**Appendix**

*Table A1. Calculation of proportional care diamond circle areas and corresponding circle diameters.*

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| **Fuzzy-set membership score** | **Calculation circle area (cm²)** | **Calculation circle diameter based on area (cm)** |
| 1.00 | π \* 4² =  | 50.27 | 2(√50.27 / π) = | 8.00 |
| 0.83 | 50.27 \* 0.83 =  | 41.72 | 2(√41.72 / π) = | 7.29 |
| 0.67 | 50.27 \* 0.67 =  | 33.68 | 2(√33.68 / π) = | 6.55 |
| 0.50 | 50.27 \* 0.50 =  | 25.13 | 2(√25.13 / π) = | 5.66 |
| 0.33 | 50.27 \* 0.33 =  | 16.59 | 2(√16.59 / π) = | 4.60 |
| 0.17 | 50.27 \* 0.17 =  | 8.55 | 2(√8.55 / π) = | 3.30 |
| 0.00 | 50.27 \* 0.00 =  | 0.00 | 2(√0.00 / π) = | 0.00 |

*Table A2. Data and fuzzy-set membership scores for the financing dimension.*

*Note: Data for system introduction refers, if available, to a time span of three years after de jure implementation date. Data for the system ‘today’ refers to the latest data available, generally for the 2010s (with exception of the Netherlands where data refers to the situation before 2015).*

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Country (time)** | **Raw data** | **Sources** | **Confidence** | **ST** | **SA** | **PPA** | **PIA** |
| Germany (introduction) | The SLTCI is financed almost exclusively from insurance contributions (mostly payed by employees and employers). No individual co-payments or state co-financing shares are foreseen. | Mager, 1999; Rothgang, 2010; PflegeVG | High | 0.0 | 1.0 | 0.0 | 0.0 |
| Germany (today) | The SLTCI is financed almost exclusively from insurance contributions (mostly payed by employees and employers). No individual co-payments or state co-financing shares are foreseen. | Bundesministerium für Gesundheit [BMG], 2021; PflegeVG | High | 0.0 | 1.0 | 0.0 | 0.0 |
| Israel (introduction) | 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 National Insurance Institute (NII) in financing LTCI (transfers to the LTCI of surpluses from other branches of the NII, mainly from the children branch): 57%It is unclear if the 57% of general NII co-financing can be attributed to the state or societal actors, as they are social contributions but not earmarked specifically for LTC. Therefore, we split the 57% between both actor types, leading to an assumed financing mix of appr. 56.3% societal actors financing and 43.8% state financing. | Asiskovitch, 2013; Borowski & Schmid, 2001; Schmid, 2005 | Low | 0.33 | 0.67 | 0.0 | 0.0 |
| Israel (today) | Today, the contribution shares to the LTCI are 0.13% for employers, 0.14% for employees and 0.02% for state co-financing (Borowski 2015).Since the inception of the scheme, the share covered by earmarked contributions has declined. The share covered by the general NII budget is even higher today than in 1994.In 2011, the shares were the following (Asiskovitch 2013):Insurance fees for LTCI: 14.1%Ministry of financing contributions: 20.6%Share of National Insurance Institute (NII) in financing LTCI (transfers to the LTCI of surpluses from other branches of the NII, mainly from the children branch): 65.3%It is unclear if the 65% of general NII co-financing can be attributed to the state or societal actors, as they are social contributions but not earmarked specifically for LTC. Therefore, we split the 65.3% between both actor types, leading to an assumed financing mix of appr. 46.75% societal actors financing and 53.25% state financing. | Asiskovitch, 2013; Borowski, 2015 | Low | 0.67 | 0.33 | 0.0 | 0.0 |
