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What is the impact of policy differences on nursing home utilization? The cases of Germany and the Netherlands.

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What is the impact of policy differences on nursing home utilization? The cases of Germany and the Netherlands.

Abstract

Though need factors would predict a higher rate of institutional use in Germany, in 2004 the percentage of people over 65 in institutions in the Netherlands was almost double the percentage in Germany. The lower nursing home utilization in Germany coincided with lower out-of-pocket costs, de facto means-testing of social assistance for such care, a lower perceived quality of nursing home, and less acceptance of the nursing home as a main care modality for adults experiencing functional impairments. These factors have developed over time and are consistent with a – relatively - large government responsibility toward care for the elderly and a preference for institutional care over home care in the Netherlands. The policy to encourage older adults to move to elderly homes to decrease the housing shortage after WWII might have had long-lasting effects. This paper points out that a key in the success of a reform is a behavioral change in the system. As there seems to be no single factor to decrease the percentage of older adults in nursing homes, a sequence of policies might be a more promising route.

Key words

Long-term care policy; Nursing homes; Home Care; Out-of-pocket costs; Social norms; Path-dependency.

1. Introduction

Older European adults typically have strong preferences not to be served in nursing homes. When asked about their preferred way to be cared for should they become dependent and in need of long-term care, less than 8% of the Europeans surveyed expressed a preference for being cared for in a long-term care institution (Eurobarometer, 2007).

In the Netherlands, nursing home utilization is among the highest in OECD-countries. The Dutch government is trying to find ways to support people so that they can age in place, which is consistent with citizen preferences and may save money. In general, the costs of a stay in a nursing home are higher than care at home. However, we know little about the way public policy affects family and caregivers' decision-making when more and more care is needed and staying at home becomes difficult. What policy measures are most successful in appropriately balancing the mix of institutional and community-based Long-Term Services and Supports (LTSS)? In particular, what are the best ways for the Dutch government to reduce the reliance on that form of LTSS?

We examine policy measures that might serve to promote reduced reliance on nursing home care by comparing long-term care in Germany and the Netherlands. In many ways, Germany is similar to the Netherlands, though the German government does have a different approach to long-term care policy than the Dutch government. It is striking that in 2004 the percentage of people over 65 living in institutions in the Netherlands was almost double the percentage in Germany. Bearing in mind that the neighboring countries exhibit similar levels of economic development, and the Dutch population is somewhat younger, we suspect that understanding the

gap between these two countries can offer lessons about the effect of LTSS policy actions for the Dutch government.

We first provide a sketch of the German and Dutch systems of long-term care. We assemble data and research from multiple sources including OECD, the Survey of Health, Ageing and Retirement in Europe (SHARE), Eurostat, the Eurobarometer, and literature on the demand for formal care and substitution of informal care for nursing home care. We investigate the impact of social norms, cost sharing, perception of quality, and availability on institutional LTC use. This paper indicates that the differences in institutional LTC utilization between Germany and the Netherlands cannot be explained by one single factor that is decisive, but rather must be considered as a complex mix of interdependent factors. These factors have developed over time and are consistent with a – relatively – large government responsibility toward care for the elderly and a preference for institutional care over home care in the Netherlands. Though in the short- and middle-long term social norms are hard to alter and may have an important impact on nursing home use, we do not believe that norms are independent of public policy. In particular, after WWII, the Netherlands established a policy to encourage older adults to obtain care in "elderly homes." The objective was to decrease the housing shortage by nudging older adults to move. To limit demand and costs, eligibility criteria were introduced and the homes for the elderly turned gradually into nursing homes. We believe that the postwar difference in availability of homes for the elderly contributed to a shift in the norms of staying at home and the responsibility for the care for older adults.

