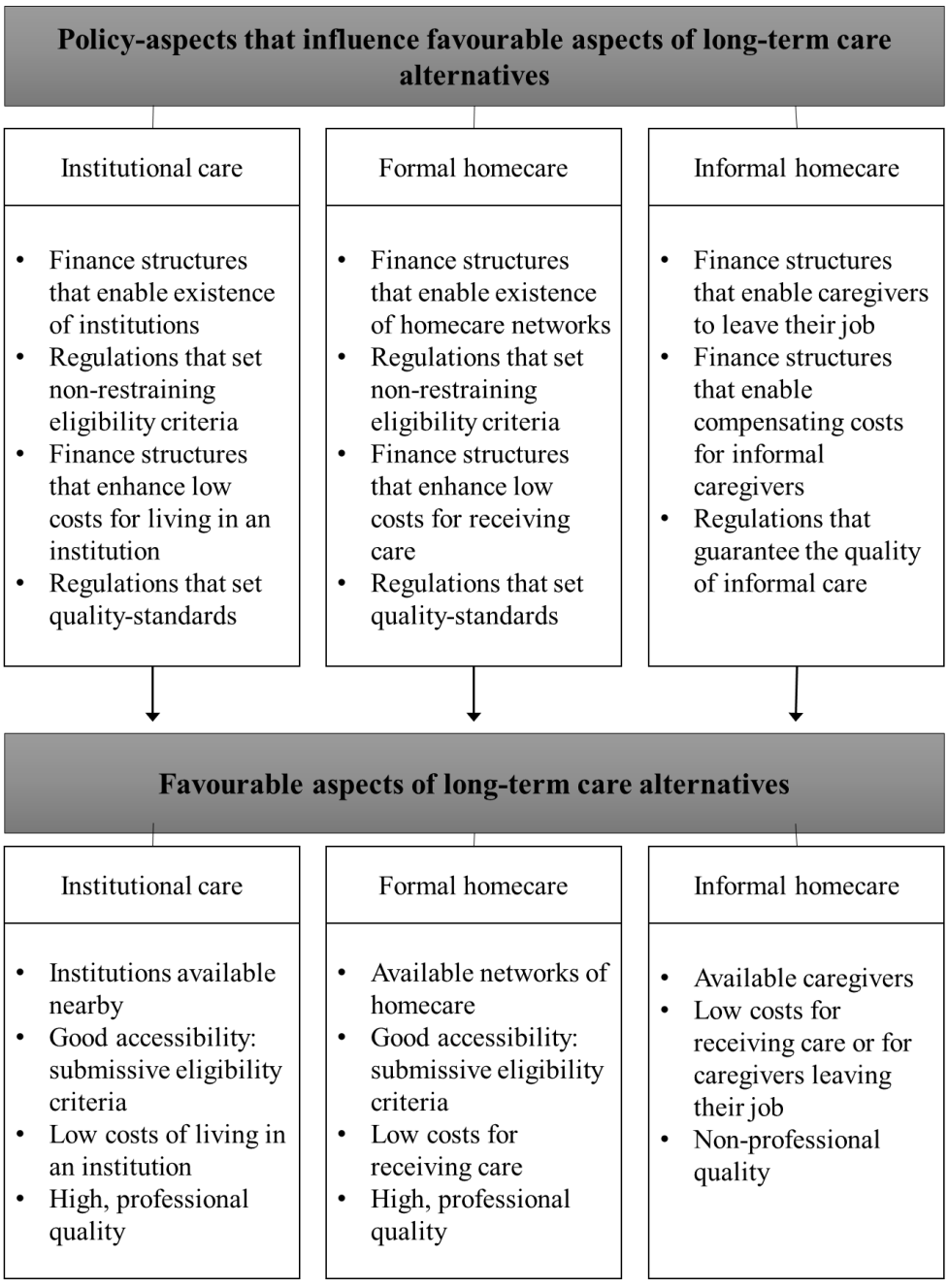

Figure 8. The link between policy-aspects and favourable aspects of long-term care alternatives.

2.3 Modelling the relation between older adults' choice processes and long-term care policy-aspects

To determine older adults' choice processes for choosing a form of long-term care, a content-specific model is developed, based on the information as mentioned earlier. This model, that is visible in Figure 9, outlines the factors that must be considered to understand choice processes for long-term care use.

The starting point of this model is rational choice theory. The choice that older adults make between the three alternatives is a rational choice and usually has a significant impact on a person's life. Choosing one alternative over the other is not a behaviour that is based on attitudes or intentions, as previously discussed. The choices of older adults are influenced by several factors. As was found in the literature, these are policies, information, societal factors and external pressure. These factors influence to what extent older adults find aspects of long-term care alternatives favourable. In addition, policy can change the favourability of aspects.

Favourable aspects of care that can be affected by policies are found to be availability, good accessibility, low costs, and high quality. Hence, older adults are likely to choose a form of care that includes these aspects. This is modelled in Figure 9. In Figure 7, that was discussed before, it is visible what these favourable aspects of care mean for each alternative in specific. Based on the favourable aspects for each form of care, policy-aspects were established that can influence a particular favourable aspect of care. This is visible in Figure 8, which is also discussed before. Figure 8, together with Figure 9, constitutes the model for this thesis.

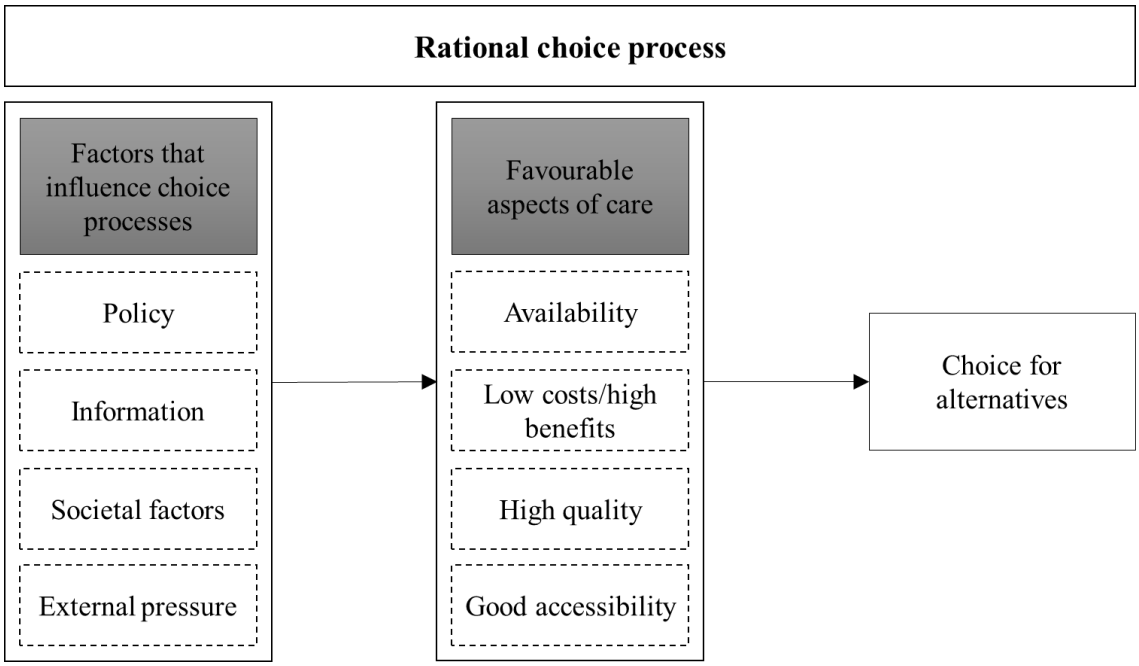

Figure 9. The rational choice process on older adults' choices for long-term care alternatives.

In conclusion, the framework for individual choice processes has been set out and it has become clear what aspects of long-term care alternatives people find favourable, and which aspects of policies generate these. These policy-aspects have an impact on the choice processes of help-needing older adults. Therefore, these policy-aspects receive attention in the Dutch-German comparative analysis of this thesis. The hypothesis is that alternatives of which the favourableness is enhanced by certain policy-aspects, are likely to be relied upon more by help-needing elderly compared to the alternatives.

Societal factors are not considered, as it can be assumed that these are comparable in Germany and the Netherlands, as is discussed in the case selection. The influence of external factors and the presentation and provision of information is not measurable within this study.

Coleman's diagram explains how micro-level choice processes lead to macro-level outcomes of long-term care use. The individual choice processes for alternatives have been theoretically defined in the previous sections. However, a gap exists between the rational choice processes that take place on the individual, micro-level, and the outcomes of choice processes on the macro-level. Coleman's classic macro-micro-macro model (in other words, 'Coleman's boat' or 'Coleman's bathtub') closes this gap. Although this thesis does not engage in the actual choice processes on the individual level, but only with macro-outcomes of choice processes, this model is explanatory of the underlying process.

With his model, Coleman attempts to solve the issue of "the movement from the individual level, where observations are made, to the systemic level, where the problem of interest lies" (Coleman, in Ramström, 2018, p. 370). He argues that it should be considered how actions combined can result in macro-outcomes. The model contradicts scholars who move from micro to macro through the aggregation of actions; Coleman states that this transition does not involve the aggregation of individual behaviour, but is rather more complex. The "rules of the game" are referred to as "the structural circumstances in which actions take place in a particular X-Y account" (Ramström, 2018, p. 371). These circumstances influence not only the effects of actors' actions on one another but also how actions combine to produce the macro-level outcomes (Ramström, 2018).

Figure 10 is created based on Coleman's model. Coleman portrays the actors in the model as rational utility maximisers. Especially the move between C and D is of relevance. C is the micro-cause and D is the macro-outcome. Therefore, D is counterfactually dependent on C. Coleman defines C as an independent variable and D as a dependent variable. He argues that C is empirical input, that, together with the rules of the game, determines the empirical output D (Ramström, 2018).

However, it is argued that Coleman's model treats analytical micro-macro relationships as being empirical, resulting in a failure to make sense in a social scientific context (Ramström, 2018). Nevertheless, Figure 10, based on Coleman's model, helps to understand the underlying causal mechanisms between micro-level choice processes and the macro-level outcome of deinstitutionalisation. The figure shows an example of long-term care policies that result in higher prices for institutional care; it is, however, valid for any other long-term care policy.

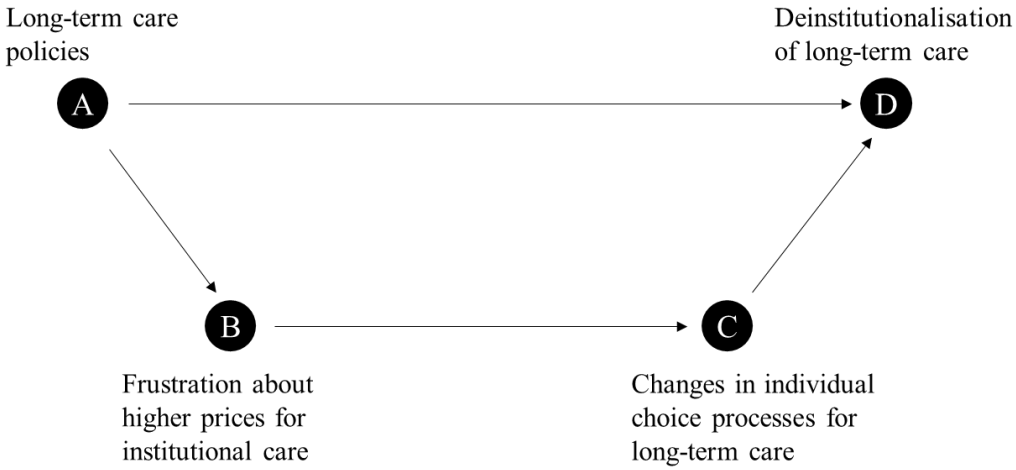

Figure 10. Macro-micro-macro model on the effect of long-term care policies on deinstitutionalisation. This effect occurs via the individual choice processes on the micro-level. The figure presents an example of how macro-inputs result in macro-outcomes via the micro-level.

3. Conceptualisation

Two concepts will be measured within this thesis. These are conceptualised hereafter.

3.1 The Dependent Variable

The first concept – the dependent variable – is the choice processes of help-needing older adults when choosing between institutional care, formal homecare and informal homecare. This is defined as processes that result in a choice for institutional care, formal homecare and/or informal homecare. Indicators for the measurement of this concept are users of each form of long-term care. How these indicators are measured is discussed in the Research Methodology.

3.2 The Independent Variable

The second concept – the independent variable – is the favourableness of alternatives (institutional care, formal homecare, informal homecare). The definition of this concept is based on the theoretic framework (especially Figure 7). It refers to the favourability of the alternatives in terms of availability, accessibility, costs and quality of care. The dimensions of the concept are availability, accessibility, costs and quality. Therefore, the indicators that can be measured to establish the favourableness of alternatives are respectively: measures and finance structures that enable the availability of care; measures and eligibility criteria that determine the accessibility of care; costs or co-payments of care; and the quality of care and quality assurance measures.

4. Research Methodology

The aim of this thesis is to explain how cross-country policy-differences between Germany and the Netherlands are related to the degree of deinstitutionalisation of long-term care for older adults.

4.1 Timeframe

This study is longitudinal; the same variables are repeatedly observed over multiple years. The study is conducted using data from the years 2004 until 2017. This time-range allows to discover any changes over the years or any impacts that specific policies may have had; it allows for more reliable outcomes. These exact years are chosen because of the available data. The Dutch statistical website only has data available from 2004. The German statistical website already has data available from 1999. The German data from the years prior to 2004 are analysed for any outstanding irregularities or other noteworthy aspects of the German long-term care system, but the formal comparative analysis is conducted using data from 2004 until 2017.

4.2 Variables

This study makes use of a combination of qualitative and quantitative analysis.

4.2.1 Quantitative measurement of the dependent variable. The dependent variable is the outcome of choice processes of help-needing older adults; the number of older adults is measured that choose to receive institutional care, formal homecare or informal homecare between 2004 and 2017 in Germany and the Netherlands. Desk research was performed to carry out this measurement, using data from national databanks on the users of institutional care and formal/informal homecare aged 65 years and older. The data are processed in Excel, employing a secondary analytic approach of existing data.

Data about long-term care use in Germany are retrieved from Statistisches Bundesamt [Destatis] (n.d.). To measure the number of elderly receiving institutional care, Destatis' data are used about people aged 65 years and older that receive (or have the right to) care under the long-term care insurance and live in an institution (*Versorgung in Heimen vollstationär*).

The number of elderly receiving formal homecare is measured using data about people aged 65 years and older that receive care at home (*Versorgung zu Hause*), and that receive care partly in institutions (*Versorgung in Heimen teilstationär*). When people only partly receive care in an institution, it means that they still live at home, but for instance make use of day or night care (Destatis, n.d.). Destatis (n.d.) has counted people receiving care at home as people

that receive care from ambulant care services as well as from people they pay with cash benefits (*Pflegegeld*) (Destatis, n.d.).

Destatis (n.d.) has only published data on the users on a biannual basis, starting in 1999. For that reason, the data used in this study are from the years 2003 to 2017 (odd numbers), instead of 2004 to 2017. In the graphs used to answer the first sub-question, the points between the years are connected, to give an indication of the users in the years in between (the even numbers).

Data from the Netherlands are retrieved from Central Bureau for Statistics Statline MLZ [CBS]. Due to the introduction of new acts in 2015, the retrieval of data is separated into two parts: from 2004 to 2014, and from 2015 to 2017. In the period from 2004 to 2014, the elderly using institutional care are measured using data about people aged 65 years and older that receive care under the AWBZ with residence (ZMV-AWBZ[13]) (CBS, 2018c). Older adults using formal homecare are measured using data about people aged 65 years and older that receive care under the AWBZ that live at home (ZZV-AWBZ[14]) (CBS, 2018c), and that receive care under the Wmo (ZZV-Wmo).

When adding up users of care covered by the Wmo and the AWBZ, an overlap exists between people that used both types in one year, and users that used both types of homecare and residential care within one year. To prevent that choices are counted double, the amount of older adults using these types of care is deduced from the total homecare users (both from the AWBZ and the Wmo). This overlap is presented in Figure 11 by the grey-marked area. In total, the amount of older adults choosing for the three types of care in one year is larger than the actual long-term care users as counted by CBS (2018c). The accessory amount is a result of older adults that make use of multiple forms of care within a year. These are included in the measurements, as this study is concerned with the choice processes for long-term care; older adults using both care with and without residence in one year, have made two choices in that year.

[13] ZMV refers to '*zorg met verblijf*', which is translated to 'care with residence'.
[14] ZZV refers to '*zorg zonder verblijf*', which is translated to 'care without residence'.

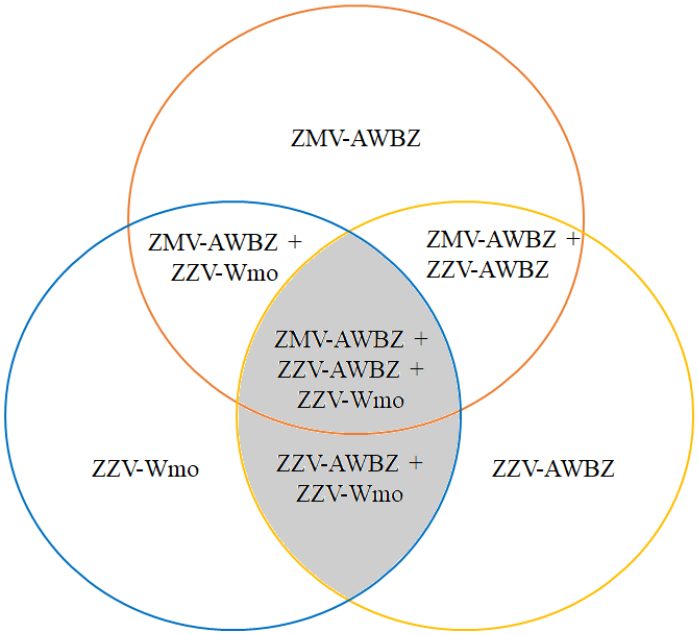

Figure 11. Overlap between different types of long-term care in the Netherlands until 2014. ZZV refers to 'care without residence'; ZMV refers to 'care with residence'. The orange circle indicates CBS' terminology to measure the use of care with residence covered by the AWBZ. The blue circle indicates the use of homecare covered by the Wmo. The yellow circle displays the terminology used to measure choices for homecare covered by the AWBZ. Adapted from "*Personen met gebruik ZZV en/of ZMV; inkomen en regio, 2004-2014* [Data file]" by CBS, 2018c. Retrieved from https://mlzopendata.cbs.nl/#/MLZ/nl/dataset/40011NED/table?ts=1558432667604.

For the year 2007, there is a lack of data for the users of AWBZ with residence. For that reason, CBS Statline was only able to publish data on reference date (CBS, 2018c).[15] Likewise, it is noteworthy that several municipalities failed to forward data on domestic help (*huishoudelijke verzorging* [HV]) (belonging to the Wmo) in the year 2013. Hence, there is underreporting of this form of care (CBS, 2018c).

For the period 2015-2017, older adults receiving institutional care are measured using CBS' data on people aged 65 years and older that receive care under the Wlz (CBS, 2019c). However, this only includes people that receive care in kind, and leaves out people with

[15] For the measurements, data about the persons with use in year is used (*personen met gebruik, in jaar*), instead of persons with use on reference data. Two reasons led to this decision. Firstly, between 2004 and 2008, CBS Statline MLZ has not published any data about AWBZ-users with care without residence (ZZV). Secondly, the use of a form of care over a year gives a more complete image of the users than the amount of users on a reference date.

personal budgets. Wlz-users only use personal budgets to a minor extent; in the years 2015, 2016 and 2017, about 5% of the elderly Wlz-users received personal budgets (CBS, 2019d). [16] It is estimated that most personal budgets holders use the budget to purchase care at home: About 80% do so, compared to 20% of the personal budget-holders who purchase institutional care (A. Gerdez, personal communication, 30 October, 2019).[17] Although most personal budgets are thus used for care at home, the amount of personal budget holders is relatively small. It is therefore not expected to significantly impact the results of the study.

Older adults receiving formal homecare are measured by using data about people aged 65 years and older that use care under the Wmo-2015, the Zvw and extramural care in-kind under the Wlz. The users of Zvw-care constitute of people that use both care in kind and personal budgets under the Health Insurance Act (CBS, 2018b). Lastly, the measurement of users of extramural care under the Wlz is conducted using CBS' measurement of users of care in kind belonging to this act that live at home and are 65 years and older. This is the group that is described as receiving a complete modular package at home (*volledig modulair pakket thuis*) and a 'normal' modular package at home (*modulair pakket thuis*) (CBS, 2019c).

CBS (2019c) points out that people can make use of multiple forms of care covered under the Wlz within one year; due to an administrative overlap, it is possible that a small amount of people was counted as receiving multiple forms of care, whereas they only used one form at a time. Furthermore, CBS (2019c) notes that some individuals receive care under the Wlz, but which is financed by a subsidy scheme carried out by the National Health Care Institute (*Zorginstituut Nederland*). It concerns primary residence (*eerstelijns verblijf*) (until 2017), activities of daily living [ADL], or extramural treatment. These people, who receive care based on one of the subsidy schemes, are not included in CBS' measurements (CBS, 2019c).

It should be pointed out that older adults can make use of formal homecare covered both by the Zvw as by the Wmo. This would be counted as one choice to stay at home. However, CBS does not provide data about the overlap between the two, in other words, the amount of elderly that both use Zvw-care and Wmo-care. For the period 2004-2014, data about the overlap is available and taken into account in the measurements. Therefore, an overestimation of formal homecare users can be expected for the years 2015-2017.

There are some differences between CBS' measurements of 2004-2014 and 2015-2017.

[16] The share of Wlz-personal budget holders compared to the total Wlz-users is 4.1% in 2015, 5.3% in 2016, and 5.8% in 2017. These percentages are found by dividing the amount of Wlz-personal budget holders by the amount of total Wlz-users per year (CBS, 2019d).

[17] A. Gerdez is a customer/field service professional at Menzis, which is a one of the largest care offices in the Netherlands.

The main reason is the transition of acts since 2015. CBS only measures care under the Wmo and the Wlz for which people have to pay a personal contribution (because then they are visible for the Central Administration Office [CAK]). Before 2015, people living at home had to pay this contribution for housekeeping services, accompaniment (available since 2011), personal care and nursing. People living in a residence had to pay a contribution for the use of the residence and its services (CBS, 2018c). From 2015 on, CBS still counted the people that use care for which they have to pay a personal contribution. However, more functions of care were added. Under the Wlz falls accompaniment, personal care, nursing, treatment, short-term residence, and housekeeping services (since 2017) (CBS, 2019c). The Wmo includes since 2015 also accompaniment, arrangements, (other) aids and services, short-term stay, protected residence and a part of personal care (CBS, 2018a). Due to these differences, it can be expected that a larger amount of people receive care since 2015, as more forms of care are included.

Moreover, CBS defines users of care covered by the AWBZ, Wmo, Wmo-2015, and the Wlz as persons using at least one type of provision as provided by the acts, for which they have to pay a personal contribution. Users that do not pay a personal contribution are thus not included in the measurements; for instance, municipalities are allowed to provide services without demanding a personal contribution. However, it is expected that most – if not all – municipalities demand an own contribution for long-term care (CBS, 2018a).

