INSTITUT FÜR HÖHERE STUDIEN
INSTITUTE FOR ADVANCED STUDIES
Vienna

A Typology of LTC systems in Europe
Results from Work Package 1 of the ANCIEN project

Monika Riedel

M. Kraus, E. Mot, P. Willemé, G. Röhrling, T. Czypionka

ANCIEN Final Conference
The future of LTC in Europe:
Challenges for LTC systems in the face of ageing populations

CEPS, 1, Place du Congrès - 1000 Brussels
Wednesday, 24 October 2012

Outline

- **Research questions**
- **Data collection**
- **Typology 1**
- **Typology 2**
- **Selection of the countries**

Objective and research question

The objective of WP 1 was:

- **to portray long-term care systems** in light of provision of care and financing and
- **to derive a typology of LTC systems**

The role of the typology within the ANCIEN project was:

- to enable **selection of representative countries** from homogeneous cluster for a detailed modelling in the later WPs
- **data availability** was an important consideration in this selection

Data collection

- An **extensive questionnaire** was developed and as far as possible completed by project partners for their respective countries. It was organised in several blocks of questions focussing on **macrostructure**, **funding and financing**, **informal care**, **formal institutional care**, **formal home based care** and **policy issues**.
- The **questionnaire-based collection of data** on LTC resulted in **limited availability** and **comparability of quantitative data**, even though done by national experts. This is particularly true when for **more detailed** or **setting-specific information** was asked.
- **Approach:** to fully exploit available quantitative and qualitative data, we derived **two typologies**, each with **different focus**.

Two typologies of LTC systems in Europe

Typology 1:
based on
system characteristics

- relies on **qualitative** characteristics
- uses **ordinal** variables
- includes **21 EU-member states**
- derived **by formal cluster analysis**

Typology 2:
based on
use and financing

- relies on **quantitative** information
- uses **metric and pseudo-metric** variables
- includes **14 (17) EU-member states**
- derived **by formal cluster analysis**

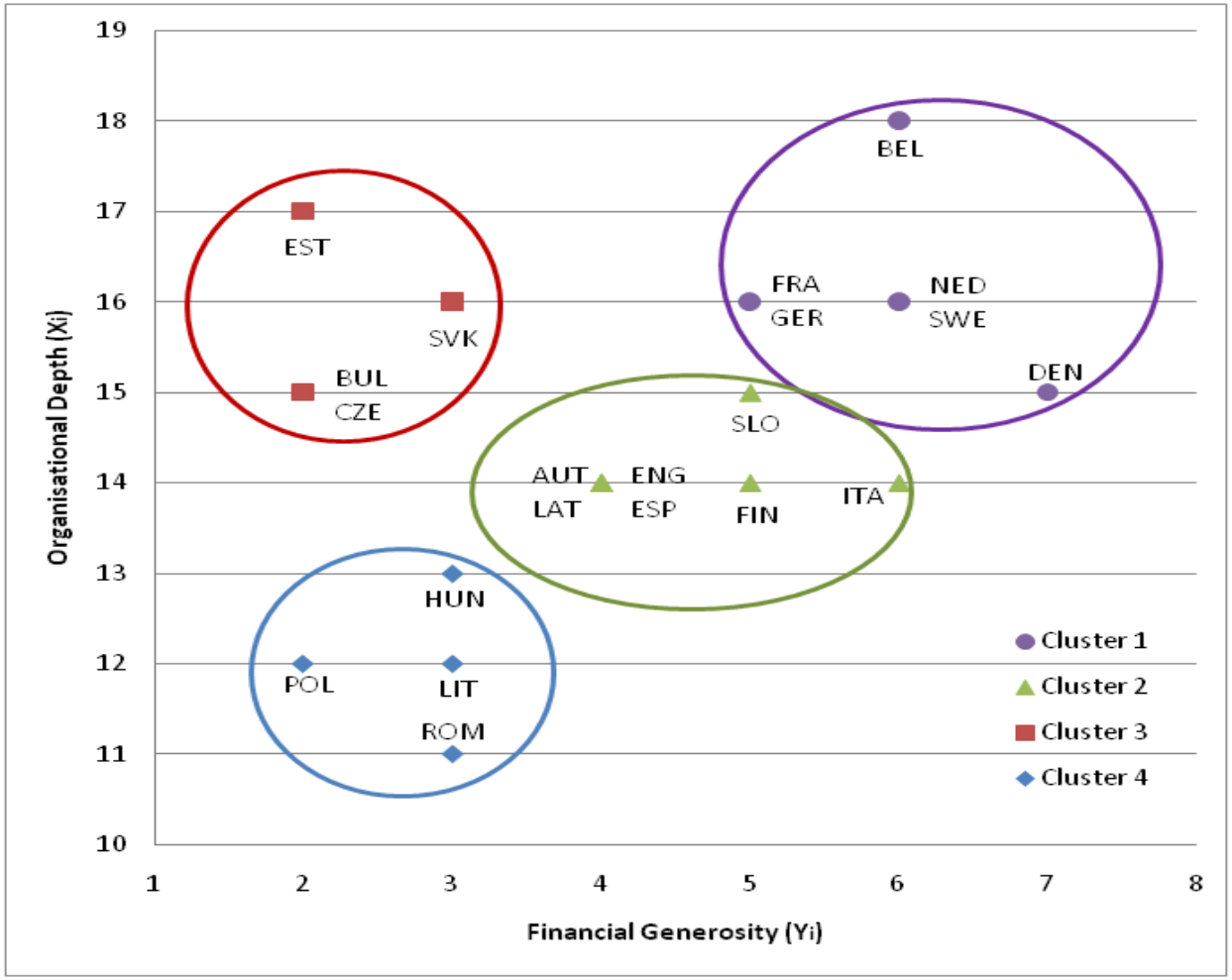
TYPOLOGY 1:
based on
system characteristics

