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The classification of distinct long-term care systems worldwide: the empirical application of an actor-centered multi-dimensional typology

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Abstract

Long-term care (LTC) systems vary between countries in several ways. One important difference exists with regard to the question of who, that is which type of corporate actor, takes over the main responsibility in providing, financing and regulating LTC. In this article, we employ a multi-dimensional, actor-centered typology of LTC systems to classify all distinct LTC systems existing worldwide at the point in time when they were first established. In doing so, the article contributes to comparative LTC research by including novel cases and adding a historical perspective. Our 18 cases fall into eight types, which we combine tentatively into three distinct clusters: A predominantly state regulated and financed cluster, a state regulated cluster with mixed financing and provision, and a cluster with private regulation and provision plus societal financing. We find that the state plays the major role in regulation (dominant in 16 countries) and financing (dominant in 11 countries), while in provision we see a broader distribution with societal and private for-profit actors taking a major role. Interestingly, and in contrast to healthcare systems, no societal pure type emerges, not even among social insurance countries.

Zusammenfassung

Die weltweit existierenden Pflegesicherungssysteme unterscheiden sich von Land zu Land in vielfacher Hinsicht. Ein wichtiger Unterschied besteht darin, welche Akteure die Hauptverantwortung für die Leistungserbringung, Finanzierung und Regulierung der Langzeitpflege (LZP) inne haben. In diesem Beitrag verwenden wir eine mehrdimensionale, akteurszentrierte Typologie, um alle weltweit vorhandenen eigenständigen LZP-Systeme zum Zeitpunkt ihrer Einführung zu klassifizieren. Damit wird die vergleichende LZP-Forschung in zwei Richtungen erweitert: Zum einen werden Fälle einbezogen, die in vergleichenden Darstellungen bislang häufig nicht berücksichtigt werden und zum anderen wird eine historische Perspektive hinzufügt. Die 18 Länder mit eigenständigen Sicherungssystemen gehören zu acht Typen, die wir zu drei verschiedenen Clustern zusammenfassen: Ein staatlich reguliertes und finanziertes Cluster, ein staatlich reguliertes Cluster mit unterschiedlichen Akteuren in Finanzierung und Leistungserbringung und ein Cluster mit privater Regulierung und Erbringung plus gesellschaftlicher Finanzierung. Der Staat ist dabei der dominante Akteur bei der Regulierung (16 Länder) und der Finanzierung (11 Länder), während wir bei der Leistungserbringung eine breitere Verteilung sehen, bei der gesellschaftliche und private, gewinnorientierte Akteure eine große Rolle spielen. Interessanterweise gibt es im Gegensatz zu Gesundheitssystemen kein System mit der Dominanz gesellschaftlicher Akteure in allen drei Dimensionen – auch nicht in Ländern mit einer sozialen Pflegeversicherung.

Contents

1. Introduction

In the last decades, long-term care (LTC) is increasingly developing into a distinct social policy field. While the need for long-term assistance with daily living due to physical and/or mental impairments is not a novel phenomenon per se, developments such as global demographic aging, changing family structures and the emergence of a (human) rights perspective on disability and aging (see e.g., Bertha, Rodrigues, Zólyomi, Sandu, & Schulmann, 2019) have contributed to the recognition of LTC as a 'new social risk' necessitating public attention (Greve, 2018; Österle & Rothgang, 2021). This development is visible both on the inter- and transnational level – where international and regional organizations have increasingly come to address LTC (e.g. Esquivel, 2017; European Commission [EC], 2013; Organisation for Economic Cooperation and Development [OECD], 2005; Scheil-Adlung, 2015; World Health Organization [WHO], 2017) – and in individual countries worldwide. Concerning the latter, LTC is still a more salient topic in the richer and older welfare states in the Global North, but is increasingly becoming a field of political concern in countries and regions in the Global South such as Latin America, China, and Southeast Asia as well (Loichinger & Pothisiri, 2018; Luo & Zhan, 2018; Nieves Rico & Robles, 2019).

Irrespective of a growing, yet tentative trend in LTC as a field of social protection, societies differ in the question of *who* takes over responsibility for caring for LTC dependent people. This issue becomes of particular interest to social policy scholars once care is no longer a mainly 'private' matter and welfare states take over formal, legal obligations for LTC, establishing *LTC systems under public responsibility*. With the (partial) 'socialization' of LTC, different types of actors such as the state, corporate societal-based organizations, commercial entities or families can take over varying degrees of responsibility for LTC provision, financing and regulation (see e.g. Lyon & Glucksmann, 2008; Ochiai, 2009; Rodrigues & Nies, 2013). In analyzing the resultant 'care-mix' of LTC systems, we can, for instance, gain important insights into the role of the state and of public versus private actors. Furthermore, this focus sheds light on interaction logics present in LTC systems and their associated outcomes (Fischer, Frisina Doetter, & Rothgang, 2021; Rothgang & Fischer, 2019).

Adopting an actor-centered perspective, the present article compares distinct LTC systems throughout the world, identifying clusters or types of countries. We ask the following question: How do distinct LTC systems differ with respect to actor types dominant in service provision, financing and regulation? To systematically analyze the variation, we make use of a *multi-dimensional, actor-centered typology of LTC systems* recently developed by Fischer et al. (2021). Typologies constitute useful instruments for comparative research, helping to transparently conceptualize categories for comparison and sort complex empirical cases according to their similarities and differences. The field of (country) comparative social policy has extensively engaged in identifying types of welfare regimes and policies during the last decades (see e.g. Lalioti, 2021; Powell, Yörük, & Bargu, 2020) and classifications focusing on LTC in particular have also been put forward since the 1990s (see Section 3). The present article aims to add to this literature by taking a rigorous multi-dimensional approach towards classifying LTC systems as well as incorporating both a more global and historical perspective by focusing on the complete population of distinct LTC systems at the time point of system introduction.

The paper is structured as follows. In Section 2, we briefly present the definition and empirical instances of what we have termed *distinct LTC systems*, which constitute our population of subsequently classified cases. Section 3 provides the theoretical background of typological research in the field

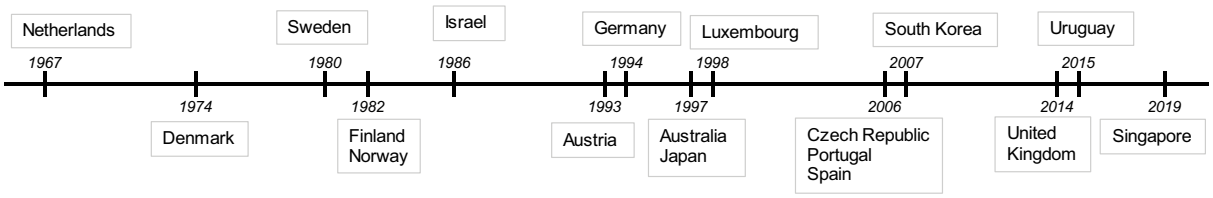
of LTC policy, with a particular focus on outlining the multi-dimensions, actor centered typology which we use as the classificatory framework for comparing LTC systems. Subsequently, the method of classification, operationalization of the typology's dimensions and data used are described in detail. We then move on to present and interpret the results of our classification in Section 5, while Section 6 continues to put them into perspective with existing research and discusses limitations of our approach. Finally, we conclude by reflecting on the insights and further use of the typology.

2. LTC SYSTEMS THROUGHOUT THE WORLD

LTC systems can be defined in different terms, for instance by stressing normative aspects of "appropriate, affordable, accessible" care (WHO, 2017) or a focus on public funding (Spasova et al., 2018). The concept used in this article builds on an extensive discussion of health and LTC systems by De Carvalho and Fischer (2020). Accordingly, a LTC system can in general be described as the sum of provision, financing and regulatory arrangements in a society. In line with our research focus on social policy and state responsibility, we limit our analytical focus by studying *LTC systems under public responsibility*. These, in turn, can – according to a statutory, formal understanding – be seen to exist in a country if country-wide legislation (i) establishes entitlements for LTC benefits (ii) and the elements of the LTC system are some-what integrated, i.e. managed by one/several designated agencies (iii) (De Carvalho & Fischer, 2020, p. 13). Moreover, whenever the LTC system/policy differs between age groups, we focus on LTC for the elderly as the population group with highest levels of care dependency (Colombo, Llena-Nozal, Mercier, & Tjadens, 2011; WHO, 2015, pp. 67–68).

When applying this definition, approximately 50 countries worldwide have so far established public LTC systems (Fischer, Polte, & Sternkopf, 2021; Fischer & Sternkopf, forthcoming). However, some of these first LTC related laws represent rather incipient and rudimentary forms of LTC systems. While, per definition, LTC benefits for at least some share of the population have been formally introduced in all these cases, LTC benefits may be granted as part of another welfare state program as LTC is not (yet) conceived of as specific social risk in its own right and a separate field of social policy making. In consequence, it is useful to distinguish yet another form of systems to capture more independent and mature developments in the field. We therefore introduced the concept of *distinct LTC systems* (under public responsibility) adding to the public system definition outlined above the criterion of LTC being acknowledged as a distinct social risk that is institutionally treated as a social policy field of its own and has achieved a certain degree of independence for other programs (cf. Fischer et al., 2021). These more fullfledged systems lend themselves much more to a comprehensive comparative analysis than single

Figure 1.
Timeline of introducing distinct LTC systems



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LTC benefits integrated in different parts of the health and/or social care systems.

Up to now, our research has identified a population of 18 distinct LTC systems existing worldwide.[1] The timeline of adoption listing all countries is presented in Figure 1. Accordingly, the first distinct LTC system was the introduction of the *Algemene Wet Bijzondere Ziektekosten* (AWBZ, Exceptional Medical Expenses Act) in the Netherlands in 1967 (Companje, 2014), followed by the Denmark, Finland, Norway and Sweden. While modern stateled development of institutional and home care services for the elderly in Scandinavian countries can even be dated back to the middle of the 20th century (Sipilä et al., 2000), the incremental development of LTC policies seems to culminate in the adoption of unifying, universal acts passed in the 1970 and early 1980s, respectively. Subsequently, in the late 1980s, Israel established a social insurance scheme dealing specifically with the risk of LTC dependency as the second country worldwide (H. Schmid, 2005), passing (to our knowledge) the first law which focused solely on the social protection for LTC (the previous introductions all include other elements of social and/or healthcare into their foundational laws as well). In later years, only few countries have chosen to follow this path of introducing distinct social LTC insurance schemes: Germany in 1994, Japan in 1997, Luxembourg in 1998 and South Korea in 2007 (Campbell, Ikegami, & Kwon, 2009; Companje, 2014). Furthermore, in the 1990s and 2000s, several more countries which previously had decentralized systems or single, non-distinct programs, introduced distinct LTC systems. Among them were Central European (Austria, Czech Republic) and Southern European (Spain, Portugal) cases as well as Australia. In 2014 and 2019, respectively, the United Kingdom (UK)[2] as the pioneer having introduced first elder care provisions in 1948, and its former colony Singapore updated and unified their legal LTC-regulated frameworks, establishing distinct systems. Furthermore, with Uruguay's *Sistema National Integrado de Cuidados* (SNIC, National System of Care), the first country from the American continent joined in recognizing LTC as a distinct area for social protection in 2015 (Nieves Rico & Robles, 2019). In the remainder of the article, these 18 systems will be classified at the point of their respective introduction point.

3. Theoretical background

The use of classifications to order and make sense of our empirical world is by no means an exclusive characteristic of the social sciences or sciences in general. It is, first and foremost, a fundamentally human and intrinsic aspect of cognition, which automatically engages in the joint processes of comparison and categorization (Freeman & Frisina, 2010). This regularly entails the grouping together of similar types of a given category or phenomenon to create *typologies*, which helps further reduce the cognitive workload otherwise involved in the generation of always new classificatory labels. Not only are typologies useful in grouping together instances bearing a shared set of attributes, they also facilitate the drawing of expectations related to those attributes. They are therefore a highly useful tool in comparative research.

1 For a detailed description of the procedure and data sources used for identifying system introductions, see Fischer and Sternkopf (forthcoming). The introduction dates (both date of adoption and dejure implementation as well as a brief description of the system and a justification for counting the case as a distinct LTC system are provided in the country data tables in the Appendix.

2 More specifically, we refer here to the Care Act regulating LTC in England, the largest nation of the UK (see also Section 4). However, both Scotland and Wales also passed novel LTC acts in 2013 and 2014 Snell (2015), respectively.

While no shortage of critical attention on (specific) typologies exists (see e.g. Arts & Gelissen, 2010; Collier, Laporte, & Seawright, 2012), a number of well-constructed classificatory systems have come to dominate the field of comparative social policy, not least of all that of Esping-Andersen's (1990) seminal welfare state regimes. Typologies are particularly abundant in the study of healthcare systems – a field of scholarship spanning roughly six decades since Roemer's classification of health departments and medical care in the 1960s (cf. Ariaans, Linden, & Wendt, 2021; De Carvalho, Schmid, & Fischer, 2020). Despite its relative infancy as a policy field, since the mid-1990s LTC has also seen the emergence of classificatory work. Most notably, in the research of Anttonen and Sipilä (1996) and Bettio and Plantenga (2004) that takes a comprehensive (social) care perspective to LTC, integrating both child and elder care arrangements into one framework. This approach has its merits and is particularly useful for broad and gendered understandings of the welfare state. However, it falls short in capturing key differences in the nature of benefits and degree of familialism distinguishing the two policy fields in many countries.

Not until the work of Pacolet, Bouten, Hilde Lanoye, and Versieck (1999) and Timonen (2005) did typologies with an exclusive analytical focus on LTC start to populate the field of comparative social policy. Since then, several typologies that have sorted countries according to their LTC arrangements, both with and without an agerelated focus. More recently, multiple quantitatively-derived classifications of LTC systems using clustering methods and standardized data have been put forward as well (Ariaans et al., 2021; Damiani et al., 2011; Halásková et al., 2017; Kraus et al., 2010), adding yet another layer to the typological study of LTC systems.

While many studies classify whole countries' LTC regimes (e.g. Halásková, Bednář, & Halásková, 2017; Nies, Leichsenring, & Mak, 2013; Ranci & Pavolini, 2013a), some also have an explicit focus on comparing public schemes specifically (e.g. Colombo et al., 2011; Joshua, 2017; Pacolet et al., 1999; Rothgang, 2009). To our knowledge, all countries whose LTC systems have been included in published typologies so far are situated in Europe and/or are member states of the Organisation of Economic Cooperation and Development (OECD). A diverse set of criteria is used in extant typological research for sorting empirical cases. Most commonly, LTC financing is addressed, followed by aspects of coverage and regulation, service provision and the integration of schemes/systems. Among the most frequently used criteria is the distinction between tax and contribution based-financing schemes (e.g. Colombo et al., 2011, Pacolet et al., 1999; Simonazzi, 2008), population coverage (Colombo et al., 2011; Kraus, Riedel, Mot, Willemé, & Röhrling, 2010; Ranci & Pavolini, 2013a), and the prominence of formal vs. informal care (Roit & Le Bihan, 2010; Kraus et al., 2010; Nies et al., 2013).

Taken together, existing classificatory approaches have strongly contributed to the conceptual and empirical understanding of the variety of LTC systems. As established in a review of 17 classifications (see Fischer et al., 2021), however, these typologies are subject to number of important limitations. First, the specification of criteria and/or underlying procedure/methods for typology construction is not always clear; second, the applicability of classifications to regions beyond Europe is hardly discussed; third, they show a paucity of information on the multi-dimensional aspects of LTC systems.

Bearing these issues in mind, Fischer et al. (2021) put forth a deductively derived, actor-centered typology that incorporates three dimensions of the LTC system that have also been used in healthcare typologies (Böhm, Schmid, Götze, Landwehr, & Rothgang, 2013; Wendt, Frisina, & Rothgang, 2009): The first, *service provision*, refers to the most elementary function of the system involving the actual task of caring. Care can consist

of medically-related tasks, such as administering medicines and maintaining hygiene, household-related tasks such as washing or cooking, as well as strengthening societal participation and providing emotional support. The second dimension, *financing*, refers to the resources necessary for 'producing' care, either in the form of monetary resources or, in case of informal, unpaid care provision, through time and foregone earnings (WHO, 2015, p. 131). Finally, the third dimension, *regulation*, that is the "intervention in the behavior or activities of individual and/or corporate actors" (Koop & Lodge, 2017, p. 97), influences and modifies the production structure of care and crucially shapes the system (Mayntz & Scharpf, 1995).

For each of these dimensions different criteria can be analyzed. We concentrate on the question of *who* bears responsibility because this is one crucial category in the analysis of care and social policy, providing insights, for instance, into redistribution processes, legitimacy, social structures, and norms. To some extent, this focus can also inform us about how and what happens within each dimension, especially the associated interaction logics (Fischer, Frisina Doetter, & Rothgang, 2021; Rothgang & Fischer, 2019). In a second step, therefore, Fischer et al.'s (2021) LTC typology conceptualizes (up to) five types of (quasi-)corporate actors which take over responsibility for provision, financing and/or regulation of the LTC system: State, societal actors, private for-profit actors, private individual actors and global actors. Firstly, the state is defined as the public institutions in the political-administrative system of a country (Johnson, 1999), comprising different – central, regional, local – state levels and as such is a relevant actor in all three dimensions. Secondly, *societal actors* are characterized by their formal, non-profit, non-governmental status and collective self-organization (Johnson, 1999; Wendt et al., 2009). Societal actors appear as providers, for example in the form of charitable or mutual aid organizations, while in the financing dimension they mostly take the form of social insurance bodies. Societal actors (self-)regulate mainly through collective negotiations (Rothgang et al., 2010, p. 14).

Moving on to private actors, thirdly, there are *private for-profit actors*, e.g. nursing homes or home care services, which can deliver care, and financing agencies in the form of private insurances collecting premiums. It is important to note that private for-profit actors in the provision dimension comprise a spectrum of providers reaching from domestic care workers, which often work (and live) in the care recipient's household to large formalized corporations. Fourthly, *private individual actors*, defined as persons from the care recipient's network, i.e. family members, neighbors or friends (Timonen, 2009), are crucial in many LTC systems in providing (informal) care. Through out-of-pocket payments, care-recipients and their relatives are also an important financing source, even in LTC systems under public responsibility (e.g. Colombo et al., 2011; Rodrigues & Nies, 2013). It is important to note that while both forms of private actors have limited means by setting general, external standards, they can (self-)regulate (Rothgang et al., 2010; see also Black, 2001; Braithwaite, Makkai, & Braithwaite, 2007). In the regulation dimension, we capture this mode of regulation by private actors jointly. Lastly, *global actors* such as foreign state, international governmental or non-governmental organizations might be involved in LTC systems in any of the three dimensions. However, this is not the case for the population of distinct LTC systems under public responsibility analyzed in this article, which is why we abstain from discussing this actor group further.