Furthermore, since 2015, CBS also included people that make use of care under the Wlz that belongs to *partnerverblijf* (Stay with Partner) (CBS, 2019c). Stay with Partner is for the partner of a person with a Wlz-indication; it allows him or her to move into an institution together with the help-needing person. The partner does pay an own contribution, but does not receive a Wlz-indication (Zorginstuut Nederland, n.d.a). Before the reforms in the social domain, CBS does not mention anything about this; it can be assumed that this is not included in the measurements. Therefore, it is probable that a minor difference exists between the measurement before and after 2015: The number of Wlz-users may be slightly greater since 2015 because of the inclusion of people staying with their partner, even though they are not ‘in need of care’.

To make a reliable comparison, the data about the users of alternatives are transferred into percentages to determine the relative use of homecare and institutional care. This demonstrates the share of help-needing people that live in an institution over the years, compared to people living at home, either receiving formal or informal care. The measurement in percentages also enables a reliable comparison between Germany and the Netherlands, in which the shares can be compared, rather than the absolute amount; the differences in elderly

population between the two countries demands this type of measurement, indicating the relative amounts.

For the German data, the amount of older adults living at home/in institutions is divided by the total amount of help-needing elderly, living either at home or in an institution. This demonstrates the share of elderly users of institutional care/homecare relative to the total amount of elderly care-users. For the Dutch data, the percentages indicate the share of choices relative to the total amount of choices, instead of the actual users. This is because Dutch elderly can choose multiple forms of care within one year (both institutional and homecare), but also multiple forms of care at the same time (such as care from the Wmo and the Zvw).

Only the German national databank has published data on the use of informal care, as the amount of elderly using cash benefits give an indication. The Dutch national databank does not have any data available on informal homecare. Therefore, other sources were used to estimate differences between the two countries. These sources are mostly international organisations, such as the European Commission (2016) and the Organisation for Economic Co-operation and Development [OECD] (2013; 2015; 2017). The organisations have published data on informal care (either provision or receival) for both Germany and the Netherlands. Therefore, it can be assumed that the same types of measurement are used for the countries by each source, ensuring the reliability and comparability of the data used for this study. The data from these sources are compared to estimate the difference of informal care use between Germany and the Netherlands. Moreover, the data from the international organisations are compared to data from Dutch, national sources, to guarantee the reliability. However, the sources use other definitions of 'informal care' than in this study[18]; the amount of cash benefit users in Germany are not included. This study defines German cash benefit users as users of informal homecare. Therefore, the amount of informal care receivers and providers as found in the aforementioned sources is counted as an addition to the cash benefit users.

There is a lack of available data about Dutch older adults that need care but pay off the books. The German data on cash benefit users only give some insight into care paid off the books. This group is thus not included; but, as this group may also make use of formal acts to receive care, there may be overlap which means that the group is not completely neglected.

[18] As Timmermans et al. (in SCP, 2010) highlight, it is complicated to determine the amount of informal caregivers in the Netherlands. The amount depends on definition that is used and the precise scope of the definition. Likewise, the European Commission (2018b) states that the total number of people in need of help and care in Germany is unknown, and with that the amount of people receiving informal care. Only people that receive benefits from the long-term care insurance scheme are statistically recorded (European Commission, 2018b).

Moreover, persons paying for care off the books may also indicate that they are not eligible for care, and thus not 'in need of care'. This group is thus not of relevance in this study.

Another group that is not included is people aged 65 years and older that pay for private institutional care or private formal homecare, without a care indication and without receiving governmental support. Not only is there a lack of data about this group, this study is also merely concerned with long-term care that is influenced by governmental policies.

4.2.2 Qualitative measurement of the independent variable. The independent variable is the favourableness of institutional care, formal homecare, and informal homecare, in the form of sufficient availability, good accessibility, low costs, and high quality. To determine the favourableness for each alternative based on the aspects, Dutch and German long-term care policies are analysed which enhance or undermine favourable characteristics of long-term care for older adults. The measurement is conducted by desk research in the form of a policy description and linking the description to the four aspects of favourable long-term care. For the analysis, it is necessary to separate each aspect, but the overall favourability of an alternative is dependent on the combination of aspects.

The aim of the study is to understand the influence of policy on choice processes. Although this study is descriptive in nature, similar questions as for policy evaluations[19] are necessary to achieve its aim. These are: 1) What are the objectives of the policy, and 2) what instruments are used to achieve these objectives (Winter, 2014). This study does not determine to what extent the policies achieve their objectives. Furthermore, not just one policy is analysed, but multiple are analysed. These are the policies that arrange instruments for the provision of institutional care, formal care at home and informal care at home.

As described in the theoretic framework and the conceptualisation, the analysed dimensions are those that are influenced by policy instruments. They include availability, accessibility, costs and quality of institutional care, formal homecare and informal homecare. Multiple sources are used to determine this, which vary between Germany and the Netherlands. For each country, the measurement of the aspects that is carried out is described below. Besides the acts and the databases that were used, literature also served as a source of information to determine the favourability of the aspects.

[19] The aim of policy evaluation is the assessment of observed content, processes or effects of a policy using certain criteria. Policy evaluations mostly include three elements: observing, criteria, and assessing. Usually, criteria are concerned with achievement of goals, effectiveness, efficiency, and legality (Hoogerwerf & Herweijer, 2014).

The German Social Code, Book XI (*Sozialgesetzbuch XI* [SGB XI]) served as the main (secondary) source for the analysis for all aspects of German long-term care.[20] The availability of institutional care was measured using data about the available places in institutional care facilities in Germany and the growth rate of these places since 2003. This is compared to the (growth rate of) people receiving care in institutions, to observe any over- or undersupplies of available places. The data is retrieved from Destatis (2019c). The availability of formal homecare was determined using Destatis' (2019b) data on the staff of homecare service providers, which is compared to the amount of help-needing people (of all ages) receiving care (partly) at home between 2003 and 2017. The developments of these two indicators allowed to observe (in)sufficient availability of formal homecare. It was not possible to retrieve information about the amount of people that are informal caregivers.

To measure the costs of the three alternatives in Germany, the coverage from the long-term care insurance is used in combination with information of the total costs of care or the co-payments, as well as the inflation rate. This information was retrieved from literature and websites from organisations. Although information about the total costs of care or the co-payments was not available for each year between 2004 and 2017, the combination of data used allowed to estimate the developments of costs.

The accessibility of each alternative was determined using the eligibility criteria for each form of care, as is in coherence with the theoretic framework. This information was retrieved from literature and from organisations. Lastly, the quality of the alternatives was indicated by the laws and regulations on long-term care quality assurance.

To determine the favourableness of the three alternatives in the Netherlands, multiple acts are of relevance: the AWBZ, the Wmo, the Wmo-2015, the Wlz, and the Zvw. For the period 2015-2017, the Wlz is used to determine the attractiveness of institutional care aspects, although it should be noted that older adults can receive formal homecare covered by the Wlz. Nevertheless, it only concerns a relatively small share of older adults who receive homecare covered by the Wlz; in general, Wlz covers institutional care (CBS, 2019d). Therefore, the Wlz is analysed to determine the favourability of institutional care.

The availability of institutional care is determined using CBS' (2019b) data on job openings in the care and welfare sector (only available since 2011), as well as information about governmental support for facilities and standards for maximum waiting times. Likewise, the availability of formal homecare is determined using the same data on job openings (CBS,

[20] In the German Social Code, the social security is arranged. Book XI is concerned with social care.

2019b). It has not been possible to measure the availability of informal homecare, although the accessibility criteria to long-term care may take into account the provision of informal care; the availability of informal care from the social network is 'forced' in some cases.

The co-payments for care under the AWBZ, Wmo and Wlz are income-dependent, which makes it impossible to determine the costs for each alternative. Nevertheless, CBS (2015) published a figure about the developments of co-payments for care under the Zvw and the AWBZ between 2009 and 2014, which is used to get an indication of the development of co-payments. Other available information about the costs of care was found in literature and from organisations' websites. Information about the costs of informal care comes from national laws and regulations for the support of informal caregivers.

The accessibility to both institutional care and formal homecare is established using information about the eligibility criteria for the alternatives over the years that is retrieved from literature and organisations. Lastly, to determine the quality of care, national laws and regulation on the quality assurance of long-term care were used.

Hence, the quality is the aspect that is most comparable between Germany and the Netherlands as it makes use of the same sort of information. For the other three aspects, differences exist in the types of information used between Germany and the Netherlands, because identical data was not found. Ideally, waiting lists would be consulted to determine the (un)availability of alternatives, but these are not (sufficiently) available for both countries. Moreover, certain policy-measures that enhance the favourability of alternatives could not be analysed within the frame of this study. For instance, governments can enhance the supply of labour, and thus availability, via improved wages and labour conditions and lower barriers to market entry (Wanless, in Geerts, 2011). This study did not allow the analysis of these types of government measures. Nevertheless, this does not interfere a valid comparison, as the data are comparable and give a solid indication of the situation. To assure reliability of the comparison, the comparative section made use of figures from Eurofound (2017) and the European Commission (2018a) that not only serve as a check, but also display a country-comparison.

Between these two variables, a causal relation is expected; a cause contributes to the production of an effect.

5. Results

5.1 What are differences in the deinstitutionalisation of long-term care for older adults between Germany and the Netherlands?

In specific, this sub-question aims to answer what the percentual differences are between Germany and the Netherlands regarding older adults receiving institutional care, formal homecare, and informal homecare.

5.1.1 Germany's deinstitutionalisation process is taking place. Germany's elderly population in need of care[21] has increased significantly between 2004 and 2017: At least 64% more elderly in 2017 were in need compared to 2004 (Destatis, n.d.). Figure 12 displays the differences between the percentual use of institutional care and formal homecare, compared to the total amount of older adults receiving formal care.

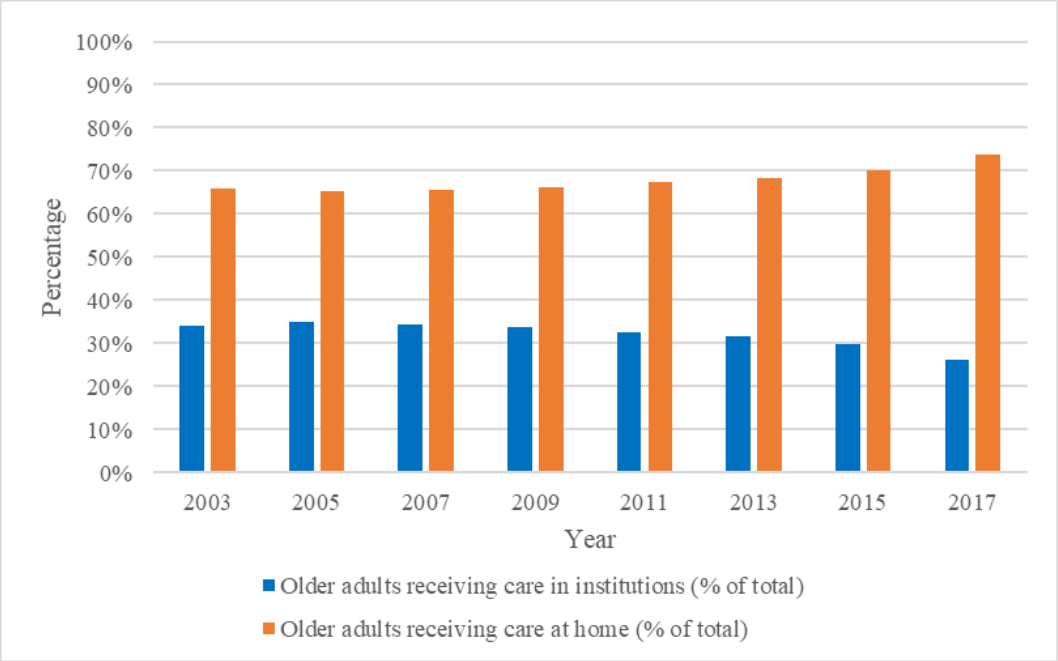

Figure 12. Deinstitutionalisation of long-term elder care in Germany, 2003-2017. The percentage indicates the share of the total amount of help-needing elderly receiving either institutional care or homecare covered by the long-term care insurance. The figure is based on Appendix A. Table 9.

The relative use of institutional care in Germany declined. The absolute amount of older adults receiving institutional care has increased between 2004 and 2017 with at least 31%; in 2005, 610,340 elderly lived in institutions, compared to 756,596 elderly in 2017 (Destatis,

[21] 'In need of care' refers to the elderly population that receives in-kind care or cash benefits covered by the German long-term care insurance. This definition is chosen because of the data that Destatis (n.d.) provides.

n.d.). Yet, the share of the elderly living in institutions has decreased compared to the total elderly population receiving long-term care, as is visible in Appendix A. Table 8 and Appendix A. Table 9; in 2004, around 34% lived in institutions, whereas 26.3% in 2017. Outstanding is the percentage of older adults receiving institutional care in 2005; with 34.9% it is the highest percentage measured between 2003 and 2017. Since that year, the amount of the elderly living in institutions decreased compared to the elderly receiving formal homecare. The most substantial decreases took place between 2015 and 2017. In 2017, only 26.3% lived in institutions (Figure 12).

German older adults moved towards long-term care at home. With an increase of at least 85.6%, the amount of older adults receiving homecare covered by the long-term care insurance boomed. In absolute numbers, this part of the population grew from around 1.1 million people in 2004 to 2.1 million people in 2017 (Destatis, n.d.). These amounts thus also include informal care users that receive cash benefits. As is visible in Figure 13, the share of formal homecare users is smaller than informal homecare users. Nevertheless, the absolute amounts of formal homecare-users has increased significantly over the years. Compared to the total German ageing population using care under the long-term care insurance, however, this increase has not been similarly impressive.

Between 2003 and 2007, the share of older adults receiving homecare remained nearly similar, around 66%. In 2005, it even slightly dropped to 65%. Since 2009, the trend of deinstitutionalisation is increasingly observable; the percentage of older adults using homecare increased to 73.7% in 2017. The largest increases took place in 2015 and 2017 (Figure 12).

The relative use of informal care only increased slightly. The German population in need of long-term care makes substantial use of informal care (home care solely by relatives), as is visible in Figure 13. Although this figure displays the use of long-term care of the complete German population (also younger than 65 years) it gives an indication of the informal care use. Informal care in this figure refers to care that is provided by relatives, when the help-needing elderly receive cash benefits. Between 2003 and 2015, the absolute informal homecare use increased with 40.4% (by all Germans, not only by older adults).[22] Compared to the total amount of homecare use, this amount is slightly lower, although the difference is not great: Between 2003 and 2015, the absolute use of (informal and formal) homecare increased with

[22] Measured using the amounts of 'home care solely by relatives' as visible in Figure 13. In 2003, 986,520 German citizens used informal homecare, compared to 1,384,604 citizens in 2015. This is an increase of 40.4%.

44.6% (by all Germans, not only by older adults).[23] The relative use of informal care, however, has not changed much between 2003 and 2017: Between 45.6% and 51.7% of the people in need of long-term care made use of this type of care (Destatis, 2019a).

The lowest percentual use of informal care was measured in 2009, with 45.6%. In the years prior to 2009, the informal care use had relatively (and with the exception of 2007, also absolutely) decreased. After 2009, both the relative and absolute use of informal care increased significantly, reaching 51.7% in 2017 (Destatis, 2019a).

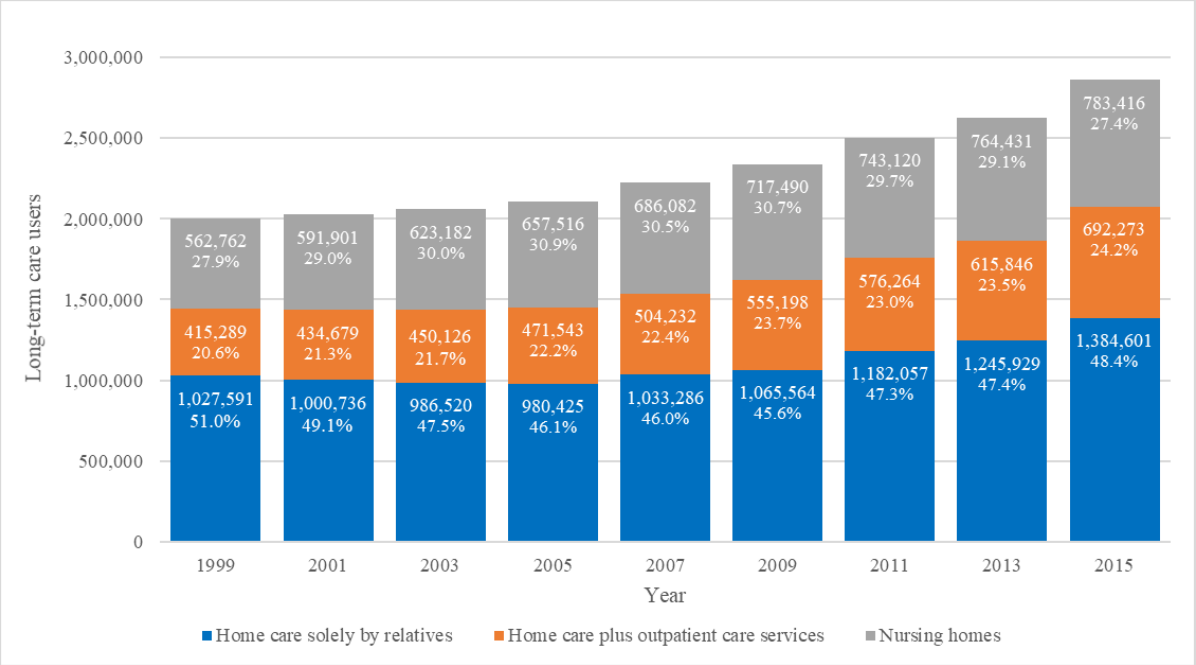

Figure 13. People in need of long-term care by type of provision, Germany, 1999-2015. Adapted from *"ESPN Thematic Report on Challenges in Long-Term Care: Germany"* by European Commission, 2018b, p. 18.

The use of German long-term care alternatives compared. Until 2005, the two groups of people (receiving institutional care and homecare) converge. The year 2009 appeared to be a turning point, when the groups started to diverge. Since 2011, the difference between the two groups even increased more significantly, with the most substantial change taking place between 2015 and 2017. By 2017, 73.7% of the help-needing elderly received homecare, whereas 29.8% received care in an institution (see Figure 12).

Altogether, the trend in Germany is an overall decrease of older adults that live in an

[23] Measured using Table 2, using the amount of "help-needing people (all ages) receiving care (partly) at home". In 2003, 1,436,646 Germans made use of homecare, compared to 2,076,877 citizens in 2015. Hence, the total homecare use (both formal and informal) increased with 44.6% between 2003 and 2015.

institution, whereas more older adults receive care at home, either formally or informally. Although the percental differences between 2004 and 2017 are relatively small, the data shows a slight deinstitutionalisation.

5.1.2 The Dutch long-term care use has witnessed a significant deinstitutionalisation. Similar to Germany and multiple other European countries, the Netherlands is dealing with a growing population of older adults that need help. This group consisted of 655,125 people in 2004, and raised to 1,054 million people in 2017 (CBS, 2018a, 2018b, 2018c, 2019c, 2019d). This is an increase of 60.9%. The top of the elderly receiving formal care had been reached in 2015. Figure 14 displays the differences between the percentual use of institutional care and formal homecare by older adults.

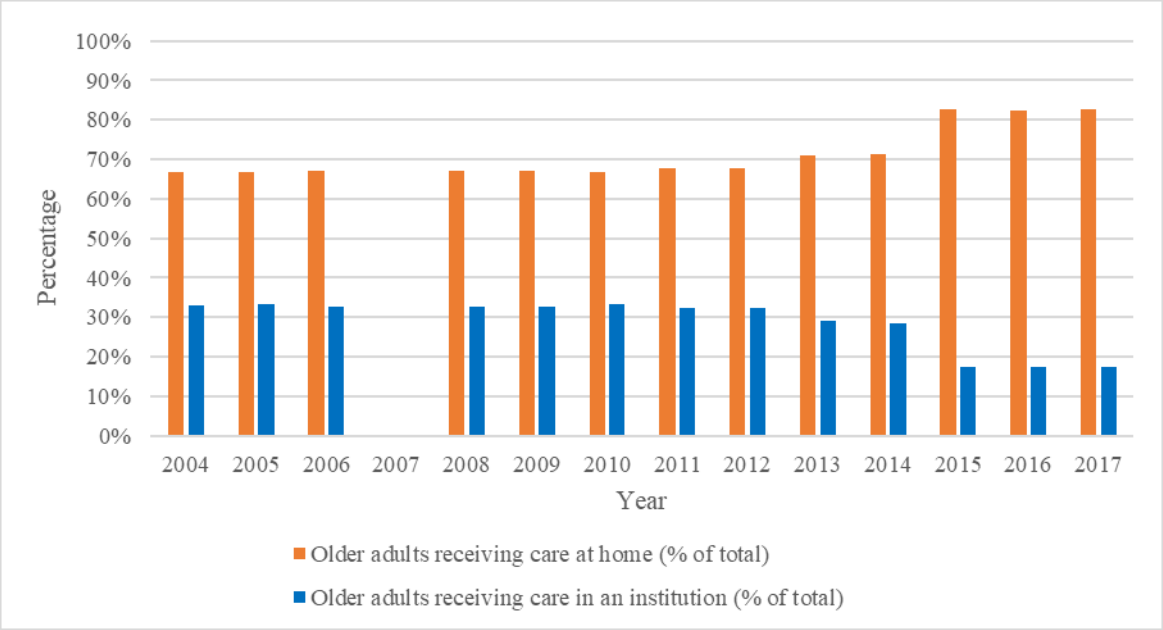

Figure 14. Deinstitutionalisation of long-term elder care in the Netherlands, 2004-2017. The figure is based on Table 10, Table 11, and Table 12 in Appendix A. For the year 2007, a gap in the graph is visible due to CBS' incomplete data on the use of care with residence.

Institutional care plays a smaller role in the Dutch long-term care system. The number of older adults choosing to receive institutional care decreased between 2004 and 2017, from 238,475 people in 2004 to 212,390 people in 2014. Since the decentralisation, the number plummeted enormously; from 186,370 people in 2015 to 182,160 people in 2017 (CBS, 2018c, 2019c, 2019d).

Relatively less people came to spend their days in institutions. The share of this group compared to the total elderly population receiving formal care decreased from 33.1% in 2004 to 28.6% in 2014. Since the decentralisation, this share has almost halved, reaching 17.3% in

2017. Noteworthy is the sharp decrease in 2013, when the percentage dropped with 3.0% in one year. Before 2013, the share had been fluctuating slightly up and down (Figure 14).

Formal homecare is increasingly used by Dutch older adults in need of help. Between 2004 and 2014, the number of older adults choosing to receive formal homecare has increased with 10.4% (from 481,595 people to 531,540 people) (CBS, 2018c). The largest change took place in 2015, when suddenly 880,315 older adults became dependent on formal homecare, meaning an increase of 65.6% compared to 2014.

Comparing these amounts to the total elderly population receiving formal care in total, a slighter increase took place: 66.9% of that group received formal homecare in 2004, whereas this share was 82.7% in 2017. A slight drop took place in 2010, when only 66.8% received formal homecare.

Estimates are that the use of informal homecare has not radically changed. Specific data on informal care use between 2004 and 2017 is unavailable. Although a lack of data on informal care use prevails, the combined data from multiple sources as visible in Table 14 and Table 15 in Appendix A demonstrate no significant variations in informal care use or provision.

Compared. Although it is not known how much elderly receive informal homecare, it is clear that an increasing amount of Dutch help-needing elderly live at home. This is the case even though the overestimation of formal homecare users between 2015 and 2017, as discussed in the Research Methodology.

