**Supplemental File 3: Table S3**: Methodological aspects and main findings from studies containing quantitative analyses employing ranking- or rating techniques (n=41)

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| **Study**  | **Study Aim** | **Population** | **DCM (RR)** | **PO** | **DA**1 | **Main Findings**2 |
| Matsumoto *et al.* (2015) | Investigate the characteristics of middle-aged adults who prefer to age in place and those who prefer to move, at two levels of disability | GP: Random sample of inhabitants of Fukui City (Japan) aged 40-64 years, drawn from a city resident registry (n=616) | Postal questionnaires (24.6%) | LTC location | CSA: DS, BS, MS (logistic regression) | ***HHCS: Unable to walk:*** *DS:* home: 57%, another place: 43% (68.8% of which chose “care facility”); *MS (OR for “move”, reference: “home”):* female gender: OR: 1.55, rented house: OR: 3.21, small house size: OR: 2.33, opportunity to drive themselves: OR: 0.58, opportunity to be driven by others: OR: 0.31, living alone or with 1 family member: OR: 2.61, attachment to community: OR: 0.58, attachment to the house: OR: 0.31***HHCS: Bedridden*:** *DS (only respondents which indicated “home” in relation to the “unable to walk” HHCS above):* home: 46.3%, another place: 53.7% (87.3% of which chose “care facility”)*;* *MS (OR for “move”, reference: “home”):* female gender: OR: 1.68, distance to hospital >3 min by car: OR: 1.94, distance to supermarkets >3 min by car: OR: 1.71, internet user: OR: 2.04, participant in community events: OR: 0.55  |
| Werner and Segel-Karpas (2014) | Examine the determinants of preferences regarding NH care  | GP: Convenience sample of community-dwelling adults aged ≥45 years in three cities in northern Israel (n=404) | Structured F2F interviews (n.i.) | LTC arrangements  | CSA: DS, BS, MS (logistic regression) | ***HHCS: Permanently physically disabled:*** *DS:* informal homecare: 37.7%, formal homecare: 44.4%, sheltered housing: 11.8%, NH: 6.1%; *MS (regression coefficients for “institutional care”, reference: “homecare”):* more diseases: β = 0.16, better financial status: β = -0.48, positive attitude towards NH: β = 0.54, worried about losing independence: β = -0.22, worried about caregiver burden: β = 0.44***HHCS: Alzheimer’s Disease (AD):*** *DS:* informal homecare: 25.2%, formal homecare: 42.9%, sheltered housing: 16.9%, NH: 15%; *BS:* differences in preferences for informal homecare, sheltered housing, and NH significant in bivariate analyses, p<0.01;*MS (regression coefficients for “institutional care”, reference: “homecare”):* higher education: β = 0.11, better cognitive status: β = -0.11, more diseases: β = 0.16, worried about losing independence: β = -0.18, worried about caregiver burden: β = 0.55, familiarity with AD: β = -0.75, perceived risk of becoming sick with AD: β = 0.44 |
| Callan and O'Shea (2015) | Elicit public preferences for five community-based care programs (family care, home care packages, telecare) | GP: Random sample of the general population aged ≥16years in Ireland (n=1,214)  | Structured F2F interviews (n.i.) | LTC programs  | CSA: DS | ***HHCS: HBTP 1 (falls)*:** *DS*: 31%, ***HHCS: HBTP 2 (cognitive):*** *DS:* 28%, ***HHCS: HBTP 3 (social connection):*** *DS:* 25%, *DS:* family care program (cash payments): 47%, home care packages program (additional formal homecare services): 38%  |
| Iwasaki *et al.* (2015) | Shed light on culturally evolving baby boomers' perceptions and preferences for LTC options  | Non-random sample of adult Japanese Americans (JA) aged 51-71 years living in Washington state, USA (n=264) | Postal questionnaires (20.2%) | LTC location, LTC services  | CSA: DS, BS  | *DS: LTC location:* home: 24%, move: 77% (retirement community: 18.8%, continuing care retirement community: 17.3%, ALF/NH: 4.6%, live with family member or friend: 4.57%, uncertain: 38.6%); remain in Washington state: 88.6%; racial/ethnic composite at LTC facility: mixture of JA and non-JA: 64.3%; *DS: LTC services (1 = not important to 10 = very important on LTS):* transportation: 8.71, high-quality dining: 8.49, internet access: 8.31, availability of assistance: 8.16, exercise facility and wellness center: 8.15, medical facilities nearby: 8.02, availability of Japanese food: 7.95, multi-level care facilities nearby: 7.90, attractive outside view of surroundings: 7.84, close to shopping, theater, museums: 7.78; *BS:* JA rated universal LTC services as more important than JA-cultural specific services, p<0.0001 |
| Rudel, Abraham and Gortler (2015) | Investigate preferences for LTC arrangements and relevant aspects of LTC infrastructure of older couples | Total population survey of persons aged ≥50 years living with a partner in a rural town in Germany (n=633) | Postal factorial survey (32%) | LTC arrangements  | CSA: DS, MS (Tobit regression) | *DS (percentage of respondents ranking the option as very attractive or attractive): 50-64/65-74/>74years:* informal care by spouse: 79%/94%/88%, informal care by children: 46%/69%/69%, informal care by friends: 9%/13%/5%, senior cooperatives: 54%/41%/29%, elder shared apartment: 62%/51%/51%, ambulatory nursing service (formal homecare): 72%/75%/77%, ALF: 68%/53%/56%, NH: 60%/63%/67%; *DS* *(total sample):* not willing to move under any circumstances: 40%; *MS (regression coefficients for a LTC related preference to “move”, reference: “not to move”*): LTC infrastructure at current place of living (i.e. availability of … ): senior cooperative: β = -1.22, ambulatory nursing service: β = -2.26, ALF: β = -1.84, LTC infrastructure in future place of living (availability of … ): NH: β = 1.12, urban area: β = 0.91, Socio-demographics: doing voluntary work: β = 0.93, years living in current residence: β = -0.03, good financial situation in old age: β = 1.06, age: β = -0.07  |