2. Background: Comparing German and Dutch LTC-characteristics

In Germany 3.8% of the population over age 65 was institutionalized in 2011. The corresponding figure was 6.5% in the Netherlands (7.2% in 2004, including palliative and rehabilitative care). The Netherlands are known to be generous in providing long-term care (Kraus et al., 2010). The higher percentage of the population institutionalized and the generous long-term care system are associated with a higher level of LTC expenditure on institutional long-term care: 2.2% of GDP in the Netherlands and 0.9% of GDP in Germany in 2010 (see Table 1). It is likely that a significant percentage of nursing home residents in the Netherlands could be cared for at home, as has been shown to be the case elsewhere. Mor et al. (2007) estimated that 5-12% of the 1.4 million long-stay residents in the US, and similar proportions of new admissions remaining in a nursing home, meet definitions for low care, making them candidates for being "deinstitutionalized". In an earlier international study, Ikegami, Morris and Fries (1997) found that 27-52% (using a broad definition) or 2-14% (with the most restrictive definition) of the residents of nursing homes in Denmark, Iceland, Italy, Japan, Sweden and the US could be characterized as low-care residents. For the Netherlands, De Klerk (2004) found that about 25% of the residents of residential care homes could age in place.

< here Table 1>

In both countries the benefit entitlements are need-based. There are some differences in the level of disability required to receive LTSS in the two countries. In Germany, to be eligible for long-term care, individuals must have functional impairments in two or more activities of daily living

(ADL) and one additional instrumental activity of daily living (IADL) for an expected duration of at least six months. The required time for care should be at least 90 minutes a day. Since July 2008, people suffering from dementia but not fulfilling other criteria can also apply for these benefits (Schulz, 2012). In the Netherlands, to be eligible for institutional care, a person must have, firstly, a somatic, psychogeriatric, or psychiatric disorder or a mental, physical, or sensory handicap; secondly, a person must be in need of a sheltered living place, a therapeutic social climate and/or permanent attendant; and thirdly, must need more than three days a week of institutional care. Home care is only granted for the care needed on top of the normal, daily care partners, parents or inhabiting children are "supposed" to give to each other. Compared to Germany, in the Netherlands an assessor makes a more tailored assessment, which leaves more space for a subjective judgment. It is reasonable to expect that with more ambiguity in the decision-making process and with detrimental effects of a rejection, assessors will approve a needs claim earlier.

In both countries, a person can choose to convert the benefits into a personal budget. Whereas in the Netherlands the personal budget can only be spent on care purposes, there is no restriction on the expense in Germany. With the personal budget, a person can freely choose his or her caregivers in both countries. In the Netherlands, all providers are private and are either not-for-profit (the large majority) or for-profit (Mot, 2010). In Germany, formal care is provided by public and private non-profit and private for-profit providers. Provinces ("Laender") are responsible for financing investments in premises for long-term care services (Rothgang, 2010).

While institutional capacity differs notably, the two nations take similar approaches to financing long-term care. Both the Netherlands (since 1968) and Germany (since 1994) have a mandatory insurance, which is non-means tested and largely financed on the basis of capped income-related contributions. In the Netherlands, almost a quarter of long-term care expenses are financed by general taxes (Schut et al, 2010). Out-of-pocket costs are dependent on an individual's income. In Germany, adults over 23 years old who never have been parents pay an extra premium of 0.25% over the "contributory" income (Rothgang, 2010). A larger part of the long-term care expenses is paid out-of-pocket.

3. Potential contributors to the gap in nursing home utilization

We use the Andersen (1995) healthcare utilization model to examine the gap in nursing home utilization. According to the Andersen model, the use of health services is determined by three dynamics: predisposing factors (like age, race and education), enabling factors (family support, income) and need. Need variables are primarily related to the physical and cognitive condition of older adults. Enabling factors are factors that stimulate or slow down the utilization of health care. Additionally, the health care system was explicitly included in this model by Aday and Andersen (1974), giving recognition to the importance of national health policy and the resources and their organization in the health care system as important determinants of the population's use of services.