"Which system characteristic is more preferable from the patient's point of view?"

Variables/Results (1)

Organisational Depth

- **Means-tested access**
- **Entitlement**
- **Availability of cash benefits**
- **Choice of provider**
- **Quality assurance**
- **Integration / coordination of care**



Financial Generosity

Cost sharing

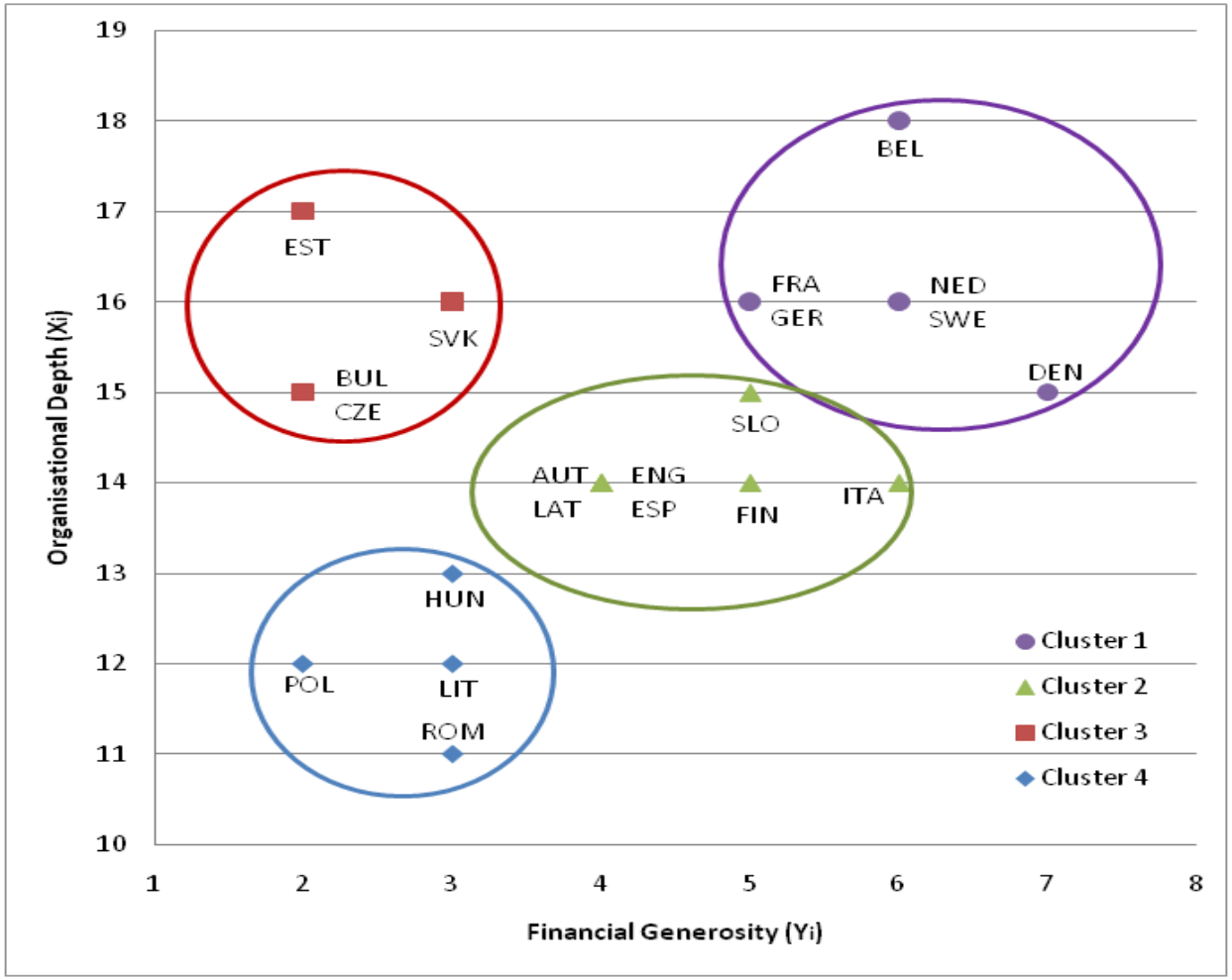
Public expenditures as share of GDP

Results (2)

high

Patient friendliness

low



low ← Patient friendliness → high

Source: Kraus et al. (2010)

