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Influence of municipal policy and individual characteristics on the use of informal and formal domestic help in the Netherlands

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ABSTRACT

Background: The responsibility for care and social support in the Netherlands has been decentralized to the municipalities, on the assumption that they are able to organise care and social support more effectively and efficiently. Municipalities are responsible for offering citizens the social support they need. They have policy discretion to decide how and to what extent they encourage and support the use of informal help. This article explored whether the local policy focus on informal or formal help influences the actual take-up of domestic help.
Methods: Data on 567 physically disabled people who use informal or formal help in the household were linked to local policy data in 167 municipalities. We performed multilevel multinomial regression analyses. Since we expected that local policy will have more influence on people with slight or moderate disabilities, cohabitees and people aged under 75, cross-level interaction terms were included between characteristics of local policy and of individuals.
Results: The findings reveal differences between municipalities in their policy on support and differences in the use of formal or informal support between municipalities.
Conclusions: We found no relationship between local emphasis on informal help and the use of informal help. Possible explanations: some people have a small social network, people using informal help did not apply for municipality support or even do not know the possibility exists.
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1. Introduction

The population of Europe is ageing, the costs of care are rising and many countries are trying to find out how to organise care and support efficiently and effectively [1–4]. The degree of decentralisation varies largely between countries [5,6]. In the Netherlands, municipalities are increasingly responsible for offering social support, such as domestic help, to citizens who need it [7]. The central government stresses that people who need support, should be encouraged to meet their own needs. This is because (1) according to the government, the tendency of citizens to lean on public services had become too strong and (2) the steady increase in cost of care and social support had to be curbed. In anticipation of a change in the law in 2015, that was foreseen to also include a substantial budget cut (with a reduction of 32% for home care), many municipalities started to focus more strongly on informal care when dealing with citizens' demands for social support from 2010 onward [8]. The aforementioned budget cost hit all municipalities equally. Municipalities receive a budget from the central government to execute their social support duties, that is based on a division model that takes into account population characteristics (such as proportion of elderly) that have a strong relationship with use of (and spendings on) social support. A study that was carried out in a number of municipalities showed that the number of clients of publicly financed home care varied between 19 and 46 per 1000 inhabitants [9]. Apart from usage differences, there are also substantial differences in local social support policy [8]. These policy differences relate to, for example, differences in vision of policy makers on the role of formal and informal home care.

Municipalities have tools to influence the use and cost of publicly financed home care (for example by setting criteria for eligibility, fixing amounts of out-of-pocket contributions and governing tender procedures for home care providers), but we do not

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know whether they have an actual influence on the use of informal care. Municipalities can facilitate the use of informal care, for example by offering informal care support. And they can encourage people in need of social support to first appeal to their social network before turning to their municipality. The outcome of court cases has demonstrated that municipalities are not allowed to enforce informal help on their citizens (by rejecting demands for publicly financed home care), unless it matters 'common care' (i.e., the usual care for each other of people who constitute a household). Housemates are, for example, supposed to take over common domestic tasks (such as preparing meals) from another housemate when the latter is no longer able to.

However, the principle is that, before providing formal support, municipalities first look at what people can do for themselves or with help from their social network. Municipalities have policy discretion to determine how and to what extent they encourage the use of informal help. Municipalities may (financially) benefit from encouraging the use of informal help. Although long term studies have shown that a decrease of formal care doesn't lead to increased informal care use [10], it is known that informal domestic help can reduce the take-up of formal help [11–14].

Earlier research mainly provides information on individual and geographical determinants of informal and formal care use [15,16,17]. A study in Flanders examined the influence of individual and municipal characteristics on formal and informal care use by older persons [18]. The characteristics related to the composition of the population or the care delivered (number of hours of domestic care provided). The study found that municipal characteristics have virtually no influence on use of informal care, but do affect the use of formal care. In particular, the supply of care is related to its use.