| Japan (introduction) | Social insurance contributions (different types of premia for persons aged 40-64 and 65+) and state funding (from central, regional and local level) each make out 45% of total SLTCI funding. The remaining 10% are OOP co-payments by recipients. | Campbell & Ikegami, 2000; Ozawa & Nakayama, 2005 | High | 0.33 | 0.33 | 0.0 | 0.17 |
| Japan (today) | The basic financing structure of the LTCI has not changed since introduction, public financing still makes out 80-90% and is equally shared between premiums and taxes. Individual co-payments for recipients with high income/asset levels have been increased to 20% in 2015 and 30% in 2018. However, this higher co-payment level is only payed by less than 10% of users (Ikegami 2019). | Ikegami, 2019; Ministry of Health, Labour and Welfare [MHLW], 2016 | High | 0.33 | 0.33 | 0.0 | 0.17 |
| Luxembourg (introduction) | There are three sources of funding for the dependency insurance according to the loi AD:1) 45% is financed by the state budget2) revenue from a special tax levied on the energy sector are used3) social insurance contributions of 1% levied on income of members (from work, transfers and capital earnings) are collected.Individual co-payments are not a source of financing.In 2004, the shares were the following (Ministère de la Sécurité Sociale 2013):53.5% contributions43.4% state3% energy tax and others | Kerschen, 2008; Ministère de la Sécurité Sociale, 2013; loi AD | High | 0.33 | 0.67 | 0.0 | 0.0 |
| Luxembourg (today) | The AD is generally financed by the same three sources outlined above. The state contribution is now by law at 40%, and the insurance contribution was increased to 1.4% of income meanwhile.In 2011, the shares were the following (Ministère de la Sécurité Sociale 2013):66.9% contributions31.8% state1.2% energy tax and others | Ministère de la Sécurité Sociale, 2013; Pacolet & Wispelaere, 2018; loi AD | High | 0.33 | 0.67 | 0.0 | 0.0 |
| Netherlands (introduction) | 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%. Co-payments were probably below 10% at system establishment, in 1983 they covered 8.93% of the care cost (Poske 1985). | Poske, 1985; van Nostrand et al., 1995; Companje, 2014; Winters, 1996 | Medium | 0.67 | 0.17 | 0.0 | 0.0 |
| Netherlands (today) | In the 2000s, the AWBZ is financed more by contributions than taxes.In 2008, 68% of the AWBZ is financed by income-related contributions and 24% by tax-based state subsidies (Schut and van den Berg 2010; see also OECD 2011). Co-payments make out 7-9% (in 2011/2008, depending on year and source). | Deken & Maarse, 2014; Organisation for Economic Co-operation and Development [OECD], 2011c; Schut & van den Berg, 2010 | High | 0.17 | 0.67 | 0.0 | 0.0 |
| South Korea (introduction) | The main share of financing in the SLTCI comes from SI contributions by employees and employers collected by the National Health Insurance Corporation (together with the Health Insurance Contribution, but managed separately). However, state and private individual financing also make out a large share. There is co-financing by the state of around 20% and 15-20% of individual co-payment financing are generally required. | Choi, 2014; Chon, 2012; Rhee, Done, & Anderson, 2015 | High | 0.17 | 0.67 | 0.0 | 0.17 |
| South Korea (today) | The financing mix of the Korean LTCI is still the same as at introduction. | Kim & Kwon, 2021 | High | 0.17 | 0.67 | 0.0 | 0.17 |

