*Typologizing OECD Long-Term Care Systems*

**Abstract**

Providing long-term care (LTC) to the elderly is a major challenge for all welfare states. The financing, provision, regulation, accessibility and performance of LTC systems differ widely across countries, however. To address differences and similarities in these dimensions systematically, we aim to typologize OECD LTC systems. Due to the maturation, economization and marketization of LTC systems an updated and extended typology is needed. Furthermore, compared to earlier typologies, we make three advancements. First, earlier typologies focus either on social services in general or on one aspect of LTC such as migration or family caregiving. Our approach clearly focuses on characteristics of LTC *institutions*. Second, earlier typologies used either solely quantitative OECD or Eurostat data or data on institutional and regulatory aspects of LTC systems. We integrate both approaches by using quantitative OCED data on financing, provision and performance *as well as* institutional data on regulation and accessibility of systems. Third, we use quantitative clustering methods, which are widely used in healthcare and welfare state typologies but not yet in LTC typologies. These advancements increase the empirical basis of comparative LTC systems research and make results more comparable to other welfare and healthcare typologies.

**Introduction**

**Long-term Care Classifications – A brief overview on comparative-institutional research**

Before reviewing the literature on cross country comparative institutional research on LTC a definitions on the definition of LTC is needed. Wide view and definition: LTC is one part of social services and thus typologies on social services include LTC (for the elderly) as one part of their data (often besides data on childcare services) (Anttonen and Sipilä, 1996; Bettio and Plantenga, 2004; Kautto, 2002; Leitner, 2003; Saraceno and Keck, 2010). But there are also typologies and categorizations which focus only on LTC for the elderly (whereby some cannot exclude LTC for the disabled) (Alber, 1995; Colombo, 2012; Damiani et al., 2011; Kraus et al., 2011; Pommer et al., 2009). Close view and concentration on special aspects of LTC: migration in the context of LTC (Anderson, 2012; Da Roit and Weicht, 2013; Simonazzi, 2008; van Hooren, 2012; Simonazzi, 2008), cash for care schemes in LTC (Da Roit and Le Bihan, 2010), informal care by families (Di Rosa et al., 2011; Leitner, 2003; Pfau-Effinger, 2014; Simonazzi, 2008).

Those typologies have several dimensions and indicators. Focusing only on those that focus on elderly care mainly quantitative indicators and dimensions are used: expenditure (Alber, 1995; Colombo, 2012; Damiani et al., 2011; Kraus et al., 2011) type of provision which includes care in cash and in-kind and further divided in home-based and institutional care (Alber, 1995; Damiani et al., 2011; Kraus et al., 2011; Pommer et al., 2009), resources including LTC professionals and bed density (Alber, 1995; Damiani et al., 2011) access (Kraus et al., 2011; Pommer et al., 2009) quality (Damiani et al., 2011). Thus, expenditure data and data on the types of provision seem to be commonly used dimensions, yet, when it comes to resources, accessibility and quality not all use these dimensions. This is a clear limitation. The main reason is the availability of indicators for these dimensions. These are not available in the standard databases of OECD and Eurostat, which are the basis for nearly all typologies (Alber, 1995; Colombo, 2012; Damiani et al., 2011; Kraus et al., 2011) only Pommer et al. (2009) use Share-Data for their typology and are thus the only ones using micro-data for their analysis. Only Kraus et al. (2011) use data which includes the institutional setting and rules for access to the system which are based on the legislative account of the system.

Coming to the clusters that are found Pommer et al. (2009) finds the clusters, that comparative country case studies in social care and studies based on common welfare state typologies (Esping-Andersen, 1990; Ferrera, 1996) use: a nordic model including Sweden, the Netherlands and Denmark, a continental model including Belgium, France, Austria and Germany and a Mediterranean model including Italy, Spain and Greecce. Colombo's (2012) typology includes also three clusters, which are based on the financing and coverage of the LTC systems: universal coverage within a single system, mixed systems and means-tested systems. Only the US and England belong to the last cluster; the first cluster is dominated by northern and western European countries and Japan and Korea. Damiani et al. (2011) find four clusters: one including mainly eastern European and some southern European countries, one southern European cluster including two eastern European countries, and two clusters that include northern and continental European cluster. Kraus et al. (2011) present two typologies. The first one finds two distinct eastern European countries and two distinct clusters including both continental and northern European countries. The second typology find four clusters, too where nearly all clusters include countries from all European regions.

The existing studies are quite weak when it comes to methods. Damiani et al.'s (2011) study uses Multiple factor analysis and principal component analysis and Kraus et al. (2011) use cluster analysis, which is a widely used method to analyse country clusters in welfare state research (Jensen, 2008 XXXXX at best Reibling, Ariaans, Wendt 2019).

What we want to improve compared to the former typologies: We want to use clear dimensions, which have been proved to be important for LTC and social services, we want to use cluster analysis which is common among typologies, we want to extend the number of cases and indictors. The only study, which uses an OECD country sample and not a sample, which is only based on European countries is Colombo (2012), yet the study uses only financing indicators. The study using a large set of indicators and countries is Kraus et al. (2011). Yet, only European countries and the cluster analysis are poorly executed (own index building instead of standardization of indicators in first analysis and for second analysis no standardization at all performed)

**Data and Methods**

Quantitative indicators are based on the OECD health data (date of extraction 10.12.2018). Missing values have been imputed by using interpolation of values by earlier country values and (mean) growth rate and nearest neighbor imputations[[1]](#footnote-1). For institutional indicators a variety of information from different sources have been coded by the first author. In case of ambiguous information, more information on the indicator has been searched and codings were discussed by all authors of the paper. We excluded [countries] due to too many missing data from the analysis.

**Results**

**Conclusion**

In many countries high **regional fragmentation** of services/ access to services which we cannot display (Spasova et al., 2018)

Hard to **draw boundaries between systems**: LTC services in total and especially for the elderly are in some countries more and in some countries less integrated with other social systems (mainly the healthcare system), which might lead differences of what is included/ excluded from a LTC system in different countries. This might lead to an inclusion/ exclusion of indicators which are/are not considered to be indicators of the LTC system.

Although in all countries **family and informal migrant LTC** plays a role in LTC, due to the informal nature of these services it is hard to get and integrate comparative indicators. In some countries, LTC systems and services are still in the process of build-up/ expansion, whereas other countries already retrench mature/ institutionalized systems especially in services and eligibility

**The gap between institutional guarantees and actual access to these rights** (e.g. rights of choice, access to services) can be limited (especially in remote areas). This gap between rights and implementation/ provision might be larger in less mature LTC systems and in general larger than in healthcare systems.

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1. For imputed values see table [XXXXXXXXXXX]. [↑](#footnote-ref-1)