The demographic and socioeconomic characteristics in the two countries do not suggest that the need for nursing home care would be higher in the Netherlands than in Germany. Whereas the percentage of the population over age 65 was 20.6% in Germany, it was 15.6% in the

Netherlands in 2011 (Eurostat). The self-reported limitations in daily activities are slightly lower in the Netherlands compared to Germany (36.0% vs. 40.6% of the people 65 years and over in 2011, Eurostat (SILC)). Slightly more people in Germany than in the Netherlands reported that an unsuitable home played a role in the transition to an institutional setting: 22% in Germany (Schneekloth and Thörne, 2007) vs. 15% for residential houses and 22% for nursing homes in the Netherlands (Den Draak, 2010)).

If the predisposing factors and need in the two countries point to higher nursing home utilization in Germany, the Andersen model predicts that the differences are the result of enabling factors and the resources of the respective health care systems. This prediction leads us to consider the following factors:

- Accessibility and Availability of care;
- Out-of-pocket costs of nursing homes and home care;
- (Perceived) Quality;
- Social values and norms.

Availability, out-of-pocket costs and quality of care act as pull and push factors for nursing homes. For instance, greater availability and higher quality of home care could make it easier to age in place. Higher out-of-pocket costs for home care lead to a lower demand for that care. The readiness to provide informal care is affected by opinions of who should take care of elderly in need. Furthermore, norms might differ in whether a nursing home is an appropriate place to age.

a. Accessibility and availability of care

Decisions about care arrangements are complex and dynamic, with the recipient and family making joint decisions about informal and formal care, which in turn affect nursing home care (Spillman and Long, 2009). The elderly and their caregivers will decide whether it is possible to stay at home or whether they should move to an assisted living facility or to a nursing home. Caregivers decide on the level of informal care they want and are able to provide, taking into account the available level of formal care.

Kraus et al (2010) mention that the highest level of formal care use is found in Belgium and the Netherlands: about 28% of older adults use formal care (either at home or in an institution). Germany and Estonia are the two countries where the use of formal care is lowest (about 7%). According to OECD data, 6.9% of the elderly received formal home care in Germany vs. 13.2% in the Netherlands in 2004. The difference in formal care availability is reflected in the number of long-term care beds per 1000 persons over age 65 in 2011: 52.1 in Germany and 64.9 in the Netherlands (in 2003 48.7 in Germany and 76.0 in the Netherlands) (OECD).

We have not found strong support in the literature that formal home care has a significant effect on nursing home utilization. Weissert and Frederick (2013) sum up the controlled or comparison group studies of Home and Community Based Services (HCBS) that have been done over the decades, about half of them controlled trials. They conclude that receiving HCBS reduced nursing home use rates on average by only a small percentage, not enough to offset the costs of HCBS. Moreover, both older and more recent studies show only small to insignificant effects on most adverse patient outcomes. Weissert (1985) argues that community care is often used by people who, with or without community care, would not have gone into a nursing home and

often are only at risk for a short period of time in a nursing home. Though the group at risk for institutionalization might be limited, the group interested in home care is much larger. Note, that a significant effect of formal home care on nursing home use would increase the gap in nursing home use in the Netherlands and Germany that has to be explained.

Family caregivers are a major part of the care delivery system, providing the majority of LTSS and often coordinating paid LTSS and health care (Commission on Long-term Care, 2013). In the Netherlands the high level of formal care is combined with a relatively low level of informal care; in Germany the level of informal care is average by European standards (Kraus et al 2010). Haberkern and Szydlik (2010) report that older adults in the northern European and Benelux countries were significantly less likely to be cared for by one of their children than older adults in Germany. Using data from Wave 4 of SHARE, we find that in 2011/2012, 9.6% of the German respondents reported they were living with other people, whereas in the Netherlands this figure was 5.2% (weighted, 2324 respondents).