5.1.3 The deinstitutionalisation process in Germany and the Netherlands appears to be largely similar. Figure 15 is created with a combination of the same data as used in Figure 12 and Figure 14, to compare the situation in Germany and the Netherlands. The trends and the percentages of care users/choices for care in both countries are similar: the data show that long-term care use by older adults is deinstitutionalising, meaning that a larger share of older adults make use of formal care at home, and that relatively less people live in institutional care facilities. Especially in the last years of measurement, since about 2013, this trend is visible (Figure 15).

One difference, however, is the rate of deinstitutionalisation between the two countries. Since 2013, the Dutch deinstitutionalisation is accelerating at a faster rate than in Germany. Especially since 2015, the gap between Germany and the Netherlands is large.

The year 2015 also marks a point of deferral between the two countries. Since that year, the share of older adults in institutions significantly dropped, whereas more older adults came to receive formal homecare. While that change took place in the Netherlands, Germany lagged

behind regarding deinstitutionalisation. The German elderly continued to deinstitutionalise, but not at such a substantial rate as the Dutch elderly.

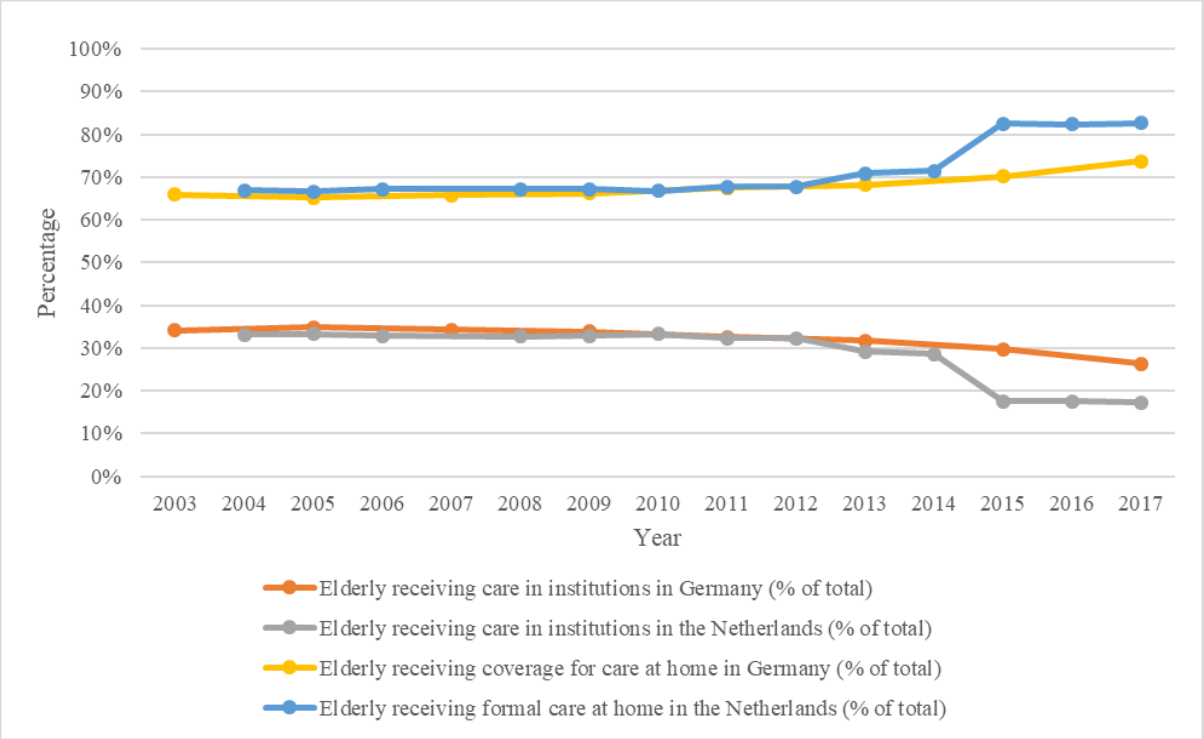

Figure 15. Deinstitutionalisation of elder care, Germany and the Netherlands, 2003-2017. The figure is a combination of Figure 12 and Figure 14. The yellow line does not only represent formal homecare use, but also a share of informal care use in Germany, due to the inclusion of cash benefits.

The use of informal homecare compared between Germany and the Netherlands. As discussed in the Research Methodology, there is no sufficing comparable data available on informal homecare in Germany and the Netherlands. Table 14 in Appendix A was created with the available data to provide an overview of the informal care use/provision. The trend that comes forward is that the Netherlands has had a larger share of informal caregivers over the years, although the differences in percentages do not exceed 2.6% between the two countries. Only the European Quality of Life Survey (in European Commission, 2018d, p. 19) found that Germany has a larger share of informal carers of the total population than the Netherlands in 2016 (23% compared to 18%). When it comes to the share of older adults that receive informal care, nonetheless, Riedel & Kraus (2011) have found that this is significantly higher in Germany, as is visible in Figure 16.

However, another definition is used in those sources. Users of cash benefits in Germany are not included as informal care users, as is the case in this thesis. To indicate the informal

care use in Germany, the users of cash benefits must be added to the shares as indicated in Appendix A. Table 14. An indication of the Dutch informal care users solely depends on the amounts that Table 14 and Table 15 in Appendix A demonstrate; users of personal budgets are not included. Hence, informal care use is in Germany significantly higher than in the Netherlands.

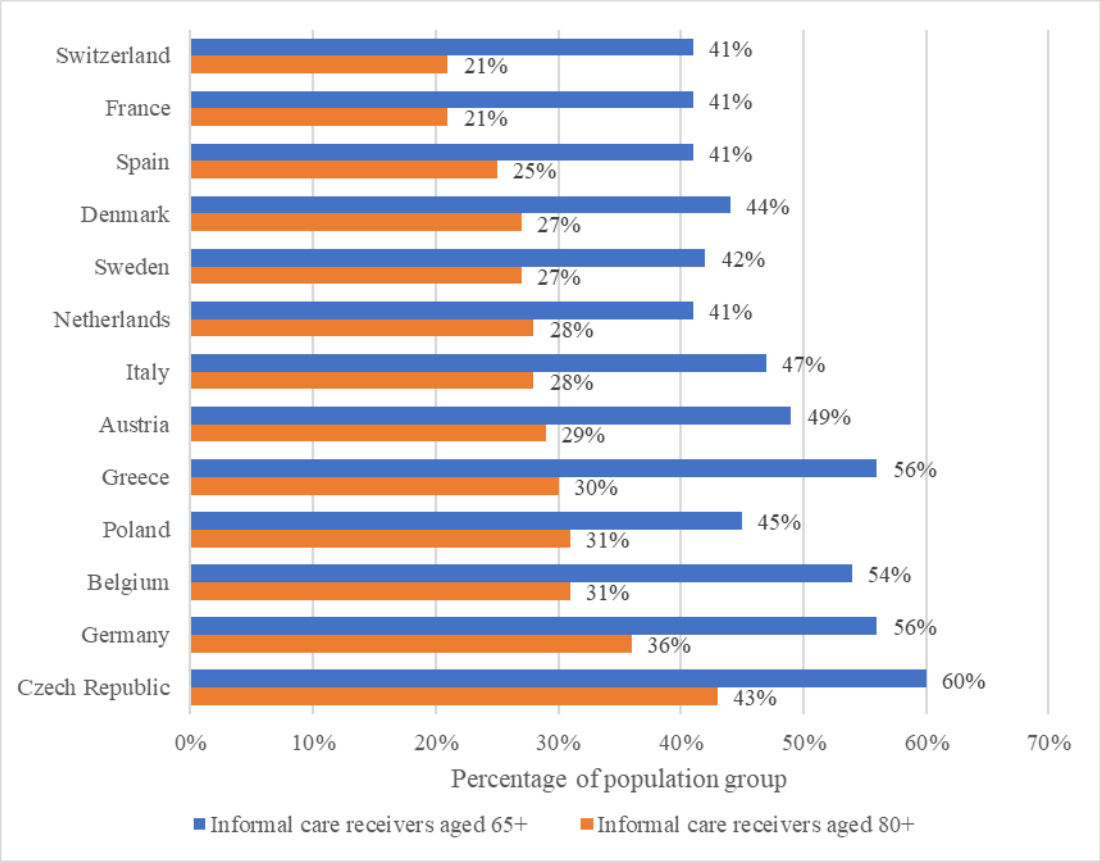

Figure 16. Receivers of informal help or support, in percentage of population group, 2006. Adapted from "*Informal Care Provision in Europe: Regulation and Profile Providers*" by Riedel, M. & Kraus, M., 2011, p. 1. Retrieved from https://www.files.ethz.ch/isn/134200/RR%20No%2096%20_ANCIEN_%20Regulation%20and%20Profile%20of%20Providers%20of%20Informal%20Care.pdf.

5.2 What are policy-differences between Germany and the Netherlands regarding long-term care for older adults?

5.2.1 The aspects of the German long-term care system.

The availability of institutional care is assumed to be slightly insufficient. The German Federal States are responsible for financing investments to enable the existence of care. A great variety exists between the Federal States: Certain Federal States choose to directly invest in nursing homes, whereas others grant subsidies to people living in institutions that rely on social assistance or would otherwise rely on it (Schulz, 2010). The national government has not set a legal obligation for Federal States to fund investment costs of long-term care infrastructure. It is, however, set out in state laws what the nature and extent of financing should be (European Commission, 2018e).

Due to the regional differences in financing investments in care, differences also exist in the availability of care for help-needing people. Especially remote regions with poor economic performance and infrastructure suffer from an undersupply of long-term care services. The shortage of care-workers is also linked to regional differences; despite a national improvement in working conditions, variations in demographics between regions still impact the availability of care-workers (European Commission, 2018b).[24]

The overall, national availability of institutional care services can be indicated by the available places in facilities. A larger demand of places than supply means an insufficient availability of places; non-availability of institutional care makes it for older adults impossible to choose this alternative. Table 1 demonstrates a greater percentual rise of people in demand of institutional places than the supply of places between 2003 and 2017. Nevertheless, the absolute numbers display an oversupply of available places compared to the people living in institutions for each year; it shows that beds would be empty in institutions. For instance, in 2009, an oversupply existed of about 100,000 places, normally pointing to economic unsustainability. The data in Table 1 agrees with Rothgang's (2010, p. 443) findings on the capacity of the formal care sector (see Appendix B. Figure 21). Rothgang (2010) describes the increase of available places in nursing homes as "impressive" as it has been growing by almost one-quarter between 1999 and 2007. The introduction of the long-term care insurance has fostered this development (2010).

[24] It is not possible within this study to go in depth on regional differences and their influences on choice processes.

Table 1

Changes in available places in institutional care facilities and in people living in institutions, Germany, 2003-2017

	Places available in residential care homes		Help-needing people (all ages) receiving care in institutions	
	Absolute numbers	Growth rate (%) compared to 2003	Absolute numbers	Growth rate (%) compared to 2003
2003	713,195	0%	640,289	0%
2005	757,186	6%	676,582	6%
2007	799,059	12%	709,311	11%
2009	845,007	18%	748,889	17%
2011	875,549	23%	786,920	23%
2013	902,882	27%	821,647	28%
2015	928,939	30%	857,302	34%
2017	952,367	34%	921,878	44%

Note. Help-needing people (all ages) receiving care in institutions is a combination of people receiving care in institutions on both a full-time basis (*vollstationär*) and on a part-time basis (*teilstationär*). Adapted from Destatis (n.d.; 2019c).

It is not completely clear how the German government can influence the availability of nursing homes, especially since almost all nursing homes are privately owned.[25] Yet, the existence of the long-term care insurance has resulted in a growth of available places (Rothgang, 2010). As appeared from the theoretic framework, finance structures play a major role in the availability as well. Although it is not possible to ascertain this within this study, it is clear that in coherence with the First Long Term Care Strengthening Act (PSG I), introduced in 2015, the German government ensured a significant increase of working staff in institutional care facilities (Federal Ministry of Health, 2016). The fact that the government deemed this urgent may refer to a shortage of staff and thus a shortage of availability in facilities. This would contradict the findings in Table 1.

Altogether, the availability of institutional care appears to be not decisively sufficient or insufficient. Waiting lists places in institutional care facilities would help to provide a better indication; unfortunately, these are only rarely available (The Netherlands Institute for Social Research [SCP], 2014b). Yet, it is generally known that virtually all European countries face capacity problems (Riedel & Kraus, in SCP, 2014b). In conclusion, it can be expected that

[25] In 2015, only 6% of the German nursing homes were public, 41% of all nursing homes were private and for-profit, and 54% were private and not for profit (European Commission, 2018b, p. 8).

Germany suffers from an undersupply of places in institutions, especially taking into account regional differences.

The availability of formal homecare does not fulfil all demands. The availability of formal homecare suffers from a shortage of care-workers linked to regional differences (European Commission, 2018b). This statement is supported by Table 2, which gives an indication of the sufficiency of available homecare service providers. Between 2003 and 2017, the staff of these providers has increased with 94% (see Table 2). In that same timeframe, the amount of people receiving homecare increased with 81%. It should be noted that receivers of homecare also include cash benefit users who only make use of informal homecare. Nevertheless, the absolute amount of homecare receivers is substantially higher than the staff of homecare service providers: In 2003, the ratio was 7.2, and in 2017, the ratio was 6.6. The supply of care providers thus grew at a faster rate than the demand for formal homecare. However, the amount of hours that the staff works is not taken into account. Care for dependent persons is highly labour intensive. Care-workers are predominantly female and the share of older workers is growing (Geerts, 2011). An increasing part of the German workforce is working part-time (Rothgang, 2010, p. 443). Furthermore, the people on waiting lists for homecare are not counted, as this information in unavailable. Hence, it is presumable that the supply of homecare services (especially taking in account the hours of care provided) has not increased as substantially as the demand has between 2003 and 2017. This agrees with Rothgang's (2010, p. 443) findings (see Appendix B. Figure 21).

Table 2

Changes in staff of homecare service providers and in people receiving formal homecare, Germany, 2003-2017

	Staff of homecare service providers		Help-needing people (all ages) receiving care (partly) at home	
	Absolute numbers	Growth rate (%) compared to 2003	Absolute numbers	Growth rate (%) compared to 2003
2003	200,897	0%	1,436,646	0%
2005	214,307	7%	1,451,968	1%
2007	236,162	18%	1,537,518	7%
2009	268,891	34%	1,620,761	13%
2011	290,714	45%	1,758,321	22%
2013	320,077	59%	1,861,775	30%
2015	355,613	77%	2,076,877	45%
2017	390,322	94%	2,594,862	81%

Note. Help-needing people (all ages) receiving care (partly) at home also includes people who use personal budgets for informal homecare, for which no homecare service providers are employed. Adapted from Destatis (n.d.; 2019b).

Furthermore, Germany knows a rising number of migrant care-workers, who have a job in Germany due to the shortage of German homecare-providers.[26] Migrant workers typically come from Eastern European countries, Russia and Ukraine (Theobald & Hampel, 2013). In 2002, the German government implemented a recruitment scheme to hire domestic workers from Eastern European countries, which became permanent in 2005. However, the scheme is only rarely used, because of bureaucratic barriers and a lack of correspondence with needs. The income for workers is often low and the officially required 38.5 hours per week is not abided (Lutz & Palenga-Möllenbeck, 2010). In 2007, only 3,032 domestic care workers were employed on the basis of the scheme (Theobald, 2012, p. 280). Hence, Germany has a significant grey care market. For instance, in 2009, estimates were that about 100,000 migrant carers cared for about 50,000 households in Germany, constituting about 3 to 4% of long-term care beneficiaries (Theobald, 2010, p. 16). Another estimate by Geerts (2011, p. 15) is that 13.2% of the total care-workers in Germany consists of workers with a foreign nationality (see Appendix B. Figure 22). Most older adults hire migrant carers on an informal basis, without formalised contracts. The increasing amount of migrant workers goes hand in hand with concerns about the quality of care (Theobald, 2010).[27] It can be assumed that without an insufficient availability of formal homecare-workers, help-needing people would not turn to migrant care-workers.[28]

Since 1 January, 2015, the German government increased long-term care benefits for people living at home by 1.4 billion EUR for every year (Federal Ministry of Health, 2016). It marked a significant improvement of benefits. Moreover, the government expanded the services available for care at home (Federal Ministry of Health, 2016). These measures can be expected to improve the availability of formal homecare since 2015. As appears from Table 2, it is likely that this was the case; in 2015 and 2017, a substantial increase took place in the growth rate of staff of homecare providers compared to the years before.

The availability of informal caregivers is assumed to not be significantly influenced by

[26] The share of care workers with a foreign nationality increased from 11.9% in 1998 to 13.2% in 2008. In 2006, 18.3% of all care workers for elderly were persons with a migration experience. This is higher than for persons working in health care (11.5%), in social care (15.8%) and for the total economy (13.9%) (Geerts, 2011, p. 15).
[27] More information on care work migration in Germany with "its contradictions and paradoxes" can be retrieved from Lutz & Palenga-Möllenbeck (2010).
[28] Another incentive for making use of migrant care-workers may be the costs for care; it may be financially more attractive to informally hire migrant care-workers compared to care-workers employed at formal homecare services.

national policies. The provisions of the German law (SGB XI) oblige relatives of help-needing older adults to organise some of the household work. Yet, they are 'freed' from performing the actual physical care, because the long-term care insurance mainly insures the physical care an older person needs; the household work is left uninsured, meaning that relatives have to step in (Frericks, Jensen, & Pfau-Effinger, 2014). In this way, the German government 'obliges' relatives to provide informal care.

The German government aims to support informal carers via several measures, indirectly influencing the availability of informal care. The authority provides informal caregivers with respite care at home (SGB XI, §39), benefits for carers who take long-term leave (§44a), and relief benefits (§45b) (see Appendix D. Informal Care Acts in Germany). However, the efficiency of these measures can be doubted, as not many informal caregivers have used these benefits. Especially the requirement that income replacements benefits have to be paid back, causes a strong disincentive for using the rights. The allowances have increased slightly over the year, although an increase for the coverage of professional respite care of EUR 40 is not expected to significantly influence the decision of an informal caregiver to use this right.

The accessibility to the three forms of care has improved in Germany. Whether older adults are eligible for care covered by the long-term care insurance is regulated by the national government. The long-term care insurance providers have to comply with the eligibility criteria as provided in the national framework for assessment (Longo & Notarnicola, 2018). The assessments are carried out by the Medical Review Board (*Medizinische Dienste der Krankenversicherung* [MDK]), which is an independent organisation (European Commission, 2018b). The selection has since 1995 been executed according to the definition of 'in need of care'.

Since that year, 'in need of care' referred to "those people who, owing to a physical, psychological or mental disease or handicap, require a significant or major amount of help to carry out the daily and recurring activities of every day life over a prolonged period of time, most likely for a minimum period of six months" (Schulz, 2010, p. 2). An individual could receive benefits when he or she needed help with carrying out at least two basic activities of daily living [ADL] and one additional instrumental activity of daily living [IADL]. Three levels of dependency existed, as is visible in Table 3; these levels distinguished benefits depending on how often assistance is needed and how long a non-professional caregiver is occupied with helping the person in need (Schulz, 2010).

Benefits are available for anyone, irrespective of age, income or wealth. Care intensity

is standardised throughout Germany; a precise amount of budget is defined for each severity status and setting. The objective of this standardisation is fairness and impartiality in the services provided to citizens (Longo & Notarnicola, 2018).

Since July 2008, individuals are eligible for benefits when they have paid contributions for at least two years. Before that time, people were eligible after five years of paying contributions (Schulz, 2010).

At that same time (since July 2008) people with dementia that do not fulfil the criteria also became eligible for the long-term care benefits (Klie, 2016). Before, assessments were merely focused on physical needs for persons; but, since 2008, people with a considerably impaired competence in coping with everyday life can also receive benefits (Schulz, 2010).

Table 3

Care levels and care needed

	Care level I (need for considerable care)	**Care level II (need for intensive care)**	**Care level III (need for highly intensive care)**
Assistance for personal care, nutrition or mobility	At least once a day for at least two tasks in one or more areas	At least three times a day at different times of the day	Assistance around the clock
Assistance for housekeeping	Several times per week	Several times per week	Several times per week
Time needed	At least 90 min./day on average thereof no more than 45 min./day for housekeeping	At least 3h/day on average thereof no more than 1h for housekeeping	At least 5h/day on average thereof no more than 1h/day for housekeeping

Note. The time needed is calculated for non-professional carers. Adapted from "*The Social Long-term Care Insurance in Germany: Origin, Situation, Threats, and Perspectives"* by Heinicke, K. & Thomsen, S.L., 2010, p. 9, Centre for European Economic Research. Retrieved from ftp://ftp.zew.de/pub/zew-docs/dp/dp10012.pdf.

In 2017, the German government renewed the definition of 'in need of care', as part of the Second Long Term Care Strengthening Act (PSG II) (European Commission, 2018e). German citizens came to be defined as 'in need of care' when they have the lack of ability to independently compensate and cope with physical, mental or psychological impartments or health-related burdens or demands (Klie, 2016, p. 130). For a person to be eligible for care, the need of substantial assistance with normal day-to-day activities should be frequent and for an estimated period of six months or longer (European Commission, 2018b). The amount of care that is necessary should be at least 90 minutes a day (Klie, 2016).

The renewal of the definition was combined with the replacement of the three care levels by five care grades, which are based on physical, mental and psychological disabilities. Accordingly, the renewed assessment of being 'in need of care' is determined by "impairments of independence or incapacitation in six areas (modules), which are weighted as follows: mobility (10%), cognitive and communicative abilities (15%), behaviour patterns and psychological patterns (15%), level of self-sufficiency (40%), health restrictions, demands and stress of treatment (20%) and structure of everyday life and social contacts (20%)" (European Commission, 2018b, p. 7). Table 4 displays the transition from levels to grades.

The new system takes into account the competence of individuals to cope with everyday life. This is a significant change compared to the system prior to 2017, that focussed merely on the physical needs for personal care, nutrition and mobility (Schulz, 2010). The result of the reform is that eligibility is extended especially to persons with cognitive impairments such as dementia (European Commission, 2018b).

Table 4

Transition from care levels to care grades

From	**To**
Care level 0	Care grade 2
Care level 1	Care grade 2
Care level 1 with impaired competence in coping with ADL	Care grade 3
Care level 2	Care grade 3
Care level 2 with impaired competence in coping with ADL	Care grade 4
Care level 3	Care grade 4
Care level 3 with case of hardship[29]	Care grade 5
Care level 3 with impaired competence in coping with ADL	Care grade 5

Note. ADL is short for 'activities of daily living'. Adapted from "*Unsere Sozialversicherung: Wissenswertes speziell für junge Leute"* by Deutsche Rentenversicherung Bund, 2019, p. 188. Retrieved from https://www.deutsche-rentenversicherung.de/SharedDocs/Downloads/DE/Broschueren/national/unsere_sozialversicherung.pdf?__blob=publicationFile&v=8.

Formal homecare or cash benefits are the standard in Germany. People are only eligible to using institutional care, when ambulatory care is not sufficient or possible, according to §43

[29] Individuals are dealing with a case of hardship when their needs exceed the requirements of care level III, meaning that they need assistance with activities of daily living (ADLs) for at least seven hours a day, with at least two of those hours during the night. Individuals are also assessed as having a case of hardship when their basic care needs may only be met by several people working at the same time (Mot, Geerts, & Willemé, 2012).

SGB XI (Klie, 2016). Only people with care grade 2 to 5 have the right to institutional care. This care can also be used in the form of short-term stay to replace homecare (so-called 'semi-stationary care') (Deutscher Bundestag, 2017).