| Schroder-Butterfill and Fithry (2014) | Explore alignments between actual care arrangements and preferences of older people in with different cultural backgrounds | Random sample of adults aged ≥60 years from rural Indonesian villages in West Sumatra (n=62) and East Java (n=68) | Survey (n.i.) | LTC caregiver | CSA: DS | *DS: West Sumatra/East Java:* spouse: 0%/6%, any child or all children: 6.5%/34.4%, daughter: 59.7%/26.9%, son: 0%/6%, other relative: 3.2%/1.5%, uncertain: 30.6%/25.6% |
| Denson, Winefield and Beilby (2013) | Compare the opinions and values of three stakeholder groups about hospital discharge plans for LTC  | Purposive sample in an Australian city: older persons aged 77-83 years (n=10), relatives aged 45-69 years (n=8), health professionals aged 45-69 years (n=18) | Semi-structured F2F interviews (n.i.) | LTC location, LTC decision making | CSA: DS, BS  | ***HHCS: Mrs. Smith (frail, isolated, medical and cognitive problems):*** *DS: LTC location: older/relatives/professionals:* home: 20%/50%/83%, residential care: 60%/50%/6%, smaller house/home unit: 20%/0%/11%; *BS:* differences between stakeholder groups statistically significant, p<0.01; *DS: LTC decision making: older/relatives/professionals:* older person itself: 10%/75%/83%, relatives/guardian: 30%/13%/0%, doctors/hospital: 30%/0%/11%, consensus (meeting of all involved): 30%/13%/6%; *BS:* differences between stakeholder groups statistically significant, p<0.001 |
| Halperin (2013) | Investigate future care preferences and examine their associations in independent older Jews and Arabs | Random sample of community-dwelling Jewish (n=168) and Arab (n=175) adults aged ≥60 years in Israel | Structured F2F interviews (n.i.) | LTC arrangements  | CSA: DS, BS, MS (logistic regression) | ***HHCS (need help on regular basis):*** *DS: Jews/Arabs:* formal care (ALF or NH): 51.6%/19.8%, informal care: 6.6%/37%, mixed care (formal LTC at home): 41.8%/43.2%; *BS:* significant differences between Jews and Arabs in preferences for formal and informal care, p<0.001; *MS (OR for “mixed care” in Jews, reference: n.i.):* greater filial expectations: OR: 0.16, more interfamily conflict: OR: 0.45, INTERACTIONS: greater filial expectations X higher number of children: OR: 0.10, higher filial expectations X more interfamily conflict: OR: 0.52; *MS* (*OR for “mixed care” in Arabs):* male gender: OR: 0.16, higher filial expectations: OR: 0.54  |
| Spangenberg *et al.* (2013) | Evaluate which type of housing older persons prefer and their associations when care needs are present | GP: Random sample of the adult population aged ≥45 years in Germany (n=1,445) | Structured F2F interviews (59%) | LTC location | CSA: DS, BS, MS (logistic regression) | *DS:* own home: 66.3%, ALF/shared apartment: 20.6%, relatives home: 5.8%, NH: 5%, others: 1.4%; *BS:* differences in LTC location preferences significant between age groups for NH, p<0.05; *MS (OR for “own home”, reference: n.i.)*: *45-59 years*: male gender: OR: 1.57, living with partner: OR: 1.49, depression: OR: 0.95, subjective dementia risk: OR: 0.76, *≥60 years:* living with partner: OR: 1.71, subjective old age perception (isolation): OR: 1.35, subjective dementia risk: OR: 0.75; *MS (OR for “relatives home”, reference: n.i.): 45-59 years:* male gender: OR: 0.46, depression: OR: 0.95, subjective dementia risk: OR: 1.76, subjective physical disease risk: OR: 0.50; *MS (OR for “ALF/shared apartment”, reference: n.i.): 45-59 years:* living with partner: OR: 0.63, *≥60 years*: living with partner: OR: 0.61, subjective old age perception (isolation): OR: 0.69, subjective dementia risk: OR: 1.29; *MS (OR for “NH”, reference: n.i.): 45-59 years:* subjective old age perception (wisdom): OR: 0.32, *≥60 years*: subjective old age perception (burden): OR: 1.98, subjective physical disease risk: OR: 1.59 |
| Spangenberg *et al.* (2012) | Analyze the willingness to accept informal care from family members among mid-aged Germans  | GP: Random sample of the adult population aged ≥45 years in Germany (n=1445) | Structured F2F interviews (59%) | LTC caregiver | CSA: DS, BS, MS (logistic regression)  | *DS*: formal care: 57%, informal care: 63% (children: 38%, spouses: 38%, other relatives: 12%, friends: 5%, uncertain: 9%); *MS* (*OR for “informal care from family members”, reference: “no informal care from family members”):* living with a partner: OR: 3.65, having children: OR: 3.12, caregiving experiences: OR: 1.35, negative age perception: OR: 0.79 |
| Khalaila and Litwin (2011) | Examine the association between modernization and future care preferences among adult children caregivers of older Arab parents in Israel  | Informal caregivers of Arab origin aged ≥18 years in northern Israel (based on a two-stage stratified sampling method) (n=250) | Structured F2F interviews (n.i.) | LTC caregiver | CSA: DS, BS, MS (logistic regression) | *DS: Men/Women/Total sample:* informal (family) care: 81.2%/73.5%/76.4%, formal care: 9.5%/12%/11.2%; *MS (OR for “informal care”, reference: “formal care”)*: social desirability: OR: 1.30, higher age: OR: 0.23, higher education: OR: 0.35, more caregiving hours per week: OR: 0.76, filial piety: OR: 3.6; *MS (OR for “formal care”, reference: “informal care”)*: social desirability: OR: 0.76, caregiving burden: OR: 5.15, filial piety: OR: 0.09  |
| Walsh and Callan (2011) | Explore preferences for three community care programs, including technological innovation within these settings  | GP: Random sample of the adult general population aged 18-75years in Ireland (n=60) | Structured F2F interviews (n.i.) | LTC arrangements, LTC programs  | CSA: DS | *DS: LTC arrangements:* informal homecare: 60%, formal (publicly funded) homecare: 12%, formal (independently hired) homecare: 10%, retirement village: 7%, homecare with assistive technology: 5%, institutional care: 4%; *DS: LTC programs:* 80% ranked the traditional care programs as more important than the technology interventions (57% ranked family-care program as most important, 60% ranked the home care program as second most important, 68% ranked the home-based technology program as third most important)  |