Using US data, Van Houtven and Norton (2004) find that informal care reduces total formal health care utilization of the elderly, primarily by reducing home health use and nursing home use. Over a two-year recall period, a 10% increase in informal care leads to a 0.87 percentage point reduction in the likelihood of home health care use (to 7.43% from a mean of 8.3%) and a two-night reduction in nights in a nursing home (to 23 nights from a mean of 25) across the full sample. The estimates of Charles and Sevak (2005) suggest that receipt of informal care reduces the probability of any nursing home use by 39-49 percentage points. Bolin et al (2008) found that informal and formal home care are substitutes, though this effect is less strong in the Central

European States. Bonsang (2009) shows that informal care substitutes for formal care, and this substitution effect disappears when the level of disability of the elderly person increases.

Family caregivers are mostly women, especially spouses or adult daughters or daughters in-law. The most intense care is usually provided within a household (Colombo et al., 2011). Though the actual level of informal care favors aging in place in Germany, it is unlikely that differences in the *availability* of informal caregivers or other endowments can explain the difference in nursing home utilization. Though a greater share of older adults in Germany lived with a partner, 59.2% compared to 55.4% in the Netherlands (authors' tabulation of SHARE-data; a cross-national panel database on health, socio-economic status and social and family networks from 20 European countries (+Israel) aged 50 or over), this might not be true in the last years before death. The difference in life expectancy between women and men in Germany was larger than in the Netherlands (in 2004, 5.4 years in Germany vs 4.6 years in the Netherlands, in 2011 4.8 vs 3.7 years (OECD, 2013)).

Of children who provide informal LTSS care, the majority are women age 45 – 65 years (Rodrigues et al, 2013). The Netherlands include slightly more people 65 years and older with children: 89.6% in the Netherlands vs. 89.2% in Germany in 2006 (authors' tabulation of SHARE-data). Labor force participation of women in the Netherlands was slightly lower than in Germany: in 2004, 45.5% of the women 50 to 65 years old were working in Germany vs 44.6% in the Netherlands (62.2 vs 55.9 in 2011 (Eurostat, 2014)). Moreover, three quarters of Dutch women work on a part-time basis, whereas 46% of German women are part-time employees (CBS, 2011). In Germany, it seems easier to get unpaid leave for half a year. Because this

measure begins in 2008, this would not help us explain any difference in nursing home use before that period.

b. Out-of-pocket costs of nursing homes and home care

The average income level of the people in the Netherlands is higher (total population € 20,310 vs. € 19,043, for people over 65 € 18,113 vs. € 17,611 in 2011 (Eurostat (SILC)). Unlike the Dutch LTC financing system, the German system is not intended to fully cover the risk of being in need of long-term care but only covers basic needs. Individuals in need of care are expected to contribute additional private funds for long-term care, with social assistance being the last resort for those lacking sufficient financial resources. When someone cannot pay the out-of-pocket costs, he or she can make a request for social assistance. Social assistance is means-tested, with income and wealth of the person applying for social assistance as well as of the spouse and first-grade relatives taken into account (Steiner and Jacobebbinghaus, 2003). Hence, children have to pay for the care of their parents when their parents spend down on their resources. About one third of the residents in nursing homes have their care paid for by social assistance (Rothgang, 2010).

Overall, older adults in Germany contribute much more out-of-pocket to long-term care use, especially in the case of a nursing home stay. Since residents have to pay for board and lodging out-of-pocket, copayments are substantial, ranging from € 892 per month at the lower disability levels to € 1354 for the highest disability level in 2007. In some cases an average amount of about € 350 for "investment costs for building or modernizing nursing homes" is added (Rothgang, 2010). In the Netherlands, for people with a high income, the maximum cost was €

1773 a month in 2007 (CVZ, 2006). In practice, the contributions are relatively limited: 50% of the elderly in institutions pay less than € 611 per month (first half year €143) and 80% pay less than € 826 (CBS, 2013). At the lowest income levels, it essentially means that people will get clothing and pocket money (€ 270 a month in 2007), though their assets and those of their relatives would not be dipped.