As far as we are aware, the influence of local policy has not been studied previously. Our question is accordingly: What influence does local policy have on the use of informal and formal domestic help, and does that influence vary for different subgroups in the population?

Our focus is on domestic help, because this is the most frequently used type of care in the Netherlands [19].

1.1. Local policy

In this article we examine whether a local policy focus on informal domestic help influences the actual use of informal and formal help. Is there such an influence, and if so does it affect some population groups more than others? Municipalities will sometimes deploy formal help and sometimes informal help, but there are differences in the emphasis they place on each. They may focus on informal help by encouraging people who need support to seek help from someone in their social network. They may also offer support to informal helpers, such as courses, financial assistance and emotional support. We expect that residents with disabilities will receive informal help more often in municipalities where there is strong focus on this type of help. Our expectation is: the more focus on informal help, the more use of informal help and the less use of formal help.

1.2. Individual characteristics

People with a severe disability, people living alone and people aged over 75 relatively often use formal help services [20] or a combination of formal and informal help [21]. People with severe disabilities are likely to need many hours of care. People living alone have no one in the household to help them, and the over–75 s often have a smaller available network because people around them also have disabilities and a number of their peers have died [22]. In this study, too, we expect that people with severe disabilities, people living alone and over–75 s will relatively often receive formal help or a combination of formal and informal help.

We therefore think that municipal policy will mainly influence people with slight or moderate disabilities (compared with people with severe disabilities), people living with a partner and people aged under 75; the rest – who have less choice – will more often be referred to formal help services. Our hypothesis is that: In municipalities which focus heavily on informal help, residents with slight or moderate disabilities, people living with a partner and people aged under 75 will use informal help more often than in municipalities with a neutral focus or a greater focus on offering formal help.

2. Methods

2.1. Data collection and operationalisation for people with physical disabilities

This study drew on survey data from the National Panel of Chronically ill and Disabled (NPCD), constructed by the Netherlands Institute for Health Services Research (NIVEL). The panel comprises approximately 3500 independent community-dwelling persons aged 15 years or older with somatic chronic illnesses and/or physical disabilities. New panel members are selected each year from general practices (national samples) based on a medical diagnosis of a chronic somatic illness. Panel members also comprise people with physical disabilities drawn from national population surveys. The NPCD is registered with the Dutch Data Protection Authority. All data are collected and handled in accordance with the privacy protection guidelines of this Authority. In April 2014, 3349 people took part in the NPCD, of whom 2605 completed a questionnaire on care use (response rate 77.8%). 768 respondents were ruled out because they did not have any physical disabilities (only a chronic illness), and 956 were excluded because they were not receiving domestic help. Finally, 389 respondents lived in municipalities for which we had no data on policy regarding informal care. Ultimately, we were left with a selection of 567 respondents.

2.2. Measures

We distinguish between use of domestic help by people from their own network (informal help), help provided via the municipality through an organisation (formal help) or a combination of the two.

The questions were: 1. Have you got domestic help (for example cooking and cleaning), in 2013, because of your health, from family members, friends, neighbours or other people from your social network? 2. Have you got formal domestic help (for example cooking and cleaning) provided via the municipality through an organisation, in 2013, because of your health?

The individual characteristics are severity of disability, sex, household composition (living alone versus living with a partner), age (ranging from 15 to 94 years), education level highest completed education in three categories: low (primary, junior secondary vocational), intermediate (junior/senior general secondary, senior secondary vocational) and high (university/university of applied sciences) and net monthly household income adjusted for household size and split into four categories: up to 1000 euros, between 1000 and 1408 euros (the average), between 1408 and 2000 euros and over 2000 euros. Severity of disability was determined by asking the NPCD members whether they were able to perform nine activities of daily living (such as washing or dressing themselves), household activities (preparing meals, heavy household work) or mobility (going up and down stairs, standing for 10 min) without difficulty, with some difficulty or not at all [23].

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