Long-term beds in facilities and hospitals

While countries have increasingly taken steps to ensure that people in need of long-term care (LTC) services who wish to live at home for as long as possible can do so, many people will at some point require LTC services that cannot be delivered at home. The number of beds in LTC facilities and in LTC departments in hospitals offers a measure of the resources available for delivering LTC services to individuals outside their home.

Across OECD countries, there were 47 beds per 1 000 people aged 65 and over in 2017 (Figure 11.26). The vast majority of beds – 44 per 1 000 people aged 65 and over – were located in LTC facilities, with just three LTC beds per 1 000 people in hospitals. The number of LTC beds per 1 000 people aged 65 and over varies enormously between OECD countries. Luxembourg, the country with the highest number (82.8 beds), had more than 18 times more beds than Greece (4.5 beds), the country with the lowest number in 2017. Five countries – Italy, Latvia, Poland, Turkey and Greece – had fewer than 20 beds per 1 000 adults aged 65 and over. Four – Luxembourg, the Netherlands, Belgium and Sweden – had more than 70 beds per 1 000 adults aged 65 and over.

Between 2007 and 2017, OECD countries reduced the number of LTC beds in facilities by an average of 3.4 beds per 1 000 people aged 65 and over (Figure 11.27). However, the change in the number of beds varied significantly between OECD countries. Over the ten-year period, Sweden, Iceland and Finland each reduced the number of beds in LTC facilities by 15 or more per 1 000 people aged 65 and over. At the other end of the spectrum, Korea increased the number of LTC beds by 36 over the same period. These substantial changes have been largely driven by changes in policies over the period. Reductions in the number of facility-based LTC beds in Sweden have been driven by a move towards community-based LTC service provision, while in Korea, the massive increase in capacity followed the introduction of a public LTC insurance scheme in 2008.

Providing LTC in facilities can be more efficient than community care for people with intensive needs, owing to economies of scale and the fact that care workers do not need to travel to each person separately. However, it often costs public budgets more, since informal carers make less of a contribution and LTC systems often pick up board, lodging and care costs. Facility-based LTC may also be against the preferences of LTC recipients, many of whom wish to remain at home for as long as possible. Most countries have taken steps in recent years to support this preference and promote community care. However, depending on individual circumstances, a move to LTC facilities may be the most appropriate option – for example for people living alone and requiring round-the-clock care and supervision (Wiener et al., 2009[1]) or people living in remote areas with limited home care support. It is therefore important that countries retain an appropriate level of residential LTC capacity, and that care facilities develop and apply models of care that promote dignity and autonomy. This includes ensuring that staff working in LTC facilities are appropriately trained and receive the support they need to discourage high turnover and facilitate the recruitment and retention of high-quality care workers (see indicator on "Long-term care workers").

Definition and comparability

LTC facilities refer to nursing and residential care facilities that provide accommodation and LTC as a package. They include specially designed facilities or hospital-like settings where the predominant service component is LTC for people with moderate to severe functional restrictions. They do not include beds in adapted living arrangements for people who require help while guaranteeing a high degree of autonomy and self-control. For international comparisons, they should also not include beds in rehabilitation centres.

However, there are variations in data coverage across countries. Several countries only include beds in publicly funded LTC facilities, while others also include private facilities (both for-profit and not-for-profit). Some countries also include beds in treatment centres for addicted people, psychiatric units of general or specialised hospitals, and rehabilitation centres.

References

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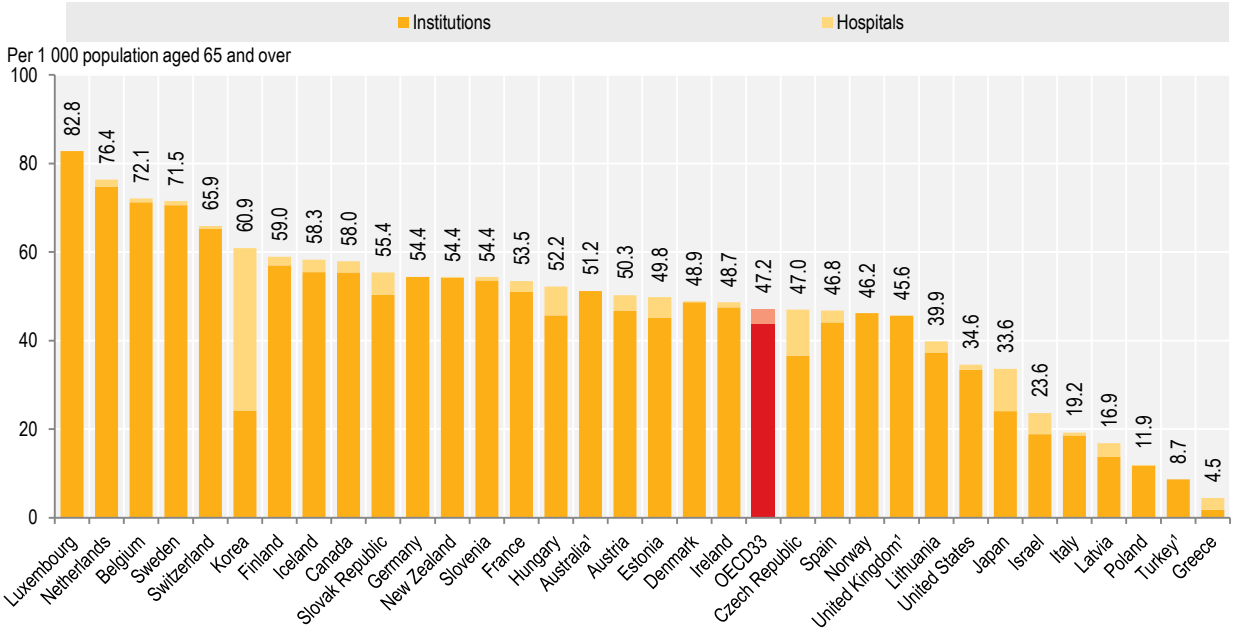
[3] Muir, T. (2017), "Measuring social protection for long-term care", *OECD Health Working Papers*, No. 93, OECD Publishing, Paris, *https://dx.doi.org/10.1787/a411500a-en*.

