

Long-term care expenditure

Long-term care (LTC) spending has seen the highest growth across the various functions (see Indicator on “Health expenditure by type of service”) and is expected to rise further in the coming years. Population ageing leads to more people needing ongoing health and social care; rising incomes increase expectations on the quality of life in old age; the supply of informal care is potentially shrinking; and productivity gains are difficult to achieve in such a labour-intensive sector. All these factors create upward pressures on spending.

A significant share of LTC services is paid for out of government or compulsory insurance schemes. Total government/compulsory spending on LTC (including both the health and social care components) accounted for 1.7% of GDP on average across OECD countries in 2015 (Figure 11.24). At 3.7% of GDP, the highest spender was the Netherlands, where public expenditure on long-term care was around double the OECD average. At the other end of the scale, Hungary, Estonia, Poland, Israel and Latvia allocated less than 0.5% of their GDP, to the public provision of long-term care. This variation can partly reflect differences in the population structure, but mostly the development of formal LTC systems, as opposed to more informal arrangements based mainly on care provided by unpaid family members. Despite problems of underreporting which limit comparability, available data on privately-funded LTC expenditure suggests in some cases it can be substantial, playing a relatively large role in Switzerland (0.7% of GDP), Germany and the United Kingdom (both 0.6%). Consequently, the share of private spending – mainly out-of-pocket expenditure – in total spending on LTC accounts for more than 30% in those countries.

The boundaries between health and social LTC spending are still not fully consistent across countries, with some reporting particular components of LTC as health care, while others view it as social spending. Sweden and Norway spend 2.5% or more of their GDP on the health part of LTC financed from government/compulsory schemes, which is around double the OECD average (1.3%). With 1.3% of GDP, the Netherlands report the highest level of public spending on social LTC, much higher than the OECD average of 0.4%.

The way LTC is organised in countries affects the composition of LTC spending and may also have an impact on overall LTC spending. Across the OECD, two-thirds of government and compulsory spending on LTC (health) was for inpatient LTC in 2015. This is mainly provided in residential LTC facilities (Figure 11.25). Yet in Poland, Finland, Denmark, Austria and Germany, spending on home-based LTC accounts for more than 50% of all LTC (health) spending. Spending for home-based LTC can be either due to services provided by professional LTC workers or informal workers, when a care allowance exists which remunerates the caregiver for the LTC services provided.

Spending by government and compulsory insurance schemes on LTC has increased more rapidly than health care expenditure over the last decade. The annual growth

rate was 4.6% between 2005 and 2015 across OECD countries (Figure 11.26). Spending growth stands out for Korea, which has implemented a number of measures to expand the coverage of their LTC systems in recent years, although total LTC spending still remains below the OECD average as a share of GDP.

Projection scenarios suggest that public resources allocated to LTC as a share of GDP could double or more by 2060 (De La Maisonnette and Oliveira Martins, 2013). One of the main challenges in the future will be to strike the right balance between providing appropriate social protection to people with LTC needs and ensuring that this protection is fiscally sustainable.

Definition and comparability

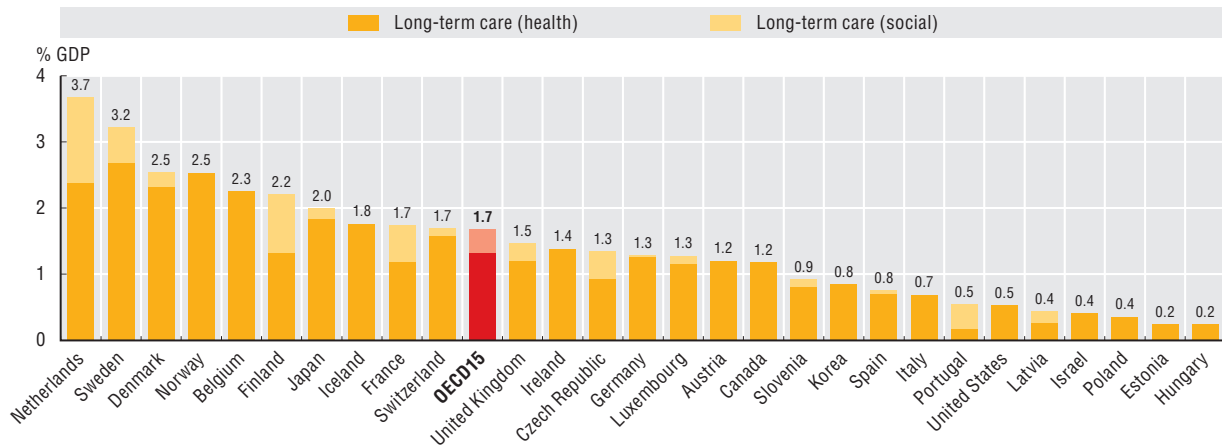
LTC spending comprises both health and social services to LTC dependent people who need care on an on-going basis. Based on the System of Health Accounts (SHA), the health component of LTC spending relates to nursing and personal care services (i.e. help with activities of daily living (ADL)). It covers palliative care and care provided in LTC institutions or at home. LTC social expenditure primarily covers assistance with instrumental activities of daily living (IADL). Despite progress made in improving the general comparability of LTC spending in recent years there is still some variation in reporting practices between the health and social components for some LTC activities across countries. In addition, LTC expenditure funded by governments and compulsory insurance schemes is more suitable for international comparisons as there is more variation in the comprehensiveness in reporting of privately-funded LTC expenditure across OECD countries.