| Min and Barrio (2009) | Examine the differential effects of ethnicity and a cultural factor on the LTC caregiver preference among Mexican-American (MA) and non-Latino white (WA) elders  | Convenience sample of Mexican Americans and non-Latino white adults aged ≥65 years in southern California (USA) recruited via social services agencies, religious organizations etc. (n=119) | Structured F2F interviews (n.i.) | LTC caregiver | CSA: DS, BS, MS (logistic regression) | ***HHCS: Hip fracture:*** *DS: Mexican Americans/Non-Latino white Americans:* formal caregiver: 54.6%/83.3%, informal caregiver: 45.4%/16.7%; *BS:* differences in LTC caregiver preferences between the two groups significant, p<0.01; *MS (OR for “informal caregiver”, reference: “formal caregiver”):* living alone: OR: 0.40, Medicaid: OR: 0.30, attitudinal variables: care should be provided by family, not an outsider: OR: 3.00, OK to send parents to NH: OR: 0.30 |
| Spencer, Patrick and Steele (2009) | Determine how older adults differentiate seven between LTC options when asked about their future support preferences | Subsample of a larger convenience sample with Caucasians from predominantly rural areas in West Virginia, Ohio, and Pennsylvania, USA (n=81)  | Structured F2F interviews (n.i.) | LTC arrangements  | CSA: MS (exploratory and confirmatory factor analyses) | ***HHCS: require help to remain independent:*** *MS (the seven LTC options could be reduced into three distinct classes of LTC arrangements):* remain-at-home LTC (loaded by items: receive home health services, change home to suit needs), formal LTC with relocation (loaded by items: move to an ALF, move to a NH), and informal care services (loaded by items: care from family member, care from a friend, moving in with a family member); summary scores for each of the three LTC classes indicate a high preference for remain-at-home LTC: M = 3.91 (SD = 0.66), a moderate preference for formal LTC with relocation: M = 3.22 (SD = 0.59), and a lower preference for informal care: M = 2.62 (SD = 0.81); differences between these LTC arrangements statistically different, p<0.001 (unexpected finding for formal over informal care may be due to particulars of the rural sample, i.e. an insufficient informal support network and wide formal LTC service availability) |
| Tang *et al.* (2009) | Examine the intention toward old age home (OAH) placement and its associated factors among young, middle-aged, and older Chinse adults | Convenience samples of adults aged 18-23 years (young), 41-60 years (middle-aged), >60 years (old) in Hong-Kong (China), recruited via local organizations (n=532)  | Postal questionnaires (young: 90%, middle-aged: 32%, old: n.i.) | LTC location | CSA: DS, BS, MS (logistic regression) | *DS*: *(young and middle-aged adults were asked if they would “refer” an older person to OAH, older adults about their “willingness” to enter OAH; measured on a Likert-type-scale with 1 = no to 4 = definitely):* *Young/Middle-aged/Old:* 3.15/3.31/2.08;*MS (standardized regression coefficients for “willing to enter OAH”, reference: “not willing to enter OAH”): Young:* independence in old age important*:* β = 0.21, positive attitude towards old age: β = 0.18; *Middle-aged:* positive attitude towards NH: β = 0.30; *Old:* positive attitude towards NH: β = 0.33 |
| Chung *et al.* (2008) | Explore preferences for LTC among older people, taking into consideration both economic and family factors | GP: Random sample of persons aged ≥65 years in northern Taiwan (n=562) | Structured F2F interviews (n.i.) | LTC arrangements | CSA: DS, BS, MS (logistic regression) | *DS*: homecare: 74%, community-based care: 10%, institutional care: 16% (residential shelter: 12%, NH: 4%); 38% stated that LTC preference and decision would largely depend on the specific situation (care needs); *BS*: significant differences in preferences for LTC options by gender, ethnic origin, educational level, religion, co-residence, primary caregiver, receipt of medical assistance, p<0.05; *MS (OR for “community-based LTC”, reference: “home-based LTC”):* medical services (vs. no need for additional medical care): receiving medical care at home: OR: 2.12, in need of self-care information: OR: 4.39; *MS (OR for “community-based LTC”, reference: “institutional LTC”):* receiving medical care at home: OR: 0.45 |
| Jang *et al.* (2008) | Examine community-dwelling Korean American elders' willingness to use a NH and its associated factors | Convenience samples of Korean American adults aged ≥60 years in Tampa and Orlando (USA) recruited via local organizations (n=427) | Structured F2F interviews (n=201) and postal questionnaires (n.i.) | LTC location | CSA: DS, MS (logistic regression) | *DS:* NH: 47% (89.4% indicated the need for culturally/ethnically oriented NH, which are non-existent in the area);*MS (OR for “intention to use NH”, reference: “no intention to use NH”):* worse self-reported health: OR: 1.46, having someone close living in a NH: OR: 2.8 |