[1] Wiener, J. et al. (2009), "Why Are Nursing Home Utilization Rates Declining", *Real Choice Systems Change Grant Program*, US Department of Health and Human Services, Centers for Medicare and Medicaid Services.

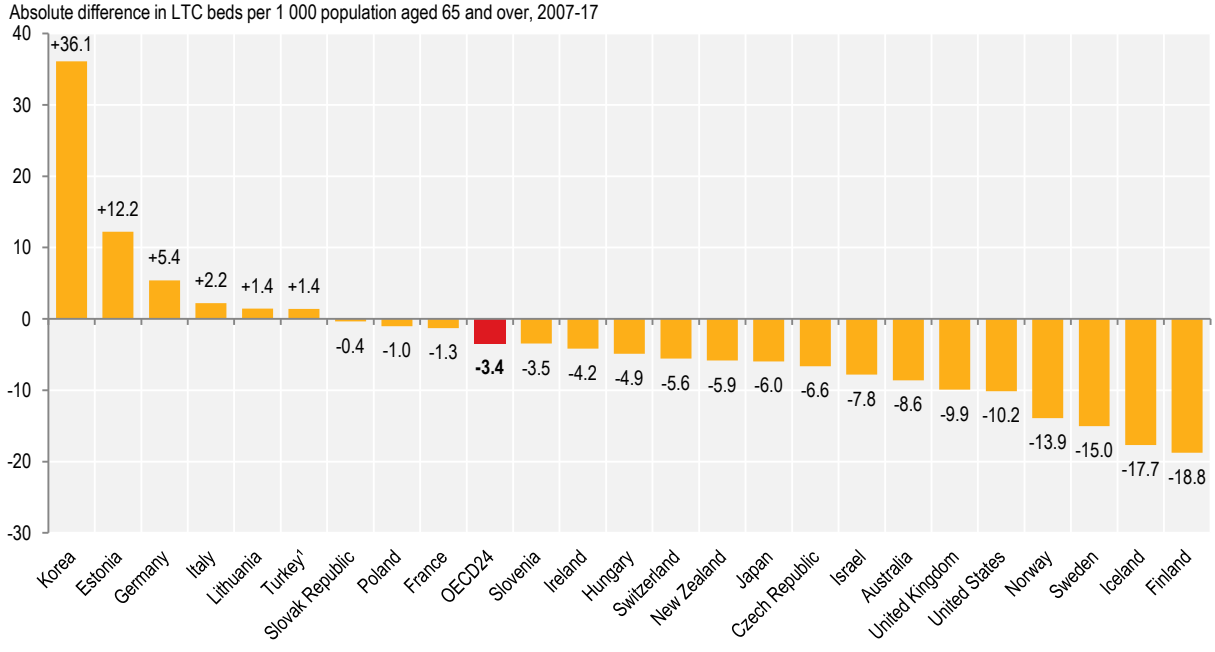
Figure 11.26. **Long-term care beds in facilities and hospitals, 2017 (or nearest year)**



1. The numbers of LTC beds in hospitals are not available for Australia, Turkey and the United Kingdom.
Source: OECD Health Statistics 2019.

StatLink https://doi.org/10.1787/888934018735

Figure 11.27. **Trends in long-term care beds in facilities and hospitals, 2007-17 (or nearest year)**



1. 2007 data refer to 2011.
Source: OECD Health Statistics 2019.

StatLink https://doi.org/10.1787/888934018754