Finally, some countries (e.g. Estonia, Israel, and the United States) can only report spending data for institutional care, and hence underestimate the total amount of spending on long-term care services by government and compulsory insurance schemes.

References

- De La Maisonnette, C. and J.O. Martins (2013), “Public Spending on Health and Long-term Care: A New Set of Projections”, *OECD Economic Policy Papers*, No. 6, OECD Publishing, <http://dx.doi.org/10.1787/5k44t7jwvwr9x-en>.
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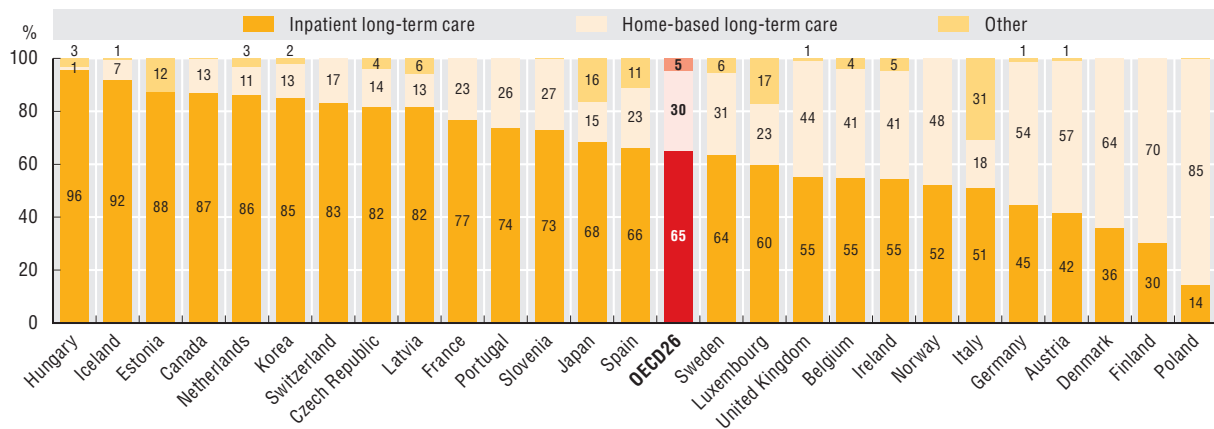
11.24. Long-term care expenditure (health and social components) by government and compulsory insurance schemes, as a share of GDP, 2015 (or nearest year)



Note: The OECD average only includes the 15 countries that report health and social LTC.
Source: OECD Health Statistics 2017.

StatLink <http://dx.doi.org/10.1787/888933606091>

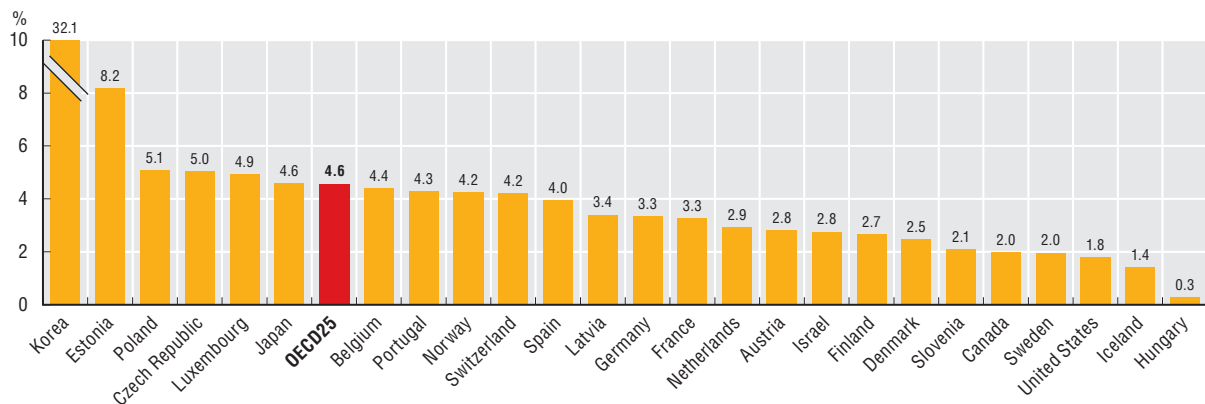
11.25. Government and compulsory insurance spending on LTC (health) by mode of provision, 2015 (or nearest year)



Note: "Other" includes LTC day cases and outpatient LTC.
Source: OECD Health Statistics 2017.

StatLink <http://dx.doi.org/10.1787/888933606110>

11.26. Annual growth rate in expenditure on LTC (health and social) by government and compulsory insurance schemes, in real terms, 2005-15 (or nearest year)



Source: OECD Health Statistics 2017.

StatLink <http://dx.doi.org/10.1787/888933606129>



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