| Kim and Choi (2008) | Examine the association between willingness to use formal LTC services and older adults attitude towards who should provide LTC for older adults | Sample consists of 627 dyads of home care receivers (mean age: 75.3 years) and their primary informal caregiver (mean age: 55.1 years) based on 2001 National Survey of LTC Need in the Elderly (nationwide random sample of Korean elders) (n=657) | Interview survey (n.i.)  | LTC location | CSA: DS, MS (logistic regression) | *DS (willingness to use in/formal LTC): care receiver/caregiver:* homecare: 32.4%/40.5%, NH: 16.6%/32.5%;*MS (regression coefficients for “homecare”, reference: “NH”): Care receivers*: *variables pertaining to care receivers*: children and government responsible for LTC (ref. = children): β = 0.76, *variables pertaining to caregivers:* children and government responsible for LTC: β = 0.55, *Caregivers: variables pertaining to care receivers*: married: β = 0.79, *variables pertaining to caregivers:* bad self-rated health: β = 0.58, care burden scores: β = 0.02, children and government responsible for LTC: β = 1.53; *MS (regression coefficients for “NH”, reference: “homecare”): Care receivers*: variables pertaining to care receivers: female gender: β = -1.05, ≥5 children: β = -1.30, low income: β = 0.77, MMSE 24-30 (ref. = <20): β = 1.01, children and government responsible for LTC: β = 1.53, *Caregivers: variables pertaining to care receivers*: ≥middle school (vs. no formal education): β = 1.06, ≥5 children: β = -0.77, children and government responsible for LTC: β = 0.62, *variables pertaining to caregivers:* care burden scores: β = 0.03, children and government responsible for LTC: β = 0.96 |
| Shin (2008) | Explore LTC preferences of older Korean Americans if they were to become bedridden | Convenience sample of Korean Americans aged ≥65 years in the Chicago metropolitan area (n=12) | Semi-structured F2F interviews (n.i.) | LTC arrangements  | CSA: DS | ***HHCS: bedridden:*** *DS:* living independently in senior housing or co-residing with adult children: 66.6%, NH: 33.3% |
| Wolff, Kasper and Shore (2008) | Explore the stability of LTC preferences across individual characteristics, shifting health needs, and time (1 year) | GP: Random sample of women aged ≥65 years with moderate to severe disability, receiving informal care in Baltimore, Maryland, USA (Women Health and Ageing Study (WHAS) study) (n=420) | Structured F2F interviews (84%)  | LTC arrangements | CSA and LGA (1 year): DS, BS, MS (logistic regression) | *CSA: DS:* LTC preferences varied by level of ADL/IADL need;***HHCS: Daily help with IADL***: *DS:* informal LTC own home: 66%, formal LTC own home: 23%, live with adult child: 5%, ALF: 4%, NH: 2%***HHCS: Daily help with IADL and ADL****:* *DS:* informal LTC own home: 48%, formal LTC own home: 28%, live with adult child: 8%, ALF:10%, NH: 7%***HHCS: Daily help with IADL and ADL because of Dementia****: DS:* informal LTC own home: 20%, formal LTC own home: 15%, live with adult child: 6%, ALF: 10%, NH: 50%; *BS*: none of the included independent variables consistently associated with LTC preferences across HHCS, except for income (higher income was associated with a preference for “formal LTC own home”, while lower income was associated with a preference for “informal LTC own home”) and race (African American women were less likely to endorse ALF or NH)*LDA:* *DS (stability of LTC preferences over 1 year):* order and magnitude of preferences for each HHCS remained largely the same over the 1-year observation period for the total sample, but only about half the participants selected the same care arrangement as most preferred at both points; *MS*: few individual characteristics significantly associated with stability over a 1-year period: older age and presence of spouse caregiver associated with greater stability of preferences, higher education with an increased likelihood of changing their initial care preference |
| Tse (2007) | Explore the NH related beliefs of Hong-Kong Chinese elders  | Convenience sample with adults aged 60-89 years recruited from clients of a community day center (n=118) | Semi-structured F2F interviews (n.i.) | LTC location | CSA: DS | ***HHCS: Unable to care for self or be cared for by relatives:*** *DS:* NH: 15%, other LTC location: 85%  |
| Imamoglu and Imamoglu (2006) | Explore attitudes and preferences for ALF in comparison to NH and assess the possible impact of familiarity on those attitudes and preferences  | Convenience sample with older adults (mean age: 62 years) in the Milwaukee area (USA) recruited from various local organizations (n=98) | Postal questionnaires (n.i.) | LTC location | CSA: DS, BS, MS (structural equation modelling) | *DS (measured on a LTS with 1 = very favorable to 5 = very unfavorable)*:own home: 1.06 (97% of respondents found “own home” very favorable), ALF: 2.43 (16% of respondents found “ALF” very favorable, 45% somewhat favorable, 27% neutral), NH: 4.44 (60% found “NH” very unfavorable, 15% somewhat unfavorable), *BS:* differences in the level of agreement (based on mean LTS value) for the three LTC options significant, p<0.001;*MS (preference for “ALF” in a path model):* familiarity with ALF predicted homelike representations and favorable impressions, which in turn predicted a preference for ALF |
| Min (2005)2 | Examine preferences toward LTC arrangements, and their correlates among older Korean Americans | Representative (two-stage sample proportional sampling procedure) of community-dwelling Korean Americans (born in Korea) aged ≥65 years living in Southern California, USA (n=144) | Structured F2F interviews (54%) | LTC arrangements  | CSA: DS, BS, MS (logistic regression) | ***HHCS: Hip fracture****:* *DS*: informal homecare: 35%, formal homecare: 49%, institutional care: 16%; *MS (OR for “mixed care””, reference: “informal homecare”):* adherence to traditional values: OR: 0.83, better self-rated health: OR: 0.23; *MS (OR for “formal care”, reference: “informal care”):* female gender: OR: 0.09, higher education: OR: 0.76, previous use of home healthcare services: OR: 5.25, adherence to traditional values: OR: 0.79, years living in the USA: OR: 1.98, better self-rated health: OR: 0.13***HHCS: Stroke****:* *DS*: informal homecare: 16%, formal homecare: 21%, formal institutional care: 51%; *MS* *(OR for “mixed care”, reference: “informal homecare”):* adherence to traditional values: OR: 0.79, independent decision making style: OR: 7.96; *MS (OR for “formal care", reference: “informal homecare”):* married: OR: 0.22, adherence to traditional values: OR: 0.71, independent decision making style: OR: 9.83, Medicaid coverage: OR: 12.72, higher number of IADL limitations: OR: 3.53 |