Fischer et al.´s (2021) typology endeavors to deliver a widely applicable classificatory framework to identify the role of specific actors across the multi-dimensional universe of the LTC system. It is an ambitious response to the aforementioned limitations of extant typological approaches – one which results in a total of 100 LTC system types (see

Figure 2.
Typological attribute space of the multi-dimensional, actor-centered typology

REGULATION	FINANCING	PROVISION				
		State	Societal actors	Private for-profit actors	Private individu-al actors	Global actors
State	State	**Type 1**	Type 2	Type 3	Type 4	Type 5
	Societal actors	Type 6	Type 7	Type 8	Type 9	Type 10
	Private for-profit actors	Type 11	Type 12	Type 13	Type 14	Type 15
	Private individual actors	Type 16	Type 17	Type 18	Type 19	Type 20
	Global actors	Type 21	Type 22	Type 23	Type 24	Type 25
Societal actors	State	Type 26	Type 27	Type 28	Type 29	Type 30
	Societal actors	Type 31	**Type 32**	Type 33	Type 34	Type 35
	Private for-profit actors	Type 36	Type 37	Type 38	Type 39	Type 40
	Private individual actors	Type 41	Type 42	Type 43	Type 44	Type 45
	Global actors	Type 46	Type 47	Type 48	Type 49	Type 50
Private actors	State	Type 51	Type 52	Type 53	Type 54	Type 55
	Societal actors	Type 56	Type 57	Type 58	Type 59	Type 60
	Private for-profit actors	Type 61	Type 62	**Type 63**	Type 64	Type 65
	Private individual actors	Type 66	Type 67	Type 68	**Type 69**	Type 70
	Global actors	Type 71	Type 72	Type 73	Type 74	Type 75
Global actors	State	Type 76	Type 77	Type 78	Type 79	Type 80
	Societal actors	Type 81	Type 82	Type 83	Type 84	Type 85
	Private for-profit actors	Type 86	Type 87	Type 88	Type 89	Type 90
	Private individual actors	Type 91	Type 92	Type 93	Type 94	Type 95
	Global actors	Type 96	Type 97	Type 98	Type 99	**Type 100**

**Note:* Bold highlighted types are pure types with one dominant actor only; grey highlighted types are presumably unlikely/implausible.

Source: Fischer et al., 2021.

Figure 2). Of these, five emerge as 'pure' types consisting of one actor dominating all three dimensions.

Thus far, this typology has yet to be applied with empirical rigor to verify its applicability and utility as a classificatory framework for LTC systems worldwide. The present contribution sets out to do just that, traversing the globe for empirical instances of distinct LTC systems and classifying them in line with Fischer et al.'s typology.

4. Methods and Data

As outlined above, the typology we use for classifying countries' LTC systems in this article consists of predefined types created by intersecting the three dimensions and five/four actor types systematically (see Figure 2). Consequently, each of the resulting types can be depicted as a *configuration*, that is as a combination of its properties which together define the type as a whole (Kvist, 2006). Similarly, each empirical case of a LTC system can be conceived of as a configuration of attributes in different dimensions

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(Rihoux & Ragin, 2009; Wagemann, 2015). Following this logic, we can classify an empirical case – that is, put it into a 'cell' – by identifying which type's configuration has the highest overlap with the properties of a case. This can be done most easily when regarding each dimension – service provision, financing and regulation – separately during the initial stage of the classification process.

However, it is important to note that, as LTC systems are very complex, cases do often not completely conform to any type. That is, adherence of real cases to the deductively constructed types of the typology can be stronger or weaker (Kvist, 2006; Schneider & Wagemann, 2012, pp. 97–98). For instance, if care in a LTC system is exclusively provided by societal actors, the country strongly confirms to the 'extreme' expression in the provision dimension; if there is a mix of providing actors with societal actors making up the majority but not as the sole actor type (e.g. a mix of 60 % societal actors, 30 % private for-profit actors, and 10 % by state-run facilities), societal actors are still dominant in the provision dimension but to a smaller degree. While both of these exemplary cases differ to some extent, they can still be assigned unambiguously to a cell in Figure 2, indicating that societal actors dominate the provision dimension. It should be noted that any classification of metric data, as e.g. the share of financing that different actors provide, leads to a loss of information. As a consequence, even small changes may lead to a reclassification of a system, if the metric value is close to the threshold. The classification of a system is, therefore, not a sufficient substitute for an in-depth study of the respective case, but is suitable for providing an overview on how cases compare to each other.

The above route of classifying cases by identifying the *dominant actor type* per dimensions[3] – which has previously been employed for classifying health care systems by Böhm et al. (2013) – is exactly the approach we follow. Our sorting is based on the logic that the homogeneity of both cases – one with 100 % and one with 60 % societal actor based LTC provision – is higher than with other cases where there is no or a minor role of societal actors in care provision (cf. Kelle & Kluge, 2010, pp. 100–101). Therefore, the classification process marks these two cases as similar by assigning them to the same type. Subsequently, when the dominant actor in each dimension has been determined for a certain case, the country is classified according to the resulting configurational setting and assigned to the respectively type in typology matrix. In the remainder of this section we discuss the operationalization of the coding process (Section 4.1) and the data basis for classifying (Section 4.2) in some detail.

4.1 Operationalization

For each of the three dimensions – regulation, financing, and service provision – operationalization rules have to be determined (Section 4.1.2 to 4.1.4). Before diving into this, however, we have to clarify what constitutes a case in the subsequent analysis (Section 4.1.1).

4.1.1 Classified unit

The aim of this article is to systematically compare and, hence fore, classify cases of *distinct LTC systems* in various countries. But what constitutes a 'case' in our study? In general, a case can be described as "an instance of a class of events" (George & Bennett, 2005, p. 17), with the event being defined by spatial, topical, and/or temporal boundaries (Bennett & Checkel, 2015). Firstly, regarding the spatial confinements, cases

3 In some cases, only a relative dominance, i.e. being the strongest actor but below a share of 50 % can be identified. If this was the case, it is noted in the data table in the appendix.

are equated with *countries*, meaning that the LTC system needs to be institutionalized by nationwide legislation and be applicable – albeit with potential regional modifications – to the whole country's territory.[4] Secondly, the topical focus is on classifying LTC systems. We define *long-term care* as being "concerned with a range of services and assistance provided to care dependent persons who need support with daily living activities over an extended time period due to physical and/or mental impairments" (De Carvalho & Fischer, 2020, p. 8). The concept of a LTC *system*, refers to the provision, financing and regulatory arrangements in a society dealing specifically with LTC as an area of social protection for (at least) (parts of) the elderly population.

If a system does not cover the whole country, we need a further specification. On the one hand, the LTC arrangement of the *whole country* can be classified, including both the public scheme(s) and all other (e.g. privately paid, informally provided) LTC. On the other hand, the analysis can be limited to the *LTC system under public responsibility* (see Section 2). Conceptually, we follow the latter approach, not least as only systems under public responsibility may guarantee access to care for the whole population, which is crucial from a human rights perspective. Nevertheless, due to data availability in some cases we have to use countrywide data instead. In countries with more than one LTC scheme simultaneous focus on the whole public arrangement is sometimes not feasible, especially when analyzing the regulation dimension where diverging actors might be dominant in different schemes. If this was the case, we took the *major LTC scheme* for identifying dominant actors only. For instance, with the distinct LTC system introduction in Germany in 1994, both a social LTC insurance (LTCI) scheme and a mandatory private LTC insurance schemes were introduced (Rothgang, 2010). As the social LTCI at that time (and also later on) covered approximately 90 % of the population (Rothgang, 2009b), we have chosen to use this scheme for classifying Germany in the regulatory dimension. For countries where the regulatory dimensions are based on parts of the overall public LTC system only, this is documented in the Appendix (row 'Dominant scheme for classification (if applicable)'). Similarly, for some countries statistical data on financing and service provision is only available for the country level, but not for the public LTC system. This is, for instance, the case with data following the System of Health Accounts (SHA) standard (OECD, WHO, & Eurostat, 2011), the most important internationally comparative data on financing shares. Using such data for classification can be regarded as a conservative estimate of public LTC system financing shares because typically the share of private financing and service provision in the system under public responsibility is lower than in the rest of the country's LTC provision.

Besides the spatial and topical definition of cases, the temporal boundary is also important. Temporally, we focus on the *introduction point* of each distinct LTC system. Empirical data about provider and financing shares in particular are only telling after the system has been implemented. Therefore, we have used, if available, data for the time span of (approximately) three years after the de jure implementation of the law to stay both close to the introduction date and the (initial) design of the introduced system. However, there are also cases where the dominant actor type has switched within the first years after system introduction, for instance in the financing dimension in the

4 One partial exception is the United Kingdom (UK), where, since the inception of the devolution process in 1999, policies for social care/long-term care are (partly) the political competence of the individual nations, i.e. England, Scotland, Wales and Northern Ireland, respectively (Bell, 2010; Glendinning, 2013). Therefore, the current legal acts do not necessarily cover the United Kingdom as a whole. Whenever necessary we focus on England as the by far largest part of the country.

Netherlands (state → societal actors) or the provision dimension in Israel (societal actors → private for-profit actors). In these cases, we have taken the initially dominant actor to characterize the system at its introduction point.[5] In short, a case in this study can be described as the complete distinct LTC system under public responsibility within a country at the point of its introduction.

4.1.2 Provision dimension

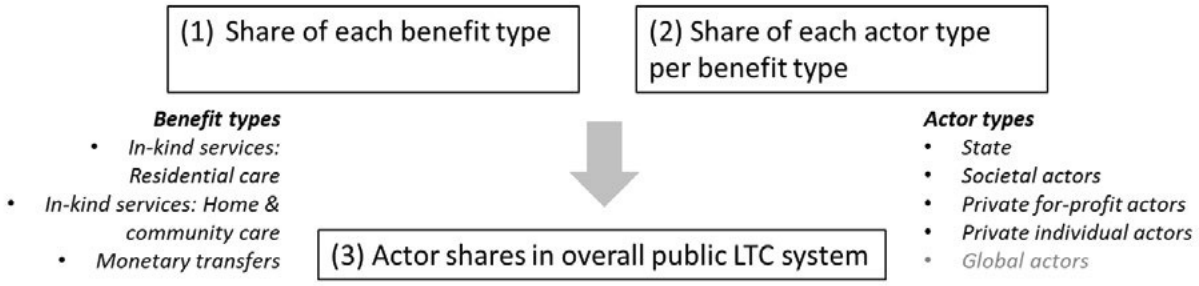
LTC provision as one of our dimensions for classifying systems can take the form of formal care, i.e. paid, (semi-)professional care provided in an organized setting, and informal care, which is provided in unregulated 'private' settings, often by family members, or fall between the poles of this ideal-typical formal-informal distinction (Pfau-Effinger & Rostgaard, 2011; Timonen, 2009; WHO, 2015, pp. 129–130). The form of care crucially depends on the benefits available within the LTC system: While benefits in the form of in-kind services generally translate into formal care provision conducted by state, societal or private for-profit actors, monetary transfers in the form of vouchers or cash benefits can – often depending also on the regulation for their use – result in a spectrum between informal and formal care arrangements provided (e.g. Da Roit & Le Bihan, 2010; Le Bihan, Da Roit, & Sopadzhiyan, 2019). In the population of distinct LTC systems classified in this paper, there is only one country offering exclusively cash benefits (Singapore), while most countries offer only in-kind benefits or a combination of in-kind services and cash benefits. Furthermore, in the category of in-kind benefits/formal care, it is important to distinguish between residential/institutional care versus home and community care as providing actor types as well as regulatory competencies do often differ between both settings. Residential care is provided continuously around the clock for care dependent persons living jointly in a specific institution, for example a nursing home or assisted living facility (Rothgang & Fischer, 2019; WHO, 2015, p. 129). In contrast, the terms 'home and community care' or 'community-based care' summarize "all forms of care that do not require an older person to reside permanently in an institutional care setting" (WHO, 2015, p. 129). It comprises both assistance with personal care and household activities in the care recipient's home as well as facilities like day care centers (Timonen, 2008, p. 142).

In order to determine the dominant actor type in service provision we follow a three-step approach (see Figure 3). First, we record the share of the three main LTC benefit types i.e., in-kind residential care services, in-kind home and community care services, and monetary benefits. In doing so, we use, where possible, data on their respective proportion in the overall care-mix based on the number of care recipients under each benefit type.[6] Second, the shares of actor types are recorded for each relevant benefit type separately. In the case of (unregulated) monetary benefits there is often no data available on where the money goes. In conjunction with evidence from secondary literature, however, we can normally assume that most unregulated cash benefits translate into care provision by private individual actors, that is mostly family members and/or domestic care workers (e.g. Da Roit & Le Bihan, 2010; Riedel & Kraus, 2016). If we have evidence that cash benefits are used to finance live-ins, i.e. mostly migrants living in the household of a care-dependent person in order to assist him or her, we subsume this arrangement under

5 In the appendix, the political adoption date of the law as well as the de jure implementation date at which the law formally enters into force are specified for each country.

6 While there are other measures such as expenditure, or, for formal care, granted hours of care or number of employees in each sector, which could be used alternatively, data on the number of recipients is most often available and counts all care recipients equally.

Figure 3.
Calculation of dominant actor in the provision dimension



Source: own illustration.

private for-profit care-giving. Third, with the information from step two and three, we calculate (if necessary) the total share of each providing actor type in the whole LTC system.

4.1.3 Financing dimension

The operationalization of the financing dimension is mostly straight forward as we can equate *financing sources* with actor types (cf. Böhm et al., 2013). Generally, four types of domestic financing sources which correspond to the four domestic actor types outlined in the typology (Fischer et al., 2021) can be distinguished: Tax revenues (state), social insurance contributions (societal actors), private insurance premiums (private for-profit actors), and household out-of-pocket expenditure (OOP) (private individual actors) (Rothgang & Fischer, 2019). To reap the benefit of using comparable data across countries, whenever possible we relied on SHA-based (see OECD et al., 2011) international comparative data from the health expenditure and financing database provided by the OECD. When doing so, we used the following SHA categories to determine actor shares: *Government schemes (HF.1.1)* for state financing, *social health insurance (HF.1.2.1)* for societal actors, *voluntary health care payment schemes (HF.2)* for private for-profit actors, and *household out-of-pocket payments (HF.3)* for private individual actors. The categories *compulsory contributory health insurance (HF.1.2)* and *compulsory private insurance (HF.1.2.2)* can contain both funding from social and/or private insurance depending on the concrete design of the scheme. This is further discussed below. For 12 out of 18 countries, respective data for a year close to the LTC system introduction point can be found in the OECD statistics.[7] Even though the statistics refer to the whole country and not the public LTC system only, they provide – especially if triangulated with national sources and case descriptions – valuable standardized and comparable information on dominant financing schemes.

However, it has to be noted that the correlation between private for-profit actors and the SHA classification poses some problems. In general, private insurance schemes can take a compulsory or voluntary form, which comes with different implications regarding the role of the state and the social protection of the schemes (OECD et al., 2011). Therefore, the SHA methodology (OECD et al., 2011) classifies compulsory private insurance (HF.1.2.2) and voluntary health insurance schemes (HF.2.1) in two different categories which stresses the – undisputable strong – relation of the former with social insurance schemes. However, as in our analytical framework regulation is considered also separately from financing we maintain that both mandatory and voluntary private insur-

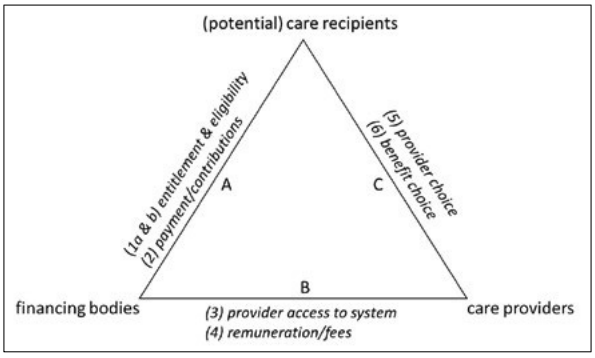
7 Respective data were unavailable for Israel, the Netherlands, Norway and Sweden (due to later start of the time series) and the non-OECD members Singapore and Uruguay. For these cases national data and secondary sources were used instead

ance provide – differently regulated – hints on the relevance of private for-profit actors in the financing dimension. This is why we classify financing in Singapore – the only classified case where actuarial private insurance premiums are a major financing source – as dominated by private for-profit actors even though the scheme is (partly) mandatory.

4.1.4 Regulation dimension

Regulation is a particularly broad category. Regarding the field of LTC, for instance the available 'benefit package', quality, care providers' standards or the extent of choice of care recipients can be centrally regulated – e.g. by the state or an (social) insurance body – or left to selfregulation of involved actors (e.g. Braithwaite et al., 2007; Da Roit & Le Bihan, 2010; Kraus et al., 2010; Murakami & Colombo, 2013; Rothgang & Fischer, 2019). Consequently, there are multiple ways of operationalizing the regulation dimension of the typology. The easiest – and probably most limited – possibility is to record who – that is which organization/agency, and, based on this, which actor type – is *generally responsible* for regulating the LTC system without formally considering any specific aspects of regulation.[8] In LTC systems under public responsibility, this will generally be the state directly, in the form of the central government, provinces/federal states and/or municipalities or other public bodies such as LTC or health insurance funds. Therefore, this form of operationalization automatically limits the kinds of actors which can achieve dominance in the regulation dimension to public actors, i.e. state or societal actors. Furthermore, identifying the main regulator by looking at the generally responsible organization(s) in the LTC system is a quite crude way of measurement.

Figure 4.
Regulatory relationships and objects in the LTC system



Source: own illustration based on Rothgang et al., 2010.

To get a more detailed picture of what goes on in the regulation dimension of each case, we use a differentiated approach of categorizing several regulatory subdimensions or relations and combine the information to arrive at a final classification. In doing so, we draw on earlier works on health care systems which have conceptualized regulatory relations and objects (Böhm et al., 2013, 2012; Wendt et al., 2009), adapting them to the context of LTC systems. The conceptualization departs from the point that in any healthcare/LTC system there are *three groups of actors* involved which form a triangular relationship: care providers, financing bodies, and (potential) care recipients (Rothgang et al., 2010, p. 11). The content of these relationships – visualized as the sides of the triangle in Figure 4 – can be regulated.

For the relation between financing bodies and (potential) care recipients (side A in Figure 4), there are two main objectives: The entitlement/eligibility (1) describes which (potential) care recipients have access to LTC benefits. Following the 'who' question, here, we can either focus on who decides the *entitlement and eligibility criteria* (e.g. citizenship status, formal employment, dependency levels, age thresholds) defining inclusion (1a), or ask which actor is responsible for executing *eligibility assessment procedures* (mostly care dependency assessment) (1b). As noted by Böhm et al. (2013) for healthcare systems

8 For each case, this information is recorded in the data table in the appendix (row 'dominant actor agency').

already, there is no variation in the former point (1a); in all (studied) systems defining entitlement/eligibility criteria is exclusively the responsibility of the state (see data tables in Appendix). Therefore, we exclude this category for classifying and focus solely on question 1b, that is *who is responsible for eligibility assessment?* In this relation we also look at a second question: *Who decides if and how much to pay/contribute to the system (2)?* The question can be applied both to co-payments – i.e. who decides if and what sum of co-payments the care recipient needs to pay – and/or contribution or premium rates – i.e. who decided if contributions/premiums need to be payed and what their level is. Interestingly, this regulatory relation is also strongly– albeit not exclusively – populated – by the state.