*Table A3. Data and fuzzy-set membership scores for provision dimension.*

*Note: Data for system introduction refers, if available, to a time span of three years after de jure implementation date. Data for the system ‘today’ refers to the latest data available, generally for the 2010s (with exception of the Netherlands where data refers to the situation before 2015).*

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Country (time)** | **Raw data** | **Sources** | **Confidence** | **ST** | **SA** | **PPA** | **PIA** |
| Germany (introduction) | SLTCI benefit recipients can receive in-kind services (home and community care or residential/stationary care) or monetary benefits or a combination of services and benefits (for home care).In 1998, shares for the different kinds of benefits within the social LTCI were distributed as follows (BMG 2020):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-profit17.3% state16.1% private for-profitThe shares of home care providers were the following in 2001 (Theobald 2004):52% private for-profit46% non-profit2% stateRecipients 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% | BMG, 2020; Mager, 1999; Rothgang, 2010; Theobald, 2004, 2012; PflegeVG | High | 0.0 | 0.17 | 0.17 | 0.67 |
| Germany (today) | The shares of benefit types received in 2015 were the following (Rothgang and Müller 2018):49.5 % cash benefitsca. 26.4 % in-kind ambulatory care ca. 24.1 %, in-kind institutionalThe shares of formal provider types were the following in 2015 (Rothgang and Müller 2018):Ambulatory care (see also Theobald et al. 2018)65.1% for-profit33.5% non-profit1.4% public bodiesInstitutional care:53% non-profit42.2 % for-profit4.8% public bodiesThe cash benefit can be used freely and supports to a great extend informal care arrangements with care provided by family members or other persons from the care recipients social network. However, approx. 8% of cash benefit recipients employ live-in migrant care workers (Benazha et al. 2021).The overall shares of different provider types are consequently the following:State: 1.5%Societal actors: 21.6%Private for-profit actors: 31.3%Private individual actors: 45.5% | Benazha, Leiblfinger, Prieler, & Steiner, 2021; Rothgang & Müller, 2018; Theobald, Szebehely, Saito, & Ishiguro, 2018 | High | 0.0 | 0.17 | 0.17 | 0.33 |
| Israel (introduction) | In the SLTCI system, 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).(Later, 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.) | Ajzenstadt & Rosenhek, 2000; Borowski & Schmid, 2001; Brodsky & Naon, 1993; Morginstin, Baich-Moray, & Zipkin, 1993; Schmid, 2005 |  Medium | 0.0 | 0.83 | 0.17 | 0.0 |
| Israel (today) | For- and non-profit agencies are still the main providers of LTC. However, their shares have reversed. In the late 2000s/ early 2010s, the market shares are ca. 30% non-profit and 70% for profit providers (Schmid 2009; Borowski 2015).The option of receiving cash-benefits was expanded during a regional pilot program running from 2008-2013. However, around 2010 the less than 1% of recipients overall received cash-benefits (Asiskovitch 2013). In 2018, a reform of the SLTCI was passed which will offer a regular choice between cash and in-kind benefits (Ayalon 2018; Hasson and Buzaglo 2019). We will not consider this new provision structure here as implementation is still too recent. | Asiskovitch, 2013; Ayalon, 2018; Borowski, 2015; Hasson & Buzaglo, 2019; Schmid, 2009 | High | 0.0 | 0.17 | 0.67 | 0.0 |
| Japan (introduction) | The LTCI offers in-kind benefits, both for home and community and residential care.In 2000, the user shares of benefit types were the following (Ikegami 2021):Home help: 25%Day care: 34.6%Visiting nurse: 11.4%* Home and community services total: 71%