The incentives in Germany to be cared for at home are stronger at all disability levels. Whereas in Germany, a family can typically incur € 500 to € 1000 a month less in long-term care expenditures when an older family member is cared for at home, in the Netherlands, the out-of-pocket costs of a stay in the community are often higher than in a nursing home. The relative out-of-pocket costs of a stay in a nursing home gradually increase with the income level of the older adult.

Perceptions of costs of care are consistent with differences in out-of-pocket costs. Home care and nursing home care costs are seen as much higher in Germany than in the Netherlands. We observe that in Germany a much higher percentage of people perceive the out-of-pocket costs of home care to be more affordable than those of nursing home care; in the Netherlands, a similar percentage of respondents think home care and nursing home care is affordable. Whereas 53.9% of the respondents of 45 years or older in Germany think home care not very or not at all affordable, in the Netherlands this is 21.4%. For nursing home care, the differences are significantly higher: in Germany 77.7% of people 45 years and older think nursing home care is not very or not at all affordable, whereas in the Netherlands the corresponding estimate is 22.5% (Eurobarometer, 2007, weighted to gender, age, region and size of locality).

The scarce literature on elasticity of out-of-pocket costs on nursing homes points to an inelastic demand. Reschovsky (1996) found that for the most part the price –and hence out-of-pocket costs for private payers – of nursing home care, income, and wealth were not found to be associated significantly with nursing home demand. The question is whether these effects can be generalized to – especially – the Dutch situation where residents might be relatively more healthy and hence more likely to have the option to stay at home. There are indications that a reform in payment policy did not have a significant effect on the admission rate. Prior to 1997, the Netherlands had a policy of means-tested access to nursing home care. After 1997, contributions for nursing homes were no longer determined by an individual's wealth (Ministry of Health, Welfare and Sport, 1995). Utilization of nursing home care did not show a significant change in the period before 1997 and after 1997. However, Bakx, De Meijer, Schut and Van Doorslaer (2013) report that being in the bottom income quartiles is negatively related to formal home care use in Germany, whereas they do not find a difference in LTC use between rich and poor in the Netherlands. This might point to an effect of the policy of means-testing for those dependent on social assistance in Germany. More research is necessary to get a good idea about the magnitude of the effect of the difference in out-of-pocket costs, and in particular, the effect on children paying for their parents' care when their parents are not able to pay for long-term care themselves and the (high rate of) low incomes.

c. *(Perceived) Quality*

Next to financial incentives, nursing home utilization will depend on quality of care and norms related to caregiving and preferences for formal or informal care. Comparing quality policies

across EU member states is difficult (European Commission, 2008). An analysis by Dandi et al. (2012) place the Netherlands and Germany in the same "quality" cluster (together with Estonia, France, Latvia, Slovakia, and the United Kingdom). In both countries the quality of care is high on the agenda. As Rothgang (2010) puts it: "There is no issue that has been given more room in the Reform Act [of 2008] than the issue of quality assurance and quality improvement". In the Netherlands the policy focus is on patient-centeredness, among others, as well as on quality innovation and the establishment of a quality institute.

For perceived quality of a nursing home, we have to rely on opinions of the elderly and their caregivers. The Eurobarometer Survey allows us to investigate the role of norms and perceived quality in the decision making of elderly and their caregivers in their care arrangements. The Eurobarometer (2007, wave 67.3) (EB) contains views of the citizens of the 27 EU countries, Croatia and Turkey on long-term care and care of the elderly; specifically, it contains opinions on the quality of health care services like nursing home care and home care (on a four-point scale) and social values and norms concerning preferred ways of caring for elderly people in need of help. The data were obtained from face-to-face interviews with individuals aged 15 and over. We restricted the analysis to respondents of Germany and the Netherlands of 45 years and older. The sample was restricted to respondents aged 45 years and older, as their parents are likely to be at least 65 and more at risk of home care and nursing home utilization as a result of old age. For all countries in the survey, a national weighting procedure was carried out, taking into account gender, age, region and size of locality. In table 2, we report the weighted means of the German and Dutch respondents concerning perceived quality of nursing home care and home care and social norms. The EB shows that quality in nursing homes is perceived as better in the