Altogether, the accessibility to care has improved over the years, especially in 2017.

Costs of the three alternatives in Germany. The German government can influence the costs for long-term care via the benefits from the long-term care insurance. The insurance only covers a part of the costs for care; the remaining costs must be paid by individuals as soon as they make use of care ('pay-as-you-go system'). The attractiveness of an alternative is dependent on the costs that an individual has to pay for the type of care, in other words, the co-payments. The co-payments are the total costs of care minus the allowance paid by the insurance.

Costs for institutional care are continuously high. The amounts of the costs for institutional care that are covered by the insurance are displayed in Table 5.

Table 5

Monthly long-term care insurance benefits for institutional care

Care level	Until June 2008	July 2008	2010	2012	2015	Care grade	2017
0						1	125
0 + dementia						2	770
I	1,023	1,023	1,023	1,023	1,064	2	
I + dementia						3	1,262
II	1,279	1,279	1,279	1,279	1,330	3	
II + dementia						4	1,775
III	1,432	1,470	1,510	1,550	1,612	4	
III + dementia/case of hardship	1,432	1,750	1,825	1,918	1,995	5	2,005

Note. The amounts are in EUR. Adapted from Heinicke & Thomsen (2010, p. 13) and Pflegegrad (n.d.)

For institutional care, estimates are that the long-term care insurance covers about 50% of the total costs of care (see Appendix C. Costs for Institutional Care in Germany). Users of institutional care do not only have to pay the other half of the costs, but they are required to pay the board and lodging costs (Rothgang, 2010). For instance, in May 2017, the recipients of benefits had to pay EUR 1,691 on average per month out of their pockets (Rothgang et al., in European Commission, 2018b, p. 9).

Moreover, the costs that care providers charge are not uniform across Germany; in

certain areas providers request higher charges, meaning that a person has to pay more for the same level of care services (Nadash et al., 2018). When persons in need, or their children, cannot pay the costs for care that remain after using the long-term care benefits, they can request social welfare grants from their municipality. However, differences between municipalities results in differences in grants (European Commission, 2018b).

Furthermore, it appears that the increases in the coverages from the insurance are not compatible with the inflation rate in Germany. The average growth rate of the benefits is 0.4% per year between 1996 and 2015, which is "far below general inflation or inflation for LTC services and therefore marks a considerable loss of real purchasing power" (Rothgang, 2010, p. 452). Between 2007 and 2012, the benefits rose nominally by 1.4% per year, which had been just sufficient to cover inflation (2010). However, it was not enough to compensate for the period until 2008, in which receivers of benefits suffered from a substantial loss of real purchasing power of long-term care insurance benefits. Since 2015, adjustments to benefits are reconsidered. Nonetheless, they are weak and an automatic adjustment mechanism is not in sight (Rothgang, 2010).

Costs for formal homecare are high, although formal homecare benefits are more adapted than for institutional care. The prices for formal homecare are not ascertainable within this study, as multiple providers exist that charge different costs. What is more, prices vary between regions (Nadash et al., 2018). The coverage from the long-term care insurance, on the other hand, are set at a national level, similar to the coverage for residential care. The amount of money that is covered is visible in Table 6. A significant increase in the coverage took place in 2017. Before that year, benefits have improved since 2008, with about EUR 40 to EUR 60 per two years, which is not significantly higher than the inflation rate in Germany (Trading Economics, n.d.). People with care level II benefitted from the highest increases. Since 2015, people with dementia or a case of hardship, exceeding the requirements for care level III, received higher benefits. This is also the case for people suffering from dementia, but without a care level (care level 0/care grade 2) (see Table 6).

Similar to institutional care users, formal homecare users can also request social welfare grants from the municipality, if older adults or their family cannot pay for care (European Commission, 2018b).

Table 6

Monthly long-term care insurance benefits for formal homecare

Care level	Until June 2008	July 2008	2010	2012	2015	Care grade	2017
0						**1**	
0 + dementia					231	**2**	689
I	384	420	440	450	468	**2**	
I + dementia						**3**	1,298
II	921	980	1,040	1,100	1,144	**3**	
II + dementia						**4**	1,612
III	1,432	1,470	1,510	1,550	1,612	**4**	
III + dementia/case of hardship					1,995	**5**	1,955

Note. The amounts are in EUR. Adapted from Heinicke & Thomsen (2010, p. 13) and Pflegegrad (n.d.)

The German government has continuously supported informal care use. The long-term care insurance also allows help-needing individuals to receive cash benefits. The benefits are meant to acknowledge and reward the giving of care by relatives or other close-ones (Nadash et al., 2018). It is also used to pay informal (migrant) care-workers. The beneficiary does not need a formal contract with the caregiver. The benefits are paid directly to the care recipient, and there is little control over the use of the money (Frericks et al., 2014).

In 2008, cash benefits were adjusted for the first time since the introduction of the long-term care insurance (Theobald, 2012), as is visible in Table 7. Between 1995 and 2008, the nominal benefits were constant, resulting in a substantial diminishing of their purchasing power (Riedel & Kraus, 2011). Since 2013, help-needing people with dementia receive a higher amount of money as well. With the reform of the system, the amounts increased significantly for certain care levels since 2017. This is especially the case for people that suffer from dementia; they are assessed to fall under a higher care level compared to people in with similar conditions, but without dementia (see Table 7).

Table 7

Monthly long-term care insurance benefits for care at home (cash benefits)

Care level	Until June 2008	July 2008	2010	2012	2013	2015	Care grade	2017
0							**1**	*
0 + dementia					120	123	**2**	316
I	205	215	225	235	235	244	**2**	316
I + dementia					305	316	**3**	545
II	410	420	430	440	440	458	**3**	545
II + dementia					525	545	**4**	728
III	665	675	685	700	700	728	**4**	728
III + dementia					700	728	**5**	901

Note. The amounts are in EUR. The table presents the amounts of benefits in the form of cash benefits. People with care grade 1 have a half-yearly consultation claim since 2017. Adapted from Bundesministerium für Gesundheit (2019); Krankenkassen Zentrale (n.d.); Sozialversicherung kompetent (n.d.a; n.d.b).

As is the case for formal homecare in kind, it is not ascertainable how much an older adult has to pay for care after using the cash benefit. Yet, Nadash, Doty, Mahoney, and Von Schwanenflugel (in Nadash et al., 2018) state that the benefits are approximately half the value of in-kind services. The beneficiary would thus have to pay for the other half out-of-the-pocket. It can be expected that the costs for an help-needing person decreased significantly since 2017, although it depends on the grade of care. Before 2017, the amounts have raised to a minor extent, presumably without much effect on the affordability of care. The introduction of cash benefits for people with dementia in 2013, however, is expected to have had a lowering effect on the costs for people with this condition.

For informal caregivers, caring for close-ones is made more attractive by the pension credits that they can receive in the framework of the Care Insurance Law. Pension credits are only available for those who care for people with at least care level 2 (Frericks et al., 2014). Informal caregivers only have this right when they provide at least 14 hours of unpaid care per week and also work up to 30 hours per week (Courtin et al., 2018). Moreover, informal caregivers are insured against accidents at the ‘workplace’ (Frericks et al., 2014). The German government thus attempts to increase the benefits for informal caregiving.

The quality of long-term care plays an important role in the German system. The German government has introduced multiple national measures to guarantee the quality of long-

term care. The major ones are the introduction of the law on Quality Assurance and Consumer Protection in 2002, the Long-term Care Further Development Act (*Pflege-Weiterentwicklungsgesetz*) in 2008, and the Health Professions Reform Act (*Pflegeberufereformgesetz*) in 2017 (see Appendix E. Quality Assurance Acts in Germany). Laws and regulations on quality assurance have continuously developed in Germany (Theobald, 2012).

The quality of care in institutions is ensured by special provisions of SGB XI (see Appendix E. Quality Assurance Acts in Germany). Since 2008, 'transparency reports' are published with the results of quality inspections. These reports demonstrate an increase in quality of long-term care (European Commission, 2018e). Furthermore, in July 2010, a wage floor has been implemented for care-workers in long-term care facilities (OECD, 2011). The quality of institutional care facilities is highly rated in general (Gereadts et al., in Nadash et al. 2018).

To assure the quality of care for users of cash benefits, the recipients have to review their care with a professional care worker at least twice a year. The care-worker reports his or her findings to the long-term care insurance funds (Schulz, 2010).

The German government also aims to secure the quality of informal care. Especially two transitions highlight Germany's effort to strengthen and expand the existing information systems. In 2008, community-based support centres were introduced, and in 2009, the legal right to counselling was implemented. The support centres were set up to provide information and counselling to the beneficiaries of cash benefits. Since then, long-term care insurance organisations have been required to offer free training courses for family members of unpaid carers, to inform them about (the organisation of) long-term care. For instance, Alzheimer Europe named the educational programme, called the "Circle of Care" (*Hilfe beim Helfen*), for carers in Germany a 'good practice'. The programme aims to exchange experiences among carers and to provide information about for instance the Alzheimer disease, legal matters and respite care (Alzheimer Europe, 2009).

The introduction of the legal right to counselling has been called "the most innovative regulative changes" (Gori & Luppi, 2019, p. 573). The government obliges informal care receivers to make use of counselling services (European Commission, 2018b). This right to counselling has been reinforced by the Long-term Care Strengthening Acts of 2015, which introduced the components of regular and timely provision of advisory services. Hence, the German long-term care system appears to support long-term care users and their informal caregivers (Gori & Luppi, 2019).

An overview of the developments of the long-term care system in Germany between 2004 and 2017. An overview of the developments in the German long-term care system is visible in Figure 16, Figure 17 and Figure 18 in Appendix A. The most substantial changes in the German long-term care system have taken place between 2015 and 2017. New services were introduced which impacted the availability, such as the funding of day-care and assistance to everyday life. Not only homecare services were supported by the Long-term Care Strengthening Acts, but also institutional care facilities were provided with additional support staff (European Commission, 2018e). Nevertheless, an overall shortage of care-workers exists in Germany, also before 2015. Although it is not completely clear to what extent unavailability prevails of institutional care, formal homecare suffers from an undersupply of care-workers. Migrant care-workers try to fill in the gaps.

The accessibility especially for people with severe conditions has been extended over the years. The eligibility to coverage focussed on physical impairments. A supplement existed for people with dementia and related cognitive impairments, as well as for people with a case of hardship. In addition, care level 0 was added in 2013. The introduction of the new eligibility categories in 2017 simplified the care-needs into five care levels, further erasing the separation between cognitive and physical impairments. What is more, the eligibility shifted from a focus on the amount of time of care needed to a focus on the individual ability to manage autonomy by means of six parameters (Nadash et al., 2018).

The largest changes in long-term care costs took place in 2017. The level of all existing benefits increased significantly, particularly those related to homecare (European Commission, 2018e). Between 2008 and 2017, minor cost-adaptations were introduced, yet, in general, not enough to cover inflation rates.

Institutional care is the most expensive alternative. Its affordability is significantly affected by the room and board costs that the elderly have to pay themselves (Nadash et al., 2018; European Commission, 2018e). The high co-payments make institutional care often a "last resort" (Heger & Korfhage, 2018, p. 4). The German government provides the greatest financial incentives to employ an informal caregiver (Keck, in Da Roit & Le Bihan, 2010; Heger & Korfhage, 2018). The causes are high co-payments for other forms of care and the availability of unmonitored cash transfers for informal care (Heger & Korfhage, 2018). Da Roit & Le Bihan (2010) state that this is caused by the fact that the insurance is not sufficient to cover all needs of the elderly; it is necessary that the family contributes. Therefore, they opt for cash benefits. However, the provision of cash benefits has supported the development of the grey market in German long-term care (Da Roit & Le Bihan, 2010).

The lack of (sufficient) adjustment of benefits has been named “the central weakness of Germany’s long-term care insurance” (Rothgang, 2010, p. 449). Especially until 2008, prices for long-term care have been increasing whereas the benefits nominally remained the same. The result has been a significant increase of co-payments (Rothgang, 2010). Moreover, due to the coverage that is non-income-dependent, poor and vulnerable citizens tend to opt for cash benefits, whereas middle and upper class citizens opt for in-kind care services (Longo & Notarnicola, 2018).

The quality of care has continuously developed for all three alternatives. Multiple measures were taken to improve and guarantee the quality of institutional care, formal homecare, as well as informal homecare.

5.2.2 Aspects of the Dutch long-term care system

Availability of long-term care in the Netherlands.

Dutch long-term care policies aim to restrict the use of institutional care and therefore limit its availability. The Dutch long-term care policies aim for older adults to live independently for longer (Government of the Netherlands, n.d.). Since 2013, the trend of deinstitutionalisation is discernible at an accelerating pace; the governmental support for institutional care facilities reduced, leaving care organisations often with no other choice than to close facilities (Movisie, 2015). The consequence is that inhabitants of nursing homes have to move out and that people with a new care-request cannot always make use of residential care (ActiZ, 2014). Between 1980 and 2010, intramural care places had already decreased from 150,000 to 84,000 (VNG, in Movisie, 2015). The facilities that are not closed turn into high-knowledge institutions for people with severe limitations and dementia (Landelijke Huisartsen Vereniging [LHV], 2009). Yet, every year until 2021, the Dutch government is in need of an extra 44,000 facilities suitable for older adults; since the economic crisis, fewer new facilities were built (Government of the Netherlands, n.d.). Hence, only for a limited amount of people, institutional care is available.

Moreover, people with an indication for institutional care could not always immediately receive care due to unavailability. To prevent that people have to wait too long, the ‘Treeknorm’ was implemented in 2000, which serves as a guideline for the time-period in which people eligible for care should receive care (see Appendix F. The Treeknorm) (ActiZ, 2013a). The Treeknorm is also valid for formal homecare. For instance, between 1 April, 2008 and 1 April, 2009, 82% of the people eligible for AWBZ-care started to receive care within the Treeknorm. This large majority may indicate an agreeable availability of AWBZ-care, yet, 18% of the eligible people did not receive care within the time-period that the Treeknorm prescribes. In

addition, variations exist in the waiting times between regions. Possible explanations are a larger separation of supply in certain regions, as well as more ageing. Furthermore, for people with a complex care-need, it is often more challenging to realise the provision of care. It especially concerns people with dementia or people with multiple health issues (Verweij, Hollander, & Diepenhorst, 2009, p. 10). More specific information on waiting lists is rarely available (SCP, 2014b).

Besides the decreasing availability of nursing homes, there has also been a growing demand of employees in the care and welfare sector, especially since 2013. Although the care and welfare sector does include other jobs than long-term care work for elderly, Figure 17 gives an indication of the demand. The highest amount of vacancies between 2011 and 2017 has been reached at the end of 2017, when 28,400 new employees were tried to be recruited (compared to 218,600 job openings in total in the Netherlands). Even in 2013, when the curve reached its lowest point, the sector demanded for 10,200 new employees (compared to 93,700 job openings in total in the Netherlands) (Figure 17).

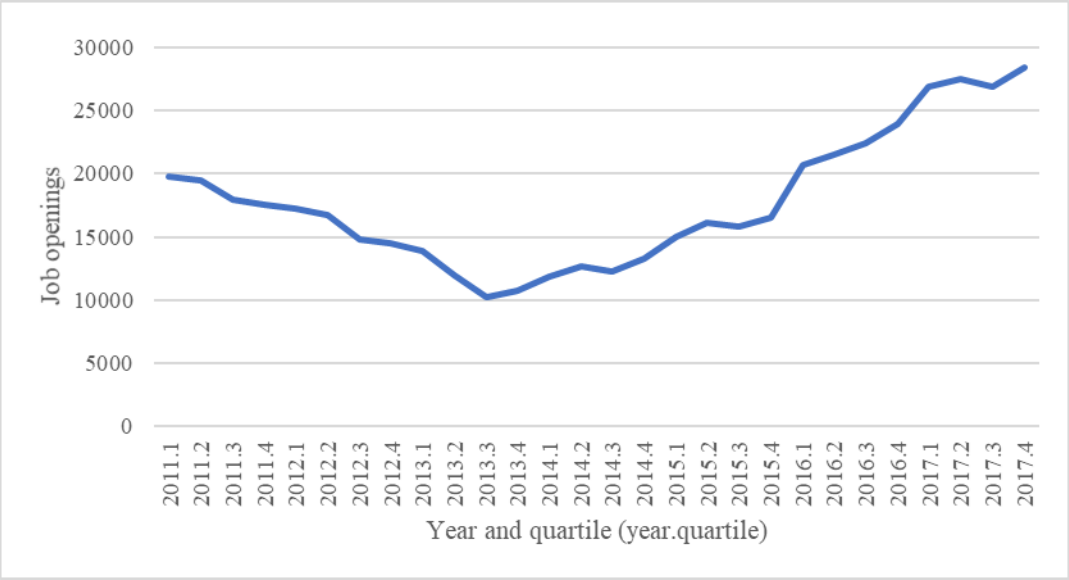

Figure 17. Job openings in the Dutch care and welfare sector, 2011-2017. Adapted from "*Openstaande vacatures: SBI 2008, regio* [Data file]", by CBS, 2019. Retrieved from https://opendata.cbs.nl/statline/#/CBS/nl/dataset/83599NED/table?ts=1569510423275.

The availability of formal homecare has increased over the years, but suffers lately from a shortage of care-workers. Whereas institutional care facilities closed, the Dutch long-term care system focusses on homecare. Therefore, it can be expected that the Dutch government enables sufficient availability of homecare. However, especially since the decentralisation in 2015, the governmental Wmo-budgets for municipalities have decreased significantly. The

reforms and the economisations since 2015 resulted in financial shortages for municipalities (Vilans, 2018). Waiting lists of municipalities are not ascertainable, but, similar to institutional care, the waiting times for homecare are not allowed to exceed the Treeknorm (ActiZ, 2013a).

Nevertheless, the vacancies in Figure 17 give an indication of the shortage of employees in the formal homecare sector. Based on this figure, it can be assumed that the demand for employees has risen significantly since 2013, in coherence with the total job openings for the care and welfare sector (Figure 17). Multiple sources have highlighted the critical shortage of care-workers in the last years (UWV, 2019; NOS, 2018). In 2007, a threat to the availability of household care also arose, when household care shifted from the AWBZ to the Wmo. The hourly tariffs paid were reduced, resulting in financial problems for care organisations. Those were forced to reduce the hourly wages for the care-workers, creating an incentive for care-workers to leave their job (Da Roit, 2013).

Besides professional care-workers, help-needing older adults can make use of formal care from relatives or other close-ones, using the personal budget [PGB]. The personal budget covers care that exceeds 'usual care'. Different types of contracts exist for this type of care.[30] The availability of the personal network of help-needing elderly cannot be retrieved within this study.

The availability of informal care is supported by the Dutch government. Family members of senior relatives have the duty to provide care; they are expected to care for older adults in terms of both household work and some physical care, without remuneration. This idea was introduced in 2005 under the 'usual care' protocol (Frericks et al., 2014). Since then, the help that fellow-household members could provide to a help-needing person was deducted from the number of hours of the allocated professional homecare. The result is a less generous system (Plaisier et al., 2017). Since 2015, the concept 'usual care' is used as a directive to determine the amount of care that does not need to be covered. The Dutch government assumes that help-needing people enjoy a large amount of self-reliance[31] and make use of informal networks to fulfil their care demands. Therefore, formal care is perceived as a solution for the shortage of personal and informal capacities (Da Roit, 2016).

The Dutch authorities can play a role in the availability of informal caregivers, in terms of financial support. Certain measures have been implemented by Dutch national and local

[30] More information on the types of contracts can be retrieved from Frericks et al. (2014, pp. 71-72), who discuss contracts for family-members of the elderly (the 'Care-Agreement' and the 'Employment-Agreement') and from Sociale Verzekeringsbank (n.d.b) (only available in Dutch).
[31] The Dutch, common term for 'self-reliance' is '*zelfredzaamheid*'.

governments to encourage informal caregiving, mainly via information and advice through interest groups and municipal councillors, respite care, and a yearly token of appreciation via the municipality (European Commission, 2018c). These measures all aim to serve as financial incentives to provide or receive informal care, and thus affect the costs of informal caregiving.

Besides the provision of compensations, municipalities have tried to encourage informal support, via for instance promotional activities, matching supply to demand and ensuring increased contact between people with and without disabilities. In 2012, more than three-quarters of the local authorities attempted to do so (SCP, 2014, p. 268).

Accessibility of long-term care in the Netherlands is not classified. The eligibility to care is based on the right that citizens have to be compensated for their disability or handicap. Explicit eligibility criteria are therefore not described. The situation of a person that requests care is evaluated on an individual level (Kroneman, Cardol, & Friele, 2012). A classification into levels of dependency does thus not exist (Mot, 2010).

The accessibility to institutional care is strictly granted. The eligibility for care covered by the AWBZ was assessed by the Care Needs Assessment Centre (*Centrum Indicatiestelling Zorg* [CIZ]). Nowadays, the CIZ grants indications for people eligible for Wlz-care. The centre identifies illnesses or disabilities that grant individuals the right to an indication for care (see Appendix G. CIZ's Eligibility Assessment Method). Indications are granted in a national, uniform manner. The organisations determines the indication for the right to care based on conversations with the demander of care (VWS, 2016). As there are no financial incentives for the CIZ, its decisions are not affected by its financial position; its task is to carry out objective, independent and integral assessments (Mot, 2010).

The CIZ distinguishes six types of help-needing people. These are people with somatic conditions, psychogeriatric conditions, psychiatric conditions, intellectual disabilities, psychical disabilities and sensory disabilities (SCP, 2015b).[32] For people with these conditions or disabilities, the AWBZ provided several sorts of care (SCP, 2015b). Those included personal care, nursing, accompaniment for general daily activities, treatments, and residence (SCP, 2015b, p. 15).

Individuals are eligible for care covered by the Wlz when they are in need of permanent supervision or in need of having 24-hour care close by; Wlz-care is only for individuals with severe and intensive care-needs (VWS, 2016).

The accessibility of institutional care was seriously reduced in 2013 by the Dutch

[32] More information about the specific conditions or impairments individuals needed to have to be eligible for the AWBZ can be retrieved from SCP (2015b) (only available in Dutch).

government. The categories of care were divided in ten severity-of-care packages (*zorgzwaartepakketten* [ZZPs]) since 2009 (see Appendix H. Severity-of-Care Packages and Care Profiles).[33] The first two packages (ZZP1 and ZZP2) were extramuralised, meaning that people with the lightest forms of residential care were expected to be able to live at home (ActiZ, 2013b). Since 1 January, 2014, the personal care and nursing sector[34] of the third package (ZZP3) is also extramuralised for new clients. Likewise, the mental healthcare[35] of ZZP3 is extramuralised for new clients since 2015. Since 2016, the separation of housing and care is applicable to 25% of new clients or re-indications for ZZP4 (Aedes-Actiz Kenniscentrum Wonen-Zorg, n.d.). Altogether, institutional care has become increasingly inaccessible for Dutch older adults.

The accessibility to formal homecare has become more tailored to individuals' needs. During the introduction of the Wmo in 2007, multiple tasks from the AWBZ were transferred to the municipalities. This also meant that these local authorities became responsible for the eligibility assessment of individuals (Mot, 2010). They reassessed the needs of AWBZ-users that received housekeeping services, resulting in a reduction of support or insufficient support for a small share of the users.[36] Furthermore, the municipalities could not prevent a decrease in hourly wages for care-workers due to financial problems; it was an incentive for workers to quit and led to a decreased quality of services (Da Roit, 2013, p. 111).