Institutional care: 29%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 corporations, NPO, agricultural cooperatives): 43.2%For-profit organisations: 53.9%Others: 2.3%Residential care is provided 70-90% (depending on type) by traditional non-profit providers (Saito 2014).Ikegami (2021) specifies the share of users serviced by for-profit providers in different home-based care services 2000 as follows:Home help: 30.3%Day care: 4.5%Visiting nurse: 6%Based on this data, overall actor shares for the mid-2000s are approximately the following.State: below 10%Non-profit: 51-60%For-profit: 38%In 2000, the for-profit share was still at 10% (Ikegami 2021). Therefore, we code mostly not provided by for-profit actors (0.17). | Campbell, 2014; Campbell & Ikegami, 2003; Ikegami, 2021; Ozawa & Nakayama, 2005; Saito, 2014 | Medium | 0.0 | 0.67 | 0.17 | 0.0 |
| Japan (today) | The shares of different service types in 2016 were the following according to the Ministry of Health, Labour and Welfare (2017):73% in-home services27% residential/in-facility servicesSplitting up the in-home services, Ikegami (2021) specifies different services as follows:Home help: 27.4%Day care: 31.9%Visiting nurse: 12.8%These are the shares of provider types in home-based care services in 2014 as specified by Theobald et al. (2018):Public: 0.3%Non-profit providers: 35.3%For-profit providers: 64.4%Ikegami (2021) specifies the share of users serviced by for-profit providers in different home-based care services 2016 as follows:Home help 64.1%Day care 44.9%Visiting nurse: 47.2%In institutional care, no private for-profit providers are allowed. Institutional care is provided 70-90% (depending on type) by traditional non-profit providers (Saito 2014).Based on this data, the overall weighted shares (2014/6) of provider types are approximately:State: below 10%Non-profit: 55-63%For-profit: 38-47% | Ikegami, 2021; MHLW, 2017; Saito, 2014; Theobald et al., 2018 | Medium | 0.0 | 0.67 | 0.33 | 0.0 |
| Luxembourg (introduction) | The AD offers both home/community and residential in-kind care services as well as monetary benefits (for home care). In home care, a combination of in-kind and cash benefits is possible and common. In 2002, shares of care recipients were distributed as follows (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 and 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 and 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 more relevant than state actors. Lacking more specific information, we assume that the state is mostly not providing and private for-profit and societal actors with similar shares not dominantly providing.(Informal care for cash beneficiaries can be provided by private individual and/or private for-profit actors (MISSOC 2009).) | Kerschen, 2008; Koster & Ribeiro, 2010; Köstler, 1999; Mutual Information System on Social Protection in the EU member states, the EEA and Switzerland [MISSOC], 2009; OECD, 2005; Pacolet & Wispelaere, 2018 | Low | 0.17 | 0.33 | 0.33 | 0.17 |
| Luxembourg (today) | In 2016, the shares of different benefits in the AD were the following (Pacolet and De Wispelaere 2018):Institutional care: 33%Home-care services: 14%Home-care cash & services: 42.1%Home-care cash: 10.7%Consequently, a majority of 89.3% receives at least some formal care. As outlined above, there is no data on the share for formal provider types but the state seems to be less relevant than private non/for-profit providers. While the share of pure cash-benefit recipients diminished in the last 15 years, with a share of a bit over 10% and a large share of mixed benefits it seems plausible that informal care is still somewhat relevant. For receiving the cash-benefit, an informal assistant must be present and registered with the CEO (MISSOC 2016). | Koster & Ribeiro, 2010; MISSOC, 2016; Pacolet & Wispelaere, 2018 | Low | 0.17 | 0.33 | 0.33 | 0.17 |
| Netherlands (introduction) | 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. | Companje, 2014; Meijer, van Campen, & Kerkstra, 2000; van Hooren & Becker, 2012; van Nostrand et al., 1995; Winters, 1999 | Medium | 0.0 | 1.0 | 0.0 | 0.0 |
| Netherlands (today) | At the end of the 2000s, around 10% of LTC recipients received the personal budget (PB, i.e. cash benefits), while 90% received services (home/community and institutional care).Formal services are mainly provided by private non-profit providers. Rodrigues and Nies (2013) report the following shares for formal services:Public: 0%Privat non-profit: 80%Private for-profit 20%In 2007, the PB was used one third only for informal care, one-third for only formal care and one-third for a combination (Da Roit 2013; see also Schut and van den Berg 2010). Consequently, the share of informal caregiving within the AWBZ scheme was below 10% overall. | Da Roit, 2013; Deken & Maarse, 2014; Mot, 2010; Rodrigues & Nies, 2013; Schut & van den Berg, 2010 | Medium | 0.0 | 0.83 | 0.17 | 0.0 |
| South Korea (introduction) | The LTCI offers in-kind residential and home/community care services. In both types of in-kind care private for-profit actors are dominant. Cash benefits are only possible in exceptional circumstances. In 2011, types of care had approximately the following shares (Lee 2014; Sunwoo 2012):35% institutional care65% home care (overwhelmingly home visit care)The shares for institutional care were the following in 2011 (Sunwoo 2012):2.9% state35.6% “institutions of various corporations”61.3% for-profit institutionsThe share of private for-profit actors in home visit care in 2011 was 81-82% (Choi 2014; Chon 2014).Based on this data, overall actor shares weighted by benefit shares are approximately the following:State: <10%Societal actors: 12-25%Private for-profit actors: 74% (<75%) | Choi, 2014; Chon, 2014; Lee & Kim, 2014; Sunwoo, 2012; LTCI Act | Medium | 0.0 | 0.17 | 0.67 | 0.0 |
| South Korea (today) | The provision structure is essentially the same. Recent publications point out that “about 70-80% of providers are from the private sector” (Kwon 2021; Jeon and Kwon 2017). While the share could therefore have increased slightly, we stay with the former coding were more fine-grained data is available. | See above; Jeon & Kwon, 2017; Kwon, 2021 | Medium | 0.0 | 0.17 | 0.67 | 0.0 |

*Table A4. Data for the six regulatory sub-dimensions.*

*Note: All data refers to the introduction point and original regulation of the system. If actor responsibilities changed, data for today is specified additionally. Data for system introduction refers, if available, to a time span of three years after de jure implementation date. Data for the system ‘today’ refers to the latest data available, generally for the 2010s (with exception of the Netherlands where data refers to the situation before 2015).*