| Bradley *et al.* (2004) | Examine the role of race/ethnicity in the intended use of LTC among African (AAE) American and White American (WAE) elders  | Random sample of community-dwelling AAE and WAE aged ≥65 years receiving Medicare Part A benefits in the two cities in Connecticut, USA (n=400) | CATI (60%) | LTC arrangements, caregiver  | CSA: DS, BS, MS (logistic regression)  | ***HHCS: physiological and cognitive impairments:*** *DS: (measured on a LTS with 1 = definitely would not use informal LTC to 5 = definitely would use informal LTC): AAE/WAE/Total Sample:* LS1: 6.3%/17.9%/12.2%, LS2: 2.5%/3.7%/3.1%, LS3: 10.7%/12.3%/11.5%, LS4: 8.2%/6.8%/7.5%, LS5: 72.3%/59.3%/65.7%; differences between groups statistically significant, p<0.05; *DS&BS:* AAE hold more pronounced family oriented norms (sig. differences between AAE and WAE), while norms concerning subjective control did not differ between AAE and WAE), attitudes towards NH care also differed in several dimensions (i.e. AAE had more negative attitudes toward NH care, whereas attitudes toward homecare did not differ as much, AAE seem to have slightly more positive attitude towards HCBS than WAE); *MS (OR for “informal LTC”, reference: “formal LTC”):* African American ethnicity: OR: 1.80, social norms regarding informal caregiving: OR: 1.68, perceived ability to obtain informal LTC: OR: 1.51, perceived privacy if NH is used: OR: 0.83 |
| Dance *et al.* (2004) | Ascertain current and anticipated needs for residential LTC by Indigenous people in the Australian Capital Territory (ACT) region  | Convenience sample of Indigenous people aged ≥45 years in the Australian Capital Territory (ACT) region (n=98) | Structured F2F interviews (n.i.) | LTC arrangements  | CSA: DS | *DS:* residential care: 0%, community-based care: 100% (shared Indigenous living with culturally appropriate services: 50%, Indigenous aged care residence: 33%, no residential care: 7%, undecided: 8%) |
| Eckert, Morgan and Swamy (2004) | Disentangle the distribution of preferences for LTC along two dimensions (location, caregiver), and to examine correlates for these dimensions | GP: Sample of adults aged 40-70years living in Maryland, USA (n=1,503) | n.i. (n.i.) | LTC location, LTC caregiver, LTC arrangements | CSA: DS, MS (logistic regression) | *DS: LTC location:* homecare: 58%, not at home: 35%, neutral: 8%; *DS: LTC caregiver:* family: 55%, non-family: 38%, neutral: 7%; *DS: LTC arrangement:* informal (family) homecare: 51%, formal (paid) homecare: 32%, informal (family) care not at home: 3%, formal (paid) care not at own home: 6% (caregiver preferences among subjects preferring homecare: kin: 89%, non-kin: 11%; caregiver preferences among subjects preferring LTC not at home: non-kin: 91%, kin: 9%; preference for location among subjects preferring LTC by kin: home/community: 94%, not at home: 6%; preference for location among subjects preferring LTC by non-kin: not at home: 93%, home: 7%); *MS (OR for “homecare”, reference: “not at home”):* very good health: OR: 0.24, high risk for NH: OR: 0.41; *MS (OR for “family care”, reference: “non-family”)*: female gender: OR: 1.60, average subjective LTC risk: OR: 0.51, knowledge of healthcare services: OR: 0.86  |
| Kim and Kim (2004) | Explore factors influencing the intention of older Koreans to use LTC facilities | Random sample (2001 National Survey of LTC Need in the Elderly) of adults aged ≥45 years in South Korea (n=1,850) | Interview survey (n.i.) | LTC location | CSA: DS, MS (logistic regression) | *DS (intention to use a formal “LTC facility”):* 18.8% (gender: female: 17.8%, male: 22.4%; age groups: 65-69 years: 22.7%, 70-77 years: 20.5%, 75-79 years: 15.8%, ≥80 years: 14.3%; marital status: married: 18.3%, bereaved/divorced: 19%; family income: <300,000 Korean won: 25.1%, ≥2,100,000: 13%; place of residence: rural: 13.8%, urban: 24.6%; self-rated health: good: 13.2%, fair: 16.4%, poor: 20.3%, number of chronic conditions: 0: 12.6%, 1-2: 14.3%, 3-4: 21%, ≥5: 24.1%)*MS (OR for “intention to use a formal LTC facility”, reference: “no intention to use a formal LTC facility”):* ≥75 years: OR: 0.72, Christian/Catholic (vs. none): OR :1.44, children 2-5 (vs. 0-1): OR: 0.49, children ≥5: OR: 0.36, family income ≥1,100,000 (vs. lower): OR: 0.53, urban residence: OR: 1.87, MMSE<20 (vs. 24-30): OR: 0.47, ≥3 chronic comorbidities (vs. 0-2): OR: 1.59  |
| Mahoney *et al.* (2004) | Assess Medicaid consumers interest in a consumer-driven cash option for personal care and other services | Random sample of adults aged ≥18 years receiving Medicaid personal care services in Arkansas, Florida, New Jersey and New York, USA (n=2,140) | Structured F2F interviews (77%-80% depending on state) | LTC programs (cash-option in HCBS) | CSA: DS, BS, MS (logistic regression) | ***HHCS: Mrs. Green (arthritis & heart trouble)****: DS: cash-option in HCBS (interested/not sure/not interested): Total sample:* 43.3%/21.3%/35.5%, *Arkansas:* 31.3%/24.7%/44%, *Florida:* 58.1%/20.4%/21.5%, *New Jersey:* 42%/19.7%/38.3%, *New York:* 40.3%/21.4%/38.2%; *DS: desired level of involvement in coordinating HCBS (more/same/less/don’t know):* *Total sample:* 31.7%/58.8%/1.4%/8.1%; *DS: willingness to perform cash option tasks: Total sample:*  hire worker: 45.7%; show worker what to do: 82.9%, schedule worker: 70.6%, supervise worker: 71.3%, pay worker: 66.1%, fire worker: 68.3% (differences between age groups, with the most interest in middle aged adults); *DS: need for help or training with the cash option (among those with some interest): Total sample:* finding a worker: 62.6%, interviewing: 54.6%, background check: 7%, deciding on pay: 76.3%, help when workers do not show up: 69.4%, firing: 51.2%, help with payroll: 76%; *MS (OR for “interest in the cash-option” in HCBS, reference: “no interest in the cash-option”):* aged 30-39 years (vs. average age in sample): OR: 1.9, aged 40-49 years: OR: 1.7, aged 70-79 years: OR: 0.76, aged 80-89 years OR: 0.66, aged 90-99 years: OR: 0.48, experience hiring, firing, or supervising: OR: 2.5, informal caregiver not living in (vs. no informal caregiver): OR: 1.4, live-in informal caregiver: OR: 1.9, high score on ADL limitations: OR: 1.5, Florida residence (vs. New Jersey): OR: 2.4, African American (vs. Caucasian): OR: 1.9, Hispanic: OR: 1.6  |