Moving on to the relationship between financing bodies and care providers (side B of the triangle), *the access of providers* to the public LTC system (3) and the *system of remuneration* of providers (4) are relevant here. It is important to note that in systems with cash transfers and in-kind services, formal as well as informal providers might need to be considered (separately). Regarding the provider access, we are looking at *who defines if and under which conditions providers can offer services in the public LTC system*. While in most countries there is the necessity to get a general license to operate a care facility/service, we are specifically interested in who controls provider access to provide publicly regulated/financed benefits. If there is no specific entry requirement, provider access is classified as 'private', otherwise as 'state' or 'societal' depending on the (dominant) regulator. Furthermore, concerning the remuneration, we ask *who decides or negotiates the payments/fees provider receive for offering (certain) care services?* Remuneration levels can for instance be determined by the state – which is mostly the case for the level of cash benefits, but sometimes also for formal in-kind care provision –, negotiated between providers and financing agencies or determined by providers themselves (for instance in a so-called "Pork Barrel Market" as termed by Gingrich (2011)).

Lastly, there is relation C connecting (potential) care recipients and care providers. This relationship is, on the one hand, about looking at the regulation of care recipients to choose a concrete provider (5), that is *who decides which provider will deliver care to the benefit recipient?* If beneficiaries can choose a provider themselves, the category is classified as private (individual), if care managers (or similar) take over the decision depending on who employs the care manager the category is classified as state, societal or private (collective). On the other hand, *the decision which care benefits* – that is, in-kind residential or home/community care or cash benefits (see above) – *a care recipient gets* can also be decided by different actor types (6). There are two steps to consider here: Firstly, if there is only one benefit type offered by law, the state regulates the choice of benefits. Secondly, if there are several benefit types on offer (e.g. residential care and home care), the care recipient might be free to choose ('private'), or care managers (or similar) employed by other actor types might determine the benefit for each care recipient.

Summing up, based on previous conceptualizations of health care system regulation we have identified six relevant regulatory categories which we used for classifying the regulation dimension of the LTC systems. In doing so, we have adhered to the following rules/steps:

1. If necessary, the principal LTC scheme in the country for classifying regulation is defined (see above).

2. Data for each of the six regulatory subdimensions (1-6) is collected. In case there are regulatory differences for several benefit types (e.g. for residential care and cash benefits), if possible information on both is recorded.

3. Additionally, the organization/agency which is generally responsible for regulating the LTC system is recorded (7).

4. Based on the raw data, the 1-2 dominantly involved actors in regulating the respective sub-dimension (1-7) are identified. If two actors are identified and data allows for it, one actor is marked as most dominant (in bold letters). If the two actors derive from the fact that benefit types are regulated differently, the dominant benefit type according to the data collected for the provision dimension is marked as most dominant.

5. Based on the actors identified for each of the six relations, the overall dominant actor is determined. Each of our six relations is weighted equally. If there is one actor in a sub-dimension, this counts with a value of 1. If a sub-dimension is populated by two actors, each of them count with a value of 0.5. The actor type achieving the highest value is rated as the dominant actor type.

6. In case two actor types are equally strong according to step (5), sub-dimension 7 capturing the general regulatory agency is used as a tie-breaker.

4.2 Data

Multiple data sources were used for identifying dominant actors in each dimension: the laws introducing the LTC system, academic publications and reports and grey literature, both on single countries or with a comparative focus, statistics (as a primary statistical source mostly the OECD health expenditure and financing database as outlined above), national online newspaper articles and (official) websites about the LTC schemes, as well as primary data collected through the project's Expert Survey on Long-Term Care in 2020/21 (see Fischer & Sternkopf, forthcoming). All data sources used per (sub-)dimension and country are specified a country data tables in the appendix, with a reference list provider for each country separately below each country data table. For reporting reliability of the data/results, for the actor classification in each (sub-)dimension, the confidence in the data/actor rating was recorded following a three-point scale: *High confidence* is achieved if the data is confirmed either by a law or reliable primary data source (e.g. official statistics) directly or by at least two independent secondary sources and retrieved information is non-contradictory. Results are rated with *medium confidence* if there is only one reliable secondary source providing the necessary information or there is some ambiguity/unclarity about dominant actors from the available information. All data that were extremely ambiguous or uncertain, or based on sources that are not deemed reliable by the researcher, are rated as *low confidence*. Overall, due to lack of data in two cases, i.e. Luxembourg and Singapore, it was not possible to determine one single dominant provider type. In these cases, we resorted to combining two actor types in the provision dimensions to classify these cases. Furthermore, data for the regulatory sub-dimension of benefit choice in Portugal was missing.

5. Classification results

Figure 5 shows the results of the classification exercise: The 18 countries with a distinct LTC system can be classified into altogether 8 types. When introduced, the systems of the Nordic countries Denmark, Finland, Norway and Sweden fell under Type 1, representing state-domination in regulation, financing and provision. Eight other countries also show state-domination in regulation and financing, however, with service provision dominated by societal actors (Australia, Netherlands, and Portugal, Type 2), private

Figure 5.
Multi-dimensional actor-centered distinct LTC system classification

REGULATION	FINANCING	PROVISION			
		State	Societal actors	Private for-profit actors	Private individual actors
State	State	**Type 1:** *Denmark (1974) Finland (1982) Norway (1982) Sweden (1980)*	**Type 2:** *Australia (1997) Netherlands (1967) Portugal (2006)*	**Type 3:** *Spain (2006) United Kingdom (2014) Uruguay (2015)*	**Type 4:** *Austria (1993) Czech Republic (2006)*
	Societal actors		**Type 7/8:** *Japan (1997) Luxembourg (1998) Israel (1986)*		
	Private for-profit actors			**Type 13/14:** *Singapore (2019)*	
	Private individual actors				
Societal actors	State				
	Societal actors				
	Private for-profit actors				
	Private individual actors				
Private actors	State				
	Societal actors			**Type 58:** *South Korea (2007)*	**Type 59:** *Germany (1994)*
	Private for-profit actors				
	Private individual actors				

Source: own illustration based on data sources and dimension-specific classification results specified in the Appendix. Cluster A is highlighted red; Cluster B green; and Cluster C blue.

for-profit actors (Spain, United Kingdom, Uruguay, Type 3), and private individual actors (Austria, Czech Republic, Type 4) respectively. At the point of introduction, the LTC systems of 12 out of the 18 countries classified thus belonged to a cluster with *predominant state regulation and financing* (Cluster A, highlighted in red, see Figure 5).

A second cluster combing *state regulation with different actors dominating financing and care provision* (Cluster B, highlighted in green, see Figure 5). can be found in another four countries. While the combination of societal financing and societal and private for-profit provision is populated by Japan, Luxembourg and Israel (Type 7/8), state regulation, private for-profit financing and private (for-profit and individual) care provision can be found in Singapore (Type 13/14). While both state financing (eleven countries) and societal financing (five countries) are quite common, Singapore occupies a unique position among the classified LTC systems being the only country with a dominance in private (for-profit) financing.

Finally, a third cluster (Cluster C, highlighted in blue, see Figure 5) can be identified with *dominant regulation by private actors, societal financing and care provision through private actors* (South Korea and Germany, Type 58 and 59). The dominance of private actors in the regulation dimension comes as a surprise: In an initial theoretical assessment of the plausibility of types, private regulation paired with societal financing was deemed as implausible following the 'hierarchy rule' hypothesized by Böhm et al. (2013) (see Figure 2).

These results are remarkable as stateled systems with state regulation and financing are by far the most common, comprising two thirds of all systems under scrutiny, while there is no counterpart to this in form of societal-dominated systems as can be found in the field of healthcare.

Although in the Netherlands, Israel, Germany, Luxembourg, Japan, and South Korea social insurance systems were introduced, they don't appear as such in Figure 5. While financing – as the central definition criterion of a social insurance system – is indeed

societal dominated in Israel, Germany, Luxembourg, Japan, and South Korea, regulation is not. The reason for this can be demonstrated with respect to the German case: While societal actors in the form of LTC funds are in charge of eligibility assessment, they do not control market access as they have to contract with all providers fulfilling some minimum requirements – irrespective of whether additional supply is needed. State actors determine not only the contribution rate, but also the amount of cash benefits granted. As care-dependent people may choose freely between different benefits and between respective providers – influencing de facto also the market chances of providers – the regulation is rather dominated by private actors, even though the formally responsible regulatory agency is a societal actor. The same applies to South Korea, where private actors decide about the choice of benefits, the choice of providers and access of providers to the market (see Appendix). Consequently, when looking beyond the type of formally responsible regulatory authority, Germany and South Korea are placed into types with private regulation, societal financing and private provision. In Japan, on the other hand, we see a strong position of state regulation with respect to the eligibility assessment, contribution, remuneration levels, and to some extent even concerning market access, while in Luxembourg state actors are dominant in regulating eligibility assessment, contribution, market access and, to a lesser extent, remuneration levels. Overall, Israel and Portugal (where societal providers are very strongly involved) come closest to being regulated by societal actors, with shared or single responsibility for regulating the eligibility assessment, provider and benefit choice, and provider access in Israel and eligibility assessment, payments, remuneration, and provider choice in Portugal. In the end, however, we do not see a leading role of societal actors in regulation in any country, not even with social insurance systems.

With respect to provision, cash benefits can lead to the dominance of private individual actors even in LTC systems under public responsibility (Austria, Czech Republic, Germany). However, this is not always (exclusively) the case: In Singapore and Spain, large parts of the cash transfers are being spend on hiring private for-profit actors, mostly in the form of migrant domestic care workers. As far as formal care-providers are concerned, state actors are only dominant in the northern European countries while societal and private for-profit providers prevail in the other countries, often also in combination (Israel, Japan, Luxembourg).

6. Discussion

The typology uses an actor-based approach that focuses on the three dimensions of regulation, financing and provision of LTC. As our results show, the state is the dominant actor in both, the financing and regulatory dimensions for most countries. The largest variations appear in the provision dimension, where private individual and private for-profit actors play a stronger role than in the other dimensions, particularly in systems where cash benefits have been introduced and/or social insurance systems are in place. Based on our country selection we identified eight different types that can be categorized into three clusters, a cluster with state domination in all three dimensions, a second cluster with state-domination in the regulation dimension but dominant actors in the other dimensions and a third cluster with dominant private regulation.

When comparing these results with the state of research it is important to note, that the resulting types are based on data at the introduction of each system, while the bulk of the literature refers to the current state of affairs. Nevertheless, our results confirm the *Nordic cluster* (type 1), in which the state dominates in all three dimensions, making this seem to be the most robust cluster across different classifications (Anttonen & Sip-

ilä, 1996; Colombo et al., 2011; Kraus et al., 2010; Nies et al., 2013; Pacolet et al., 1999) and – keeping in mind the different reference periods – also over time. The state has played an important role in the northern European countries since the beginnings of the LTC systems in Denmark, Finland, Norway and Sweden, and, according to the literature, has continued to be the dominant actor in almost all three dimensions until today, although there might have been some changes, particularly in the provision dimension, as the systems in these countries have been opened to service providers other than municipalities since the 1990s (Anttonen & Häikiö, 2011; Rostgaard, 2006; Szebehely & Meagher, 2013).

With respect to *financing*, we find twelve countries relying primarily on taxes (type 1 – 4) and five countries with predominantly societal financing (type 7/8, 58, 59), which more or less reflects previous findings, where countries have been clustered along the financing dimension (Joshua, 2017; Pacolet et al., 1999). Only Singapore has found a specific solution with its recently established private mandatory insurance where premiums are calculated according to actuarial principles. A private mandatory and substitutional insurance was also introduced in Germany, but only for a small part of the population and with a premium calculation containing numerous elements of redistribution (Wasem, 1995, 2000).

Regarding *service provision*, the role of cash benefits is in particular interesting. When such benefits have been introduced they were meant to stabilize informal family care and are often used for this purpose (Da Roit & Le Bihan, 2010; Leitner, 2003). Eventually, however, they have also been used to finance a 'migrant-in-the-family' care model, where care and assistance is provided by paid (semi-)informal caregivers (Kilkey, Lutz, & Palenga-Möllenbeck, 2010; Kniejska, 2016; Rothgang et al., 2021). Although this type of care is mostly provided without much regulation we subsumed it under private for-profit provisions as – different to family care – the payment is the principle motive for care-giving.

Interestingly, there are no distinct LTC systems which conform to other *pure types* (type 32, 63, 69 in Figure 2) besides the pure state type (type 1), most notably no country is classified as completely societal dominated. This finding is a little surprising, but can be explained as the *regulation* dimension in systems that are commonly subsumed under the label of 'social insurance' is rather dominated by private (Germany, Korea) or state (Israel, Luxembourg, Netherlands, Japan) actors.

Considering the *historical perspective*, the results provide some insight into the evolution of LTC systems over time. Many of the early adopters of LTC systems are heavily dominated by public (state and societal) actors: The Nordic cluster (Type 1) completely by the state and the Netherlands and Israel by state and societal actors. A dominance of private actors, mostly in the provision dimensions, only starts to emerge from the 1990s onwards. Of the youngest systems introduced after 2000, a majority makes use of private for-profit provision, as can be seen in Type 3, 13/14 and 58. The only exceptions here are Portugal and the Czech Republic. Similarly, systems with a predominance of cash benefits start to emerge in the 1990s, with Austria and Germany, later joined by the Czech Republic and Spain. However, there are still many countries which introduce new systems which are focused on formal care, so it is debatable if a clear trend can be seen from this data. Furthermore, the only two non-state regulated systems, that is Germany and South Korea, come into being only in 1994 and 2007, respectively. Thus, the finding could be interpreted to tentatively reflect trends of marketization and a move away from state provision and, to some extent, regulation of LTC (e.g. Ranci & Pavolini, 2013; Rodrigues & Nies, 2013). Interestingly, there seems to be no clear time-related trend in financing, suggesting that the

financing model might be rather driven by other factors such as within country path dependencies or transnational policy learning instead of periodical trends.

In some countries, LTC systems developed out of healthcare provision. The *comparison with healthcare systems*, therefore, is also instructive. When introduced before WW II, healthcare systems were mostly born as societalbased systems, while they have predominantly been born as statebased systems thereafter (A. Schmid, De Carvalho, Basilicata, & Rothgang, 2021). This observation could hint at a shift in the zeitgeist. Against this backdrop, it seems less surprising that they are predominantly statebased as all distinct LTC systems have been introduced in the 2nd half of the 20th century. Moreover, we can observe that societal-based healthcare systems have come under pressure in the regulation dimension with an increasing role of private regulation as well as state regulation (Rothgang, 2009a; Rothgang et al., 2010). This relates well to the above finding of no LTC system being predominantly regulated by societal actors.

In general, our classification offers several insights which go beyond existing comparative work. Firstly, as already mentioned, classifying systems at *time of introduction* – as we do in this article – differs from other LTC typologies' approaches. In the literature there are only a few classifications that explicitly consider a time dimension going beyond an analysis of presently existing LTC systems. Halásková et al. (2017) compare the developments in provision and financing of LTC in 2008 and 2013 and classify OECD countries according to these two points in time. Their approach to classify countries which reflects the evolvement of LTC systems is therefore different from our typology. Other works (e.g. Pacolet et al., 1999; Ranci & Pavolini, 2013b) describe developments in LTC regimes over time, but without comparing them systematically at one starting point, which was the approach we followed here. In future, the classification could also be extended to capture subsequent major reforms to capture (potentially) changing country classifications over time.

Secondly, regarding the rational of *case selection*, our approach differs from existing typologies as well. While some classifications employed a more inductive approach, using some countries as examples for ideal types (Bettio & Verashchagina, 2012), others have used a convenience sampling approach, which was sometimes led by data availability (e.g. Kraus et al., 2010). Furthermore, most existing classifications either concentrated on a specific region, that is Europe (e.g. Bettio & Plantenga, 2004; Kraus et al., 2010), or membership in international organizations such as the OECD (e.g. Colombo et al., 2011; Halásková et al., 2017). In contrast, our selection is based on the existence of a distinct LTC system in a country. This leads to a country selection, where social protection for LTC is not only formally established by law but also recognized as a distinct field of social policy making (see Section 2). Consequently, and in contrast to many previous LTC classifications, we relied on a strongly theory-based criterion for selecting our cases. In doing so, we capture several cases which have, to our knowledge, never – Singapore, Uruguay – or rarely – Australia, Israel, Japan, South Korea – been included in internationally comparative LTC typologies. However, as most distinct LTC systems have so far emerged in the OECD-world (important exceptions are Singapore and Uruguay) and, to a lesser extent, in Europe, we also classify many countries which have been extensively included in typologies previously, such as Sweden and Germany. Furthermore, our selection criteria also excluded some countries that were part of many previous classifications, such as France, Italy and also some countries in Eastern Europe, limiting the scope and comparability of our classification. In general, with our analytical focus on comprehensive, formally legislated LTC arrangements introduced at the national level, many countries are excluded, limiting the

analytical value of the present classification for studying countries with informal or private LTC arrangements that are not regulated by the state. Furthermore, countries are excluded in which LTC is regulated regionally and where there is no distinct overarching national legislation (yet). Thus, despite our global approach, the number of countries included in the typology is very small, which is why some of the identified types contain only one country.

Turning to further limitations of our classification, it is important to note that our method of classification does not capture the extent or *degree of conformity* of an empirical care to a theoretically constructed type (see Section 4). In some cases, the dominant actor in the respective dimension is only slightly more strongly represented than others, which makes classification into a type possible, but disregards the second most dominant actor. This phenomenon has occurred in all three dimensions for some cases. For instance, in both Israel and Japan societal actors and private for-profit actors are both strong in service provision: While societal actors have been slightly dominant close to system introduction, a few years later the balance has shifted and commercial providers have taken up a bigger share. Especially in some social LTCI countries such as the Netherlands, Israel and Japan, there is (initially) a high co-financing of social insurance budgets by the state, leading to high shares for both societal actors and the state in the financing dimension. Furthermore, in some instances like Portugal, high co-payments result in a large, albeit not dominant share of private individual actors. Finally, the regulation dimension also shows a mixed picture for some countries, for example in the Czech Republic were private actors are almost as strong in the regulation index as the state. While this information is available from the raw data employed, it remains invisible in the classification result.

A similar problem occurs with the definition of domestic care-givers living together with the care receiver in a household. We defined them as private for-profit actors, even though they could also be operationalized as informal (private individual actors) due to their relationship to the care receiver and also to the conditions of work. Furthermore, the typology also does not distinguish between responsibilities of the central state, the regional or the municipal level, as they are all defined as a state actor. For some countries, where different state levels are strongly involved (e.g. Australia, Denmark, Spain, Sweden), the classification might thus obscure important actor responsibilities within the 'state' actor (cf. Fischer et al., 2021).

The *data* collection process also imposes some limitations on our findings, as most of the data were collected from legal sources and secondary literature, which take very different forms for most countries and cannot easily be compared (see Section 4). Thus, the determination of a dominant actor depends to some extent on our own interpretations, which is particularly challenging in country cases where little information is available or the original laws are not accessible.