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| **Germany** |
| *Eligibility assessment* | Societal actorsThe Medical Review Board (Medizinischer Dienst der Krankenversicherung) of the sickness/LTC funds conduct the assessment of care dependency. (§18 PflegeVG) | PflegeVG; Mager, 1999; Rothgang, 2010 | High |
| *Payment/contributions* | StateThe pay-roll contribution rates for employers/employees are set by law (§55 PflegeVG). | PflegeVG | High |
| *Provider access to system* | Private actorsThere are no specific regulation/criteria for home-care and residential care providers to fulfil to access the public LTC system, except general licencing for fulfilling formal minimum standards (regarding staff qualifications). Any provider who meets these standards can offer benefits and receive remuneration within the public LTC system.There is no regulation for the use of the cash benefit, it can be employed (or not) to remunerate any care provider without access control (family member, domestic care worker, etc.). | Evers, 1998; Rothgang, 2010 | High |
| *Remuneration/fees* | State & societal actorsThe 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 associations), i.e. by societal actors. | PflegeVG; Mager, 1999; Rhee et al., 2015; Rothgang, 2010 | High |
| *Provider choice* | Private actorsThere is price-based competition within the public LTC system, implying that care recipients can choose providers themselves. | Götze & Rothgang, 2014; Rothgang, 2009 | Medium |
| *Benefit choice* | Private actorsCare 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 residential care is not specifically controlled by public actors and can normally also be chosen by care recipients. | PflegeVG; Mager, 1999; Rothgang, 2010 | High |
| **Israel** |
| *Eligibility assessment* | State & societal actorsEligibility 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). | Ajzenstadt & Rosenhek, 2000; Borowski & Schmid, 2001; Morginstin et al., 1993 | High |
| *Payment/contributions* | StateThe contribution rates were specified by the state in the LTCI law. | OECD, 2011a; Schmid, 2005 | High |
| *Provider access to system* | Societal actorsProviders 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. | Ajzenstadt & Rosenhek, 2000; Brodsky & Naon, 1993; Iecovich, 2012; Morginstin et al., 1993 | Medium |
| *Remuneration/fees* | StatePrices 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 |
| *Provider choice* | State & societal actorsLocal 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. | Ajzenstadt & Rosenhek, 2000; Borowski & Schmid, 2001; Iecovich, 2012; Morginstin et al., 1993 | High |
| *Benefit choice* | State & societal actorsBy 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 package 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). | Ajzenstadt & Rosenhek, 2000; Asiskovitch, 2013; Iecovich, 2012 | High |
| **Japan** |
| *Eligibility assessment* | StateMunicipalities 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; Maags, 2020; Ozawa & Nakayama, 2005 | High |
| *Payment/contributions* | StateThe premium is defined by municipal governments for a period of three years.Co-payments are determined centrally by the state. | Campbell & Ikegami, 2009; Ikegami, 2019; Ozawa & Nakayama, 2005 | High |
| *Provider access to system* | State & private actorsIn 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 prohibited by the state. | Campbell, 2014; Campbell & Ikegami, 2003; Ozawa & Nakayama, 2005 | Medium |
| *Remuneration/fees* | StateThere are centrally set fees (national applicability with regional cost adjustments) decided by the Ministry of Health, Labour and Welfare every three years. | Campbell & Ikegami, 2003; Rhee et al., 2015; Tsutsumi, 2014 | Medium |
| *Provider choice* | Societal actors & private actorsThe 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. | Campbell & Ikegami, 2003; MHLW, 2016; Ozawa & Nakayama, 2005; Saito, 2014 | High |
| *Benefit choice* | Societal actors & private actorsThe 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. | Campbell & Ikegami, 2003; MHLW, 2016; Ozawa & Nakayama, 2005; Saito, 2014 | High |
| **Luxembourg** |
| *Eligibility assessment* | StateCare dependency is assessed by the Cellule d’Evaluation et d’Orientation (CEO), a public administration body under the Ministry of Social Security. | Kerschen, 2008; Koster & Ribeiro, 2010; Spruit & Hohmann, 2014 | High |
| *Payment/contributions* | StateThe law defines the shares of the different sources used for financing the AD. The income contribution was set at 1% originally (now 1.4%) by law (Art. 376 Loi AD). | Loi AD; Luxembourg Presidency, 2005 | High |
| *Provider access to system* | StateMinistries (of Health/Social Affairs/Family Affairs) are responsible for licencing/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. | Loi AD; MISSOC, 2009; OECD, 2011c; Pacolet & Wispelaere, 2018 | Medium |
| *Remuneration/fees* | State & societal actorsRemuneration 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. | Loi AD; Kerschen, 2008; MISSOC, 2013 [2002]; OECD, 2011c; Pacolet & Wispelaere, 2018; Spruit & Hohmann, 2014 | High |
| *Provider choice* | Private actorsBoth formal and informal providers can be chosen by the care recipient. | MISSOC, 2009; OECD, 2005; Spruit & Hohmann, 2014 | High |
| *Benefit choice* | State & private actorsCare 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. | Kerschen, 2008; Luxembourg Presidency, 2005; MISSOC, 2009 | High |
| **Netherlands** |