Results (3)

- **Old EU-member states** tend to have LTC-systems with a **higher degree of patient friendliness**.
- Organisational depth: there is **NO clear distinction** between **old** and **new EU-member states**. Only Lithuania, Poland, Romania and, to a lesser degree, Hungary are lacking behind in this matter.
- Financial generosity: a **gap between old** and **new EU-member states can be observed**. Old EU-member states tend to be more generous to care recipients than new EU-member states.
- A **Scandinavian, Continental** and **Mediterranean country group cannot be exactly identified** but there is some degree of compatibility with this classification.
- **New EU-member states do not form a cluster by themselves**. Though sharing the feature of low spending on LTC, they differ widely with regard to organisational aspects.
- Not even the **Baltic States are altogether in one cluster**. They are spread over three clusters.

TYPOLOGY 2:
based on
use and financing

Variables

- **Formal cluster analysis** with composite variables:
  - ➔ Public expenditure on LTC as a share of GDP, corrected for the share aged 65+
  - ➔ Private expenditure as a share of LTC spending
  - ➔ Informal care recipients aged 65+ as a share of the population aged 65+
  - ➔ Support for informal care givers
- The following **variables** were considered, but **excluded** by factor analysis:
  - ➔ Formal care recipients aged 65+ as a share of the population aged 65+
  - ➔ Accessibility (sum of means testing and entitlements)
  - ➔ Targeting with respect to level and severity of needs
  - ➔ Average cash-benefit available for HBC and FIC, income corrected

Results (1)

Nature of the system	Countries	Characteristics
Cluster A informal care oriented, low private financing	Belgium,* Czech Republic, Germany, Slovakia	low public spending, low private spending, high IC use, high IC support, cash benefits modest
Cluster B generous, accessible and formalised	Denmark, the Netherlands, Sweden	high public spending, low private spending, low IC use, high IC support, cash benefits modest
Cluster C informal care oriented, high private financing	Austria, England, Finland, France, Spain	medium public spending, high private spending, high IC use, high IC support, cash benefits high
Cluster D high private financing, informal care seems necessity	Hungary, Italy	low public spending, high private spending, high IC use, low IC support, cash benefits medium

Note: IC = Informal care; * medium public spending

Source: Kraus et al. (2010)

Results (2)

In terms of expenditure:

- **Cluster B** is characterised by countries with a **highly developed and "generous" public LTC system**.
  This group represents the so-called **"Scandinavian" model**.
- On the opposite side, **Cluster C** and **Cluster D** are characterised by **low- or medium- expenditure countries with considerable private financing**.
  There is no clearly discernible geographical pattern as these two clusters include Mediterranean, Central European and Scandinavian countries as well as England.
- **Cluster A** is an **intermediate case, comprising less generous systems with a low share of private financing**.
  Geographically, **Cluster A** is rather **compact and Central European**.

Results (3)

In terms of the role of informal care:

- **There are two opposite (Cluster B, Cluster D) and two intermediate (Clusters A, C) systems**

Cluster B	Clusters A, C	Cluster D
Low informal use High carer support	**High informal use High carer support**	**High informal use Low carer support**
Highly developed system with high funding Low informal use: • High availability of formal care • Preferences	High informal care use and support with various spending patterns High informal use: • Preferences	Poorly developed formal system with low funding High informal use: • Low availability of formal care

Selection of countries

Selection needed to balance two aspects:

1.) availability of data and

2.) being representative for the cluster

Nature of the system	Countries
Cluster A informal care oriented, low private financing	Belgium, Czech Republic, **Germany,** Slovakia, (Estonia)
Cluster B generous, accessible and formalised	Denmark, **the Netherlands**, Sweden
Cluster C informal care oriented, high private financing	Austria, England, Finland, France, (Slovenia), **Spain**
Cluster D high private financing, informal care seems necessity	Hungary, Italy, (**Poland**)

Thank you for your attention!

Contact

Dr. Monika Riedel

Institute for Advanced Studies, Vienna (IHS)
Stumpergasse 56
A- 1060 Vienna

Phone: +43 1/59991 229
E-Mail: riedel@ihs.ac.at