The Wmo exists to support people with a limitation, such as people with a physical, mental or psychical limitation. Individuals are eligible for Wmo-care when they have difficulties in participating in society, when they are not self-reliant, or when they are in need of protected residence or shelter (VWS, 2016). The policy sets out that municipalities should take a tilted approach when they assess the care-needs of individuals. This approach focusses on what a person can do, instead of what a person cannot do (SCP, 2015b, p. 15).[37] An important aspect of the Wmo since 2015 is that the care that persons receive should be an addition to what they can do by themselves, or what the informal care-network can provide for them. This is different than the Wmo before 2015, in which the plight to compensate formed the central basis

[33] Before 2009, only two categories of care existed: nursing homecare and residential care (Mot, 2010).
[34] 'Personal care and nursing sector' is a translation for '*sector verpleging en verzorging* [VV]'.
[35] 'Mental healthcare' in this case refers to the Dutch terms '*geestelijke gezondheidszorg'* [GGZ] and '*verstandelijke gehandicaptenzorg'* [VG].
[36] More information about the reduction of support, especially exact numbers, can be retrieved from Da Roit (2013).
[37] Help-needing people can request support at a Wmo-counter, that multiple municipalities have established. The decision of municipalities to provide an indication for care to individuals depends on a conversation between the two, a so-called 'kitchen-table meeting' (*keukentafelgesprek*). During that conversation, the municipality researches the abilities of the client, with help of his or her network and general facilities (VWS, 2016).

of the act (SCP, 2018).

It is not possible to analyse all criteria from municipalities within the frame of this study. Municipalities enjoy significant freedom when it comes to eligibility criteria. It is important to note that they have a financial incentive to contain the costs of care. Nevertheless, when a municipality exerts strict control over help-needing people, their reputation may deteriorate for future voters (Mot, 2010).

Since 1 January, 2015, almost all personal care and nursing came to be covered by the Zvw. The objective of this change was to let people live home longer and to limit expenditures. To receive care under the Zvw, Dutch citizens need to get a referral from the general practitioner to a specialist, unless it concerns urgent care. The specialist, together with the patient, determines the care needs. The patient can choose from the available care; the health insurer can advise and mediate in this process (VWS, 2016). Every citizen is obliged to be insured and accessibility to care is supposed to be similar each year, as it only depends on the referral that the general practitioner provides. Hence, there are no eligibility criteria that change over time and accessibility should be similar for anyone at any time.

Costs of care are highest for institutional care, although costs for any alternative should be endurable due to income-dependency. Older adults using long-term care have to pay an own contribution, in other words, a co-payment (except for users of community nursing covered by the Zvw since 2015). This payment is dependent on the income of the individual or the family, the living situation and the care-needs. The dependent income is determined based on the taxable income, the indebted taxes, the premium to be paid for the health insurance, and money for clothing and personal care (Zorgwijzer, 2019). Measures have changed over the years with regard to co-payments. Yet, an overview is not available of the costs for each form of care, as the relationship manager of the CAK indicated in an email conversation (X. De Graaf, personal communication, 17 October, 2019). Nevertheless, due to the income-dependency of the co-payments, Dutch older adults are not supposed to have problems to make use of care, even when having a lower income (De Meijer et al., in Duell et al., 2017).[38]

Beneficiaries can also apply for a personal budget. They can use the budget not only to arrange care in institutions or formal care at home, but also to pay relatives, friends or neighbours for their help, on the condition that they have a formal contract (Mot, 2010).[39]

[38] For instance, the AWBZ regulated that an individual should have at least EUR 276.41 left per month as clothes allowance and pocket money. For a couple, this amount is EUR 430 per month (Mot, 2010, p. 32).
[39] The Dutch Social Insurance Bank (*Sociale Verzekeringsbank*) manages the personal budget. The bank demands a contract between the person in need and the care provider, which describes the needed care and a budget plan (Gori & Luppi, 2019).

Patients that choose this option received a budget that is 25% lower than costs of in-kind care, assuming that they can purchase care more efficiently (Mot, 2010, p. 10). However, accessibility to a personal budget has not always been guaranteed, because short-term government budget decisions determine the amount of social expenditure. During the second half of 2010, for instance, it was not allowed to claim new personal budgets due to difficulties in national finances. Since then, conditions for receiving personal budgets have become more restrictive (Rijksoverheid, in Frericks et al., 2014).

Before the reform in 2015, personal budgets were granted under the AWBZ and the Wmo. The number of personal budget holders has increased substantially over the years until 2015.[40] During the reform in 2015, personal budgets for older adults became fragmented under the Wlz, the Wmo, and the Zvw. Since then, users of the budgets need to meet more requirements than before. The individual responsibility for managing the care process has increased significantly. Tightened constraining mechanisms aim at improved cost-containment and prevention of misuse. What is more, personal budgets covered by the Wlz, the Wmo, and the Zvw are since 2015 paid by the Dutch Social Insurance Bank (*Sociale Verzekeringsbank*) directly to the care providers, instead of to the insured persons (CPB & SCP, 2015). Altogether, the reform of 2015 has resulted in fragmentation and complicated coordination across programmes (Maarse & Jeurissen, 2016).

The costs for institutional care have raised. In general, co-payments for institutional care are significantly higher than for formal homecare, because the users have to pay for board and lodging costs (depending on their income), besides the care they receive (Mot, 2010). Despite the income-dependency of co-payments, it is reported by Mot (2010) that people using institutional care might have to contribute such a significant amount "that they just have 'a clothing allowance and pocket money' left to spend according to their own preferences" (p. 12).

During the AWBZ-reforms in 2005 an increase in users' co-payments took place (Da Roit, 2013). Moreover, the budgets that regional care offices administered came to be based on past expenditure.[41] The result was an increase in the risk of waiting lists and a deterioration of quality (Da Roit, 2013, p. 105). In 2013, another significant increase in co-payments took place,

[40] The amount of users developed from only 5,000 in the second half of the 1990s, to 60,000 in 2003 (De Boer & De Klerk, in Da Roit, 2013, p. 107) and 80,000 in 2007 (VWS, in Da Roit, 2013, p. 107). After the decentralisation in 2015, the personal budgets were significantly less used than before: the amount of users decreased from 120,000 in 2014 to 38,500 in 2016 (European Commission, 2018c). VWS (in Da Roit, 2013, p.108) found that in 2007, one-third of the personal budgets users solely purchased care from relatives or other close-ones, one-third solely purchased formal care, and one third depended on a combination of the two.

[41] The task of regional care offices is to negotiate the tariff levels and the maximum production level with care providers (Da Roit, 2013).

in order to cover the rising care expenditures (CIZ, 2017).

The costs for formal homecare are income-dependent as well. For formal homecare covered by the Wlz and the Wmo, and the AWBZ before, the system works the same; care users have to pay an own contribution and the remaining part is covered by the Dutch authorities. Only the system of the Zvw is set up differently. Individuals are ensured via a health insurer and pay a monthly premium. Users of the Zvw for community nursing do not have to pay a personal contribution since the decentralisation; this type of care is not included in the own risk of the insured person. Before 2015, an own contribution did exist for community care. As CPB & SCP (2015) state, personal care and nursing as part of the Zvw is for clients thus more attractive compared to similar care covered by the Wmo or the Wlz, when it comes to co-payments. There is no reason why a difference in co-payments exist for the same sort of care (CPB & SCP, 2015).

Similar to institutional care, no overview is available of the costs for formal homecare. Yet, Plaisier et al. (2017) state that financial co-payments for community-based care have raised, particularly for higher income groups. This agrees with Figure 18, which shows an increase in the payments between 2010 and 2014. The dark blue bars indicate the increase in co-payments for the AWBZ. The most substantial increase took place in 2013, with more than 10% compared to 2012. In 2010 and 2011, the co-payments also increased with at least 5% (Figure 18). Similar to institutional care, the costs have risen again since 2013 (CIZ, 2017).

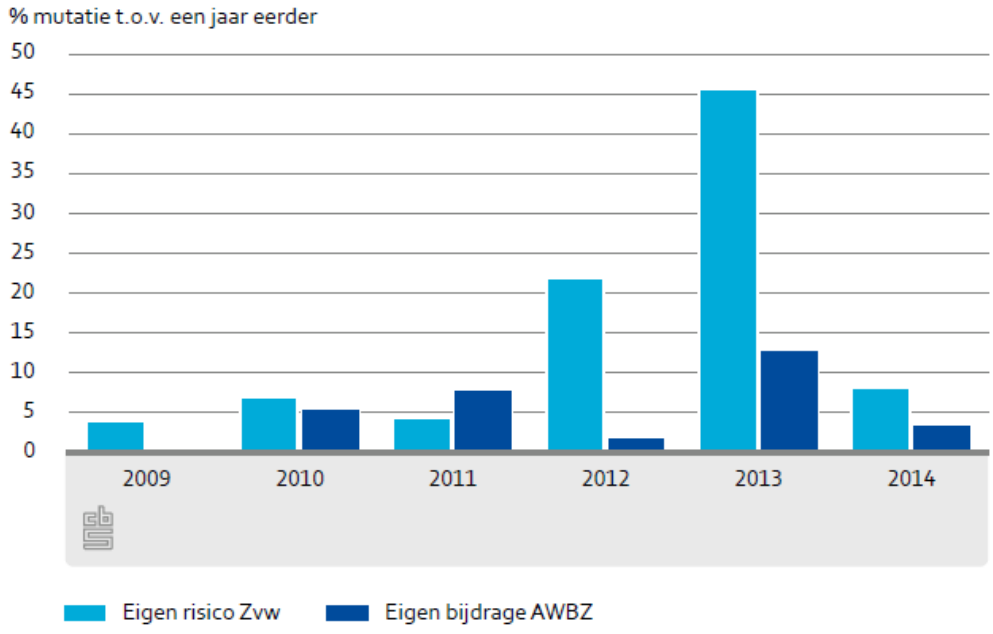

Figure 18. Growth-rate of co-payments for Zvw-care and AWBZ-care. The bars indicate the

percentual mutation compared to the year before.[42] Reprinted from "*De Nederlandse economie. Ontwikkeling en financiering van de zorglasten sinds 2006*" by Cpb, 2015, p. 11.

The Dutch government supports informal care by reducing costs for informal caregivers. Several Dutch national laws aim to support informal caregiving. The Employment and Care Act (*Wet arbeid en zorg* [Wazo]) grants the right to both short- and long-term care leave. During short-term care leave, the employer has to pay at least 70% of the wage. Long-term care leave is generally unpaid, unless a collective agreement or other regulations of employers state differently (European Commission, 2018c) (see Appendix I. Informal Care Acts in the Netherlands). Dutch informal caregivers can also make use of their right to respite care, if the person in need of care receives support from the Wmo or the Wlz (or AWBZ before) (see Appendix I. Informal Care Acts in the Netherlands).

Another resort for informal caregivers is the token of appreciation.[43] Informal caregivers can request a token of appreciation at the municipality, which is responsible for the reward (Sociale Verzekeringsbank, n.d.a); the amount of money available for such rewards differs per municipality. Although this reward is covered by the Wmo, it is supposed for people with a personal relation to the help-needing person who do not provide support on the basis of a formal contract (MantelzorgNL, n.d.a).

Quality of long-term care is protected via multiple measures.

The quality of formal care is guaranteed by multiple acts. The Dutch authorities have implemented multiple national laws to ensure the quality of care. These laws are not necessarily linked to the long-term care system, but are also valid for other parts of the Dutch care system. The law on Quality in Care Organisations (*Kwaliteitswet zorginstellingen* [KWZ]) is concerned with organisations that deliver care, which are obliged to provide care of good quality (see Appendix J. Quality Assurance Acts in the Netherlands). The law on Professions in Personal Healthcare (*Wet op de Beroepen in de Individuele Gezondheidszorg* [Wet BIG]) aims to protect patients and clients by ensuring that professional's do not damage their health (see Appendix J. Quality Assurance Acts in the Netherlands).

The Dutch Health and Youth Care Inspectorate (*Inspectie Gezondheidszorg en Jeugd* [IGJ]) is responsible for the quality of care, and the Dutch Health Authority (*Nederlandse Zorgautoriteit* [NZa]) is a supervisor of the quality of care, as well as a market maker and regulator in health and long-term care. What is more, this authority determines the tariffs for

[42] The light blue bars demonstrate the increase of the 'own risk' for the Zvw; these are however not relevant in this study, as the Zvw only covers community care since 2015.
[43] A 'token of appreciation' is a translation for "*mantelzorgwaardering*".

institutional care, the description of care that should be delivered, and monitors the compliance of care-providers to these rules (Mot, 2010).

The quality of care in institutions is maintained. On 13 January, 2017, the quality framework for nursing homes was implemented. The core of the framework is to "learn and improve". It describes the care that clients and close-ones can expect from institutions, and it provides guidance to care organisations for the realisation of the preconditions for care (ActiZ, n.d.).

The combination of quality assurance acts and measures such as the quality framework ensure the quality of institutional care. It can therefore be assumed that older adults have no major concerns about this issue.

The quality of formal homecare is good, but the decentralisation has resulted in rising concerns. Since the decentralisation in 2015, concerns about the quality of community care have risen, due to the increase of older adults in need of care and support at home. ActiZ (2015) describes this to be the result of the stricter attitude of the CIZ; the CIZ makes use of other eligibility criteria for the Wlz than was the case for the AWBZ. The consequence is that less people are eligible for care under the Wlz, meaning that more people turn to community care covered by the Wmo. The quality of this type of care is said to be suffering from this situation (ActiZ, 2015).

Quality of informal care. National policies that guarantee the quality of informal care are not found; it was not possible to analyse local initiatives.

An overview of the developments of the long-term care system in the Netherlands between 2004 and 2017. The Dutch policy-changes and characteristics of long-term care alternatives are presented in Table 19, Table 20, and Table 21 in Appendix A.

The availability of Dutch long-term care is mainly influenced by two issues. One of them is the closing of institutional care facilities due to reduced financial support from the government, especially since 2013. Whereas institutions closed, a larger variation of homecare services became available since 2015. The other issue is the shortage of care-workers, both in institutions and in homecare. An increase in job openings is especially visible since 2013. Hence, the availability of formal homecare is significantly greater than for institutional care. Informal homecare is supposed to be available according to the Dutch authorities, as it is perceived as 'usual care'. This trend fits with the deinstitutionalisation policy of the Dutch government.

The accessibility to long-term care has developed over the years in the direction of deinstitutionalisation. One of the most significant developments of eligibility criteria, is that

most people with ZZP1, ZZP2, and ZZP3, and some people with ZZP4 were not granted access to institutional care facilities anymore since 2013 and 2014. Only older adults with the most severe care-needs are eligible for institutional care. Furthermore, other approaches for assessing care under the Wmo were implemented during the reforms in 2007 and 2015. Since 2007, municipalities become responsible for eligibility assessments and a reduction of support took place. The plight to compensate individuals for their disabilities formed the basis for the provision of care. Since the decentralisation in 2015, the approach for assessing care-needs for Wmo-care is based on the principle of self-reliance. Moreover, older adults are to a certain extent less accessible to formal care, as the informal network is increasingly expected to support older adults in the form of usual care. Altogether, the governments became less generous.

The costs for long-term care are the highest for institutional care. Nevertheless, it can be expected that for each form of care, the costs are endurable. Increases in co-payments have occurred, in 2005, and between 2010 and 2013. Concerning community care, it is most attractive in financial terms to receive this type of care under the Zvw compared to the Wmo.

Personal budgets were increasingly used before the 2015 decentralisation. However, afterwards, a substantial decrease took place. Over the years, the requirements for personal budget holders have raised, especially since 2015.

The financial situation for informal caregivers or receivers of informal care has not changed (significantly).

The quality of long-term care is continuously guaranteed by multiple acts. It is therefore unlikely that this substantially influences the choice processes of older adults. However, the large shortages of care-workers has resulted in rising concerns about the quality of care, which may impact the elderly's choices.

5.2.3 Dutch and German long-term care compared

Availability of care is in both countries a critical issue. As mentioned before, most European countries face capacity problems in elder care (Riedel & Kraus, in SCP, 2014b). Although comparable information on waiting lists is not available for Germany and the Netherlands (SCP, 2014b), the analysis demonstrated a difference between the two countries.

In general, it is not clear-cut if the availability of institutional care is sufficient in Germany and the Netherlands. Nevertheless, it has been demonstrated that the availability of institutional care is higher in the Netherlands than in Germany. This did not only appear in the analysis, but Figure 24 and Figure 25 in Appendix B also demonstrate this: in the Netherlands, there are about 70 beds in residential long-term care facilities per 1,000 population, whereas in Germany there are only about 50 beds available. Moreover, Appendix B. Figure 26 shows a

greater availability of long-term care services in the Netherlands, based on waiting lists, distance and lack of services. However, especially since 2013, the places in institutions have decreased in the Netherlands and the Dutch government has reduced the financial support for institutional care facilities.

With regard to formal homecare, both countries suffer from a lack of availability. The shortage of care-workers plays a significant role in the unavailability. In the Netherlands, this is especially visible since 2013. Germany differs from the Netherlands due to the increasing number of migrant care-workers that try to fulfil the care demands of German older adults, constituting a part of the informal care market in Germany. The Netherlands only knows a relatively small increase in foreign nationality care workers in the first decade of this century, from 3.8% in 1999 to 4.9% in 2008 (Geerts, 2011, p. 15).

Whereas Germany has a larger informal care market constituted by migrant care-workers, the Netherlands enjoys a higher density of care-workers, both in 1993 as well as in 2008, compared to Germany (Geerts, 2011). Nevertheless, in both countries, the share of part-time employment in the care sector is considerably higher than in other sectors. In 2008, for instance, more than 80% of the care-workers worked part-time in the Netherlands, making the Netherlands the country with the highest share of part-time care-workers (Geerts, 2011, p. 15). Hence, even though the Netherlands has a higher density of care-workers than Germany, it does not necessarily mean that they provide more care, due to a larger share of part-time employment.

In the Netherlands, the government puts greater pressure on the availability of the informal care network than in Germany since the introduction of the ‘usual care’ protocol in 2005. The eligibility is dependent not only on the care-needs, but also on the availability of informal care. The German government, on the other hand, does not pressure informal caregivers in terms of eligibility for long-term care benefits; long-term care is publicly financed regardless of the presence of informal caregivers. Nevertheless, the high co-payments in Germany make it almost impossible for older adults to pay for physical care; the informal network is ‘forced’ to be involved in care for older adults.

Accessibility to long-term care has undergone radical changes in Germany and the Netherlands. The largest changes in terms of accessibility to long-term care took place in 2015 in the Netherlands, and in 2017 in Germany. The Netherlands changed the eligibility to long-term care during the reforms in 2015. The intention was that the elderly would be more self-reliant and that the informal network would carry greater responsibility for the elderly. Germany introduced a new eligibility scheme in 2017, shifting from care levels to care grades. Consequently, the accessibility for older adults improved .

In both countries, older adults are only accessible to institutional care when they have severe care-needs (German elderly have to have care level 2 to 5, Dutch elderly have to have care profile 4 (before ZZP4) or higher. The Dutch eligibility to institutional care has decreased since 2013 with the shift of most clients with ZZP1, ZZP2 and ZZP3 (and clients with ZZP4 to a minor extent) to care homes with lower provisions of care, or to home (Alders & Schut, 2019, p. 85); in Germany, the accessibility to institutions appears to be steady.

One significant difference between the countries has been the accessibility of people with dementia to long-term care benefits. For a long time, until 2008, the German government did not grant benefits to dementing people or people with other cognitive impairments, that did not belong to a care level. Since 2008, this group of people has slowly started to benefit from the insurance.

Costs for care are generally more bearable in the Netherlands due to income-dependent co-payments. A significant difference exists between German and Dutch co-payments for long-term care. In Germany, long-term care insurance beneficiaries receive a cash benefit, or a certain amount of care, based on their care-needs, and not on their financial situation. In the Netherlands, on the other hand, the amount of care that is covered under the acts is dependent on a person's available income. Since 2015, older adults do not even have to pay an own contribution for community care under the Zwv. In general, the co-payments in Germany are significantly higher than in the Netherlands. In Germany, if users are unable to pay the bill, their children are expected to do so. If this is impossible, social assistance ultimately steps in (Schulz, in Bakx et al., 2015). In the Netherlands, co-payments never exceed the household income (CAK, in Bakx et al., 2015). For these reasons, it can be assumed that, in general, people have greater ease in paying co-payments for long-term care in the Netherlands.

Since 2010, the long-term care insurance benefits for homecare have risen considerably in Germany, compared to the benefits for institutional care. The benefits for most care levels/grades only increased since 2015 to some extent, whereas the benefits for formal homecare in kind and the cash benefits rose substantially for the second time since 2008.

A difference between the two countries also exists in the coverage of 'usual care' provided by informal caregivers, as discussed previously: in the Netherlands, care that the personal network can provide to an elderly is not covered, whereas in Germany, informal caregivers are not taken into account for the amount of coverage. Furthermore, the costs of informal caregiving differ between Germany and the Netherlands. German long-term care beneficiaries can make use of the personal budget scheme. The budget can be used to compensate informal caregivers; the German authorities do not have much control over the

spending of the money, and no formal contracts are needed. The Netherlands presents a different situation: personal budgets are strictly controlled and formal contracts between the provider and receiver of care are a requirement. Therefore, the type of care that is paid for by personal budgets are formal care, rather than informal care.

The coverage for the provision of informal care in the Netherlands comes from support directly to the informal caregiver, in terms of respite care, short- and long-term care leave, and a token of appreciation. Most of these support systems also exist in Germany. However, the largest difference between the two countries is the amount of support that is covered. In both countries, informal carers have the right to ten working days per year as short-term care-leave (in the Netherlands, when working full-time). German employees are allowed to take long-term care leave for more days than Dutch employees. However, In Germany, care-leave users have to pay back income-replacing benefits. In the Netherlands, on the other hand, during short-term care leave caregivers receive at least 70% of their wage (see Appendix D. Informal Care Acts in Germany and Appendix I. Informal Care Acts in the Netherlands). The support systems in both countries thus appear to have advantages and disadvantages.

Quality of long-term care continuously improves in both countries. Both Germany as well as the Netherlands have implemented national measures to assure the quality of long-term care. Nevertheless, Appendix B. Figure 27 shows a slightly poorer quality of long-term care services in Germany than in the Netherlands. Yet, both countries score high on quality compared to other European countries (Eurofound, 2017, p. 32). Germany and the Netherlands are also placed in the same quality cluster; they both have quality of care high on the agenda (Dandi et al., in Alders et al., 2015).

5.3 What is the Relation Between Long-Term Care Policies and Choice Processes of Help-Needing Older Adults?

The central question addressed in this study is: How can cross-country policy-differences between Germany and the Netherlands explain differences in the degree of deinstitutionalisation of care for help-needing older adults? The hypothesis in this study holds, meaning that this study has provided evidence that long-term care alternatives of which the favourableness is enhanced by certain policy-aspects, are likely to be relied upon more by help-needing older adults compared to other alternatives.

5.3.1 Developments in German long-term care policies mostly cohere with changes in outcomes of older adults' choice processes, except for choices for institutional care.

Institutional care. The policy-changes for institutional care appear to coincide to a minor extent with changes in choice processes. The largest change in the share of institutional care use took place between 2015 and 2017, when the German long-term care system was reformed. Eligibility and benefits for institutional care increased. Yet, in that time-period, the steepest decrease of institutional care use occurred, whereas it would be expected that greater eligibility and lower costs increase the attractiveness of the alternative. It should be noted that the benefits for formal homecare and cash benefits had already been raised earlier.