Finally, the examined systems vary a lot in regarding the *time point* of their introduction. The earliest systems date from the 1960s and 1970s, while others were introduced more recently, and some only in the last years. Thus, it is important to keep in mind that the introduction of systems of the same type may nevertheless have happened at a completely different historical period and thus meaning different thinks. Moreover, countries falling in the same cell might at any chronological time be quite different.

7. Conclusion

In the present study, we have applied a multi-dimensional, actor-centered typology to classify empirical instances of distinct LTC systems at the point of their respective introductions. Overall, the 18 countries have

fallen into eight types, from which we have tentatively identified three main clusters: A pure state dominated cluster, a state regulated and financed cluster, and a privately regulated cluster. This shows that the state plays a large role in LTC systems in a diverse set of countries and that pure type societal-based systems do not – in contrast to health care systems – seem to exist in the field of LTC. Furthermore, we have found that a dominance of private regulation can be possible even in LTC systems under public responsibility.

While carrying several limitations, for instance regarding the method of classification and the comparability of time points, our study offers a rigorous and transparent classification for comparing complex LTC arrangements. In doing so, our approach extents the wellknown country sample (to some extent) by including also countries with newly established LTC systems such as Singapore and Uruguay, and by employing a historical focus on system introduction points. In this way, we hope to add a novel perspective to the existing scholarship on LTC system typologies.

Our classification results open up several avenues of research for further exploring the variance of LTC system types. One question that arises pertains to why these types of systems have been introduced and why and how they have changed subsequently. The second part of the question is of particular relevance for understanding the 'early birds' of distinct LTC schemes, that is the Netherlands, the Scandinavian countries, and Israel. Here, it would be interesting to see to what extent new public management and neoliberal ideas have subsequently shaped the systems introduced in the 1960s-1980s and if reforms have resulted in a change of system type. Furthermore, the classification so far focuses solely on responsible actors while leaving other important characteristics of LTC systems aside. Therefore, another avenue of research would be to investigate if there is a systematic correlation between actor-centered types and system generosity and/or inclusiveness. Are specific types connected to high levels of population coverage or high levels of benefits, for instance? And, asking the other way around, how do system types influence dynamics/levels of generosity and inclusiveness of LTC? We hope to turn more to these questions in further research endeavors.

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Appendix

Australia

Indicator	Description	Source	Confidence
SYSTEM INTRODUCTION AND OVERVIEW			
Name law (English)	Aged Care Act	Aged Care Act (ACA)	High
Name law (original)	Aged Care Act	ACA	High
Adoption date	07.07.1997	ACA	High
De jure implementation date	01.10.1997	ACA	High
Brief summary	The Aged Care Act serves as a comprehensive legal framework for the regulation and funding of federal level LTC services in Australia, both in residential facilities and in home and community care settings. The Act specifies mainly the provider approvals and certifications, the allocation of care places, care recipient assessment and classification and the state subsidies and grants for aged care. The state finances large parts of the system and care recipient need to contribute with – partly meanstested – co-payments.	ACA; Gray, Cullen, & Lomas, 2014; OECD, 2011; Australian Government - Department of Health, 2020; Australian Government Productivity Commission, 2008	
Justification introduction point	The Aged Care Act is the main federal law on long-term care, defining both regulation and funding of aged care in detail. The act is a comprehensive regulatory instrument focusing solely on LTC for the elderly. It can be seen as a major reform unifying especially the residential care sector and also setting standards for community care under federal responsibility (community care packages).	Australian Government - Department of Health, 2020; Aged Care Act; Expert Survey K. Eagar; OECD, 2005; Australian Government Productivity Commission, 2008	High
SERVICE PROVISION DIMENSION			
Dominant actor provision	Societal actors	OECD, 2005	High
Data basis	The Australian LTC system includes both formal residential and several different programs on home/community care services. According to OECD (2005) statistics, in 2000, there are more than 2.5 times more care recipients receiving home care benefits than in institutions (albeit at very low care intensity, often). In both residential and home/community care, not-for profit agencies are the dominant provider form, even more so in the later, followed by private for profit and, lastly, direct state provision.		
FINANCING DIMENSION			
Dominant actor financing	State	OECD, 2020; A. Howe & Sarjeant, 1999; Woodward, 2004; OECD, 2011	High
Data basis	The major part of LTC is financed by the state, with a mix of federal government budget (strong in residential care) and state/territory budget (stronger in community care). According to OECD health statistics, in 2000 90% of total LTC expenditure were covered by government schemes. Additionally, there are user co-payments in the form of out-of-pocket expenditure.		

REGULATION DIMENSION			
Dominant actor regulation	State		
Dominant scheme for classification (if applicable)	Schemes under the Aged Care Act (ACA) The Aged Care Act covers both residential and community/home care, but in the community care sector there are also different parallel programs, especially the Home and Community Care Program (HACC) managed mainly by the states and territories with only some involvement by the federal state. As the HACC is regulated differently and also variably between state, the classification of the regulatory dimensions focuses on residential and packaged community care covered under the ACA.	OECD, 2005; Australian Government Productivity Commission, 2008; Gray et al., 2014	
Entitlement & eligibility criteria	Eligibility criteria for different types of care are outlined in Aged Care Act	ACC	Medium
Dominant actor criteria	State		
Eligibility assessment	Eligibility assessment is conducted by regional assessment teams called 'Aged Care Assessment Teams' (ACATs) in a standardized form. The ACATs are funded by the government and consist of health professionals. They are thus appointed and resourced by the state, but there might be some private for-profit actors (e.g. doctors) involved as the outpatient healthcare sector is dominated by private actors (Böhm, Schmid, Götze, Landwehr, & Rothgang, 2012)	OECD, 2011; Fine & Chalmers, 2000; A. L. Howe, 2000; Healy, 2002; OECD, 2005; Australian Government Productivity Commission, 2008	Medium
Dominant actor assessment	State & private actors		
Payment/contribution	The government regulates the amount of co-payments/user fees.	Healy, 2002; OECD, 2005; Australian Government Productivity Commission, 2008	High
Dominant actor payment	State		
Provider access	The state strongly regulates providers access to the public LTC system, as there are not only general accreditations but there is a strict quota for beds/places. The government allocates care places through competitive tendering.	Brennan et al., 2012; OECD, 2011; Healy, 2002; Australian Government Productivity Commission, 2008; Gray et al., 2014	High
Dominant actor access	State		
Remuneration providers	Prices are regulated by the state, both the amount of government subsidies as well as user co-payments.	Fine & Chalmers, 2000; Healy, 2002; Australian Government Productivity Commission, 2008; Gray et al., 2014	Medium
Dominant actor remuneration	State		
Provider choice	There is no indication that there is no choice of (approved and accredited) providers. However, due to the limited no of places, choice might in practice be limited.	Brennan et al., 2012; Fine & Chalmers, 2000; Grove, 2016	Medium
Dominant actor provider	Private actors		High
Benefit choice	There are no cash benefits or personal budgets in the ACA framework. During the eligibility assessment, the ACAT decides if the recipient shall receive residential or community care, acting as gatekeepers.	ACA; Healy, 2002; Brennan et al., 2012; Fine & Chalmers, 2000; A. L. Howe, 2000; OECD, 2005	Medium
Dominant actor benefit	State & private actors	Aged Care Act (ACA)	High

Main regulation agency	The main regulator of the residential care and packaged community care under the ACA is the central state. There are also some competencies for the states/territories, but mainly in the separate home and community care program.	Gray et al., 2014; Fine & Chalmers, 2000; Australian Government Productivity Commission, 2008	High
Dominant actor agency	State		

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Austria

Indicator	Description	Source	Confidence
SYSTEM INTRODUCTION AND OVERVIEW			
Name law (English)	1) Federal Long-term Care Allowance Act 2) 15a B-VG Agreement between the Federal State and the Provinces for People in Need of Care	BPGG Nr. 110/1993 BGBl. Nr. 866/1993	High
Name law (original)	1) Bundespflegegeldgesetz 2) Vereinbarung gemäß Art. 15 B-VG über die gemeinsamen Maßnahmen des Bundes und der Länder für pflegebedürftige Personen	BPGG Nr. 110/1993 BGBl. Nr. 866/1993	High
Adoption date	1) 1993.01.19 2) 1993.05.06	BPGG Nr. 110/1993 Art. 15 a B-VG	High
De jure implementation date	1) 1993.07.01 2) 1994.01.01	BPGG Nr. 110/1993 BGBl. Nr. 866/1993	High
Brief summary	The long-term care allowance (Pflegegeld) is defined as a contribution to care-related expenses, in order to ensure the necessary care and help and to improve the opportunities for autonomy and needs orientation. Service provision is regulated in the Art. 15a Agreement, where the Provinces (Länder) are made responsible in developing a sufficient level of social services until 2010.	BPGG Nr. 110/1993; BGBl. Nr. 866/1993	
Justification introduction point	The law recognizes LTC as an own risk and it unifies existing regulations in the provinces, as some of them already introduced cash benefits for care dependent people. Furthermore, it replaces the old "Hilflosenzuschuss" in the pension and accident insurances and regulates the responsibilities for social services with the Art 15a Agreement.	Badelt & Österle, 1997; Keigher, 1997; Mager & Manegold, 1999; Österle, 2013	
SERVICE PROVISION DIMENSION			
Dominant actor provision	Private individual actors		
Data basis	The BPGG introduces a tax-financed cash benefit, giving beneficiaries the choice how to use the money. The cash benefits are not means tested, but are based on a person's needs (7 levels of LTC dependency). The Art. 15a Agreement makes the 9 provinces responsible to develop an adequate level of social services until 2010. Shares benefit types 1997: (public expenditure) Federal LTC allowance (Bundespflegegeld): 55.1% Provinces LTC allowance (Landespflegegeld): 11.2% Provinces home care services: 5.6% Provinces partial institutional services: 1.2% Provinces institutional services: 26.9%	BPGG Nr. 110/1993; BGBl. Nr. 866/1993; Mühlberger, Knittler, Guger, & Schratzenstaller, 2010; Badelt & Österle, 1997; Hammer & Österle, 2001; Schneider, Österle, & Schober, 2006; Riedel & Kraus, 2010; Österle, 2013; Ganner, 2017	High

	Informal care by family members is according to Badelt & Österle the dominant type of service provision. This implies that cash benefits are used as a contribution for informal care expenses. Informal care provision by private for-profit actors (e.g. live-ins) were at the time just emerging, and even in 2017 they are used by 5% of the LTC allowance receivers. This leads to a dominance of LTC provision by private individual actors within the formal care system.		
FINANCING DIMENSION			
Dominant actor financing	State		
Data basis	According to OECD health statistics, financing shares of total LTC spending in Austria in 1997 were distributed as follows: 1997: all financing schemes: 9.0 % of total GDP Government schemes: 6.8% of total GDP Voluntary payment schemes: NA Household out-of-pocket expenditure: NA According to OECD health statistics, in 1997 75,5% of total LTC ex-penditure were covered by government schemes. As the monetary benefits are financed by taxes, the dominant actor is the state.	OECD, 2020	High
REGULATION DIMENSION			
Dominant actor regulation	State & private actors		
Dominant scheme for classification (if applicable)	Bundespflegegeldgesetz & Federal Agreement (complete system)		
Entitlement & eligibility criteria	State: Entitlement and eligibility are defined in the law.	BPGG Nr. 110/1993	High
Dominant actor criteria	State		
Eligibility assessment	Eligibility is determined by a medical expert opinion, other professionals such as nurse care professionals can be included in the assessment.	Keigher, 1997; Badelt & Österle, 1997; Mager & Manegold, 1999	Medium
Dominant actor assessment	Private actors		
Payment/contribution	Cash benefits are defined in the law and are based on the degree of need for care. The cash benefits generally serve as a contribution to individual expenses related to care services, regardless of whether they are used for informal care or for purchased professional care services. Recipients who are cared for in institutions do not receive the money themselves, but it is paid directly to the home provider.	BPGG Nr. 110/1993; Ba-delt & Österle, 1997; Hammer & Österle 2001; Da Roit, Le Bihan, & Ös-terle, 2007	High
Dominant actor payment	State		
Provider access	There are no regulations on how the cash benefits are used by the beneficiaries, control mechanisms are not specified in the law. For service provision the provinces are responsible to regulate access and quality of services according to the Art 15a agreement, the binding force of this agreement however, is rather limited as there are no sanctions attached.	BPGG Nr. 110/1993; BGBl. Nr. 866/1993; European Commission, 2018; Mager & Manegold, 1999; Hörl, 1993; Leichsenring, 2009	High
Dominant actor access	Private actors		

Remuneration providers	In Austria, there is no specific distinction between accreditation and licensing, as most nursing homes are traditionally run by public or quasi-public providers. However, private for-profit or non-profit providers may choose not to apply for public funding, i.e. their residents would have to cover all costs from their own funds. Nevertheless, these nursing homes must also comply with the general legal guidelines. All other nursing homes are co-financed by the public sector - in most provinces on the basis of generally defined "daily nursing rates", in some provinces the providers can negotiate these daily rates individually.	BPGG Nr. 110/1993; BGBl. Nr. 866/1993; Leichsenring, 2009	Medium
Dominant actor remuneration	State		
Provider choice	The provinces are responsible for setting an appropriate level of service provision. In the Art. 15 a Agreement there is a "catalogue of services" which specifies the different services that the provinces should provide as a minimum, but the law takes regional differences into account. The recipients in general can choose freely between the different providers, but the level of available services differs in the provinces.	BGBl. Nr. 866/1993; Keigher, 1997; Leichsenring, 2009	High
Dominant actor provider	Private individual actors		
Benefit choice	In the Austrian LTC system there only exist cash allowances, the care recipients cannot decide whether they want benefits in-kind or cash benefits. However, they are free to choose which kind of services they buy, as the overall aim of the introduction of the cash benefit was to achieve consumer choice.	Riedel & Kraus, 2010; Österle & Hammer, 2004	High
Dominant actor benefit	State		
Main regulation agency	The main regulation agency is the state (Federal state and provinces), who is responsible in regulating the monetary benefits. According to the law several institutions were in charge of decisions (depending on the social insurance status of the applicant), in particular social pension insurance funds (for those receiving a public pension), accident insurance funds (for those receiving another benefit from this fund) or an institution for public employees. In addition, the Länder (according to the respective Länder laws) were in charge of longterm care allowances for certain groups of applicants (e.g. disabled younger people or public employees on the Länder level). For services the Länder are the main responsible actor, but the law gives them freedom in regulating service provision.	BGBl. Nr. 866/1993; Mager & Manegold, 1999; Österle & Hammer, 2004	High
Dominant actor agency	State		

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Czech Republic

Indicator	Description	Source	Confidence
SYSTEM INTRODUCTION AND OVERVIEW			
Name law (English)	Act No. 108/2006 Coll. Social Services Act	Act 108/2006 Coll.	High
Name law (original)	ZÁKON ze dne 14. března 2006 o sociálních službách	Act 108/2006 Coll.	High
Adoption date	14.03.2006	Act 108/2006 Coll.	Highv
De jure implementation date	01.01.2007	Act 108/2006 Coll.	High
Brief summary	The Act No. 108/2006 Coll. regulates provision of home care, access to cash benefits for individuals with limitations in activities of daily living (ADL) and different types of residential care, including care for seniors.	Sowa, 2010	
Justification introduction point	The provision of social services was previously regulated by the law of 1988. The new legal regulations anchored in law the services that had been in practice since 2001. It also offers a wider choice for care recipients as they can combine home care and institutional care services with the introduction of the cash allowance.	Sowa, 2010	
SERVICE PROVISION DIMENSION			
Dominant actor provision	Private individual actors		
Data basis	There are three different benefit types regulated in the law, home care, institutional care and cash benefits. The public expenditure on cash benefits is the highest, also the share of people aged 65 years and over receiving home care is much higher than institutional care. That could indicate that the majority of people are cared informally by family members and use the cash allowance to supplement their pensions. Public expenditure in 2010 total: 0.81 % of total GDP Shares of benefit types: home care: 7.4% institutions: 28.4% cash benefits: 65.4 (Horák, Horáková, & Sirovátka, 2013, p.11) Population aged 65 years and over receiving long-term care in 2009: Institutions: 16.8% Home: 83.2% Total: 13.1% of total population (Horák, Horáková, & Sirovátka, 2013, p. 13) Providers of social services in 2008: Municipality: 40% Private: 3% NGO: 38% Reg. authority: 19% (Sowa, 2010, p. 9)	Horák, Horáková, & Sirovátka, 2013; Sowa, 2010; Formánková, 2013	High

FINANCING DIMENSION			
Dominant actor financing	State	OECD, 2020	High
Data basis	Social services are financed by general taxes, regional budgets and indi-vidual contributions. Institutions are also funded by the state (municipalities). According to OECD health statistics, financing shares of total LTC spending in Czech Republic were distrib-uted as follows: Government schemes: 84% Voluntary payment schemes: 1% Household out-of-pocket expenditure: 16%		
REGULATION DIMENSION			
Dominant actor regulation	State & private actors		
Dominant scheme for classi-fication (if applicable)	NA		
Entitlement & eligibility criteria	State: Entitlement and eligibility are defined in the law.	Act 108/2006 Col.; Sowa, 2010	High
Dominant actor criteria	State		
Eligibility assessment	The eligibility assessment is conducted by medical professionals or social workers, therefore the domi-nant actors are private for-profit actors. For medical services the eligibility is supervised by a medical doctor and eligibility is based in the health insurance. Social services in institutional settings (daily and weekly care centers) and in home care are assessed by a social worker. The eligibility for cash benefits is defined by the law based on the concept of ADL and is conducted by a medical doctor.	Act 108/2006 Col.; Barták & Gavurová, 2014; Sowa, 2010	Medium
Dominant actor assessment	Private actors		
Payment/contribution	Cash benefits are defined in the law and are based on the degree of need for care. For service provision it depends on the provided service whether a recip-ient has to pay the full price, a contribution or if the service is without cost considerations, the different services are defined in the law.	Act 108/2006 Col.	High
Dominant actor payment	State		
Provider access	The dominant actor is the state. Social services can be provided only on the basis of an authorization for social services provision, as they have to be registered at the Ministry. Residential care is also controlled by the health insur-ance together with the state, but in general the state is the main actor in controlling provision of LTC. Informal care providers need a written confirmation by the municipality, where the dependency degree of the cared person and the duration of the care is stated, but according to the Social Service Act they do not need to register.	Act 108/2006 Coll.; Sowa, 2010; Horák, Horáková, & Sirovátka, 2013	High
Dominant actor access	State		
Remuneration providers	For monetary benefits the amount for each level is defined by the law. Social Services receive a state subsidy for service pro-vision, when they are registered at the Ministry.	Act 108/2006 Col.; Formánková, 2013	High
Dominant actor remuner-ation	State		

Provider choice	Care recipients receiving cash benefits are free to de-cide for which providers they use the money. The state (municipalities, regions) is responsi-ble for providing information on available services	Act 108/2006 Col.	High
Dominant actor provider	Private actors		
Benefit choice	The recipients are free to choose which benefits they chose, and it is possible to combine institutional and home-based care.	Horák, Horáková, & Siro-vátka, 2013; Sowa, 2010	High
Dominant actor benefit	Private actors		
Main regulation agency	Residential and social care services are regulated by different ministries, the medical care services are regulated by the Ministry of Health and by the health insurance, and social care services are regulated by the Ministry of Labor and Social Affairs. The main regulating actor is therefore the state.	Sowa, 2010; Horák, Horá-ková, & Sirovátka, 2013	High
Dominant actor agency	State		