| *Eligibility assessment (introduction)* | Societal actors & private actorsUntil 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 et al. 2012; Schäfer et al. 2010). Formally, eligibility had to be approved by the health insurance funds as the main administrative body. | Böhm, Schmid, Götze, Landwehr, & Rothgang, 2012; Poske, 1985; Schäfer et al., 2010; Winters, 1996, 1999 | Medium |
| *Eligibility assessment (today)* | StateThe eligibility/needs assessment is conducted by the Centrum Indicatiestelling Zorg (CIZ, Center for Care Needs Assessment) since 2005. The CIZ is an independent national organisation with regional branches under the responsibility of the Ministry of Health, Welfare and Sport. | Centrum indicatiestelling zorg [CIZ], 2021; Da Roit, 2013; Deken & Maarse, 2014; Dijkhoff, 2018 | High |
| *Payment/contributions (introduction)* | StateThe main financial responsibility rests with the government. The information retrieved implies that the state decides on contribution rates, level of government subsidies and level/organization of co-payments. | Mot, 2010; Spoor, 2014; Winters, 1996 | Medium |
| *Payment/contributions (introduction)* | StateRevenues of the AWBZ are collected by a General Fund centrally. Both the contribution rates and co-payments seem to be determined by the state (AWBZ Art 6, 17). | AWBZ (version 2014); Dijkhoff, 2018; Schut & van den Berg, 2010 | Medium |
| *Provider access to system (introduction)* | StateNursing 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. | Da Roit, 2013; Winters, 1996 | High |
| *Provider access to system (today)* | State & societal actorsThe Regional Care Offices are responsible for contracting providers. For some time in the 2000s, they were allowed to selectively contract care providers (Gingrich 2011). In the instiutional care sector, for-profit providers are not allowed, while in home care they are (next to non-profit actors) (EC 2016; Riedel and Kraus 2011). This seems to be determined by the state. The use of the PB is to some extend regulated/controlled yb the regional care offices (Kelders and De Vaan 2018). | Deken & Maarse, 2014; European Commission [EC], 2016; Gingrich, 2011; Kelders & De Vaan, 2018; Riedel & Kraus, 2011 | Low |
| *Remuneration/fees (introduction)* | Societal actorsUntil 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 |
| *Remuneration/fees (today)* | State & societal actorsIn 2010 care packages with defined levels of remuneration are employed. The maximum tariffs providers can receive for providing packages is set by the Dutch Healthcare Authority. In this framework, the regional care offices (zorgkantoren) who function as the purchasers negotiate the concrete remuneration levels with care providers. Care providers are mainly societal actors (see above). The Care Offices are independently and are connected to the largest healthcare insurer in a region (Zorguerzekeraars Nederland n.d.). Health Insurers are dominantly non-for profit organisations (Kroneman et al. 2016). | Da Roit, 2013; Deken & Maarse, 2014; Kelders & De Vaan, 2018; Kroneman et al., 2016; Zorguerzekeraars Nederland, n.d. | Medium |
| *Provider choice (introduction)* | Private actorsRecipients can choose their preferred care facility. (In practice, this can be limited as places are scarce and there are waiting lists.) | Mot, 2010; Poske, 1985; Winters, 1996 | Medium |
| *Provider choice (today)* | Private actorsCare recipients can choose providers (from the ones contracted with the Care Offices). There is no change in this sub-dimension. | Dijkhoff, 2018 | Medium |
| *Benefit choice (introduction)* | StateAs there is only one type of benefits (residential care, see provision), the state has predefined the benefit type by law. |  | High |
| *Benefit choice (today)* | State & private actorsIn the later years of the AWBZ system (mid 1990s-mid 2010s), there was limited choice of benefit types for care recipients. Besides residential and home care in kind, there was also the possibility of receiving a personal budget (PB). However, there was no “legal right” to the PB option and it was subject to budgetary constraints (Dijkhoff 2018). The regulations of the PB were made my ministerial degree. (This was later changes with more choice being introduced with the Wlz). (From the late 2000s, parts of home care were transferred to a separate scheme, the WMO, under responsibility of the municipalities). | Da Roit, 2013; Deken & Maarse, 2014; Dijkhoff, 2018 | High |
| **South Korea** |
| *Eligibility assessment* | Societal actorsThe National Health Insurance Corporation (NHIC) is responsible for eligibility assessment. (The NHIC can also delegate assessment to municipalities/cities.) | LTCI Act; Maags, 2020; OECD, 2011b; Rhee et al., 2015 | High |
| *Payment/contributions* | StateThe LTCI Act defines that the premiums will be set by a Presidential Decree (Art. 9). | LTCI Act | Medium |
| *Provider access to system* | Private actorsThere is no specific entry control for service providers in the LTCI system, a “provider market” was established. (There are general minimum licensing requirements, regulated by the state.) | Chon, 2012; Rhee et al., 2015 | Medium |
| *Remuneration/fees* | Societal actorsThe provider fees are nationally uniform, set by the NHIC. | Rhee et al., 2015 | Medium |
| *Provider choice* | Private actorsBeneficiaries are free to choose providers, there is no external regulation. | Choi, 2014; OECD, 2011b | High |
| *Benefit choice* | State & private actorsThere 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. | Choi, 2014; Kim, 2020; Seok, 2010 | High |