Netherlands than in Germany. On the question "Thinking now about your experience of health care services in [our country] and those of people close to you, please tell me if you think that the quality of the following is very good, fairly good, fairly bad or very bad?," 59.7% in Germany and 69.5% in the Netherlands perceived the nursing home care as (fairly) good; home care is perceived relatively equally: 74.4% in Germany and 70.4%. Note that a much higher percentage of respondents give higher rating to home care than to nursing home care in Germany, whereas in the Netherlands the ratings are similar.

d. Social values and norms

Long-term care policies should be seen in their historical context. Policies at one point determine the direction of future reforms, as the cost of reversing such arrangements increases over time. Path dependency or inertia in policymaking takes place when long-term care policy reform favors the reforms currently in place without evaluating them based on their efficiency or equitable grounds. The latter could be due to the prevalence of certain social norms, or the high acceptance among the population of certain ways to provide long-term care services (Liebowitz and Margolis, 1995).

In the Netherlands, to combat housing shortage older adults have been nudged to move to "elderly homes" since WW II. The number of people in elderly homes increased from 73,000 to 135,000 (9.5% of people over 65 in the period 1965 to 1975(Van der Voordt, 1998)). The enactment of the "Elderly Homes Act" improved the financing of new facilities; furthermore demand for "Elderly homes" increased by the enactment of the Social Assistance Act. In 1980, 80% of the people in elderly homes received social assistance. 80% of the population in the

Netherlands has a nursing home or home for the elderly within 5.2 kilometers (Riedel and Kraus, 2011). This often makes visiting by family, neighbors and friends easier, thus reducing social isolation in nursing homes in the Netherlands compared to in Germany. Though the utilization of nursing homes is relatively high, there has been a downward trend of institutionalization in the Netherlands since 1980: the percentage of people over the age of 80 years living in an institution dropped from 63% in 1980 to 24% in 2010 (Ministry of Health, Welfare and Sport, 2013).

The broad availability of home care and nursing homes might have affected social norms related to helping parents. The 60 years during which many older adults in need of care moved out of the community may have created a social norm with respect to the appropriate setting for care of older adults with disabilities and the assignment of responsibility for financing that care (government or family). When relatively large numbers of older adults are going to special homes for the elderly in a period when they are still relatively healthy, the government takes on responsibility when they need care or when abuse is revealed. Moreover, the default option for the family of letting a parent go to an elderly home becomes more socially acceptable. In general, it is easier to approve a request for placement than to decline it. As a result, the whole system (general practitioners, nurses, assessors) has become oriented toward letting people go to a nursing home - or advising them to go to a nursing home. Moreover, there might be a dynamic effect: at the moment that people with relatively fewer ADLs and cognitively fewer impairments are in the nursing home, a nursing home is relatively more appealing to other people.

Alesina and Guiliano (2007) show that with strong family ties, home production is higher. Haberkern and Szydlik (2010) claim that the Scandinavian countries and the Netherlands can be

regarded as having state-funded services-based care systems, where there are only weak legal obligations for relatives to provide care, and the state is regarded as being responsible for providing care. In the countries with family-based care systems, i.e. most of Mediterranean countries, Germany and Austria, the responsibility for the care of an older person with needs is primarily borne by their relatives, as required by the state. This is consistent with Costa-Font (2010), who finds a negative relationship between family ties and expected coverage of long-term care insurance. To compare opinions on social norms, we used from the Eurobarometer questionnaire the question "Imagine an elderly father or mother who lives alone and can no longer manage to live without regular help because of her or his physical or mental health condition. In your opinion what would be the best option for people in this situation? Firstly?" "They should move to a nursing home" was chosen by 22.4% of the respondents in Germany and 46.3% in the Netherlands. Moreover, in the Netherlands 5.3% said that they should live with their children, whereas in Germany 40.7% said so.