Besides this sharp decrease, the percentual use of institutional care also decreased between 2004 and 2017. For that time-span, it was not possible to precisely determine the availability of institutional care, although it is known that regional differences exist. Furthermore, the quality of institutional care facilities is expected to continuously be improved. Since 2008 in particular, multiple measures were implemented to maintain and improve the quality of care in institutional care facilities. However, although this is a favourable aspect of institutional care, no relative increase in the use took place.

It is necessary to place this in perspective: in comparison with formal and informal homecare, the attractiveness of institutional care did not increase significantly. Institutional care is the most expensive alternative. What is more, the benefits for institutional care remained the same, whereas benefits for the other alternatives increased. Besides that, the eligibility for institutional care facilities is restrictive; older adults are only eligible with care level 2 to 5.

The highest percentual use measured was in 2005. However, in the analysis of German long-term care policy-changes, no considerable changes are found.

Formal homecare. The policy-changes for formal homecare demonstrate greater coherence with the developments of formal homecare use. Between 2003 and 2007, the

percentage of formal care users remained nearly similar. Only in 2005, a slight drop in users took place, although no corresponding policy-change was found in the analysis. Since 2009, a deinstitutionalisation trend is clearly visible: The formal homecare use increased. At that same time, older adults with dementia or other cognitive impairments, without a care level, became eligible for benefits. Furthermore, in 2008, the benefits for homecare had been adapted for the first time since the introduction of the long-term care insurance. Therefore, it can be expected that the attractiveness in terms of costs increased for formal homecare, also compared to the attractiveness of institutional care for which the benefits were not (significantly) adapted.

In 2013, care level 0 was added and benefits for people with dementia raised. In that year, the increase in formal homecare continued, but without a substantial difference compared to previous or following years.

The largest increase in formal homecare use took place between 2015 and 2017, when the German government reformed the long-term care system. More people became eligible for care and the benefits for homecare raised significantly compared to the years before, because of the shifting focus to the individuals' autonomy and the further erasing of the separation between cognitive and physical impairments. What is more, new services were introduced in 2017, such as funding for day-care, which is likely to increase the availability of formal homecare. However, the availability of formal homecare was afflicted by a shortage of homecare-workers. Nevertheless, between 2004 and 2017, a substantial growth of formal homecare use took place by German older adults.

Informal homecare. A large share of the help-needing elderly in Germany make use of informal homecare. As discussed in the analysis, this group constitutes about 45 to 50% of the total long-term care use. Between 2003 and 2015, the informal homecare use increased with 40.4% (by all Germans, not only by older adults), which is slightly lower than the 44.6% increase of the total use of (informal and formal) homecare covered by the long-term care insurance. In comparison with formal homecare and institutional care, it is understandable that many older adults are, in general, attracted by the favourable aspects of informal homecare. In general, costs are the lowest for informal care. In addition, the probable insufficient availability of formal care in combination with eligibility criteria that need to be fulfilled is likely to turn older adults to informal homecare.

In 2009, the lowest percentual use of informal homecare was measured. The years after, the use was suddenly higher: Between 2009 and 2011, the amount of elderly informal homecare users as a share of the total elderly users of long-term care increased with almost 2%. Although this may not appear as a large increase, it is relatively high compared to other years. Around

that time period, the German government had implemented multiple changes for informal caregivers that raised the attractiveness of informal caregiving. In 2008, public pensions contributions and unemployment insurance contributions were introduced for informal caregivers. In that same year, community-based care support centres were set up. The year after, in 2009, the legal right to counselling consultation was introduced. The value of respite care has also increased over the years. Furthermore, the use of informal homecare had become more appealing for help-needing older adults themselves. Cash benefits had raised for the first time in 2008 since the introduction of the long-term care insurance. Moreover, in 2009, older adults with dementia or other cognitive impairments, but without a care level, became eligible for benefits. These people could also start to make use of cash benefits.

Similar to formal homecare and institutional care, the use of informal homecare increased the most between 2015 and 2017. In those years, the reform of the long-term care insurance resulted in increased cash benefits and increased accessibility to benefits. Furthermore, since 2016, pension benefits could be extended to more than one informal caregiver.

5.3.2 Developments in Dutch long-term care policies are largely correlated to changes in the use of long-term care alternatives.

Institutional care. Although it can be expected that all costs for long-term care are endurable in the Netherlands due to the income-dependency of co-payments, the costs for institutional care are the highest for older adults. Especially in 2005 and between 2010 and 2013 co-payments increased, for both institutional care as well as formal homecare. It is noteworthy that the relative use of institutional care slightly decreased since 2006, just after the heightening of co-payments for the AWBZ, as well as in 2011 and 2012, when the co-payments increased again. Although it is only a minor decrease, it should be pointed out, because the overall use of formal care by older adults increased over those years.

Since 2013, the use of institutional care sharply decreased, with about 3% within one year. In that same year, the accessibility to institutional care was drastically changed, with the extramuralisation of ZZP1 and ZZP2. Subsequently, ZZP3 and ZZP4 partly became extramurally organised between 2014 and 2016. What is more, multiple institutions had to be closed at that time, due to reduced governmental support. It is likely that the availability of institutions also suffered from underemployment; the amount of job openings has especially been substantial since 2013.

The largest reduction of institutional care use took place between 2015 and 2017. The renewed long-term care system aimed for a shift from residential to non-residential care and for

a cut in expenditures. People were only eligible for care under the Wlz when in need of permanent supervision or 24-hour care.

In the analysed time-period, quality measures for institutional care facilities have continuously developed.

Formal homecare. The use of formal homecare increased substantially, whereas the aspects of this alternative improved. With the introduction of the Wmo in 2007, municipalities became responsible for eligibility assessments for household care, resulting in a reduction of support. The services provided became more tailored to the needs of individuals and a greater appeal was done on informal caregivers. With the decentralisation, the wages of care workers dropped, causing a reduced availability of workers and possibly lowered quality of formal homecare. However, the data on formal homecare use is not sufficiently available for the year 2007. In 2008, the percentual use of formal homecare is 67.2%, which is the same for 2006 and 2009. Although these numbers may seem contradictory to the developments in formal homecare-policy, the data from the following years shows an increased use of formal homecare.

The only exception is the year 2010, in which a drop in formal homecare users took place of about 0.5% compared to 2009. During the second half of that same year, the governmental budget for personal budgets was exceeded. The consequence was that no new personal budgets were granted in that period. In 2011, the amount of users increased again.

Whereas the use of institutional care decreased in 2013, at the time when the accessibility declined and institutional care facilities were closed, the use of formal homecare increased significantly in 2013 (with 3% compared to 2012[44]). At that same time, in 2013, the amount of job openings started to increase significantly, implying an unavailability of formal homecare.

The largest change in formal homecare use occurred in 2015, when the share of elderly users increased substantially. During the reform in that year, personal care and nursing at home came to be covered by the Zvw. To be eligible for this type of care, only a referral from a general practitioner is needed. Older adults making use of this type of care under the Zvw do not have to pay co-payments. For the Wmo-2015, a new framework was used for assessing eligibility, based on the principle of self-reliance and the plight to care. Especially the provision of tailored services by municipalities is expected to correlate to increased use of formal homecare. The developments went together with a greater appeal on informal caregivers;

[44] An increase in the use of formal homecare since 2013 is observable even though several municipalities failed to forward data on the use of domestic help in 2013, resulting in underreporting, as discussed in the Research Methodology.

support from the Wmo-2015 became less generous. In comparison with institutional care, formal homecare is significantly more accessible and lower in costs. In addition, it is presumable that the availability of institutional care is poorer to some extent, making it a less appealing alternative compared to formal homecare.

Furthermore, since 2015, personal budgets were used to a lesser extent than before. Requirements for its use became stricter at that time, as the Dutch government had implemented more restraining mechanisms.

Informal homecare. It is not known how much older adults used informal homecare between 2004 and 2017. From Appendix A. Table 14 it appears that the share of informal caregivers is quite steady over the years; there is no sign of any considerable changes.

The availability of informal homecare in the Netherlands was pushed by the 'usual care' protocol in 2005. Later, during the reforms in 2007 and 2015, a greater appeal was made to informal caregivers. Since the decentralisation in 2015, older adults were not eligible for coverage of care when an informal caregiver could provide the care; it aimed to stimulate the provision of informal care.

5.3.3 Germany and the Netherlands compared.

Institutional care. As discussed in first part of the analysis, a trend of deinstitutionalisation is visible in both Germany and the Netherlands, meaning that older adults make less use of institutional care facilities and increasingly rely on homecare services. Especially since 2013 this trend is evident, mostly in the Netherlands but also in Germany.

It is outstanding how close the percentages of homecare use and institutional care use are in Germany and the Netherlands. Since 2013, the curves of both countries distance from each other, indicating that Dutch older adults choose to a lesser extent for institutional care compared to German older adults. At that same time, it is found that the costs for institutional care were relatively high in Germany compared to costs for other alternatives. In the Netherlands, co-payments have increased between 2010 and 2013. Since 2013, the Dutch long-term care system also restricted access to institutional care and reduced the availability of institutional care facilities.

Both countries have radically reformed their long-term care system between 2015 and 2017. However, in the Netherlands, a significantly greater drop of institutional care use took place since 2015 compared to Germany. It might be possible that Germany also witnessed a steep decrease of institutional care use after 2017, but the data for those years were not available.

Formal homecare. Overall, Germany has fewer elderly users of homecare benefits than

the Netherlands, especially considering the fact that the German measurement also includes the use of cash benefits, which is largely used for informal care. Similarly, both countries suffer from unavailability of formal homecare due to a shortage of care-workers, although it is not known in which country long-term care policies provide the greatest availability of formal homecare.

What is known, is that the costs for formal care are higher in Germany than in the Netherlands, both for formal homecare as well as for institutional care. The quality of care is maintained in both countries and they were found to be in the same 'quality cluster'.

Whereas before 2015, Germany and the Netherlands showed a parallel use of homecare, the year 2015 marked a point of deferral: Germany's deinstitutionalisation rate came to lag behind compared to the Netherlands. The elder care is deinstitutionalising in Germany, but not at such a considerable rate as the Dutch elder care since the reform in 2015. The German long-term care system was reformed somewhat later than the Dutch system. Therefore, correlating changes in long-term care use may also be visible in subsequent years than for the Dutch situation. Nevertheless, the absolute numbers demonstrate a substantial increase in the use of homecare by German elderly: from 1.5 million people in 2013, to 1.7 million people in 2015 and 2.1 million people in 2017. The amount of elderly using institutional care only increased with about 50,000 between 2013 and 2017 (Destatis, n.d.).

The data on formal homecare users from the Netherlands shows more variations in use between years than the German data. This may be connected to Destatis' (n.d.) biannual measurements, compared to the yearly measurements of CBS.

Informal homecare. It is estimated that the use of informal care is significantly higher in Germany than in the Netherlands. It was not possible to retrieve information about variations over time. At the same time, co-payments for formal care in Germany are much higher than in the Netherlands, making informal care more attractive. On the other hand, the Dutch government has implemented eligibility assessments that rather 'encourage' the use of informal care: care for older adults is not covered when it can be provided by an informal caregiver, either household work or physical care. In Germany, this is not taken into account, and the coverage from the long-term care insurance is only dependent on the care-needs of an older person.

Measures for informal caregivers in terms of short- and long-term care leave and respite care are largely similar between the two countries. The support systems in both countries have advantages and disadvantages.

6. Conclusions

In conclusion, changes in the outcomes of choice processes of older adults often occur in coherence with changes in national long-term care policies. Nevertheless, at the time of some policy-changes, a change in outcomes of choice processes is not visible. The changes in terms of eligibility and of costs often parallel changes in choice processes. Measures concerning quality do not appear to cohere with changes in choice processes, possibly because the quality of long-term care in Germany and the Netherlands is already adequate. In Germany, especially adaptations in eligibility and costs correlate to changes in choices for long-term care alternatives. The most considerable development is visible between 2015 and 2017. The increase in homecare use appears to correlate to a heightening of benefits from the long-term care insurance and an extended eligibility for older adults, especially due to the diminishment of the separation between physical and cognitive impairments. In that period, benefits for institutional care also increased, but they do not appear to correlate to a move from older adults to institutional care facilities; compared to the other alternatives, co-payments for institutional care remain high.

In the Netherlands, costs of alternatives appear to relate to choice processes to a lesser extent than in Germany, which is presumably related to the income-dependency of co-payments for long-term care in the Netherlands. Accessibility and eligibility mainly appear to correlate to choices. Evidence for these findings is especially visible since 2013: When eligibility became stricter for institutional care and the availability of facilities declined, a reduced use of institutional care is perceivable. Moreover, since 2015, the results show that the reforms impacting the eligibility and the availability of alternatives correlated to a steep drop in the share of institutional care users, whereas the share of formal homecare users grew immensely.

The most substantial difference between Germany and the Netherlands concerns the correlation between higher costs for an alternative and a reduced use of that same alternative: In Germany, this correlation is relatively strong compared to the Netherlands.

7. Discussion

This study has given an overview of the developments in long-term care policies for older adults between 2004 and 2017 in Germany and the Netherlands, and the outcomes of older adults' choice processes for institutional care, formal homecare and informal homecare over those years in both countries.

The internal validity in this thesis is ensured to a large extent. It is highly likely that cross-country long-term care policy-differences relate to cross-country differences in older adults' choice processes. However, as indicated in the theoretic framework, other factors besides policy may also influence choice processes. These are societal factors, external pressure, information, and other factors. Societal factors are expected to be negligible within this study, as the Dutch and German society are comparable. It cannot be excluded that external pressure, information, and/or other factors played a role in choice processes for long-term care. Hence, these are third variables, besides long-term care policies and elderlies' choice processes, that could not have been measured within this study, but that may have had an impact on the conclusions. Yet, this study has shown strong evidence for the influence of policy on choice processes of older adults.

The content validity of this study is largely guaranteed, as the variables are measured using the correct indicators. Only minor aspects could not be measured as intended, which are discussed in the limitations section hereafter.

The conclusions of this study are generalisable to other countries and groups of people. In other words, it is expected that similar mechanisms occur in other countries or for other groups of people. Nevertheless, Germany and the Netherlands have similar cultures, they are both West-European welfare states and have a certain type of long-term care regime that provides particular services. Therefore, it is likely that similar mechanisms may only occur in countries with similarities in these areas to Germany and the Netherlands.

Moreover, it can be assumed that the long-term care alternatives of which the favourableness is enhanced by certain policy-aspects, are not only relied upon more by older adults, but also by other population groups. Examples include parents or young adolescents. Likewise, the results are likely to be valid not only for long-term care alternatives, but also for other forms of care, such as maternity care. Another example is that it is highly likely that long-term care policies influence the favourability of alternatives and affect choice processes in other countries, or on another level than the national level. However, it should be noted that variations in external pressure, societal factors and information (and other factors) may play a role when

analysing different groups. Altogether, this study is externally valid.

One of the results from the analysis is a correlation between high co-payments for an alternative and a low use of that alternative. It is expected that costs for alternatives have the greatest impact on choice processes of older adults, compared to the other factors. This has especially been visible in Germany, where the co-payments are not income-dependent as in the Netherlands. The substantial use of informal care in Germany serves as evidence. Even though the availability of informal care is not assessed during eligibility assessments, as in the Netherlands, older adults make the most use of this alternative. It is highly likely that this explains this difference with the Netherlands; the high co-payments for formal care in Germany force German elderly to turn to relatives and other close-ones, as was also found by Bakx et al. (2015). This agrees with Heger & Korfhage (2018), who found that informal care is most widely used by countries that have a strong emphasis on cash benefits, which can be used to pay informal carers. Nevertheless, the increase in informal care use has increased to a lesser extent between 2003 and 2017 than the total homecare use. Explanations may be the increase in benefits for formal homecare and the less restrictive eligibility to care.

Furthermore, a correlation between accessibility and the use of care has appeared from the analysis. For instance, the use of institutional care in the Netherlands significantly decreased since 2013, when the lowest severity-of-care-packages were extramuralised. At the same time, the availability of facilities decreased. This agrees with Bakx et al. (2015), who found that long-term care use is strongly affected by country-specific eligibility criteria for public long-term care coverage.

It has been most complicated to determine the influence of availability on choice processes. This is mainly due to a lack of information about the availability of alternatives and the policy-aspects that influence it, but also because of regional variations in availability of alternatives. Nevertheless, correlations are found between availability and use. For instance, when in 2015 the range of services covered by the Wmo grew, the amount of users increased simultaneously. It should be noted that increasing the availability of alternatives is a time-requesting processes, as the necessary infrastructures need to be build up (Heger & Korfhage, 2018).

Quality of long-term care alternatives has shown to be the aspect that influences choice processes to the smallest extent. In both countries, quality of long-term care is enhanced by multiple national measures and the countries belong to the same ‘quality cluster’. Moreover, there have not been signs of great differences in quality between alternatives. Nevertheless, when applying this study to other countries with variations in quality of care, other results are

probable; the quality of long-term care in both Germany and the Netherlands is assumed to be good (Alders et al., 2015; Figure 27 in Appendix B).

In both countries, institutional care is the most unfavourable alternative for older adults: Co-payments are the highest, eligibility criteria are highly restrictive and unavailability prevails. This goes hand in hand with the lowest share of use by older adults in both countries. The largest difference between the two countries concerns the informal care use: German older adults make significantly more use of informal care than Dutch older adults.

Outstanding is the extent to which the German government encourages informal care. It may be assumed that the high informal care use directly derives from the cultural value of family. This study contradicts that statement, as it is found that German long-term care policies are strongly related to the choices of older adults for informal care, especially compared to the Dutch situation. It agrees with Alders et al. (2015) who argue that the post-war difference in availability of institutional care facilities for older adults contributed to a shift in the norms towards residing at home at an older age and a family's increased responsibility to care for older adults. Hence, norms are dependent of public policy.

Altogether, a combination of favourable aspects of alternatives appears to attract the most elderly users. For instance, the Dutch government has consistently aimed for deinstitutionalisation and implemented measures restricting eligibility and availability for institutional care. The decentralisation in 2015 formed the turning point. Likewise, the German reform, in which the government combined cost- and accessibility-related measures, appeared to have the most effect on choice processes. Alders, Costa-Font, De Klerk and Frank (2015) also name a sequence of policies a "promising route" for decreasing the percentage of elderly in institutional care facilities (p. 819). Hence, the policy-implication is that aspects of long-term care alternatives should be adapted in coherence with each other to achieve the desired results; the combination of multiple steering models is likely to best achieve policy objectives. For instance, when the co-payments for an alternative are lowered via policy, but the eligibility for the alternative are still relatively strict, it is unlikely that the policy influences changes in the use of the alternative.

Another policy-implication is that the three alternatives need to be taken into account when aiming to deinstitutionalise long-term care. In other words, when attempting to make more older adults choose for formal homecare, it means that not only that alternative should become more appealing, but that institutional care should become less attractive. What is more, an increased attractiveness of formal homecare may also attract older adults that relied on informal homecare before, which may not be the desired outcome.

Lastly, it is found that the most effective policy-measures appeared to be judicial instructions in terms of eligibility criteria, and financial stimulations that affect co-payments for long-term care alternatives. Nevertheless, as discussed before, a combination of steering models is found to relate to the greatest changes in long-term care use.

7.1 Limitations

Several limitations afflict the content validity of this study. One of them is related to the measurement of the dependent variable. The amount of older adults using informal homecare could not be measured as intended, because of two reasons. Firstly, multiple definitions of informal care are used by multiple scholars and organisations. According to the definition used in this study, cash benefits in Germany are merely used for informal care, whereas personal budgets in the Netherlands are considered to be for formal care, even if a relative performs the care. For that reason, if the German government decides that receivers of cash benefits have to have formal contracts with their care-provider, it means that about 50% of long-term care, that now is informal, suddenly becomes formal care. Secondly, there is a lack of data about informal care use; for (statistical) organisations, it is only possible to make estimations when care is not formally organised.

Another limitation influences the measurement of the independent variable: Long-term care policies that remained the same are not discussed, while change would have been necessary. For instance, Germany has a high amount of migrant care-workers, mainly from Eastern European countries, Russia and Ukraine. The proportion of migrant workers has increased significantly over the years and issues arose concerning their working conditions and the quality of provided care (Theobald & Hampel, 2013). However, the German government failed to implement policies to correctly regulate the quality of care for older adults who employ migrant care-workers. These types of ‘insufficient’ governance could not have been analysed in detail in this study.

Furthermore, the measurement of the independent variable is slightly undermined due to the impossibility to measure all factors influencing the favourability of long-term care alternatives. An example is the number of women in the labour force that could not be measured within this framework; more working women may result in reduced availability of informal caregivers.

A limitation that afflicts the internal validity of this study is the fact that other factors may have influenced choice processes of older adults, beside long-term care policies. This has been elaborated in an earlier section.

The last limitation in this study has been the greater familiarity with the Dutch language than with the German language. Therefore, it might be the case that information about the long-term care system was found with greater ease and with greater magnitude for the Netherlands than for Germany. Moreover, because of inhabiting the Netherlands, it cannot be ruled out that a larger awareness existed of the Dutch long-term care system compared to the German system.

7.2 Recommendations for Future Research

One recommendation is to continue this study for the years after 2017. Until now, it has only been possible to conduct the analysis between 2004 and 2017 due to data limitations outside those years. However, in the period since 2015, significant changes in the long-term care systems have taken place in both Germany and the Netherlands. The correlation with older adults' choice processes could not have been fully analysed within this study, as changes in care us patterns happen slowly (Heger & Korfhage, 2018). This would be possible with more data of subsequent years. Especially for Germany it is expected that the major consequences of the reform show up in the years following 2017.

Moreover, the existing data did not allow a more specific definition of the target groups. For the future, if the data becomes available, it would be interesting to look at the specific care-needs per person.[45] For instance, the Wmo also provides the right to care for assistance that a person not only needs when he or she is an older adult, but also at a younger age. In this case, it is thus not clear whether a person receives care because of age, or because of other characteristics of a person. Likewise, separating institutional care, formal homecare and informal care in more sub-groups could also provide more insights. For instance, great differences exist between formal homecare: it ranges from nursing for severe illness multiple times a day, to household work for one and a half hour per week.

Another recommendation is to research the influence of long-term care policies on the combinations of long-term care use for older adults. This study has not discussed the choices of older adults for combinations of multiple alternatives, such as formal homecare and informal care. Previous research has shown that informal care can replace or supplement formal care. The relationship between the two is dependent on the type of care (Plaisier et al., 2017). Moreover, it is found that formal homecare has a significant effect on the use of institutional care (Alders et al., 2015). Formal and informal care are interdependent, as Swinkels, Suanet, Deeg, & Broese van Groenou (2016) state.

[45] For the Wmo-2015, it is already visible how many older adults use support at home, household support, residence and shelter, aids and services (CBS, 2018a).

Lastly, a recommendation for future research is to study the influence of the height of incomes on the use of long-term care alternatives. As discussed in the analysis of this thesis, long-term care insurance benefits in Germany are set and non-income-dependent. It could be questioned whether only older adults with higher incomes make use of costlier alternatives, such as institutional care. Longo and Notarnicola (2018) have also engaged in this topic, and found that in Germany, poor citizens tend to opt for cash benefits, while middle and upper class citizens choose in-kind care services. In the Netherlands, the co-payments for care covered by the Wmo have become similar for everyone since 1 January, 2019. Per four weeks, users have to pay EUR 17.50, despite their income or financial resources (Zorgwijzer, 2018).[46] This adaption may lead to a different role of aspects of long-term care alternatives; it could be interesting to research the changes.

[46] From 1 January, 2020, the co-payments for Wmo-care are EUR 19 per four weeks (CAK, n.d.).