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Denmark

Indicator	Description	Source	Confidence
SYSTEM INTRODUCTION AND OVERVIEW			
Name law (English)	Social Assistance Act	Edvartsen, 1999; Levinter, 1997; Shenk & Christiansen, 1993	High
Name law (original)	Bistandsloven/Lov om social bistand	Bistandsloven	High
Adoption date	19.06.1974	Rauch, 2008	High
De jure implementation date	01.04.1976	Levinter, 1997	High
Brief summary	The new Social Assistance Act made the local and regional municipalities responsible for both administration and provision of almost all social services. It merged prior legislation on home help for the elderly and the individual was able to apply to one single government office.	Henriksen & Bundensen, 2004; Shenk & Christiansen, 1993	
Justification introduction point	The law merged prior legislations on home help for the elderly and the so-called "housewife act", where help was provided to care dependent people.	Edvartsen, 1999; Levinter, 1997; Henriksen & Bun-densen, 2004; Shenk & Christiansen, 1993	
SERVICE PROVISION DIMENSION			
Dominant actor provision	State		
Data basis	In Denmark, municipalities were explicitly made responsible for care provision. The Social Welfare Act also gave priority to home care over institu-tional care, which was emphasized even more in later reforms. Home help was provided exclusively by the municipalities, in residential care also societal actors were present, but to a small degree.	Horák, Horáková, & Siro-vátka, 2013; Sowa, 2010; Formánková, 2013	High
FINANCING DIMENSION			
Dominant actor financing	State	OECD, 2020	High
Data basis	LTC in Denmark is financed by taxes (municipal and central state). Accordingly, the state is the dominant financing actor. According to OECD health statistics, financing shares of total LTC spending in Denmark in 1979 were distributed as follows: Government: 87% Voluntary: 1% Household: 12%		
REGULATION DIMENSION			
Dominant actor regulation	State		
Dominant scheme for classification (if applicable)	NA		
Entitlement & eligibility criteria	The Municipality decides on the individual needs of a person, there is no national eligibility criteria (e.g. different levels of dependency).	Colmorten et al., 2003; Rauch, 2008	High
Dominant actor criteria	State		
Eligibility assessment	A nurse, home-helper or home-help manager from the municipality conducts the eligibility assessment.	Colmorten et al., 2003	High
Dominant actor assessment	State		
Payment/contribution	As the provision of services is entirely by the state, the decision on possible payments also lies with the state, however service provision is free of charge.	Colmorten et al., 2003; Vrangbaek & Christiansen, 2005	Low
Dominant actor payment	State		

Provider access	The municipalities decide on providers access to the public system, as they provide almost all the services for the care dependent elderly.	Raffel & Raffel, 1987	Medium
Dominant actor access	State		
Remuneration providers	The state decides the remuneration levels for providers, as hospital and medical care are owned and administered by the counties. Home nursing is free to all recipients.	Raffel & Raffel, 1987	Medium
Dominant actor remuneration	State		
Provider choice	The provision of services is exclusively by the state (municipality), therefore there is no choice of providers. The debate on the introduction of consumer choice started in the 80ies and led to a reform in 2002.	Schulz, 2010	Medium
Dominant actor provider	State		
Benefit choice	Prioritization of home care, as it is more cost efficient than institutional care	Shenk & Christiansen, 1993; Schulz, 2010	High
Dominant actor benefit	State		
Main regulation agency	State: hospitals are run by the counties, but nursing homes and service provision (home care) are regulated by the municipalities.	Raffel & Raffel, 1987; Shenk & Christiansen, 1993	High
Dominant actor agency	State		

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Finland

Indicator	Description	Source	Confidence
SYSTEM INTRODUCTION AND OVERVIEW			
Name law (English)	Social Welfare Act (SWA)	SWA 710/1982	High
Name law (original)	Sosiaalihuoltolaki	Karsio & Anttonen	High
Adoption date	17.09.1982	SWA 710/1982	High
De jure implementation date	01.01.1984	SWA 710/1982	High
Brief summary	The Social Welfare Act obliged municipalities to provide services according to need and it introduced a monetary benefit to support informal carers.	Anttonen & Häikiö, 2011	
Justification introduction point	The SWA repealed former Acts on Social Administration and Public Welfare, as it replaced social assistance by income support. So Finland had a system of social services planned and directed by the state and implemented by the municipalities, which included social work, home help services, housing services, institutional care and support for informal care. These welfare services had a universal approach as they covered the whole society and all regions.	Karsio & Anttonen, 2013; Niemelä, Salminen, & Taylor, 2006; Salonen & Haverinen, 2003	
SERVICE PROVISION DIMENSION			
Dominant actor provision	State		
Data basis	1990 (Coverage of publicly-funded services supporting care at home among clients aged 65 and over, as % of total population of same age) Home Help Services: 18.7% Support Services: 15.3% Informal Care Allowance: 2.0% (Karsio & Anttonen, 2013, 90) 1997: (Client fees in municipal social and health services) - Institutional care: 19.8% of expenditure (-> 46.7% of all benefit types) - Home care: 13.7% of expenditure (-> 32.3% of all benefit types) - All other services: 8.9% of expenditure (-> 21% of all benefit types) (Karsio & Anttonen, 2013, 104) Shares of personnel 1990: The share of personnel working in public, non-profit and for-profit social services in Finland: - Public: 87.9% - Private (non-profit and for-profit): 12.1% - Non-profit: 11.6% - For-profit: 0.5% (Karsio & Anttonen, 2013, p.107) In 1990 the home-care allowance was not used to a great extent, in home help people mainly used the services provided by the municipality. In general, the public sector is the dominant actor in providing services.	Karsio & Anttonen, 2013	High
FINANCING DIMENSION			
Dominant actor financing	State	OECD, 2020	High
Data basis	According to OECD health statistics, financing shares of total LTC spending in Finland in 1987 were distributed as follows: Government: 78% Voluntary: 3% Household: 17% The LTC system is mainly financed by local taxes, supplemented by central government transfers and fees.		

REGULATION DIMENSION			
Dominant actor regulation	State		
Dominant scheme for classification (if applicable)	NA		
Entitlement & eligibility criteria	There is no national definition of care dependency and the assessment of need is decided by the local level (municipalities).	Johansson, 2010	High
Dominant actor criteria	State		
Eligibility assessment	The social services department in the municipality conducts the eligibility assessment.	Johansson, 2010; Anttonen & Karsio, 2016	High
Dominant actor assessment	State		
Payment/contribution	For the care allowance the Social Welfare Act defines how much an informal carer is entitled to and the local authority and the carer make a commission agreement on the provision of informal care. So the state is the dominant actor in deciding if and how much a carer receives.	Karsio & Anttonen, 2013; Johansson, 2010	High
Dominant actor payment	State		
Provider access	The regional evaluation of basic services is the task of the State Provincial Office, with the aim to establish accessibility and quality of these services. The central state (Ministry of Social Affairs and Health) regulated outsourcing of service provision until 1992, as state subsidies were ear-marked.	Johansson, 2010; Karsio and Anttonen, 2013	High
Dominant actor access	State		
Remuneration providers	The law governs the user fees, which depend on the ability of the recipient.	Johansson, 2010	High
Dominant actor remuneration	State		
Provider choice	Regarding the recipients, ideas of choice, market principles have been introduced much later in the 90ies. So it can be assumed that the municipality decided which providers recipients can choose.	Anttonen & Häikiö, 2011	Medium
Dominant actor provider	State		
Benefit choice	The municipality decides whether the elderly is to receive home care or institutional care, however home care is favored.	Johansson, 2010; Anttonen & Karsio, 2016	High
Dominant actor benefit	State		
Main regulation agency	The municipality is the main regulating actor in deciding on services, such as home care and institutional care. The provincial office and the Ministry of Social Affairs and Health regulated providers access and evaluation of services.	Anttonen & Karsio, 2016; Johansson, 2010; Salonen & Haverinen, 2003	High
Dominant actor agency	State		

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Germany

Indicator	Description	Source	Confidence
SYSTEM INTRODUCTION AND OVERVIEW			
Name law (English)	Long-Term Care Insurance Act	PflegeVG (own transla-tion)	High
Name law (original)	Gesetz zur sozialen Absicherung des Risikos der Pflegebedürftigkeit (Pflege-Versicherungsgesetz – PflegeVG)	PflegeVG	High
Adoption date	26.05.1994	PflegeVG	High
De jure implementation date	01.01.1995	PflegeVG	High
Brief summary	The LTCI law introduces a novel branch of social insurance, the Social Long-Term Care Insurance - plus the mandatory private LTCI for - social protection against the risk of care dependency. Together both schemes cover almost the whole population. The LTCI offers capped benefits for in-kind (home & community care, residential care) and monetary benefits to care dependent persons of all ages.	PflegeVG § 1; Rothgang, 2010	
Justification introduction point	The LTCI law establishes a new chapter/book of the German social security code specifically on social protection for LTC (Sozialgesetzbuch, Buch XI). Before the introduction of the law, benefits for care dependent people were only covered by means-tested social assistance and no distinct LTC scheme existed.	Götting, Haug et al., 1994; Evers 1998; Mager, 1999; Rothgang, 2010; Theobald, 2013	
SERVICE PROVISION DIMENSION			
Dominant actor provision	Private individual actors		
Data basis	The LTCI law provides for different types of LTC services which are specified in § 36-43 PflegeVG. Care recipients can receive in-kind services - both in the form of home and community care or residen-tial/stationary care - as well as monetary benefits (or a combination of services and benefits). Monetary benefits make up the highest share of all benefits. In 1998, shares for the different kinds of benefits within the social LTCI were distributed as follows (BMG 2019): Monetary benefits: 53.6% In-kind home care: 7.5% Combination monetary & in-kind home care: 9.6% (attributed to in-kind for calculation below) Stationary care: 28.4% Other (respite care etc.): 0.9% The shares of actor types in residential facilities were the following in the mid-1990s (Mager 1999): 66.6% non-profit 17.3% state 16.1% private for-profit	PflegeVG; Rothgang, 2010; BMG, 2019; Mager 1999; Theobald 2004, 2012; Benazha 2021	High

	The shares of home care providers were the following in 2001 (Theobald 2004): 52% private for-profit 46% non-profit 2% state Recipients of cash benefits overwhelmingly relied on family care, i.e. by private individual actors. Domestic care workers also play a small role in providing care for recipients at home, but data for the 2000s suggests that they made up (at most) 5% (Theobald 2012) of the provider mix of cash benefit recipients at system introduction. Based on this data, overall actor shares weighted by benefit shares are the following State: 5% Societal actors: 27% Private for-profit actors: 16% Private individual actors: 51%		
FINANCING DIMENSION			
Dominant actor financing	Societal actors	OECD, 2020	High
Data basis	According to OECD health statistics, financing shares of total LTC spending in Germany in 1998 were distributed as follows: Government schemes: 13.8% 61% compulsory insurance schemes (i.e. social insurance schemes, data for compulsory private insurance missing): 61% Voluntary payment schemes: 5.9% Household out-of-pocket expenditure: 19.3% Accordingly, social insurance is the dominant financing scheme.		
REGULATION DIMENSION			
Dominant actor regulation	Private actors		
Dominant scheme for classification (if applicable)	Social LTCI scheme The social LTC insurance is the dominant LTC scheme, with approx. 90% of the population being members of the scheme.	Rothgang, 2009	
Entitlement & eligibility criteria	Entitlement and eligibility criteria are defined in the LTCI law.	PflegeVG	High
Dominant actor criteria	State		
Eligibility assessment	The Medical Review Board (Medizinischer Dienst der Krankenversicherung) of the sickness/LTC funds conduct the assessment of care dependency.	§18 PflegeVG; Rothgang, 2010; Mager, 1999	High
Dominant actor assessment	Societal actors		
Payment/contribution	The pay-roll contribution rates for employers/ employees are set by law.	§55 PflegeVG	High
Dominant actor payment	State		

Provider access	There are no specific regulation/criteria for homecare and residential care providers to fulfil to access the public LTC system, except general licencing for fulfilling formal minimum standards (regarding staff qualifica-tions). Any provider who meets these standards can offer benefits and re-ceive remuneration within the public LTC system. There is no regulation for the use of the cash benefit, it can be employed (or not) to remu-nerate any care provider without access control (family member, domestic care worker, etc.).	Rothgang, 2010; Evers, 1998	High
Dominant actor access	Private actors		
Remuneration providers	The level of monetary benefits is set by law (PflegeVG § 37), i.e. by the state. Fees for in-kind services vary within Germany. They are negotiated between LTC funds (or their associations) and care providers (or their associa-tions), i.e. by societal actors.	Rothgang, 2010; Rhee, Done et al., 2015; Mager, 1999; PflegeVG	High
Dominant actor remuner-ation	State & Societal actors		
Provider choice	There is price-based competition within the public LTC system, implying that care recipients can choose providers themselves.	Götze and Rothgang, 2014; Rothgang, 2009	High
Dominant actor provider	Private actors		
Benefit choice	Care recipients can choose which kind of benefits, i.e. in-kind home care, monetary benefits or a combination, they prefer. The LTCI law stipulates a priority for home-based care over residential care, but access to residen-tial care is not specifically controlled by public actors and can normally also be chosen by care recipients.	Rothgang, 2010; PflegeVG; Mager, 1999	High
Dominant actor benefit	Private actors		
Main regulation agency	The LTC funds (independent but coupled with sickness funds) are the main administrative/ management bodies of the social LTCI scheme. Furthermore, there are some responsibilities for state agencies, e.g. infrastructure planning and co-funding by federal states.	Rothgang, 2010; Evers, 1998; Rhee et al., 2015; PflegeVG §8-12	High
Dominant actor agency	Societal actors		

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Israel

Indicator	Description	Source	Confidence
SYSTEM INTRODUCTION AND OVERVIEW			
Name law (English)	National Insurance Law (Amendment No. 61) / Long-Term Care Insurance Law (LTCI law; informal title)	Expert Survey H. Schmid; Morginstin, Baich-Moray, & Zipkin, 1993; Schmid, 2005; Ajzenstadt & Rosenhek, 2000	High
Name law (original)	חוק הביטוח הלאמי (תיקון מס' 61), התשמ"ו 1986	LTCI law	Medium
Adoption date	04.1986	Brodsky & Naon, 1993; Schmid, 2009); Morginstin, 1987; LTCI law	High
De jure implementation date	04.1988	Brodsky & Naon, 1993; Schmid, 2009; Morginstin, 1987	High
Brief summary	The LTCI law introduced a social LTC insurance scheme under the administration of the National Insurance Institute. The scheme covers older care dependent persons who reside in their own home, offering (mainly) in-kind LTC benefits for home and community care. Eligibility depends on age, dependency and income. Contributions for financing the LTCI are paid by employees and employers (including a state subsidy).	Morginstin, 1987; Brodsky & Naon, 1993; Borowski & Schmid, 2001; Cox, 2001	
Justification introduction point	The LTCI law relies on social security principles and provides a statutory obligation for the state to provide LTC benefits. It clearly defines entitle-ment and eligibility criteria for receiving benefits. By creating a distinct LTCI, LTC is addressed as a separate social security field. This approach can be seen as an important shift from the discretionary approach to LTC provision before the introduction (and for other still parallel schemes).	Morginstin, 1987; Brodsky & Naon, 1993; Schmid, 2005	
SERVICE PROVISION DIMENSION			
Dominant actor provision	Societal actors	Brodsky & Naon, 1993; Ajzenstadt & Rosenhek, 2000; Borowski & Schmid, 2001; Schmid, 2005; Morginstin et al., 1993; Brodsky & Naon, 1993; Weihl, 1998	High
Data basis	Disclaimer: Actor assessment regarding provision under the LTCI scheme only (due to data unavailability) Under the LTCI, in-kind services for home and community care are the main benefit (cash benefits are only granted in exceptional circumstances). Care is provided by societal and private for-profit actors only (not by state agencies). At implementation in 1988, 82 % of home care were delivered by non-profit organisations (mostly voluntary non-profit organisations) and 18% by for-profit organisations (Schmid, 2005). At the beginning of the 1990s, the share of non- and for-profit organisations was approximately equal and later in the 2000s for-profit organisations became dominant. Therefore, at introduction societal actors still dominated. [Regarding public programmes outside the LTCI scheme, there is no information on the extent of LTC services offered on the local level by the welfare bureaus for the whole country (Weihl, 1998). The ownership structure of residential care in Israel (for persons receiving LTC benefit or not) was mixed between state, voluntary and for-profit organisations, with the latter dominating slightly (Weihl, 1998).]		