3. Options for reducing reliance on nursing homes in the Netherlands

The differences in enabling factors and resources in health care systems in Germany and the Netherlands are consistent with a – long-lasting – relatively large government responsibility in the Netherlands for the care and living situation of the elderly. The change in nursing home utilization in the Netherlands is a very slow process that was already set in motion two decades ago. Still, it seems that in the Netherlands elderly adults go relatively early to a nursing home, especially those with a lower income. Keeping people out of nursing homes is not a goal in itself: many people with severe functional or cognitive impairments are better off in nursing homes.

However, both individual preferences and public budgets demand that we carefully consider whether these costly settings are being used properly.

This paper points out that a key in the success of a reform is a behavioral change in the system. As far as differences are the result of social norms, governments have limited instruments to affect the institutionalization rate in the short term. Existing norms and values are difficult to change. Family ties and familism in general are deeply rooted, show persistence and evolve during one or several generations (Fernandez, 2010). As there seems to be no single factor to decrease the percentage of older adults in nursing homes, a sequence of policies might be a more promising route. What are the options for a government to reduce the reliance of nursing homes?

The Dutch government already initiated several measures: they announced in "the spring covenant 2012" that criteria to be eligible for nursing home care will be strengthened (Ministry of Health, Welfare and Sport, 2013). Moreover, since 2013 the out-of-pocket costs for long-term care depend on the (income from) wealth. More research is necessary to investigate whether the effects can be amplified with financial incentives that favor home care over nursing home care.

A further option is to let older adults weigh the costs and quality of housing and services more deliberately. For example, by disentangling institutional care into two parts: "housing and services like meals, laundry and activities" and "care." By restricting the mandatory social insurance to "care," an older adult in need and his or her family will compare the housing and services in a nursing home with the situation at home. A less far-reaching alternative is to make out-of-pocket costs dependent on the quality and level of "housing and services," thereby making

the costs of a room or apartment more visible. Furthermore, aging in place can be encouraged by facilitating the growth of assisted living facilities and the use of domotics. By giving a clear signal to the whole system – in accordance with citizens' preferences – that people should be able to stay longer in the community, the social norm might be affected in the longer term as well.

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Table 1: Comparison German and Dutch core characteristics

	Germany	**Netherlands**
Percentage of persons aged 65+ living in institutions	3.8 (2004) 3.8 (2011)	7.2 (2004) 6.5 (2011)
Number of beds per 1000 persons aged 65+	48.7 (2003) 52.1 (2011)	76.0 (2003) 64.9 (2011)
LTC elderly care in percentage of GDP	0.9 (2010)	2.2 (2010)
Percentage of population aged 65+	20.6 (2011)	15.6 (2011)
Percentage of people aged 65+ with self-reported ADL problems	40.6 (2011)	36.0 (2011)
Average income aged 65+ in €	17,611 (2011)	18,113 (2011)
Insurance	Mandatory	Mandatory
Out-of-pocket costs	High; Independent of income though elderly might need means tested social assistance	Relatively low; Dependent on income (since 2013 as well means tested).

Eligibility in-patient long-term care	>2 ADL + 1 IADL for at least 6 months	In need of more than three days a week institutional care.

Table 2: Opinions of respondents 45 years and older towards need of long-term care [in %][1]

	Germany	**Netherlands**	**N (G, NL)**
The best option for an elderly father or mother in need is to move to a nursing home [2]	22.4	46.3	(901; 602)
The quality of nursing home care is (fairly) good	59.7	69.5	(588; 400)
The quality of home care is (fairly) good	74.4	70.4	(605; 412)

[1] Eurobarometer (2007); Weighted to gender, age, region and size of locality.

[2] The other possible answers were "They should live with one of their children", "Public or private service providers should visit their home and provide them with appropriate help and care", "One of their children should regularly visit their home, in order to provide them with the necessary care". The percentages correspond to the added results of the first and second choice of respondents.