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Appendices

Appendix A. Tables

Table 8

Older adults receiving care in institutions and at home (absolute numbers), Germany, 2003-2017

	2003	2005	2007	2009	2011	2013	2015	2017
Older adults receiving care in institutions	575,726	610,340	638,187	667,060	689,975	707,767	726,980	756,596
Older adults receiving care (partly) at home	1,113,961	1,140,903	1,223,117	1,306,397	1,430,492	1,519,567	1,714,912	2,117,589
Total amount of older adults receiving long-term care	1,689,687	1,751,243	1,861,304	1,973,457	2,120,467	2,227,334	2,441,892	2,874,185

Note. Older adults receiving care in institutions is calculated by adding up the people aged 65 years and older that receive care in institutions (*Versorgung in Heimen vollstationär*). Older adults receiving care (partly) at home is calculated by adding up the people aged 65 years and older that receive both care at home (*Versorgung zu Hause*), or care partly at home (*Versorgung in Heimen teilstationär*). The total amount of help-needing older adults is calculated by adding up the older adults that receive institutional care and the older adults that receive homecare. Adapted from "*Pflegebedürftige: Deutschland, Stichtag, Art der Versorgung, Altersgruppen"* [Data file] by Destatis, n.d.

Table 9

Older adults receiving care in institutions and at home (percentages of total help-needing elderly population), Germany, 2003-2017

	2003	2005	2007	2009	2011	2013	2015	2017
Older adults receiving care in institutions (% of total)	34,1%	34,9%	34,3%	33,8%	32,5%	31,8%	29,8%	26,3%
Older adults receiving care at home (% of total)	65,9%	65,1%	65,7%	66,2%	67,5%	68,2%	70,2%	73,7%

Note. Adapted from Table 8. To calculate the relative use of long-term care alternatives by German older adults, the absolute number of older adults receiving institutional care/homecare is divided by the total amount of older adults receiving long-term care.

Table 10

Older adults that chose to receive care in institutions and at home within one year (absolute numbers), the Netherlands, 2004-2014

	2004	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
Older adults receiving care at home	481,595	479,905	492,415	496,930	504,815	521,265	513,470	543,970	552,800	543,905	531,540
Older adults receiving care in institutions	238,475	240,145	240,805	0	245,910	249,865	255,580	258,800	262,850	223,825	212,390
Total amount of older adults receiving LTC	720,060	720,050	733,220	0	750,720	761,135	769,050	802,780	815,650	767,730	743,925

Note. 'LTC' refers to 'long-term care'. The amount of help-needing elderly choosing to receive care at home (*zorg zonder verblijf* [ZZV]) is represented by CBS' data on the amount of older adults that received homecare covered by the Wmo and/or homecare covered by the AWBZ (total ZZV-Wmo and/or ZZV-AWBZ). The older adults choosing to receive institutional care (*zorg met verblijf* [ZMV]) are represented by CBS' data of the total amount of elderly that received residential care covered by the AWBZ (Total ZMV-AWBZ). For the year 2007, the table shows a gap in data, due to CBS' incomplete data about the use of care with residence. It should be noted that the total amount of older adults receiving long-term care in the table is larger than the actual amount of elderly long-term care users, because it concerns choices per year; older adults can make multiple choices within one year. Adapted from "*Personen met gebruik ZZV en/of ZMV; inkomen en regio, 2004-2014* [Data file]" by Central Bureau for Statistics Statline MLZ [CBS], 2018. Retrieved from https://mlzopendata.cbs.nl/#/MLZ/nl/dataset/40011NED/table?ts=1558432667604.

Table 11

Older adults that chose to receive care in institutions and at home within one year (absolute numbers), the Netherlands, 2015-2017

	2015	**2016**	**2017**
Older adults receiving formal care at home	880,315	855,535	871,345
Older adults receiving care in institutions	186,370	182,460	182,160
Total amount of older adults receiving long-term care	1,066,685	1,037,995	1,053,505

Note. The amount of older adults choosing to receive formal care at home is calculated by adding up people aged 65 years and older choosing to receive community nursing covered by the Zvw, those choosing to receive care covered by the Wmo, and those choosing to receive a modular package at home (*modulair pakket thuis* [mpt]) or a complete package at home (*volledige pakket thuis* [vpt]) covered by the Wlz. The amount of older adults choosing to receive institutional care is measured using data about people aged 65 years and older using care in-kind covered by the Wlz (*Zin verblijf*, referring to 'care in-kind in a residence'). Adapted from CBS (2018a; 2018b; 2019c; 2019d).

Table 12

Older adults that chose to receive care in institutions and at home within one year (percentages of total choices), the Netherlands, 2004-2017

	2004	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**
Older adults receiving formal homecare (% of total)	66,9%	66,6%	67,2%		67,2%	67,2%	66,8%	67,8%	67,8%	70,8%	71,4%	82,5%	82,4%	82,7%
Older adults receiving care in an institution (% of total)	33,1%	33,4%	32,8%		32,8%	32,8%	33,2%	32,2%	32,2%	29,2%	28,6%	17,5%	17,6%	17,3%

Note. The relative use of formal homecare is calculated by the amount of older adults choosing for formal homecare divided by the total amount of choices that older adults made. The relative use of institutional care is calculated by the amount of older adults choosing institutional care divided by the total amount of choices that elderly made. For the year 2007, a gap exists due to CBS' incomplete data. Adapted from Table 10 and Table 11, for the years 2004-2014 and the years 2015-2017 respectively.

Table 13

Overview of long-term care acts in the Netherlands, 2004-2017

Until 2015	**Institutional care**	**Formal homecare**	**Informal homecare**
AWBZ	Care with residence	Short-term residence (respite care) (for people without Wlz-indication) Short-term residence (respite care) (for people with Wlz-indication living at home) (Individual) guidance and (group) treatment Personal care with need for medical care Nursing Palliative terminal care for people with/without Wlz-indication	
Wmo (since 2007)		Housing adjustments, transport services, etc. Household support	Support for informal caregivers
From 2015			
Wmo-2015		Housing adjustments, transport services, etc. Household support Short-term residence (respite care) (for people without Wlz-indication (Individual) guidance Personal care coherent with guidance	Support for informal caregivers
Wlz	Care with residence	Short-term residence (respite care) for people with Wlz-indication living at home (Individual) treatment Palliative terminal care for people with/without Wlz-indication	
Zvw		Personal care with need for medical care Nursing	

Note. Before the introduction of the Wmo in 2007, the types of care covered by this act prior to 2015 were covered by the AWBZ. Adapted from "*Keuzeruimte in de langdurige zorg: Veranderingen in het samenspel van zorgpartijen en cliënten*" by CPB & SCP, 2015. Retrieved from https://www.cpb.nl/sites/default/files/publicaties/download/cpb-scp-boek-18-keuzeruimte-de-langdurige-zorg.pdf.

Table 14

Providers and receivers of informal care, Germany and the Netherlands

Source	What is measured?	Year	Germany	The Netherlands
Hoffman & Rodrigues (2014, p. 2)	Percentage of the population that provides informal care to a relative aged 60 years and older	1999	13%	14%
Riedel & Kraus (2011, p. 1)	Percentage of population of 65 years and older and 80 years and older that receive informal care	2006	36% of 65+ population; 56% of 80+ population	28% of 65+ population; 41% of 80+ population
Eurostat (2019)	Percentage of people that provide informal care or assistance at least once a week	2014	15.5%	18.1%
European Quality of Life Survey (in European Commission, 2018d, p. 19)	Percentage of informal carers as a percentage of the total population	2016	23%	18%
OECD (2013, p. 181; 2015, p. 203; 2017, p. 209)	Percentage of population aged 50 years and older that are informal carers and aged 50 years and older	2010 2013 2015	15.7% 14.4% 15%	16.9% 15.9% 17%

Table 15

Informal care provision, the Netherlands

Source	What is measured?	Year	The Netherlands
SCP (2010, p. 3)	Dutch citizens providing informal care	2001 2008	3,7 million 3,5 million
CBS (2019a)	Percentage of the 50+ population that provides informal care	2015 2016 2017	14,9% 13,9% 14,9%

Table 16

Long-term care policy-changes and aspects: institutional care in Germany

Aspect/year	**Policy-changes and aspects: institutional care**
Availability	
	Regional differences exist in the availability of institutional care Controversy between sources about availability: expectations are that, overall, availability does not suffice care-needs.
Accessibility	
2008	People with dementia that do not fulfil the criteria became eligible for long-term care benefits
2008	Individuals are eligible for benefits after paying contributions for at least two years, compared to five years before
2017	New definition of 'in need of care' enables access to more people
	Older adults only receive insurance for care in an institution when homecare is insufficient or impossible for them, and when having care grade 2 to 5
Costs	
2008	Benefits for care level III increased, although incompatibly with inflation
2017	Benefits for all beneficiaries increased
	Overall, small adaptations of benefits, and high co-payments of about 50% of the total costs of care. Costs for institutional care are the highest compared to the alternatives.
Quality	
2008	The Long-term Care Further Development Act was implemented
2008	Results of quality inspections of institutional care facilities became published in 'transparency reports'
2010	Introduction of wage floor for care workers in long-term care facilities
2017	The Health Professions Reform Act was implemented
	Continuous increase of quality of formal care

Table 17

Long-term care policy-changes and aspects: formal homecare in Germany

Aspect/year	**Policy-changes and aspects: formal homecare**
Availability	
	Insufficient availability of homecare providers; (illegal) care-workers from abroad try to fill in gaps
2017	New services were introduced (funding for day-care/assistance to everyday life)
Accessibility	
2008	People with dementia that do not fulfil the criteria became eligible for long-term care benefits
2008	Individuals are eligible for benefits after paying contributions for at least two years, compared to five years before
2013	Care level 0 was introduced, incorporating people needing general supervision and homecare (typically for people with dementia)
2017	New definition of 'in need of care' enables access to more people
Costs	
2008	Benefits for all beneficiaries increased, although it is expected that the costs for formal homecare decreased significantly
2013	Benefits for people with dementia raised
2017	Significant increase of all benefits, except for people with care grade 5
Quality	
2008	The Long-term Care Further Development Act was implemented
2017	The Health Professions Reform Act was implemented
	Continuous increase of quality of formal care

Table 18

Long-term care policy-changes and aspects: informal homecare in Germany

Aspect/year	**Policy-changes and aspects: informal homecare**
Availability	
	The German government enhances informal caregiving via multiple measures (respite care/long-term care leave), though lacking attractiveness
	Family-members of elderly relatives are 'freed' from performing physical care, but are expected to organise the household work
Accessibility	
	Eligibility for cash benefits has improved, similarly to the eligibility for formal homecare
Costs	
2008	Introduction of public pensions contributions
2008	Introduction of unemployment insurance contributions
	Increase in cash benefits
	Value of respite care coverage has increased over the years
2016	Extension of pension benefit to more caregivers
Quality	
2008	Introduction of community-based care support centres, that offer free training courses for informal carers to improve quality of care
2009	Introduction of legal right to counselling consultation

Table 19

Long-term care policy-changes and aspects: institutional care in the Netherlands

Aspect/year	**Policy-changes and aspects: institutional care**
Availability	
	Decline in existence of institutional care facilities
	Waiting lists for institutional care
2013-2017	Significant increase of job openings in the care and welfare sector, implying a shortage of care-workers in institutions
Accessibility	
2013	Transition of older adults with ZZP1 and ZZP2 to the Wmo, resulting in deinstitutionalisation
2014-2016	Transition of some older adults with ZZP3 and ZZP4 to the Wmo, resulting in deinstitutionalisation
Costs	
	Co-payments are income-dependent, meaning that no one should have problems with paying for the care
2005	Increase in co-payments
2010	During the second half of 2010, the financial situation of the Dutch government did not allow new personal budgets to be granted
2010-2013	Increase in co-payments, especially between 2010 and 2013
Quality	
	Continuous improvement in the quality of care in institutions
2017	Quality framework for nursing homes was implemented

Table 20

Long-term care policy-changes and aspects: formal homecare in the Netherlands

Aspect/year	**Policy-changes and aspects: formal homecare**
Availability	
2007	With the introduction of the Wmo, wages of care workers dropped, resulting in a reduced availability of workers and reduced quality
2015	Wmo changed from providing 'a clean house' to 'household support', which also includes services as 'meals on wheels'. In addition, government budgets to municipalities decreased
2013-2017	Significant increase of job openings in the care and welfare sector, implying a shortage of care-workers in formal homecare
Accessibility	
2007	With the introduction of the Wmo, municipalities re-assessed eligibility and reduced support for a part of the users. The guiding principle for eligibility assessments was the plight to compensate.
2015	The principle of self-reliance was implemented as a basis for eligibility assessments for the Wmo: The amount of covered care should be an addition to what older adults can do themselves, or what the informal care-network can provide.
2015	Most personal care and nursing at home came to be covered by the Zvw, for which people need a referral from the general practitioner
Costs	
2005	Increase in co-payments for care under the AWBZ
2010	During the second half of 2010, the financial situation of the Dutch government did not allow new personal budgets to be granted
2010-2013	Increase in co-payments for care under the AWBZ, especially between 2010 and 2013
2015	The transfer of personal care and nursing to the Zvw meant that older adults did not have to pay co-payments anymore for community-care covered by the Zvw
Quality	
	Continuous improvement in the quality of care in institutions
2015	Due to a rising use of formal homecare since the decentralisation, the quality of care suffered from the pressure

Table 21

Long-term care policy-changes and aspects: informal homecare in the Netherlands

Aspect/year	**Policy-changes and aspects: informal homecare**
Availability	
2005	The ‘usual care’ protocol was introduced: family members were expected to care for elderly relatives without remuneration. The result is a less generous system
2015	Since the reform, ‘usual care’ is used as a directive to determine the amount of care that does not need to be covered; the Dutch government ‘forced’ availability.
Costs	
	Costs for receivers of informal care and for informal caregivers have not changed significantly
Accessibility	
	Not applicable
Quality	
	Quality measures for informal care are not found

Appendix B. Figures

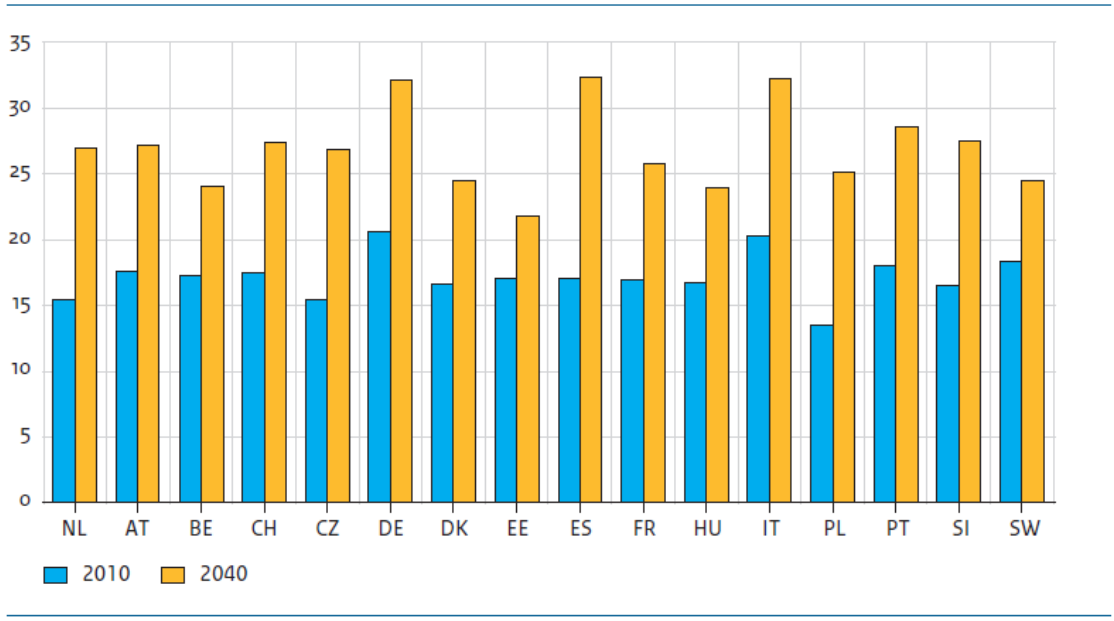

Figure 19. Share of people aged 65 and older in the population in 2010 and 2014 (in percentages). *Note.* Reprinted from "*Who cares in Europe? A comparison of long-term care for the over-50s in sixteen European countries*" by SCP, 2014b, p. 29.

		Public spending	Private spending	Informal care use	Informal care support
Cluster 1	Germany Belgium Czech Republic Slovakia	Low	Low	High	High
Cluster 2	The Netherlands Denmark Sweden	High	Low	Low	High
Cluster 3	Spain Austria Finland France England	Medium	High	High	High
Cluster 4	Poland Hungary Italy	Low	High	High	Low

Figure 20. Typology of long-term care systems. *Note.* Adapted from "The Long-Term Care Workforce: Description and Perspectives" by Geerts, J., 2011, p. 2.

	Home care			Nursing home care	
	Number of providers	Employees	Full-time employees	Number of providers	Number of beds
			Absolute numbers		
1999	10,820	183,782	56,914	8,859	654,456
2001	10,594	189,567	57,524	9,165	674,292
2003	10,619	200,897	57,510	9,743	713,195
2005	10,977	214,307	56,354	10,424	757,186
2007	11,529	236,162	62,405	11,029	799,059
			Overall growth rate (%)		
1999-2001	-2.1	3.1	1.1	3.5	4.5
2001-2003	0.2	6.0	0.0	6.3	5.8
2003-2005	3.4	6.7	-2.0	7.0	6.2
2005-2007	5.0	10.2	10.7	5.8	5.5
1999-2007	6.6	28.5	9.6	24.5	23.8

Figure 21. The capacity of the formal care sector, Germany, 1999-2007. *Note.* Reprinted from "Social Insurance for Long-term Care: An Evaluation of the German Model" by Rothgang, H., 2010, *Social Policy & Administration, 44*(4), p. 443.

Foreign nationality workers (%)	**1998[2]**					**2008**				
ISCO-88 OCCUPATIONAL CATEGORY[1]	223/323	513	913	Total Care	Total Labour Force	223/323	513	913	Total Care	Total Labour Force
Germany	5.3	7.1	22.2	11.9	7.9	1.4	6.9	26.2	13.2	8.6
The Netherlands	1.8	1.7	8.3	3.8	3.1	1.8	2.7	10.7	4.9	3.7
Spain	0.0	2.1	2.8	2.3	1.6	0.0	12.9	39.7	28.9	14.3
Poland[3]	0.0	0.0	0.9	0.5	0.1	0.0	0.4	0.1	0.1	0.2

[1] 223: Nursing and midwifery professionals; 323: Nursing and midwifery associate professionals; 513: Personal care and related workers; 913: Domestic and related helpers, cleaners and launderers

[2] Data relate to 1998 for Germany and Spain, to 1999 for The Netherlands and to 2004 for Poland

[3] For 2008, foreign nationality figures for Poland relate to only two groups: EU27 and Europe outside EU27, all other nationalities were recoded to "No Answer"

Figure 22. Foreign nationality workers (in percentages), Germany, 1998 and 2008. Adapted from "The Long-Term Care Workforce: Description and Perspectives" by Geerts, J., 2011, p. 15.

Euros Level of care	(1) Care costs	(2) Board and lodging	(3) = (1) + (2) Daily rate (investment excluded)	(4) LTCI benefits	(5) = (1) – (4) Co-payments, care costs only	(6) = (3) – (4) Co-payments, care and hotel costs
Level I	1,307	608	1,915	1,023	284	892
Level II	1,733	608	2,341	1,279	454	1,062
Level III	2,158	608	2,766	1,432	726	1,334

Figure 23. Average monthly rates for nursing homes, long-term care insurance benefits, and co-payments, Germany, 2007. Adapted from "Social Insurance for Long-term Care: An Evaluation of the German Model" by Rothgang, H., 2010, *Social Policy & Administration, 44*(4), p. 440.

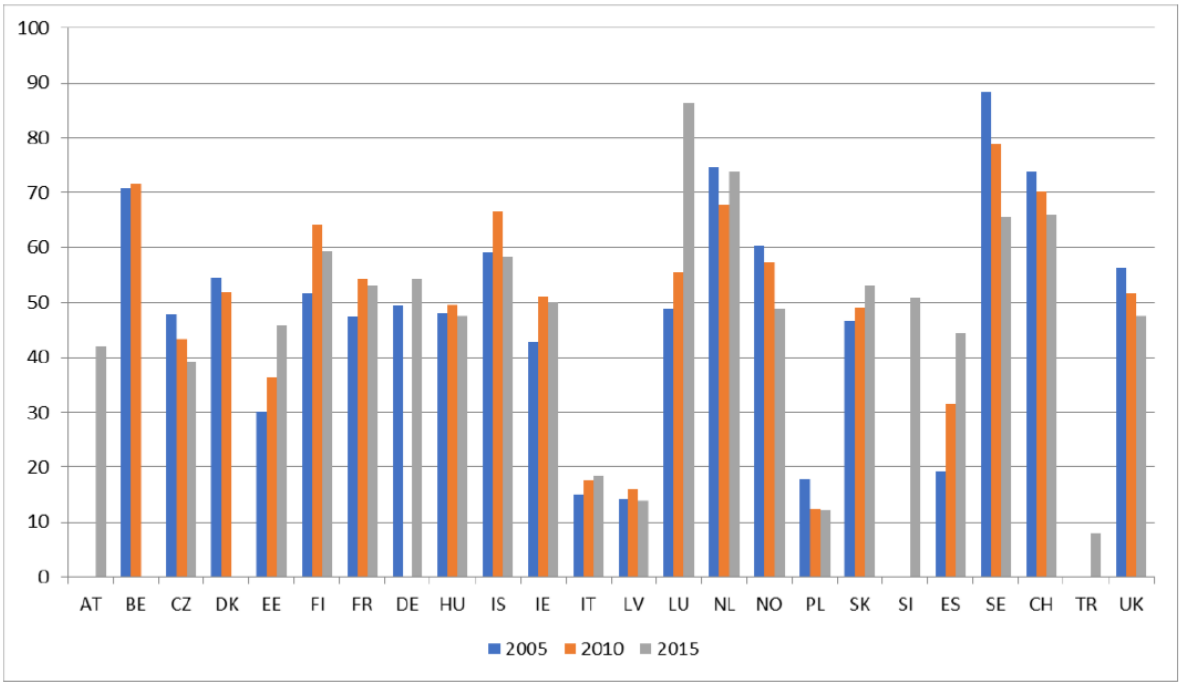

Figure 24. Beds in residential long-term care facilities (65+, per 1,000 population), 2005, 2010, 2015. Reprinted from "*Challenges in long-term care in Europe. A study of national policies*" by European Commission, 2018a, p. 23.