| Sciegaj, Capitman and Kyriacou (2004) | Explore preferences for three consumer-directed care options (which vary in the degree to which the elder is involved making decisions in his/her care) among aged adults receiving HCBS  | Sample of adults (mean age: 77.6 years) receiving HCBS recruited from three service provider agencies in the greater Boston area, USA (n=731)  | Structured F2F interviews (n.i.) | LTC programs: Cash and Counselling Model (CCM), Negotiated Care Model (NCM), Traditional Case Management Model (TCM)  | CSA: DS, BS, MS (logistic regression) | *DS: African American/Chinese/Hispanic/Caucasian: CCM:* 9%/3%/2%/8%, *NCM:* 18%/47%/10%/16%, *TCM:* 73%/50%/88%/76%*; BS:* differences between ethnic groups statistically significant for NCM and TCM, p<0.01*MS (OR for “TCM”, reference: “CCM/NCN”):* desiring control over services: OR: 0.653, Chinese: OR: 0.004, Hispanic: OR: 0.005, INTERACTIONS: African American X desiring control over services: OR: 0.624, Chinese X desiring control over services: OR: 0.655, Chinese X greater sense of control in life: OR: 1.116, Hispanic X desiring control over services: OR: 3.73, Hispanic X desiring control over workers: OR: 0.384 |
| Wang *et al.* (2004) | Investigate attitudes of older people and their primary caregivers toward LTC arrangements | GP: Random sample of persons aged ≥65 years (n=593) and their primary caregiver (n=587) in northern Taiwan  | Structured F2F interviews (n.i.) | LTC arrangements | CSA: DS, BS, MS (logistic regression) | *DS: older/caregiver:* homecare: 74%/68%, community care: 10%/12%, institutional care: 17%/20%; *BS:* differences between groups not statistically significant; *DS (concordance between choice of older persons and caregivers):* homecare: 59%, community care: 4%, institutional care: 9% of the sample (indicates differences in the preferences for LTC arrangements between older persons and caregivers); *MS (OR for “community care” in older persons, reference: “homecare”):* 65-74 years: OR: 3.12; *MS (OR for “institutional care” in older persons, reference: “homecare”):* Chinese origin: OR: 2.15, living in rural area: OR: 1.81, receiving no government subsidy: OR: 1.78; *MS (OR for “community care” in caregivers, reference: “homecare”:* Chinese origin: OR: 2.26, unharmonious relationship with care recipient: OR: 1.84, no care difficulties: OR: 1.90; *MS (OR for “institutional care” in caregivers, reference: “homecare”):* Chinese origin: OR: 2.24, elementary school education: OR: 3.79, unharmonious relationship with care recipient: OR: 1.66 |
| Wu, Tang and Yan (2004) | Explore the psychosocial factors associated with the acceptance of old age home (OAH) placement among older Chinese  | Convenience sample of adults aged ≥60 years in Hong-Kong (China) recruited via community centers for older Chinese (n=185) | Structured F2F interviews (n.i.) | LTC location | CSA: DS, BS, MS (logistic regression) | *DS (measured on a LTS with 1 = very unwilling to enter OAH to 4 = very willing to enter OAH):* LTS average: 1.8 (LTS1: 52%, LTS2: 28%, LTS3: 8%, LTS4: 12%); *BS:* significant differences between males and females, p<0.05; *MS (regression coefficients for “willing to enter OAH”, reference: “not willing to enter OAH”):* positive attitude towards OAH: β = 0.304, poor physical health: β = 0.217, male gender: β = 0.174, need for independence: β = -0.183 |
| Chapleski, Sobeck and Fisher (2003) | Examine generational differences in the preferences for LTC, as well as their predictors among American Indians | Random sample of American Indian parents aged ≥65 years (n=426) and their children aged ≥35 years (n=74)  | Structured F2F interviews (parents: 74%, children: n.i.) | LTC arrangements | CSA: DS, BS, MS (logistic regression) | ***HHCS: unable to take care of yourself:*** *DS: parents/children:* formal care own home: 30.4%/13.4%, informal care own home: 31.3%/46.3%, move in with family: 4.4%/31.3%, ALF/foster care/group home: 22.5%/5.9%, NH: 8%/3.1%; *MS (OR for “care at home”, reference: “institutional care”):* female gender: OR: 2.08, maintaining traditional culture: OR: 1.25 |
| Pinquart, Sorensen and Davey (2003) | Compare attitudes regarding future care needs, process of preparation for these needs, and outcomes of preparation between German and US elders | GP: Total sample consists of four random samples, each two regional samples from the USA (Utah (n=288), Georgia (n=302)) and Germany (Thuringia (n=294), Baden-Württemberg (n=288)) | Postal questionnaires (39% to 51%, depending on sample) | LTC arrangements | CSA: DS, MS (MANOVA, logistic regression) | ***HHCS: Short-term care needs:*** *DS*: *German/US sample:* informal (family) care own home: 41%/44%, informal (friends) care own home: 12%/14%, formal homecare: 16%/11%, informal (family) care at their home: 18%/18%, remodel own home: 7%/16%, ALF: 4%/5%, NH: 3%/4%; *MS*: German elders more likely to prefer “formal homecare”, US elders more likely to prefer “remodel own home”, p<0.05***HHCS: Long-term care needs:*** *DS*: *German/US sample:* informal (family) care own home: 29%/31%, informal (friends) care own home: 7%/7%, formal homecare: 8%/6%, informal (family) at their home: 13%/15%, remodel home: 6%/13%, ALF: 5%/5%, NH: 2%/5%; *MS*: US elders more likely to prefer “remodel home”, p<0.01 |