*Table A5. Fuzzy-set coding for regulatory dimension based on data from Table A4.*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Country (time)** | **Raw data** | **ST** | **SA** | **PA** |
| Germany (introduction) | 1.5 dimensions state1.5 dimensions societal actors3 dimensions private actors | 0.17 | 0.17 | 0.5 |
| Israel (introduction) | 3.5 dimensions state2.5 dimensions societal actors | 0.67 | 0.33 | 0 |
| Japan (introduction) | 3.5 dimensions state1 dimension societal actors1.5 dimensions private actors | 0.67 | 0.17 | 0.17 |
| Luxembourg (introduction) | 4 dimensions state0.5 dimension societal actors1.5 dimensions private actors | 0.67 | 0 | 0.17 |
| Netherlands (introduction) | 3 dimensions state1.5 dimensions societal actors1.5 dimensions private actors | 0.5 | 0.17 | 0.17 |
| Netherlands (today) | 3.5 dimensiosn state1 dimension societal actors1.5 dimensions private actors | 0.67 | 0.17 | 0.17 |
| South Korea (introduction) | 1.5 dimensions state2 dimensions societal actors2.5 dimensions private actors | 0.17 | 0.33 | 0.33 |

*Table A6. Main regulatory agency of SLTCI system.*

*Note: Data is valid for introduction and today.*

|  |  |  |  |
| --- | --- | --- | --- |
| **Country** | **Raw data** | **Sources** | **Confidence** |
| Germany | Societal actorsThe LTC funds (‘Pflegekassen’), which are independent but coupled with sickness funds are the main administrative/management bodies of the SLTCI scheme. | Evers, 1998; Rhee et al., 2015; Rothgang, 2010; PflegeVG | High |
| Israel | Societal actorsThe National Insurance Institute (NII) is the main responsible institution for administering the SLTCI scheme. | Asiskovitch, 2013; Chernichovsky, Koreh, Soffer, & Avrami, 2010 | Medium |
| Japan | StateThe municipalities act as the insurer and are the main responsible agency. | Campbell & Ikegami, 2003; Ozawa & Nakayama, 2005 | High |
| Luxembourg | State & societal actorsThe main administrator of the AD is the Caisse Nationale de la Santé (CNS, national health fund). However, different state agencies (Ministries, Cellule d’Evaluation et d’Orientation/CEO) are also heavily involved in regulating LTC. | Koster & Ribeiro, 2010; OECD, 2011c; Pacolet & Wispelaere, 2018; Loi AD | High |
| Netherlands | State & societal actorsHealth 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. The sickness funds/regional offices are only partially responsible for financing, there is a central budget managed by the state. | Companje, 2014; Meijer et al., 2000; Mot, 2010; Spoor, 2014; Winters, 1999 | High |
| South Korea | Societal actorsThe National Health Insurance Corporation is the main regulatory/administrative body of the SLTCI. | Chon, 2012; Maags, 2020; LTCI Act | High |

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