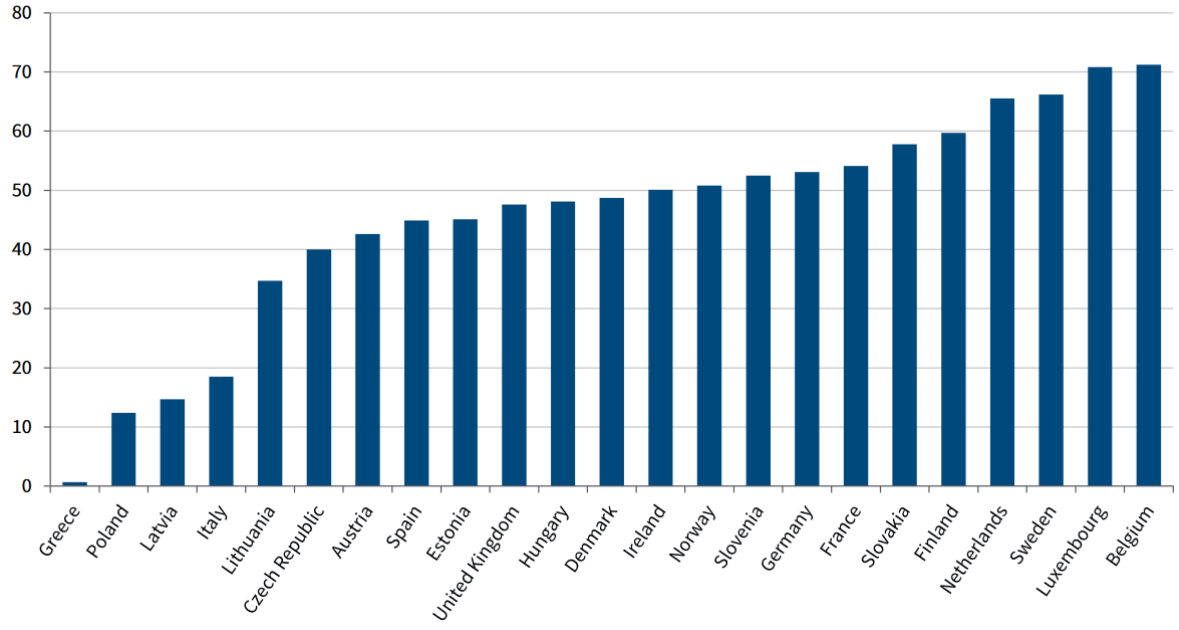

Figure 25. Beds in residential long-term care facilities for service users aged 65 years and older. "Data are per 1,000 people aged 65+ in 2014 with the following exceptions: data for Denmark correspond to 2011; data for Italy, Belgium and the Netherlands correspond to 2012; data for Spain correspond to 2013; data for Luxembourg, Ireland and the UK correspond to 2015" (Eurofound, 2017, p. 16). Reprinted from "Care homes for older Europeans: Public, for-profit and non-profit providers" by Eurofound, 2017, p. 16. Retrieved from https://www.alzheimer-europe.org/var/plain_site/storage/original/application/f5253c2c572b6e0c28b45922149d2289.pdf.

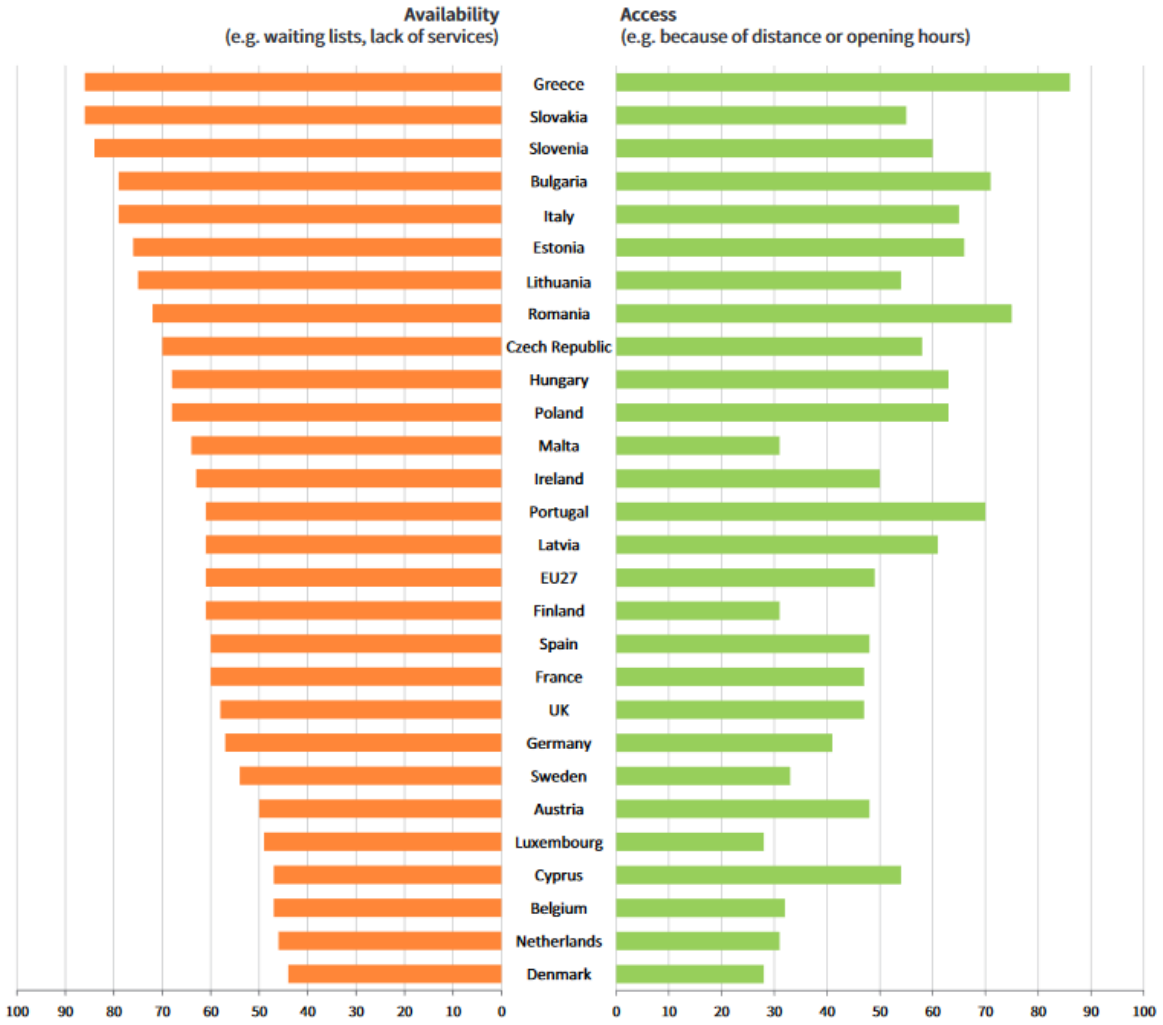

Figure 26. Difficulties in accessing long-term care because of barriers to access and availability (in percentages). Reprinted from "Care homes for older Europeans: Public, for-profit and non-profit providers" by Eurofound, 2017, p. 26. Retrieved from https://www.alzheimer-europe.org/var/plain_site/storage/original/application/f5253c2c572b6e0c28b45922149d2289.pdf.

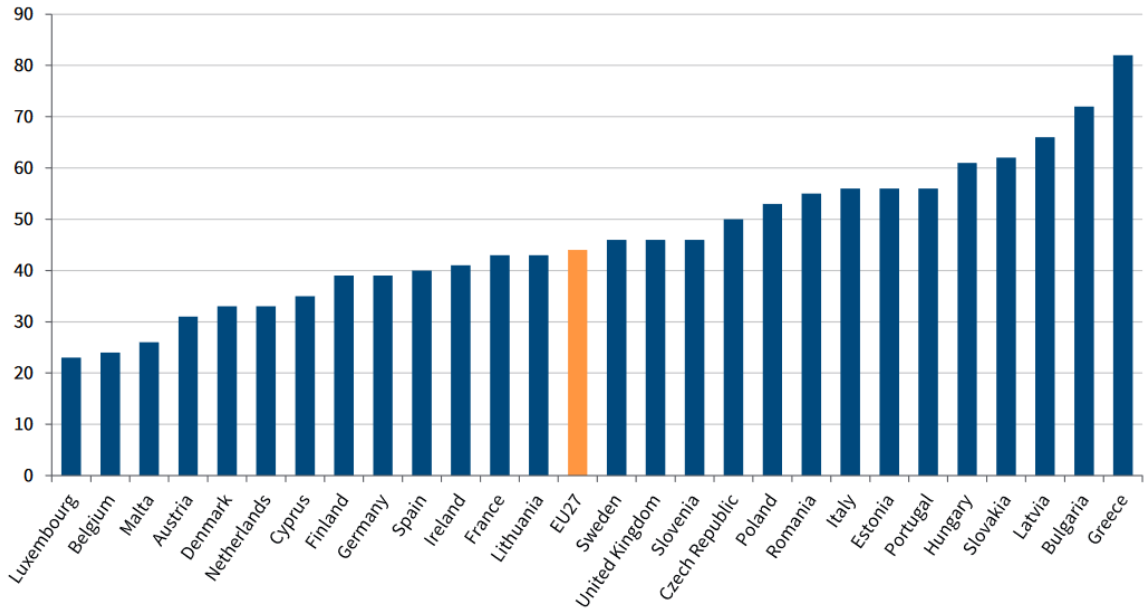

Figure 27. Poor quality as a barrier: Difficulty in accessing long-term care services. Reprinted from "Care homes for older Europeans: Public, for-profit and non-profit providers" by Eurofound, 2017, p. 32. Retrieved from https://www.alzheimer-europe.org/var/plain_site/storage/original/application/f5253c2c572b6e0c28b45922149d2289.pdf.

Appendix C. Costs for Institutional Care in Germany

Schulz (in Heger & Korfenhage, 2018, p. 4) states that estimates are that the long-term care insurance covers about 50% of the total costs for institutional care. This agrees with Rothgang (2010, p. 440), as this scholar found that the total co-payments are close to the long-term care insurance benefits (see Appendix B. Figure 23). Also, according to Rothgang's (2014) estimation (in Nadash et al., 2018), an individual living in an institution typically costs EUR 3,302 per month. Even with the highest level of benefit, the person would have to pay EUR 1,792 per month out of his or her pocket (Rothgang, in Nadash et al., 2018). This co-payment thus even exceeds 50% of the total costs of care.

Appendix D. Informal Care Acts

Social Code Book XI, §44a – Long-term care leave benefits. Employees are entitled by law to take a leave from work to care for relatives or others. They can reduce their working hours by at least 15 hours for up to 24 months, including a leave of maximum six months. Additionally, employees can take a short-term leave of up to 10 working days per year without prior notice. There are some requirements for these sorts of leave: The right to six months care leave can only be taken by employees working in companies with more than 15 workers, and the right to work part-time for up to 24 months can only be taken when there are more than 25 workers in the company. Hence, the right to these leaves from work are not available for a substantial part of German workers. What is more, employees have to pay back the income replacement benefits for reducing working hours or for claiming care leave; it causes a strong disincentive to make use of the rights. The result is that up to 2015, only about 6,000 persons had made use of short-term care leave, and only 313 persons had claimed a credit-financed benefit (Schwesig, in European Commission, 2018b, p. 10).

Social Code Book XI, §39 – Respite care. German informal caregivers can claim their right to respite care (*Verhinderungspflege*); when an informal caregiver is sick, going on vacation or has other reasons for not being able to take care, he or she can request substitutive support. The maximum is six weeks per year, and the costs cannot exceed EUR 1,612 per year. This type of coverage can only be granted to persons with care level 2 to 5. When people that receive cash benefits make use of respite care, they continue to receive only the half of the cash benefits for up to six weeks (Deutsche Rentenversicherung Bund, 2019). A requirement is that informal care should have been provided for at least six month before the request for respite care (Heinicke & Thomsen, 2010). Earlier, respite care was only granted for a maximum duration of four weeks per year. The costs of professional respite care were not allowed to exceed EUR 1,470 in 2008, EUR 1,510 in 2010, and EUR 1,550 in 2012 (Heinicke & Thomsen, 2010). The value of respite care has thus gradually increased.

Social Code Book XI, §45b – Relief benefits (*Entlastungsleistungen*). Help-needing people can receive EUR 125 per month to reduce the burden for informal caregivers, such as relatives. This amount of money is the same for every care grade (Pflege.de, n.d.). The right to relief benefits is valid since 1 January 2017. Money that is not used can be used until 30 June of the following year. The allowance can be used for multiple forms of support, such as guidance to the general practitioner or going to day-care with an everyday companion (‘*Alltagsbegleiter’*) (Deutsche Rentenversicherung Bund, 2019).

Appendix E. Quality Assurance Acts in Germany

General quality assurance acts in Germany. In 2002, the law on Quality Assurance and Consumer Protection came into effect. This law required care providers to conduct ongoing quality assurance measures and to comply with national expert standards. The Medical Review Board [MDK] carries out external quality control measures. Since 1 July, 2008, the new Long-term Care Further Development Act (*Pflege-Weiterentwicklungsgesetz*) reformed the quality assurance system regarding long-term care insurance (Bavarian State Ministry & Federal Ministry of Health, 2010). For instance, the act resulted in spot check quality controls at least once a year from 2010. Moreover, it demanded the transparent and accessible publishing of inspection results (Theobald & Hampel, 2013). As Rothgang (2010) states, "there is no issue that has been given more room in the Reform Act than the issue of quality assurance and quality improvement" (p. 451).

In July 2017, the Health Professions Reform Act (*Pflegeberufereformgesetz*) was passed. The act aimed at "modernising care education, providing for better training conditions" and "strengthening the identity of care professions" (European Commission, 2017, p. 1). The introduction of the act is a reaction to the extension of the range of long-term care insurance beneficiaries since the implementation of the Long-term Care Strengthening Acts (I to III) between 2015 and 2017. A severe shortage of care-workers has appeared to be the result, due to the rising demand of care and a decreasing labour force potential due to demographic change (European Commission, 2017).

Quality assurance of institutional care facilities. The long-term care insurance ensures the quality of institutional care facilities by special provisions of SGB XI. The facilities are obliged by law to respect human dignity, and to implement quality management and define quality assurance procedures on the basis of expert standards. In addition, they are required to cooperate in quality inspections. The standards and principles underlying the special provisions of SGB XI are agreed upon by the key players involved in care. These are binding not only to institutional care facilities, but also to providers of other care services. The long-term care insurance funds monitor the quality (European Commission, 2018e).

Appendix F. The Treeknorm

The Treeknorm indicates the social acceptable waiting-times for care. For homecare and institutional care, the Treeknorm is six weeks. For care in a care home (home for the elderly), the norms is thirteen weeks, if the case is not urgent. However, the Treeknorms were introduced in 2000, when the care under the AWBZ was organised in a substantially different way. At that time, people with a light request for care were also eligible for institutional care, which affected the duration of acceptable waiting times (ActiZ, 2013a). Nowadays, only people with severe conditions can make use of institutional care, which demands a revision of the Treeknorms, as ActiZ (2013a) states.

Appendix G. CIZ's Eligibility Assessment Method

The CIZ uses certain standards to determine whether someone is eligible for one or more services within AWBZ care. The first step of the so-called funnel model (see Figure 28) is to assess not only a person's disorders and functional limitations, which are scored on a four-point scale, but also the circumstances under which the person is functioning. These circumstances concern "the availability of usual care and informal care and the existing use of provisions for living, welfare, care, labour and education" (Mot, 2010, p. 19). The second step is the decision of the CIZ about how a person can best be helped. This could also be through other means than AWBZ-care. For instance, solutions can be adjustments to the environment or the use of medical devices. The third step is concerned with the role voluntary care can possibly play; for informal care that exceeds usual care, an entitlement to AWBZ care exists, for instance in the form of a personal budget. The fourth step is for the CIZ to decide whether to provide institutional care or homecare to a person. For each service, the CIZ determines the amount of care the individual needs. 'Usual care' is not covered by the AWBZ, as it is expected that family members provide this to the help-needing person (Mot, 2010).

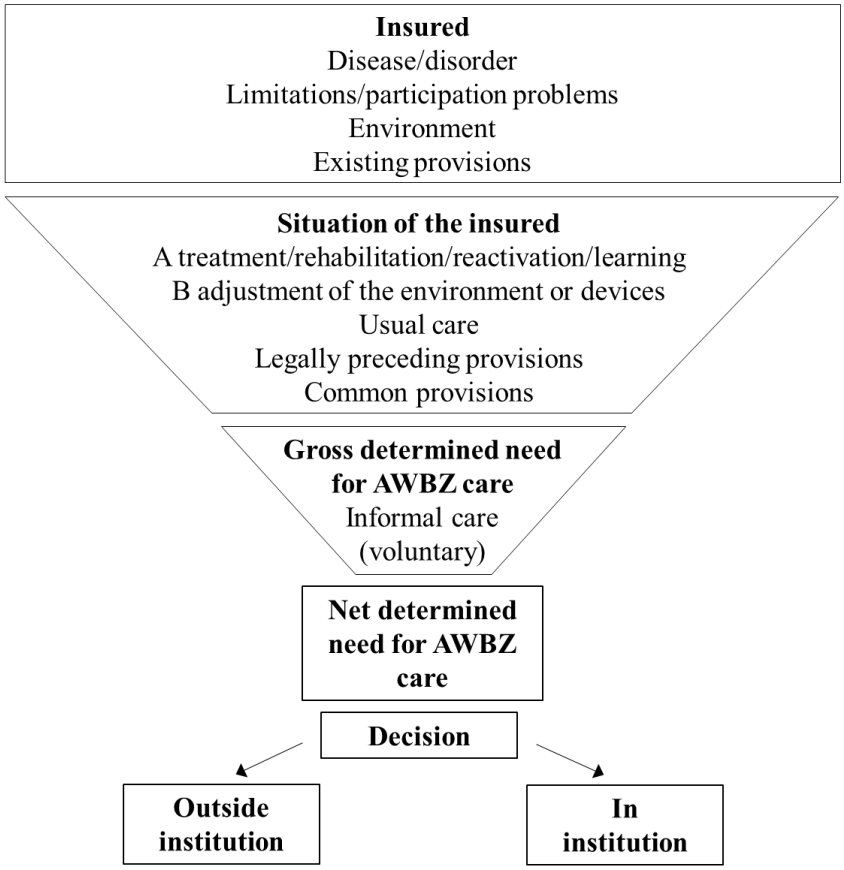

Figure 28. Funnel model for assessment, the Netherlands. Adapted from CIZ in "*The Dutch system of long-term care*" by Mot, E., 2010, p. 20.

Appendix H. Severity-of-Care Packages and Care Profiles

Severity-of-care packages (*zorgzwaartepakketten* [ZZPs]) packages referred to ten separate products within institutional care, and each of them represented a combination of different care functions in the AWBZ. They ranged from "sheltered living with some assistance" (ZZP1) to "sheltered living with very intensive care, because of specific disorders, with the emphasis on care and nursing" (ZZP8), and rehabilitative and palliative care (ZZP9 and ZZP10) (see Table 22) (Mot, 2010, p. 22).

Table 22

Severity-of-care packages (ZZPs)

Severity-of-care package (ZZP)	Type of care
1	Sheltered housing with some assistance
2	Sheltered housing with assistance and personal care
3	Sheltered housing with assistance and intensive personal care
4	Sheltered housing with intensive assistance and extended personal care
5	Sheltered housing with intensive care for patients with dementia
6	Sheltered housing with intensive personal care and nursing
7	Sheltered housing with very intensive personal care, due to specific conditions, with the emphasis on assistance
8	Sheltered housing with very intensive personal care, due to specific conditions, with the emphasis on personal care/nursing
9	Restorative treatment with personal care and nursing
10	Sheltered housing with intensive palliative-terminal care

Note. Adapted from "*Zorgzwaartepakketten sector Verpleging & Verzorging 2011"* by Bureau HHM, 2010. Retrieved from https://www.zorgvisite.nl/wp-content/uploads/2011/05/Zorgzwaartepakketten.pdf.

In 2015, at the time of the decentralisation, the severity-of-care packages were converted to so-called 'care profiles' (see Table 23) (ActiZ, 2013b). The numbers of the severity-of-care packages (ZZP4 to ZZP10) correspond to the numbers of the care profiles (Woonz, n.d.).

Table 23

Care profiles, the Netherlands

Care level	Type of care
4	Sheltered housing with intensive assistance and extended personal care
5	Sheltered housing with intensive care for patients with dementia
6	Sheltered housing with intensive personal care and nursing
7	Sheltered housing with very intensive personal care, due to specific conditions, with the emphasis on assistance
8	Sheltered housing with very intensive personal care, due to specific conditions, with the emphasis on personal care/nursing
9	Restorative treatment with personal care and nursing
10	Sheltered housing with intensive palliative-terminal care

Note. Adapted from "Wat is een zorgprofiel? (Vroeger een zorgzwaartepakket – ZZP)" by Woonz, (n.d.) Retrieved from https://www.woonz.nl/informatie-inspiratie/zorg/wat-is-een-zorgzwaartepakket/.

Appendix I. Informal Care Acts in the Netherlands

Employment and Care Act. Dutch citizens are enabled to care leave to care for a sick partner, parent or child. This is organised under the Employment and Care Act (*Wet arbeid en zorg* [Wazo]), which grants the right to both short-term and long-term care leave. In the case of short-term care leave, employees working full-time can have ten days of care leave per year. The employer continues to pay at least 70% of the wage during this leave (European Commission, 2018c, p. 7). The right to short-term care leave exists since 2001. Since 2005, employees also have the right on long-term care leave, in this case of having a parent or family member with a life-threatening disease (SCP, 2015a). Long-term care leave gives informal caregivers the right to leave on a more substantial basis. They can leave the workplace for a maximum of six times the weekly working hours per year. The maximum with a full-time contract is thus 30 days per year. This form of care leave is however unpaid, unless a collective agreement or other regulations of employers state differently (European Commission, 2018c).

Respite care. Dutch informal caregivers also have the right to respite care; they can request voluntary or professional care when they need help with informal caregiving. Some of the possibilities are day-care for the help-needing person, help at home, or short-term care, for instance once a week or during a vacation (Rijksoverheid, n.d.). Respite care is only covered when the help-needing elderly receives support from the Wmo or the Wlz. In case of care under the Wmo, only the own contribution per four weeks has to be paid. When the person receives care under the Wlz using a personal budget, this budget can be used for respite care with approval of the care office. Sometimes, the health insurer can (partly) cover the costs of respite care as well (MantelzorgNL, n.d.b). Before 2015, informal caregivers could request respite care via the AWBZ, when the older person had an AWBZ-indication (Gezondheidsplein, 2018).

Appendix J. Quality Assurance Acts in the Netherlands

The law on quality in care organisations. The law on quality in care organisations (*Kwaliteitswet zorginstellingen* [KWZ]) is concerned with organisations and group practices that deliver care, such as nursing homes and hospitals, but also group practices with cooperating physiotherapists. Organisations have the obligation to provide care of good quality, which means that care should be "effective, efficient, patient-centred and attuned to the realistic needs of the patient" (Mot, 2010, p. 24). The organisations enjoy a degree of discretion in their realisation of this good care. In 2008, parties involved in the long-term care sector published a set of performance indicators for good care. They defined necessary aspects of good care to be well-organised care, good internal communication, and sufficient and capable personnel. Organisations are required to have a quality system to ensure the quality of care, and they are supposed to send an annual quality report to the Dutch Health and Youth Care Inspectorate [IGJ] (there are some difficulties and serious quality problems, however) (Mot, 2010, p. 25).

The law on professions in personal healthcare. The law on professions in personal healthcare (*Wet op de Beroepen in de Individuele Gezondheidszorg* [Wet BIG]) states that a professional providing personal care is criminally offending the law when he or she damages a client's health. Hence, the law aims to protects patients. The wet BIG sets out criteria that professionals have to meet, depending on their profession and the activities they carry out. Certain activities, such as catheterising and anaesthesia, are only allowed to be carried out by professionals qualified to do so according to the wet BIG. Furthermore, educational requirements are determined in the law for eight professions: dentists, physicians, pharmacists, psychotherapists, physiotherapists, clinical psychologists, nurses and midwives. People who have one of these professions need to be registered in the 'BIG-register', which is also visible for patients (Mot, 2010).