| Mahoney *et al.* (2002) | Determine preferences for consumer-directed services and the cash option in New Jersey (USA) | Random sample of adults aged ≥18 years receiving Medicaid personal care services in New Jersey, USA (n=683)  | CATI (38%) | LTC programs (cash-option in HCBS) | CSA: DS, BS, MS (logistic regression) | ***HHCS: Mrs. Green (arthritis & heart trouble):*** *DS: cash-option in HCBS (interested/not sure/not interested):* 42%/19.7%/38.3%; *DS: reasons for interest in the cash option among “interested” participants (interested/not sure/not interested)*: get services when you want them: 87.6%/7.5%/4.9%, hire whomever you want: 90.2%/4.2%/5.7%, buy different services: 90.5%/2.8%/5.7%; *DS: subjective care related needs among “interested” participants*: more hours of service: 68.8%, grab bars or shower equipment: 47.6%, social adult day care: 30.9%, home remodeling services: 35.5%, transportations services: 62.5%; *DS: subjective need for help or training with tasks among “interested” participants:* finding worker: 60.9%, interviewing worker: 51.7%, background check: 77.4%, deciding on pay: 80%, worker does not show: 66.2%, firing worker: 49%, payroll: 83.5%;*MS (OR for “interest in the cash-option”, reference: “no interest in the cash-option”):* aged <65 years: OR: 2.69, African American (vs. Caucasian): OR: 1.70, Hispanic: OR: 3.85, more involvement with current services desired (vs. same or less involvement): OR: 1.39, higher scores on satisfaction with worker subscale: OR: 0.67, willingness to assume responsibility (with managing personal care workers) subscale: OR: 1.66  |
| McCormick *et al.* (2002) | Compare preferences towards LTC of healthy older Japanese and Caucasian Americans | Total sample consists of two representative parallel cohort studies in the state of Washington, USA: Nikkei LTC Project (community-based study of older Japanese Americans living in King County (n=1244), Adult Changes in Thought (ACT) Project (sample of older Caucasians from the GHC registry (n=1354))  | Structured F2F interviews (n.i.) | LTC arrangements | CSA: DS, BS, MS (logistic regression) | ***HHCS: Hip fracture:*** *DS: Japanese Americans/Caucasians:* informal home: 28%/16%, formal home: 53%/56%, NH: 13%/13%, undecided: 6%/15%; *BS:* significant differences between Japanese and Caucasians, p<0.001; *MS (OR for “formal homecare” among Japanese, reference: “informal homecare”)*: higher age: OR: 1.07, female gender: OR: 2.24; *MS (OR for “NH” in Japanese, reference: “informal homecare”):* married: OR: 0.36; *MS (OR for “formal homecare” in Caucasians, reference: “informal home”):* higher age: OR: 1.07, female gender: OR: 1.82; *MS (OR for “NH” in the total sample, reference: “informal home”):* age: OR: 1.05, female gender: OR: 1.51, married: OR: 0.48***HHCS: Dementia****:* *DS: Japanese Americans/Caucasians:* informal home: 11%/7%, formal home: 28%/35%, NH: 53%/38%, undecided: 8%/20%; *BS:* significant differences between Japanese and Caucasians, p<0.001; *MS (OR for “formal homecare” in Caucasians, reference: “informal homecare”):* married: OR: 0.43; *MS (OR for “NH” in Japanese, reference: “informal homecare”):* higher age: OR: 0.96, female gender: OR: 1.41, married: OR: 0.53; *MS (OR for “formal homecare” in Caucasians, reference: “informal homecare”):* married: OR: 0.65; *MS (OR for “NH” in the total sample, reference: “informal homecare”)*: married: OR: 0.60, Caucasian: OR: 0.54 |
| Pinquart and Sorensen (2002) | Investigate what types of assistance US and German older adults prefer for eventual future personal care | GP: Total sample consists of two random samples from Germany (n=772) and the USA (n=558) | Postal questionnaires (45% and 47%, respectively) | LTC caregiver | CSA: DS, BS, MS (logistic regression) | ***HHCS: Short-term care needs:*** *DS*: *German/US/total sample:* informal: 32%19%/27% formal: 14%/17%/15%, mixed: 52%/60%/55%, no preferences: 2%/4%/3%; *BS*: preference for informal caregivers stronger in German elders, preference for mixed care stronger in US elders, p<0.001); *MS* *(characteristics of respondents from the total sample more likely to prefer “informal support”):* younger age, male, married, high frequency of contact with relatives; *MS (characteristics of respondents from the total sample more likely to prefer “formal support”):* not married, received formal care in the past*; MS (characteristics of respondents from the total sample more likely to prefer “mixed support”)*: younger, male, better educated, not married, frequency of contact with relatives, received informal and formal support in the past***HHCS: Long-term care needs:*** *DS: German/US/total sample:* informal: 25%15%/21% formal: 29%/36%/31%, mixed: 40%/43%/42%, no preferences: 6%/6%/6%; *BS*: preference for informal caregivers stronger in Germans, preference for mixed care stronger in US elders, p<0.001*;**MS (characteristics of respondents from the total sample more likely to prefer “informal support” or “mixed support”*): male, high frequency of contact with relatives, more children, received informal care in the past; *MS (characteristics of respondents from the total sample more likely to prefer “formal support”):* received formal support in the past; stratifying the sample by nationality generated broadly similar results with some effects no longer being statistically significant due to the smaller sample sizes; *BS (total sample):* informal and mixed assistance more often preferred for short-term needs, p<0.001; formal assistance more often preferred for long-term care needs, p<0.001; *MS (characteristics of respondents from the total sample more likely to prefer “informal and mixed assistance”):* male, having more children, high frequency of contact with relatives, received informal care in the past; *MS (characteristics of respondents from the total sample more likely to prefer “formal assistance”)*: received formal care in the past |