FINANCING DIMENSION			
Dominant actor financing	Societal actors	Expert Survey H. Schmid; Asiskovitch, 2013; Schmid, 2005; Borowski & Schmid, 2001	Medium
Data basis	Disclaimer: Actor assessment regarding financing under the LTCI scheme only (due to data unavailability) The LTCI scheme is financed by wage contributions of in total 0.2 %, initially (until 1990), split between employees (0.1%) and employers (0.1%). From April 1990, the employer contribution was reduced to 0.04% with the state taking over funding of the remaining 0.06% (Schmid, 2005). For 1994, (Asiskovitch, 2013) reports the following financing shares of the LTCI: Insurance fees for LTCI: 27.8% Ministry of financing contributions: 15.3% Share of NII in financing LTCI (transfers to the LTCI of surpluses from other branches of the NII, mainly from the children branch): 57% Consequently, contributions and co-financing from other National Insurance Institute managed programmes makes up the major financing share.		
REGULATION DIMENSION			
Dominant actor regulation	State		
Dominant scheme for classification (if applicable)	Long-term care insurance scheme We classify the LTCI scheme introduced in 1986/88 as a distinct LTC system. There are also other LTC programs in Israel, most notably for residential care managed on the local level with more responsibility by the state.	Brodsky & Naon, 1993; Weihl, 1998	
Entitlement & eligibility criteria	Entitlement and eligibility criteria are defined by the state by law.	Borowski & Schmid, 2001; Iecovich, 2012	High
Dominant actor criteria	State		
Eligibility assessment	Eligibility for LTCI benefits is assessed by both the National Insurance Institute (NII, societal actor) (formal decision, basic eligibility criteria such as residence, income) and a public health nurse from the Ministry of Health (concrete dependency evaluation).	Morginstin et al., 1993; Ajzenstadt & Rosenhek, 2000; Borowski & Schmid, 2001	High
Dominant actor assessment	State & societal actors		
Payment/contribution	The contribution rates were specified by the state in the LTCI law.	Schmid, 2005	Medium
Dominant actor payment	State		
Provider access	Providers of LTCI scheme benefits need to register/establish a contract with the NII. Authorised suppliers need to fulfil certain criteria regarding the training and remuneration of their staff. There seems to be no strict control of number of providers or other strict criteria.	Iecovich, 2012; Morginstin et al., 1993; Brodsky & Naon, 1993; Ajzenstadt & Rosenhek, 2000	Medium
Dominant actor access	Societal actors		
Remuneration providers	Prices for an hour of care are set by a joint committee of different ministries (Ministry of Welfare and Social Services, Ministry of Finance).	Asiskovitch, 2013	Medium
Dominant actor remuneration	State		

Provider choice	Local committees are responsible for selecting a service provider for benefit recipients. The committees are composed of professionals employed by both the state and the NII: a social worker from the municipal welfare burau, a nurse from the health service/sickness fund and an official from the NII.	Morginstin et al., 1993; Iecovich, 2012; Borowski & Schmid, 2001; Ajzenstadt & Rosenhek, 2000	High
Dominant actor provider	State & Societal actors		
Benefit choice	By law the state defined that home and community care services are the main benefit offered by the LTCI and cash benefits can only be provided in exceptional circumstances. The concrete type of services/service pack-age for each benefit recipient is defined in a care plan constructed by the local committee, i.e. by state and societal actors (for the status of the local committee see description above).	Asiskovitch, 2013; Iecovich, 2012; Ajzenstadt & Rosenhek, 2000	High
Dominant actor benefit	State & Societal actors		
Main regulation agency	The National Insurance Institute is the main responsible institution for administering the LTCI scheme.	Expert Survey H. Schmid; Asiskovitch, 2013; Chernichovsky, Koreh, Soffer, & Avrami, 2010	High
Dominant actor agency	Societal actors		

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Japan

Indicator	Description	Source	Confidence
SYSTEM INTRODUCTION AND OVERVIEW			
Name law (English)	Long-Term Care Insurance Act (LTCI Act)	LTCI Act; Campbell & Ikegami, 2003	High
Name law (original)	介護保険法 (Kaigo Hoken)	LTCI Act; Campbell & Ikegami, 2003	High
Adoption date	17.12.1997	LTCI Act	High
De jure implementation date	01.04.2000	Campbell & Ikegami, 2000; Olivares-Tirado & Tamiya, 2014	High
Brief summary	The LTCI Act introduced a mandatory social insurance scheme financing LTC for the elderly population in Japan. The LTCI is financed from em-ployee/employer contributions, the state budget and beneficiaries' co-payments. It is administered by municipalities (functioning as insurers). The LTCI offers in-kind benefits, both for residential and home/community care, only. The system emphasises provider competition and choice.	Campbell & Ikegami, 2000; Olivares-Tirado & Tamiya, 2014; Tamiya et al., 2011	
Justification introduction point	The LTCI is comprehensive, universal LTC scheme which is based on so-cial insurance principles. With its introduction, the state took over responsibility for LTC from families, broadened and unified previous LTC pro-grammes. The act establishes a distinct social insurance branch for LTC.	Campbell & Ikegami, 2000; Tamiya et al., 2011; Campbell, Ikegami, & Kwon, 2009; Olivares-Tirado & Tamiya, 2014	
SERVICE PROVISION DIMENSION			
Dominant actor provision	Societal actors		
Data basis	The LTCI (sole unified LTC scheme in Japan) offers in-kind benefits, both for home/community and residential care. In 2005 (earliest available data), benefit recipient shares were as follows (OECD, 2020a): 23.6% in institutions 76.4% at home In the home care sector, all types of (formal) providers (state, societal, private for-profit) are allowed, in residential care delivery is restricted to public agencies (state and societal actors). In 2005, shares of actor types in home help services were the following (Saito, 2014): Municipalities: 0.7% Societal actors/non-profit (social welfare corporations, medical corpora-tions, NPO, agricultural cooperatives): 43.2% For-profit organisations: 53.9% Others: 2.3% Residential care is provided 70-90% by traditional non-profit providers (Saito, 2014). When calculating the share of actor types in overall care provision (home and residential care) with a conservative estimate of 70% societal actors in residential care, societal actors have a relative majority with 49%, fol-lowed by private for-profit actors with 41%.	PflegeVG; Rothgang, 2010; BMG, 2019; Mager 1999; Theobald 2004, 2012; Benazha 2021	High

FINANCING DIMENSION			
Dominant actor financing	Societal actors	OECD, 2020b	Medium
Data basis	According to the OECD statistics on total LTC financing, financing shares were as follows in 2003: Government schemes: 2.5% Compulsory insurance schemes: 86.9% Voluntary payment schemes: 1.4% Out-of-pocket payments: 9.2% (However, it has to be noted that state financing is probably underesti-mated here as the state co-financing of the LTCI seems to have been largely attributed to the compulsory insurance schemes.)		
REGULATION DIMENSION			
Dominant actor regulation	State		
Dominant scheme for classification (if applicable)	LTCI scheme (only scheme)		
Entitlement & eligibility criteria	Defined by the state by law.	LTCI Act	High
Dominant actor criteria	State		
Eligibility assessment	Municipalities are responsible for assessing care dependency and confirming eligibility. They do so with a standardized questionnaire and the help of an independent committee appointed by the major.	Campbell & Ikegami, 2003; Ozawa & Nakayama, 2005; Maags, 2020	High
Dominant actor assessment	State		
Payment/contribution	The premium is defined by municipal governments for a period of three years.	Ozawa & Nakayama, 2005; Campbell & Ikegami, 2009	High
Dominant actor payment	State		
Provider access	In home/community care, all kinds of actors are allowed to deliver LTC and can entry the market without specific regulation (they need a general licence as care providers). In residential care, for-profit providers are pro-hibited by the state.	Campbell & Ikegami, 2003; Ozawa & Nakayama, 2005; Campbell, 2014	Medium
Dominant actor access	State & private actors		
Remuneration providers	There are centrally set fees (national applicability with regional cost adjustments) by (an expert committee headed by?) the Ministry of Health, Labour and Welfare.	Campbell & Ikegami, 2003; Rhee, Done, & Anderson, 2015; Tsutsumi, 2014	Medium
Dominant actor remuner-ation	State		
Provider choice	The beneficiary can choose providers and services. However, there is an incentive to make use of care managers to assist with the choice which normally is employed with a provider. Providers are mainly societal.	Ministry of Health, 2016; Campbell & Ikegami, 2003; Saito, 2014; Ozawa & Nakayama, 2005	High
Dominant actor provider	Societal actors & Private actors		
Benefit choice	The beneficiary can choose providers and services. However, there is an incentive to make use of care managers to assist with the choice which normally is employed with a provider. Providers are mainly societal.	Ministry of Health, 2016; Campbell & Ikegami, 2003; Saito, 2014; Ozawa & Nakayama, 2005	High
Dominant actor benefit	Societal actors & Private actors		
Main regulation agency	The municipalities act as the insurer and are the main responsible agency.	Campbell & Ikegami, 2003; Ozawa & Nakayama, 2005	High
Dominant actor agency	State		

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Luxembourg

Indicator	Description	Source	Confidence
SYSTEM INTRODUCTION AND OVERVIEW			
Name law (English)	Law of 19. June 1998 on the introduction of dependency insurance	Pacolet & De Wispelaere, 2018; assurance dépend-ance (AD) law (own translation)	High
Name law (original)	Loi du 19 juin 1998 portant introduction d'une assurance dépendance	AD law	High
Adoption date	19.06.1998	Mutual Information System on Social Protection in the EU member states, 2013 [2002]; AD law; Pacolet & De Wispelaere, 2018	High
De jure implementation date	01.07.1998	AD law	Medium
Brief summary	The assurance dépendance (AD) is a compul-sory social insurance with mixed financing from contributions and state funding. The introduced scheme insures the risk of LTC dependency and covers the whole popula-tion, independent of age and means-test. The scheme provides in-kind (home, community and residential care) benefits and/or monetary benefits and is administered centrally by the national health fund.	Kerschen, 2008; Mutual Information System on Social Protection in the EU member states, 2009; OECD, 2011; Pacolet & De Wispelaere, 2018	High
Justification introduction point	Luxembourg is recognised as one of the few countries worldwide which have established a separate social insurance branch for LTC, recog-nizing LTC as a social risk. The AD is a compul-sory social LTCI with universal population cover-age. With its introduction, a separate chapter (V) was added to the social security code (Code des Assurances Sociales).	Companje, 2014; Pacolet & De Wispelaere, 2018 Kerschen, 2008; AD law	High
SERVICE PROVISION DIMENSION			
Dominant actor provision	Societal actors & private for-profit actors	Mutual Information System on So-cial Protection in the EU member states, 2009; Kerschen, 2008; OECD, 2005; Köstler, 1999; Koster & Ribeiro, 2010; Pacolet & De Wispelaere, 2018	Medium
Data basis	The AD offers both home/community and resi-dential in-kind care services as well as monetary benefits (for home care). In home care, a com-bination of in-kind and cash benefits is possible and common. In 2002, shares of care recipients were distributed as follow (OECD, 2005): Institutional care: 47% Home care, cash benefits: 26% Home care, combination: 22% Home care, services: 5% From these shares we can conclude that the majority (74%) of recipients receive at least some formally provided care. There is no data on actor shares of formal care available (cf. Pacolet & De Wispelaere, 2018). All three provider types (state, societal actors, private-for profit actors) are present in both home and residential care. State providers seem to be a minority compared to non-/for-profit agencies (Köstler, 1999; Koster & Ribeiro, 2010). While no single dominant actor can be determined with the data available, it can be concluded that societal actors and private-for profit actors are likely dominant together. (Informal care for cash beneficiaries can be provided by private individual and/or private for-profit actors (Mutual Information System on Social Protection in the EU member states, 2009).)		

FINANCING DIMENSION			
Dominant actor financing	Societal actors	OECD, 2020; OECD, 2005; Kerschen, 2008	High
Data basis	In 2001, financing shares were as follows (OECD, 2020): Government schemes: 20.5% Compulsory insurance schemes: 48% Voluntary payment schemes: 1.9% Out-of-pocket expenditure: 29.6% In general, 55% of the AD are funded by insurance contributions and 45% co-funded by the state.		
REGULATION DIMENSION			
Dominant actor regulation	State		
Dominant scheme for classification (if applicable)	Assurance Dépendance (AD)		
Entitlement & eligibility criteria	Defined by the state in the law.	AD law	High
Dominant actor criteria	State		
Eligibility assessment	Care dependency is assessed by the Cellule d'Evaluation et d'Orientation (CEO), a public administration body under the Ministry of Social Security.	Kerschen, 2008; Spruit & Hohmann, 2014; Koster & Ribeiro, 2010	High
Dominant actor assessment	State		
Payment/contribution	The law defines the shares of the different sources used for financing the AD. The income contribution is set at 1% by law.	AD law; Luxembourg Presidency, 2005	High
Dominant actor payment	State		
Provider access	Ministries (of Health/Social Affairs/Family affairs) are responsible for li-cencing/approving formal LTC providers. Informal care givers are also examined (availability and training needs). There seems to be no strict regulation controlling e.g. numbers of providers strongly.	Mutual Information System on Social Protection in the EU member states, 2009; OECD, 2011; Pacolet & De Wispelaere, 2018; AD law	Medium
Dominant actor access	State		
Remuneration providers	Remuneration of formal providers (majority of care) are negotiated between the Health Insurance Fund and provider associations, i.e. societal actors. The level of cash benefits is defined by law, i.e. set by the state	Mutual Information System on Social Protection in the EU member states, 2013 [2002]; Pacolet & De Wispelaere, 2018; OECD, 2011; Spruit & Hohmann, 2014; Kerschen, 2008; AD law	High
Dominant actor remuneration	State & Societal actors		
Provider choice	Both formal and informal providers can be chosen by the care recipient.	Mutual Information System on Social Protection in the EU member states, 2009; Spruit & Hohmann, 2014; OECD, 2005	High
Dominant actor provider	Private actors		
Benefit choice	Care recipients can in principle choose which kinds of benefits they want (residential care, home care, cash benefits, combination). However, there is a threshold of care hours which can be taken up in the form of cash benefits defined in the law, over this threshold only services are granted. Therefore, there is also some state regulation involved.	Luxembourg Presidency, 2005; Kerschen, 2008; Mutual Information System on Social Protection in the EU member states, 2009	High
Dominant actor benefit	State & Private actors		

Main regulation agency	The main administrator of the AD is the Caisse Nationale de la Santé (CNS, national health fund). However, different state agencies (Min-is-tries, CEO) are also heavily involved in regu-lating LTC.	Pacolet & De Wispelaere, 2018; Koster & Ribeiro, 2010; OECD, 2011; AD law	High
Dominant actor agency	State & societal actors		

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Netherlands

Indicator	Description	Source	Confidence
SYSTEM INTRODUCTION AND OVERVIEW			
Name law (English)	Exceptional Medical Expenses Act	Companje, 2014; SPLASH-db.eu, 2012; Dijkhoff, 2018	High
Name law (original)	Algemene Wet Bijzondere Ziektekosten (AWBZ)	AWBZ; Companje, 2014; Dijkhoff, 2018	High
Adoption date	14.12.1967	AWBZ; Dijkhoff, 2018	High
De jure implementation date	01.01.1968	Winters, 1996; SPLASH-db.eu, 2012; Companje, 2014	High
Brief summary	The AWBZ established a national compulsory social insurance scheme for insuring the risk against "exceptional medical expenses". The scheme covers the whole population and is funded by income-related employer/employee contributions plus government subsidies and individual co-payments. Recipients are persons (independent of age) in need of long-term care due to old-age, sickness, disabilities, or mental health issues. At its inception, benefits funded under the AWBZ were limited to in-kind residential care services.	Winters, 1996; Winters, 1999; van Nostrand et al., 1995; Da Roit, 2013; Da Roit, 2010; van Hooren & Becker, 2012	High
Justification introduction point	The Netherlands are recognised as the first country in Europe to address LTC dependency within a separate social security system on "exceptional medical risks" The introduced scheme is comprehensive, universalistic and constitutes a separate national social insurance scheme.	Winters, 1999; Da Roit, 2013; Companje, 2014	High
SERVICE PROVISION DIMENSION			
Dominant actor provision	Societal actors	Winters, 1999; van Nostrand et al., 1995; Meijer, van Campen, & Kerkstra, 2000; van Hooren & Becker, 2012; Companje, 2014 FINANCING DIMENSION Poske, 1985; Companje, 2014); Winters, 1996; van Nostrand et al., 1995	High
Data basis	At its inception, benefits funded under the AWBZ were limited to in-kind residential care services. The overwhelming majority of nursing homes was non-governmental and non-profit. For-profit care provision was not allowed. A small share was operated by state-run homes.		
FINANCING DIMENSION			
Dominant actor financing	State	Poske, 1985; Companje, 2014); Winters, 1996; van Nostrand et al., 1995	High
Data basis	The scheme is funded by social insurance contributions collected from income, government subsidies and a (minor) share of individual co-payments. In the first years after introduction, the state co-funding share was still higher than the share from contributions (this changed in during the 1970s when contributions were raised steeply). For 1968, Poske (1985) specifies the state share with 71.7%.		
REGULATION DIMENSION			
Dominant actor regulation	State		
Dominant scheme for classification (if applicable)	(Residential) LTC covered under the AWBZ (only scheme))		

Entitlement & eligibility criteria	Defined by the state in the law.	Companje, 2014	Medium
Dominant actor criteria	State		
Eligibility assessment	Until the end of the 1980s, dependency assessment of (potential) care recipients lay with general practitioners (GPs). The majority of GPs operate as private entrepreneurs (Böhm, Schmid, Götze, Landwehr, & Rothgang, 2012; Schäfer et al., 2010). Formally, eligibility had to be approved by the health insurance funds as the main administrative body.	Poske, 1985; Winters, 1999; Winters, 1996; Böhm et al., 2012; Schäfer et al., 2010	Medium
Dominant actor assessment	Societal actors & Private actors		
Payment/contribution	The main financial responsibility rests with the government. The infor-mation retrieved implies that the state decides on contribution rates, level of government subsidies and level/organization of co-payments.	Winters, 1996; Spoor, 2014; Mot, 2010	Medium
Dominant actor payment	State		
Provider access	Nursing home expansions and new nursing homes needed state licenses. There is a direct, strict control by the state of the number of nursing home beds.	Winters, 1996; Da Roit, 2013	High
Dominant actor access	State		
Remuneration providers	Until 1983, there was no systematic cost control by the government (nor insurance bodies). Nursing homes got reimbursed for the incurred cost retrospectively. Nursing homes are predominantly societal actors (see provision)	Winters, 1996	Medium
Dominant actor remuneration	Societal actors		
Provider choice	Recipients can choose their preferred care facility. (In practice, this can be limited as places are scarce and there are waiting lists.)	Poske, 1985; Winters, 1996; Mot, 2010	Medium
Dominant actor provider	Private actors		
Benefit choice	As there is only one type of benefits (residential care, see provision), the state has predefined the benefit type by law.		High
Dominant actor benefit	State		
Main regulation agency	Health insurance bodies administer/implement the AWBZ. One regional care/liaison office responsible for the insured in several health insurance funds within a region takes over the responsibility/administration. The sickness funds/ regional offices are only partially responsible for financing, there is a central budget managed by the state.	Winters, 1999; Meijer et al., 2000; Companje, 2014; Spoor, 2014; Mot, 2010	High
Dominant actor agency	State & societal actors		

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Norway

Indicator	Description	Source	Confidence
SYSTEM INTRODUCTION AND OVERVIEW			
Name law (English)	Municipal Health Services Act	MHSA; Horák, Horákova, Seeberg & Jessen, 2017; Edvartsen 1999	High
Name law (original)	Lov om helsetjenesten i kommunene	MHSA	High
Adoption date	19.11.1982	MHSA	High
De jure implementation date	01.01.1984	MHSA	High
Brief summary	The Municipal Health Services Act (Lov om helsetjenesten i kommunene) became effective in 1984 and regulated the Norwegian health system, including the field of LTC. The federal law made municipalities responsible for providing basic health and care services, both in- and outpatient. The law covered all residents of Norway and made no distinctions based on citizenship, gender, or age.	MHSA; Horák et al, 2017; Edvartsen, 1999; van den Noord & Iversen, 1998	
Justification introduction point	LTC legislation evolved incrementally in Norway. However, the MHSA served as the first legal act that recognized the long-term care needs of all residents and applied to the whole country (i.e. all municipalities). §1-3 of the MHSA specifies the responsibility to provide nursing services at home and in residential facilities.	MHSA; Horák et al, 2017; Edvartsen, 1999; van den Noord & Iversen, 1998	
SERVICE PROVISION DIMENSION			
Dominant actor provision	State	MHSA; Romoren, 1995; Edvartsen, 1999; AARP, 2006; Ringard, Sagan, Sperre Saunes & Lindahl, 2013; Horák et al, 2017	High
Data basis	Benefits included those which were covered by the MHSA, i.e. they had to belong to nursing and care services. They were provided both in institu-tions (e.g. nursing homes) and within the community (e.g. home help and home nursing). Facilities that were entirely owned and financed by the state dominated the LTC sector in Norway. Additionally, there were some voluntary, pri-vate actors that run their facilities independently but received financial support from the state. However, their impact was less significant than from the state enterprises. Charities and other societal actors made up ca. 15% of the LTC providers in the 1980s while private, for-profit actors were almost non-existent at that time.		
FINANCING DIMENSION			
Dominant actor financing	State	Romoren, 1995; Edvartsen, 1999; OECD, 2020	Medium
Data basis	According to earliest available observation year from OECD health statis-tics, financing shares of total LTC spending in Norway in 1997 were dis-tributed as follows: Government/compulsory schemes: 85.69% Household out-of-pocket expenditure: 14.04% Total LTC expenditure was 1.71% of the GDP. The data does not differentiate between government and compulsory so-cial insurance schemes since individual shares of them were not available. However, Edvartsen (1999) states that the beneficiaries' contribution comprised ca. 12% of the total costs in health and social care. This implies that the state was the main financing actor of the system.		