| Laditka, Pappas-Rogich and Laditka (2001) | Examine gender differences in HCBS use, interest in HCBS and in attitudes and preferences about HCBS  | Convenience sample of n=169 caregivers aged >60 years in New York state (USA) recruited from an elder organization (n=169)  | Postal questionnaires (47%) | LTC caregiver | CSA: DS, BS | *DS: Total sample/women/men:* HCBS: 38.7%/33.9%/59.3%, informal (family) care: 56.7%/60.2%/40.7%; *BS:* gender differences significant for HCBS (p<0.05) and informal care (p<0.1) preferences |
| Kasper, Shore and Penninx (2000) | Describe types of caregiving arrangements in a representative sample of disabled older women living in an urban community in the USA | GP: Random sample of older women with moderate to severe disability and receiving informal care (WHAS study) and their informal caregivers (WHAS caregiving study) in Baltimore, Maryland, USA (n=426) | Structured F2F interviews (84%) | LTC arrangements | CSA: DS | ***HHCS: Daily help with IADL****:* *DS: care receiver/spouse caregiver/daughter caregiver:* informal home: 65%/81%/58%, formal home: 25%/14%/19%, living with adult child: 4%/3%/15%, ALF: 5%/6%/7%, NH: 2%/0%/1%***HHCS: Daily help with IADL and ADL****:* *DS: care receiver/spouse caregiver/daughter caregiver*: informal home: 48%/74%/42%, formal home: 29%/12%/26%, living with adult child: 8%/2%/15%, ALF: 11%/8%/14%, NH: 8%/6%/2%***HHCS: Daily help with IADL and ADL because of Dementia****: DS: care receiver/spouse caregiver/daughter caregiver:* informal home: 21%/41%/22%, formal home: 15%/19%/7%, living with adult child: 5%/4%/13%, ALF: 11%/3%/18%, NH: 53%/37%/41  |
| McEachreon *et al.* (2000) | Explore the anticipated self- informal- or formal care choices of older persons when presented with different potential health problems | GP: Convenience sample of adults aged 65-95 years in Canada recruited through senior groups and by word of mouth (snowball sampling) (n=80) | Structured F2F interviews (n.i.) | LTC arrangement, caregiver | CSA: DS, BS, MS  | ***HHCS: Arthritis:*** *DS:*self-care: 8%, informal care: 31%, formal care: 61%; severity of arthritis symptoms increased in four steps: females choose formal care at all stages of severity, males choose self-care at stage 1 while equal numbers of males choose informal or formal care at stages 2-4; ***HHCS: Parkinson’s:*** *DS:*self-care: 1%, informal care: 41%, formal care: 58%; *MS (predictors for “self-care”, reference: n.i.):* greater perceived health status (+); *MS (predictors for “informal care”, reference: n.i.):* male gender (+), worse perceived health status (+); *MS (predictors for “formal care”, reference: n.i.):* female gender (+) |

*Note:* 1This column indicates which types of statistics were used to generate findings, i.e. descriptive- (DS), bivariate- (BS), and multivariate- (MS), whether it was a cross-sectional- (CSA) or a longitudinal (LGA) data analysis and the type of multivariate analyses (e.g. logistic regression). Note that for some studies only findings from selected analyses are displayed. Further information on each study/reference can be found the manuscript. 2An example is provided as to how read table based on the study by Min (2005). Min (2005) examined preferences for different LTC arrangements (=PO) and their correlates among older Korean Americans (=study aim), using a representative (two-stage sample proportional sampling procedure) of community-dwelling Korean Americans aged ≥65 years and living in Southern California, USA (=population). Data were collected via structured F2F interviews (=DCM); the response rate was 54% (=RR). Descriptive, bivariate, and multivariate (logistic regressions) data analyses were conducted (=DA). Findings were separately presented for two HHCS, i.e. hip fracture and stroke. Regarding the hip fracture HHCS, descriptive analyses show that 35% of respondents preferred informal homecare, 49% formal homecare, and 16% formal institutional care. Multivariate analysis indicate that respondents preferring “mixed care” (compared to informal homecare) were less likely to “adhere to traditional values” (OR: 0.83) and to have “better self-rated health” (OR: 0.23), while respondents preferring “formal care” (compared to “informal care) were less likely to be “female” (OR: 0.08), have “higher education” (OR: 0.76), to “adhere to traditional values” (OR: 0.79), to have “better self-rated health” (OR: 0.13), and more likely to have “previously used home healthcare services” (OR: 5.25) and have “lived longer in the USA” (OR: 1.98). The findings for the HHCS displaying stroke are interpreted in the same manner. (I)ADL = (instrumental) activities of daily living, ALF = assisted living facility, BS = bivariate statistics, CATI = Computer assisted telephone interview, CSA = cross-sectional (data) analysis, DA = data analysis, DCM = data collection methods, DS = descriptive statistics, F2F = face-2-face (interview), GHC = Group Health Corporative, GP = general population, HCBS = home and community-based services, HBTP = home based technology program, HHCS = hypothetical health/care scenario (vignette), LDA = longitudinal data analysis, LTC = long-term care, LTS = Likert-Scale, LTCP = long-term care preferences, MANOVA: multivariate analysis of variance, MMSE = Mini-Mental State Examination, MS = multivariate statistics, n.i. = not indicated, NH = nursing home, OR = odds ratio, PO = preference outcome, RR = response rate, SD = standard deviation, USA = United States of America.