REGULATION DIMENSION			
Dominant actor regulation	State		
Dominant scheme for classification (if applicable)	NA		
Entitlement & eligibility criteria	Entitlements are defined in the MHSA. Eligibility criteria for specific benefits may vary among the municipalities.	MHSA; AARP, 2006	High
Dominant actor criteria	State		
Eligibility assessment	Municipal teams consisting of provider representatives and physicians conduct the eligibility assessment. Since the state dominates the provision dimension, its representatives will also be involved in the assessment of potential beneficiaries.	MHSA; Romoren, 1995; van den Noord & Iversen, 1998; Blackman, 2000; Ringard et al, 2013	High
Dominant actor assessment	State		
Payment/contribution	The contribution rates are set by municipalities. They are responsible according to the MHSA.	MHSA	High
Dominant actor payment	State		
Provider access	The municipalities decide which providers can access the LTC system. They are also responsible for monitoring them (e.g. guaranteeing basic standards).	MHSA; Romoren, 1995; van den Noord & Iversen, 1998; Blackman, 2000; Ringard et al, 2013	High
Dominant actor access	State		
Remuneration providers	As both LTC financing and provision is dominated by the state and no additional information on remuneration processes could be found, we can conclude that the state defines remuneration.		
Dominant actor remuneration	State		
Provider choice	Provider choice varies among the municipalities. Some local authorities let users choose between public or private providers. Among the private pro-viders, beneficiaries may further choose a specific institution. However, among public providers the freedom of choice is restricted. In 2004, only 3% of the municipalities in Norway had introduced free choice for benefi-ciaries. As a result, the dominant actor for provider choice is the state.	MHSA; Vabø, Christensen, Fadnes Jacobsen & Dalby Trætteberg, 2013	High
Dominant actor provider	State		
Benefit choice	Municipalities decide which individual benefits are granted according to the needs assessment of each individual beneficiary.		High
Dominant actor benefit	State		
Main regulation agency	General legislation on health and social care is provided by the Ministry of Health. It consults advisory bodies such as the Norwegian Board of Health or County Medical Officers. The regulation of LTC, such as eligibility assessment, service provision etc. is by law the responsibility of the municipalities.	MHSA; Romoren, 1995; Edvartsen, 1999; AARP, 2006; Ringard et al, 2013; Horák et al, 2017	High
Dominant actor agency	State		

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Portugal

Indicator	Description	Source	Confidence
SYSTEM INTRODUCTION AND OVERVIEW			
Name law (English)	Decree-law n.° 101/2006	Baptista & Parista, 2018; Lopes, Mateus, & Hernández-Quevedo, 2018	High
Name law (original)	Decreto-Lei n.° 101/2006	Law 101/2006	High
Adoption date	06.06.2006	Law 101/2006	High
De jure implementation date	NA (gradual implementation 2006-2016)	Santana, 2010; Joel, Dufour-Kippelen, & Samitca, 2010	Medium
Brief summary	The law created the National Network for Integrated Longterm Care (*Rede Nacional de Cuidados Continuados Integrados – RNCCI*) as a joint responsibility of central, regional and local authorities and different kinds of public and private providers. It coordinates a variety of health and social care facilities in the provision of LTC.	MHSA; Horák et al, 2017; Edvartsen, 1999; van den Noord & Iversen, 1998	
Justification introduction point	While the law builds on the pre-existing provision and financing structures, it introduced an important change in coordinating and formalising provider networks and setting out public responsibilities for LTC organisation and provision. It entitles the care dependent population to LTC benefits.	MHSA; Horák et al, 2017; Edvartsen, 1999; van den Noord & Iversen, 1998	
SERVICE PROVISION DIMENSION			
Dominant actor provision	Societal actors	Lopes et al., 2018; Joel et al., 2010; Costa-Font et al., 2012; OECD, 2011	High
Data basis	LTC benefits in the RNCCI are predominantly in the form of in-kind services (residential and home/community care), the amount of cash benefits is minimal (ca. 1%) (Lopes et al., 2018). LTC (in both sectors) is to a large extent provided by non-profit agencies, most notably Misericórdias, that is "independent, non-profit institutions with a religious background" (Joel et al., 2010). The shares of different provider types were the following at the beginning of the system (Organisation of Economic Cooperation and Development (OECD), 2011): Misericórdias: 61% (2008) / 48% (2011) Other non-profit organizations: 16% (2008) / 20% (2011) Public NHS entities: 11% (2008) / 9% (2011) For-profit private organizations: 12% (2008) / 23% (2011)		
FINANCING DIMENSION			
Dominant actor financing	State	Enderlein, 1999; OECD, 2020; Lopes et al., 2018; OECD, 2011; Costa-Font et al., 2012; Joel et al., 2010	Medium
Data basis	According to the OECD health statistics, the financing shares for LTC were the following in 2010: Government schemes: 6.7% Compulsory insurance schemes: 51,1% Voluntary payment schemes: 0.4% Out-of-pocket payments: 41.8%		

	The dominance of compulsory insurance schemes without there being any concrete LTC (or other) mandatory insurance involved seems to derive from the fact that the state finances its social security expenditure from employee/employer contributions generally (Enderlein, 1999). Several other sources (including OECD reports themselves) state that the public LTC financing share is funded from Government/State budget, more specifically the Ministry of Health and Ministry of Social Solidarity (Lopes et al., 2018) (Organisation of Economic Co-operation and Development (OECD), 2011) (Costa-Font et al., 2012) (Joel et al., 2010). The funds do not seem to be collected or earmarked for LTC. Therefore, we attribute the compulsory insurance share to government schemes, classify Portugal as state funding.		
REGULATION DIMENSION			
Dominant actor regulation	State		
Dominant scheme for classification (if applicable)	Rede Nacional de Cuidados Continuados Integrados (RNCCI)		
Entitlement & eligibility criteria	Defined by the state by law.	OECD, 2011; Santana, 2010	High
Dominant actor criteria	State		
Eligibility assessment	There is no specific institution which determines eligibility. The assessment is conducted either by care providers themselves, including health care providers (e.g. hospitals when patient is discharged, family) and/or and/or Instituições Particulares de Solidariedade Social (IPSS, Solidarity Private Institutions), also in the form of local coordination teams. RNCCI providers are mainly societal (see provision), health care providers mainly state owned/employed (Böhm, Schmid, Götze, Landwehr, & Rothgang, 2012).	OECD, 2011; Costa-Font et al., 2012; Lopes et al., 2018; Böhm et al., 2012	Medium
Dominant actor assessment	State & Societal actors		
Payment/contribution	A limit for co-payments is determined by the state by law. Otherwise, providers (IPSSs, Misericórdias) set prices themselves (within the scope of guidelines/regulations).	Costa-Font et al., 2012	Medium
Dominant actor payment	State & Societal actors		
Provider access	(For-profit) providers entering the RNCCI have to be accredited by the state (mainly fulfilling general standards, a certification is also partly requested).	Baptista & Parista, 2018; Santana, Szczygiel, & Redondo, 2014	Medium
Dominant actor access	State		
Remuneration providers	The Ministry and the three unions representing IPSSs are negotiating remuneration (typically values per user per month) annually.	Santana et al., 2014; Costa-Font et al., 2012	High
Dominant actor remuneration	State & Societal actors		
Provider choice	The providers/coordination teams determining eligibility (see above, state and societal actors) refer beneficiaries to appropriate providers.	Costa-Font et al., 2012; Lopes et al., 2018	Medium
Dominant actor provider	State & Societal actors		

Benefit choice	NA		
Dominant actor benefit	NA		
Main regulation agency	The system is coordinated by the Ministries of Health/Social Solidarity and regional state levels. Still, there is a lot of autonomy and competences for provider (networks) themselves, i.e. societal actors.	Santana, 2010; Santana et al., 2014; Costa-Font et al., 2012; Lopes et al., 2018	High
Dominant actor agency	State		

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Singapore

Indicator	Description	Source	Confidence
SYSTEM INTRODUCTION AND OVERVIEW			
Name law (English)	CareShield Life and Long-Term Care Act 2019	CareShield Life and Long-Term Care Act 2019 (LTCA)	High
Name law (original)	CareShield Life and Long-Term Care Act 2019	LTCA	High
Adoption date	02.09.2019	LTCA	High
De jure implementation date	1.10.2020	Ministry of Health Singapore, 2020a	Medium
Brief summary	The CareShield Life and Long-Term Care Act 2019 establishes the CareShield Life Scheme (CSHL) and regulates other financial support for LTC. CSHL is a LTC insurance scheme administered by the government providing monthly cash-payouts to insurance policy holders in the case of severe disability.	LTCA; Luk, 2020; Ministry of Health Singapore, 2020a	
Justification introduction point	The LTCA establishes a (partly) mandatory scheme for the protection against the financial risk of LTC dependency. The CSHL scheme is based on principles of universal coverage and inclusivity (according to the government of Singapore). With the CSHL scheme the government has taken over greater responsibility for regulating and financing LTC, enhancing the pre-existing voluntary ElderShield scheme.	Luk, 2020; Ministry of Health Singapore, 2020a	
SERVICE PROVISION DIMENSION			
Dominant actor provision	Private for-profit actors & private individual actors	Ministry of Health Singa-pore, 2020a; Luk, 2020; Peng & Yeandle, 2017; Chin & Phua, 2016; Rozario & Rosetti, 2012; Huang et al., 2012; Liew et al., 2020; Peng, 2018	Low
Data basis	The CSHL scheme offers only cash-benefits and no in-kind services. The use of the cash benefits is not regulated, they could be used to pay for formal care, informal care or not directly for care provision at all. Previous studies on LTC in Singapore (not connected to the LTCA introduction in 2019/20) stress that elder care is a family responsibility, resulting mostly either in direct care provision by family members or a purchase of assistance, often in the form of migrant domestic care workers. Also, the government encourages both domestic care work and family care provision strongly (e.g. with tax incentives). Several sources state that about half of dependent elderly in Singapore receive LTC services (also) by (foreign) domestic care workers employed by the family (Huang et al., 2012; Liew et al., 2020; Peng, 2018). As there is no data on the use of cash benefits of the CSHL scheme (yet), from the existing evidence we assume that benefit recipients will rely mainly on both private for-profit actors (mostly in the form of migrant care workers) and private individual actors (mostly in the form of familial care).		

FINANCING DIMENSION			
Dominant actor financing	Private for-profit actors	LTCA; Luk, 2020; Minis-try of Health Singapore, 2020a	Medium
Data basis	The CSHL scheme is financed by pre-funded premiums payed until the age of 67 (or until benefits are claimed). Premiums are calculated individ-ually based on actuarial principles. Premi-ums can also be paid from MediSave accounts. There are means-tested government subsidies depending on household income and housing situation available up to 20-30% of premiums. Additionally, there is "additional premium sup-port" by the government if premiums can still not be payed after subsidy and family support. While there is no data on shares available yet, from the CSHL set-up it is evident that individual premiums make up the main funding source.		
REGULATION DIMENSION			
Dominant actor regulation	State		
Dominant scheme for classification (if applicable)	CareShield Life There are several measures and programs for LTC in Singapore. The LTCA specifically intro-duced the novel CareShield Life Scheme which will be the main financial insurance scheme for severe disability. The CSHL scheme is used for classifying the regulatory dimension.		
Entitlement & eligibility criteria	Criteria are defined in the LTCA.	LTCA	High
Dominant actor criteria	State		
Eligibility assessment	The eligibility assessment is conducted by Ministry of Health (MoH) ac-credited severe disability assessors. The claim/assessment is the handed over to the Agency of Integrated Care operating under the MoH. Asses-sors are medical personnel based at hospitals or housecall doctors. Health-care in Singapore is provided both by state and private for-profit actors (Bai, Shi, Li, & Liu, 2012)	LTCA; Luk, 2020; Minis-try of Health Singapore, 2020a; Agency for Integrated Care, 2021; Bai et al., 2012; Agency for Inte-grated Care, n.d.	Medium
Dominant actor assessment	State & private actors		
Payment/contribution	With its start, membership in the CSHL scheme is made compulsory by the state for a certain age-group which is later extended. Premium levels are set by the state initially, later revisions will be based on recommenda-tions by the CareShield Life Council. The Council comprises members from different fields such as accountancy, actuari-al science, investment, medicine, law, union, and government	Luk, 2020; Ministry of Health Singapore, 2020a	Medium
Dominant actor payment	State & societal actors		
Provider access	The payed-out cash benefits can be used freely, thus there is no central regulation of access to the system	Ministry of Health Singapore, 2020a; Luk, 2020	High
Dominant actor access	Private actors		
Remuneration providers	Benefit levels are set by the state initially, later re-visions will be based on recommendations by the CareShield Life Council. The Council comprises members from different fields such as accountan-cy, actuarial science, investment, medicine, law, union, and government.	Ministry of Health Singapore, 2020a; Luk, 2020	Medium
Dominant actor remuner-ation	State & societal actors		

Provider choice	The payed-out cash benefits can be used freely, thus there is no central regulation of provider choice	Ministry of Health Singa-pore, 2020a; Luk, 2020	High
Dominant actor provider	Private actors		
Benefit choice	The CSHL scheme only offers cash-benefits, there is no possibility to choose in-kind services directly. The cash benefits can be used freely.		High
Dominant actor benefit	State		
Main regulation agency	The Government of Singapore is the main of the CareShield Life scheme. The government sets payouts and premiums (with recommendations from the CareShield Life Council) and manages the funds. Other agencies (Central Provident Fund Board, CareShild Life Council, etc.) are also involved in administration.	Ministry of Health Singa-pore, 2020a; Ministry of Health Singa-pore, 2020b; Luk, 2020	High
Dominant actor agency	State		

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South Korea

Indicator	Description	Source	Confidence
SYSTEM INTRODUCTION AND OVERVIEW			
Name law (English)	Act on Long-Term Care Insurance for Senior Citizens (LTCI Act)	LTCI Act	High
Name law (original)	인장기요양보험법	LTCI Act	Medium
Adoption date	27.04.2007	LTCI Act	High
De jure implementation date	01.07.2008	LTCI Act	High
Brief summary	The LTCI Act introduced a social LTC insurance scheme for LTC specifically. It provides mainly in-kind benefits (residential and home/community care) to the older population (aged 65+ and younger with age-related dependency needs). The LTCI is financed by wage contributions plus a government subsidy and user co-payments. The National Health Insurance Cooperation functions as the insurer.	Kwon, 2009; S.-H. Kim, Kim, & Kim, 2010; Seok, 2010; Rhee, Done, & Anderson, 2015	
Justification introduction point	The LTCI Act introduced a distinct social insur-ance branch focused ex-clusively on LTC. The system rests on clear entitlements and universality principles. With the introduction, the state took over the major responsibil-ity for elderly care (previously family responsibility, rudimentary system). The introduction is regarded as a major change in social care/welfare state development.	Kwon, 2009; Seok, 2010; J. W. Kim & Choi, 2013	
SERVICE PROVISION DIMENSION			
Dominant actor provision	Private for-profit actors	LTCI Act; Choi, 2014; Maags, 2020; Rhee et al., 2015	High
Data basis	The LTCI offers in-kind residential and home/community care services. Cash benefits are only possible in exceptional circumstances (like residing on an island without service availability). In 2011, the share of home-based care was 52.9% and residential care 43.3% (Choi, 2014). In both sectors, private for-profit actors were dominant with respective shares in 2011 (Choi, 2014): 81.2% in home-visit care 76.8% in home-visit nursing 61.3% residential care		
FINANCING DIMENSION			
Dominant actor financing	Societal actors	OECD, 2020; Rhee et al., 2015; Chon, 2012	High
Data basis	According to OECD health financing statistics, LTC financing shares were as follows in 2011: Government schemes: 17.1% Compulsory insurance schemes: 51.3% (50.4% social insurance; 0.9% compulsory private) Out of-pocket expenditure: 31.6% In the following years, the share of the insurance schemes increases further. For the LTCI, Chon (2012) states the financing shares as follows: 60% social insurance contributions; 20% state budget; 20% co-payments.		

REGULATION DIMENSION			
Dominant actor regulation	Private actors		
Dominant scheme for classification (if applicable)	Long-term care insurance (LTCI) (only scheme)		
Entitlement & eligibility criteria	Defined by the state by law.	LTCI Act; OECD, 2011	High
Dominant actor criteria	State		
Eligibility assessment	The National Health Insurance Corporation (NHIC) is responsible for eligibility assessment. (The NHIC can also delegate assessment to municipal-ities/cities.)	LTCI Act; Rhee et al., 2015; Maags, 2020; OECD, 2011	High
Dominant actor assessment	Societal actors		
Payment/contribution	The LTCI Act defines that the premiums will be set by a Presidential De-cree (Art. 9).	LTCI Act	Medium
Dominant actor payment	State		
Provider access	There is no specific entry control for service pro-viders in the LTCI system, a "provider market" was established. (There are general minimum licensing requirements, regulated by the state.)	Rhee et al., 2015; Chon, 2012	Medium
Dominant actor access	Private actors		
Remuneration providers	The provider fees are nationally uniform, set by the NHIC	Rhee et al., 2015	Medium
Dominant actor remuner-ation	Societal actors		
Provider choice	Beneficiaries are free to choose providers, no external regulation.	Choi, 2014; OECD, 2011	High
Dominant actor provider	Private actors		
Benefit choice	There are no care managers, beneficiaries can generally decide between residential and home/ community care services (but institutional care was restricted to severe dependency at the inception). The law, i.e. state, does not provide for a choice of cash benefits.	H. Kim, 2020; Seok, 2010; Choi, 2014	High
Dominant actor benefit	State & Private actors		
Main regulation agency	The National Health Insurance Corporation is the main regulato-ry/administrative body of the LTCI.	Chon, 2012; Maags, 2020; LTCI Act	High
Dominant actor agency	Societal actors		

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Spain

Indicator	Description	Source	Confidence
SYSTEM INTRODUCTION AND OVERVIEW			
Name law (English)	Law 39/2006 of 14 December on the Promotion of Personal Autonomy for Persons in Situation of Dependency	Law 39/2006; (Mutual Information System on Social Protection in the EU member states, 2009); (Pena-Longobardo, Oliva-Moreno, García-Armesto, & Hernández-Quevedo, 2016)	High
Name law (original)	Ley 39/2006, de 14 de diciembre, de Promoción de la Autonomía Personal y Atención a las personas en situación de dependencia	Law 39/2006	High
Adoption date	14.12.2006	Garcia-Gomez et al. (2019), Ley 39/2006	High
De jure implementation date	01.01.2007	Cabrero and Gallego (2013), Spijker and Zueras (2018), Law 39/2006	High
Brief summary	Ley 39/2006 created the so-called System for Autonomy and Care for Dependency (SAAD – Sistema para la Autonomía y Atención a la De-pendencia). The law establishes a universal right to LTC. The SAAD rests on cooperation and shared responsibility between the federal state and the regions and is mainly funded by taxes. The SAAD offers both in-kind and monetary benefits in case of care dependency.	(Costa-Font & García González, 2007); (Pena-Longobardo et al., 2016); (Cabrero & Gallego, 2013)	
Justification introduction point	The law provides for a universal right for receiving LTC benefits in case of care dependency. It has been denoted as a new "fourth pillar of the welfare state" in Spain, providing for publicly financed and organised LTC benefits.	(Costa-Font & García González, 2007); (Gutiérrez, Jiménez-Martín, Vegas Sánchez, & Vilaplana, 2010); (Pena-Longobardo et al., 2016)	
SERVICE PROVISION DIMENSION			
Dominant actor provision	Private for-profit actors & private individual actors	Cabrero & Gallego, 2013; Moreno-Colom, Recio Càceres, Torns Martín, & Borràs Català, 2017; De la Fuente Robles & Sotomayor Morales, 2015; Rodrigues, Huber, & Lamura, 2012; Simonazzi, 2009; León, 2014; Da Roit & Weicht, 2013	Medium
Data basis	The SAAD offers in-kind services, both home/community and residential care, as well as different types of cash benefits. In the years after imple-mentation, around 50% of benefit recipients received cash benefits that could be used for family/informal carers (e.g. Cabrero & Gallego, 2013; Moreno-Colom et al., 2017; De la Fuente Robles & Sotomayor Morales, 2015). Cabrero and Gallego (2013) provide the following benefit shares for 2010: Cash benefits for families: 49.4% Cash benefits linked to a service: 6.9% Cash benefits personal assistance: 0.1% Services benefits: home help: 11% Service benefits: day centers: 5.5% Tele-aid: 10.3% Residential care: 15.7% Data on the actor type shares for the respective benefits differentiating between state, societal/non-profit and private for-profit for the time after system introduction could not be retrieved. However, two sources provide information on the dominance of actor types in formal home and residen-tial care (Rodrigues et al., 2012; Simonazzi, 2009). Accordingly, private for-profit actors seem to be dominant overall (more so in residential care). If weighted with the shares of services, they make up just over 50% in formal services.		

	The ca. 50% cash benefits to support informal care go both to private in-dividual actors (family etc.) and are used for hiring domestic care worker/buying assistance privately. From the data available, we can estimate that at least approx. half of the recipients of these cash benefits hire do-mestic (migrant) care workers (León, 2014; see also Da Roit & Weicht, 2013; Simonazzi, 2009). Therefore, at least 25% of cash benefit recipients seem to also rely (partly) on for-profit actors. In total, this results in a (relative) dominance of for-profit actors in provision.		
FINANCING DIMENSION			
Dominant actor financing	State	LTCA; Luk, 2020; Ministry of Health Singapore, 2020a	High
Data basis	CThe OECD health financing shares for LTC are the following for 2010: Government schemes: 74.9% Compulsory insurance schemes: 7.8% Voluntary payment schemes: 0.6% Out-of-pocket payments: 16.7% The state share is financed by both the federal state and autonomous re-gions. Co-payments of users are about 10-20% (Marbán Gallego, 2014).		
REGULATION DIMENSION			
Dominant actor regulation	State		
Dominant scheme for classification (if applicable)	Sistema para la Autonomía y Atención a la Dependencia (SAAD) (only scheme)		
Entitlement & eligibility criteria	Defined by the state by law.	Law 39/2006; Gutiérrez et al., 2010	High
Dominant actor criteria	State		
Eligibility assessment	Eligibility assessment Dependency assessment is conducted by autonomous communities/administration.	Mutual Information System on Social Protection in the EU member states, 2009; Gutiérrez et al., 2010	High
Dominant actor assessment	State		
Payment/contribution	The law provides for co-payments (depending on a means test). Within this framework, the autonomous regions have some leeway for defining co-payments.	Cabrero & Gallego, 2013; Gutiérrez et al., 2010; OECD, 2011	High
Dominant actor payment	State		
Provider access	(Private) providers must be accredited to deliver care within the SAAD. The accreditation is obtained from autonomous regions. The standards for accreditation are set by the Territorial Council.	Gutiérrez et al., 2010; Cabrero & Gallego, 2013; Ley 39/2006; Rodríguez Cabrero, Montserrat Codorniu, González de Durana, Marbán Gallego, & Moreno Fuentes, 2018	High
Dominant actor access	State		
Remuneration providers	The amount of cash benefits is fixed by law (later adapted by the Territorial Council), i.e. the state. In-kind benefits: NA	Mutual Information System on Social Protection in the EU member states, 2009; Reinhard, 2018	Medium
Dominant actor remuneration	State		
Provider choice	Cash benefits: The provider can be chosen by the recipient (has to register with social security). In-kind: Provider choice is limited to home-based care.	Mutual Information System on Social Protection in the EU member states, 2009; Riedel & Kraus, 2011; Rodríguez Cabrero et al., 2018	Medium
Dominant actor provider	State & private actors		

Benefit choice	The law sets out a priority of in-kind benefits. There is a care plan/management system managed by public administrations limiting recipient choice of benefits to some extent. However, the family/recipient is also involved in the decision.	Mutual Information System on Social Protection in the EU member states, 2009; Gutiérrez et al., 2010; Triantafillou et al., 2010; Moreno-Colom et al., 2017; Cabrero & Gallego, 2013	High
Dominant actor benefit	State & private actors		
Main regulation agency	The central state and the autonomous regions are together responsible for regulating the system.	Costa-Font & García González, 2007; Gutiérrez et al., 2010	High
Dominant actor agency	State		

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Sweden

Indicator	Description	Source	Confidence
SYSTEM INTRODUCTION AND OVERVIEW			
Name law (English)	Social Services Act	SoL; Johansson, 1993	High
Name law (original)	Socialtjänstlag (SoL)	Betts, 2014; Johansson, 1993; Erlandsson, 2013; Szebehely & Trydegard, 2012	High
Adoption date	19.06.1980	SoL	High
De jure implementation date	01.01.1982	SoL; Erlandsson, 2013; Betts, 2014; Johansson, 1993	High
Brief summary	The Social Services Act introduced the right/ entitlement for all individuals to assistance and support for (amongst others) persons in need of LTC. As a framework law, the Act does not specify concrete regulations or services but places the responsibility for organizing and providing such assistance with the municipalities. LTC is provided, financed and regulated mainly by the state (municipalities and central state level).	Johansson, 1993; Erlandsson, 2013; Weber, 2018; Brodin, 2005	
Justification introduction point	The Social Services Act provides a uniform framework for social services, including LTC (for the elderly and younger disabled people). It sets out the individual rights and entitlements to receive care if needed. Even if the Act covers several social services besides LTC, it clearly recognizing the public responsibility for the risk of LTC dependency.	Trydegard, 2000; Erlandsson, 2013; Johansson, 1993	
SERVICE PROVISION DIMENSION			
Dominant actor provision	State		High
Data basis	Municipalities provide both home/community care and institutional care. In the 1980s, the overwhelming majority of care providers were the municipalities themselves, that is the state is clearly dominant in provision.		
FINANCING DIMENSION			
Dominant actor financing	Societal actors	Brodin, 2005; Erlandsson, 2013; Lagergren, 2002; Johansson, 1993	High
Data basis	LTC is financed mainly by the state, both municipal and central state tax revenues. In some cases individual co-payments are requested by the municipalities. However, they only made up about 10% by the beginning of the 1990s (Johansson, 1993)		
REGULATION DIMENSION			
Dominant actor regulation	State		
Dominant scheme for classification (if applicable)	NA		
Entitlement & eligibility criteria	Entitlement to care is defined by law (SoL §6 & § 22). Eligibility criteria are defined by municipalities.	SoL	High
Dominant actor criteria	State		
Eligibility assessment	The municipality, via a social worker/care manager, determine the depend-ency/eligibility of care recipients.	Trydegard, 1998; Trydegard, 2000; Erlandsson, 2013	High
Dominant actor assessment	State		

Payment/contribution	Municipalities decide if and how much recipients have to contribute as a co-payment.	Erlandsson, 2013; Tryde-gard, 2000	Medium
Dominant actor payment	State		
Provider access	As municipalities are the care providers, this is decided by the state.		High
Dominant actor access	State		
Remuneration providers	As both providers and financing lies with the state, remuneration is decided by the state.	Erlandsson, 2013	High
Dominant actor remuner-ation	State		
Provider choice	As the state is the main provider, there is no recipient choice of providers. Purchaser/provider splits and consumer choice were only introduced in the 1990s and 2000s.	Meagher & Szebehely, 2013; Karls-son, 2002	High
Dominant actor provider	State		
Benefit choice	The care manager employed by the municipality decides the care plan and level and types of services.	SoL §2-3; Weber, 2018; Erlandsson, 2013; Johansson, 1991; Trydegard, 2000	High
Dominant actor benefit	State		
Main regulation agency	Municipalities are the main responsible agency: They provide, administer and supervise care, and decide eligibility and care plans. General guide-lines, regulations and policies are additionally set by the central government.	SoL §2-3; Weber, 2018; Erlandsson, 2013; Johansson, 1991; Trydegard, 2000	
Dominant actor agency	State		

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United Kingdom

Indicator	Description	Source	Confidence
SYSTEM INTRODUCTION AND OVERVIEW			
Name law (English)	Care Act 2014	Care Act	High
Name law (original)	Care Act 2014	Care Act	High
Adoption date	19.05.2014	Care Act	High
De jure implementation date	01.04.2015	Contact, 2021	High
Brief summary	The Care Act provides local authorities in England with a comprehensive legal framework for the provision of LTC services, mechanisms for the prevention of LTC dependency and assistance for family carers. It recognizes LTC as a particular social risk by introducing the principle of "well-being" (Art. 1) for all UK residents. Although the Care Act does only apply to England, very similar laws were passed in Scotland (2013) and Wales (2014).	Care Act; Glendinning, 2018; Snell, 2015	High
Justification introduction point	The Care Act has been labelled the "most significant change in social care law for 60 years" (Snell, 2015). In addition to the reorganization of the care system and existing benefits, it has a stronger rights-based principle. As such, it serves as the legal foundation for claiming a needs assessment, regardless of the likelihood of success.	Glendinning, 2018; Snell, 2015; Brindle, 2014	High
SERVICE PROVISION DIMENSION			
Dominant actor provision	Private for-profit Actors	Care Act; NHS Digital, 2019; Spasova, Baeten, Coster, Ghailani, Pena-Casas & Vanhercke, 2018; Trigg, Kumpunen, Holder, Maarse, Sole Juvés & Gil 2018; Thorlby, Starling, Broadbent & Watt, 2018; Glendinning, 2018; Auth, 2017; European Commission, 2016	High
Data basis	Disclaimer: The provision dimension is only classified using the schemes regulated under the Care Act 2014, excluding e.g. Attendance Allowance, Carer's Allowance schemes According to Art. 8 of the Care Act, the following benefits are covered by the legislation: a) Residential care b) Home care/support c) Social work, such as counselling, advocacy, information etc. Around 94-97% of residential facilities are run by private enterprises which are used by ca. 4% of the British population aged 65 or older. Home care services are with ca. 89% also predominantly provided by private for-profit entities. Consequently, only a few facilities and services are delivered by public actors (ca. 460,000 residential beds and 500,000 pub-licly funded home care recipients in 2018). In 2018/19, the majority of LTC beneficiaries received care at home. Of 548,435 total clients aged 65 or older 60.7% were provided with home support services.		
FINANCING DIMENSION			
Dominant actor financing	State	OECD, 2020	High
Data basis	According to OECD health statistics, financing shares of total LTC spending in the United Kingdom in 2018 were distributed as follows: Government schemes: 64.27% Voluntary payment schemes: 9.42% Household out-of-pocket expenditure: 26.36% Total LTC expenditure was 2.25% of the GDP. Accordingly, the state is the main actor for financing the LTC system.		

REGULATION DIMENSION			
Dominant actor regulation	State		
Dominant scheme for classification (if applicable)	Care Act 2014 (England only)		
Entitlement & eligibility criteria	Local authorities determine which benefits are granted for certain levels of dependency. However, they must comply with the rules laid down in the Care Act, for instance the principle of well-being.	Care Act; Spasova et al, 2018; Glendinning, 2018; Cylus et al, 2015	High
Dominant actor criteria	State		
Eligibility assessment	Local authorities and their social workers, physicians etc. conduct the eligibility assessment.	Care Act; Spasova et al, 2018; Trigg et al, 2018; Cylus et al, 2015	High
Dominant actor assessment	State		
Payment/contribution	Local authorities determine the financial contributions of beneficiaries. However, the Care Act introduced a cap on individual care costs that should not be exceeded. As of March 2021, this rule has not been implemented yet.	Care Act; Spasova et al, 2018; Cylus et al, 2015	High
Dominant actor payment	State		
Provider access	Local authorities contract service providers for including them into the care system and purchasing services on behalf of the beneficiaries.	Care Act; Trigg et al, 2018; Glendinning, 2018; Auth, 2017	High
Dominant actor access	State		
Remuneration providers	Fees for in-kind services at home or in institutions vary within the United Kingdom. They are negotiated between local authorities and care providers. Remuneration levels for service providers are considerably low due to the market power of the governments	Spasova et al, 2018; OECD, 2011; Bode, 2008	High
Dominant actor remuneration	State and private actors		
Provider choice	Users can choose freely among providers that are contracted by local authorities.	Trigg et al, 2018	Medium
Dominant actor provider	Private actors		
Benefit choice	Beneficiaries may let local authorities directly purchase their granted benefits. However, they may instead receive a personal budget that meets their care needs. With this budget, they can personally purchase benefits from contracted providers. As such, the benefit choice may be with indi-vidual users.	Trigg et al, 2018; Glendin-ning, 2018; Brennan et al., 2012; Yeandle & Stiell, 2007	High
Dominant actor benefit	State & Private actors		
Main regulation agency	The responsibility of organizing social care and LTC is delegated to the county councils and local authorities of the United Kingdom. General legislation on social care is provided by the governments of England, Wales, Scotland, and Northern Ireland.	Care Act; Trigg et al, 2018; Glendinning, 2018; Thorl-by et al, 2018	High
Dominant actor agency	State		

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Uruguay

Indicator	Description	Source	Confidence
SYSTEM INTRODUCTION AND OVERVIEW			
Name law (English)	National System of Care	Ley 19.353; Matus-Lopez & Terra, 2021	High
Name law (original)	Sistema National Integrado de Cuidados (Ley 19.353) (SNIC)	Ley 19.353	High
Adoption date	27.11.2015	Ley 19.353; LTC Expert Survey M. Matus-Lopez; Matus-Lopez and Cid Pedraza, 2016	High
De jure implementation date	NA (LTC services are being implemented since second semester 2017)	Matus-Lopez & Terra, 2021	Medium
Brief summary	The SNIC makes provisions for childcare (0-12), disabled individuals (all age) and dependent elderly (+65), expanding and unifying available ser-vices and establishing new benefits. It is fund-ed by the state budget and co-payments. The SNCI offers home and community LTC services to the dependent older population.	Amarante, Colacce, & Tenenbaum, 2017; Matus-Lopez & Cid Pedraza, 2016; Esquivel, 2017; Matus-Lopez & Terra, 2021	
Justification introduction point	The SNIC is an independent care system/law, conceived as the 4th pillar of the Uruguayan social protection system next to health, education and social security. While not having an exclusive focus on LTC only (child care is also included), it created a distinct LTC system, proclaiming a universal and rights-based approach. It is recog-nized as the first compre-hensive LTC system in Latin America.	Amarante et al., 2017; Matus-Lopez & Cid Pedraza, 2016; Esquivel, 2017; Nieves Rico, 2019	
SERVICE PROVISION DIMENSION			
Dominant actor provision	Private for-profit actors	Matus-Lopez & Terra, 2021; Ma-tus-Lopez & Cid Pedraza, 2016; Amarante et al., 2017	Medium
Data basis	The SNIC offers home and community care services (personal assistants, day & night care centers, teleassistance) for care recipients. There is an-other called Cupo Cama (outside SNIC) offering residential care. The number of recipients of the different types of benefits are as follows for 2020 (Matus-Lopez & Terra, 2021): Home-care assistant: 6125 Teleassistance: 1533 Day/night centers: 229 Subsidized quota residential care: 479 Home care assistance is clearly dominant with 72.6%. For home care, personal assistants are contracted by the care recipients. They need to be registered and certified by the Banco de Previsión Social (BPS, social security fund). Relatives etc. can not become personal assistants.		

FINANCING DIMENSION			
Dominant actor financing	State	Matus-Lopez & Terra, 2021	Medium
Data basis	LTC benefits (both under SNIC and Cupo Cama) are funded by the state budget plus individual co-payments. State-funding makes out the dominant share of the LTC benefits in the SNIC (96% of funding for personal assistance). For residential care (Cupo Cama), state subsidies amount to 33% only, 65% are individual OOP. However, this program makes up only a frac-tion of the overall LTC system, leading to the conclusion that the state is the overall dominant actor.		
REGULATION DIMENSION			
Dominant actor regulation	State		
Dominant scheme for classification (if applicable)	Sistema National Integrado de Cuidados (SNIC)		
Entitlement & eligibility criteria	Defined by the state by law.	Law 19.353	High
Dominant actor criteria	State		
Eligibility assessment	Eligibility assessment is conducted by the SNIC Secretariat, an inter-ministerial coordination body responsible for the SNIC situated within the Ministry of Social Development.	Matus-Lopez & Terra, 2021; Decreto 117/016	High
Dominant actor assessment	State		
Payment/contribution	Decree 117/016 (Art. 24-26) sets out level of subsidies/co-payments for personal assistants according to level of income of recipients (for four different income groups).	Matus-Lopez & Terra, 2021; Decreto 117/016	High
Dominant actor payment	State		
Provider access	Providers need to be certified. The BPS, a state agency, is responsible for registration of home care providers and lists them in a registry.	Matus-Lopez & Terra, 2021; Matus-Lopez & Cid Pedraza, 2016; Decreto 117/016, Art. 3	High
Dominant actor access	State		
Remuneration providers	The remuneration for personal home care assistants is "predefined". Art. 25 of the Decree 117/016 defines the amount of the state subsidy as max-imum hours of care.	Matus-Lopez & Terra, 2021; Decreto 117/016, Art. 25	High
Dominant actor remuner-ation	State		
Provider choice	Home care assistants and teleassistance providers can be chosen from the list of certified providers. (No information on day/night centers.)	Matus-Lopez & Terra, 2021; Decreto 117/016, Art. 14-15	High
Dominant actor provider	Private actors		
Benefit choice	The SNIC Secretariat defines the type of services (home care, teleassis-tance, day/night care). By law, only home and community care services are offered.	Matus-Lopez & Terra, 2021; Law 19.353	Medium
Dominant actor benefit	State		
Main regulation agency	The main body in charge is the SNIC Secretariat, an inter-ministerial body. (Additionally, there are a national care council, the SNIC board and an advisory board.)	Esquivel, 2017; (Matus-Lopez & Terra, 2021; LTC Expert Survey M. Matus-Lopez	High
Dominant actor agency	State		

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