Long-term care spending and unit costs

While LTC spending has been growing at a slower pace than overall health spending in most OECD countries since the pandemic, LTC was the healthcare activity with the highest growth rate leading up to this health emergency. It is probable that LTC spending growth will outpace health spending growth again in the years to come, driven by a number of factors. Population ageing will lead to more people needing ongoing health and social care, rising incomes increase expectations of quality of life in old age, the supply of informal care is likely to shrink, and productivity gains are difficult to achieve in such a labour-intensive sector. All these factors create upward cost pressures, and substantial further increases in LTC spending in OECD countries are projected for the coming years.

In 2021, 1.8% of gross domestic product (GDP) was allocated to LTC (including both the health and social components) across OECD countries (Figure 10.23). At 4.4% of GDP, the highest spender was the Netherlands, followed by the Nordic countries of Norway (3.5%), Sweden (3.4%) and Denmark (3.2%). In contrast, Greece, Poland and Latvia only spent around 0.5% of GDP or less on LTC services. This variation partly mirrors differences in the population structure, but mostly reflects the stage of development of formal LTC systems, as opposed to more informal arrangements based mainly on care provided by unpaid family members. Some level of underestimation can exist for those countries unable to record spending on social LTC. Across OECD countries, four out of five dollars spent on LTC come from public sources.

The way LTC is organised in countries affects the composition of LTC spending and can also have an impact on overall spending. Across OECD countries, around half of health and social LTC spending in 2021 occurred in nursing homes (Figure 10.24). In most OECD countries, these providers account for the majority of LTC spending. On average, around one-fifth of all LTC spending was used for professional (health) care provision at home. Other LTC providers include hospitals, households – if a care allowance exists that remunerates the informal provision of such services – and LTC providers with a clear social focus. These service providers each account for around one-tenth of total LTC spending across OECD countries. The importance of these modes of provision varies widely across countries, reflecting differences in the organisation of LTC and policy priorities.

Public schemes play a crucial role in ensuring the affordability of LTC costs for individuals aged 65 and over with LTC needs. Without public financial support, the total costs of LTC would be higher than median incomes among older people in most OECD countries. On average across OECD countries, institutional care for severe needs would cost more than twice the median income among older people (Figure 10.25). Among countries that provided data in 2022, institutional care for older individuals with severe needs was more than four times their median income in the Netherlands, Denmark, Finland and Sweden. Only in Slovenia and Hungary can an older person earning the median income afford the total cost of institutional care for severe needs solely from their income and without public support. In addition to income, older individuals may rely on other sources such as savings, assets or support from family and friends to finance the care they need. Public social protection systems are crucial in ensuring that older people can access necessary care without falling into poverty. Thanks to these support systems, the actual costs faced by older people are significantly lower than those depicted in Figure 10.25 for a majority of countries (Oliveira Hashiguchi and Llena-Nozal, 2020[1]).

Definition and comparability

LTC spending comprises both health and social services provided to LTC-dependent people who need care on an ongoing basis. Based on the System of Health Accounts, the health component of LTC spending relates to nursing care and personal care services (help with ADL). It also covers palliative care and care provided in LTC institutions (including costs for room and board) or at home. LTC social expenditure primarily covers help with IADL. Progress has been made in improving the general comparability of LTC spending in recent years, but there is still some variation in reporting practices between the health and social components of some LTC activities. In some countries, social LTC is (partly) included under health LTC; in others, only health LTC is reported. There is also some variation in the comprehensiveness of reporting for privately funded LTC expenditure. Further, LTC providers can offer additional services to their main activity, notably in the Netherlands where around 20% of expenditure allocated to nursing homes is for homecare service provision.

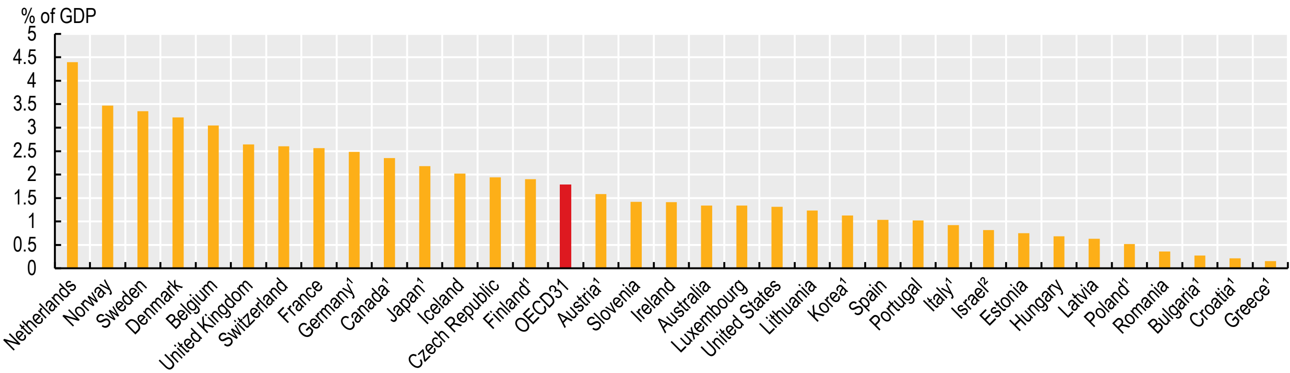
LTC institutions refer to nursing and residential care facilities that provide accommodation and LTC as a package. They are specially designed institutions where the predominant service component is LTC for dependent people with moderate to severe functional restrictions. An older person with severe needs is defined as someone who requires 41.25 hours of care per week. A detailed description of their needs can be found in Muir (2017[2]).

References

Muir, T. (2017), “Measuring social protection for long-term care”, *OECD Health Working Papers*, No. 93, OECD Publishing, Paris, https://doi.org/10.1787/a411500a-en. [2]

Oliveira Hashiguchi, T. and A. Llena-Nozal (2020), “The effectiveness of social protection for long-term care in old age: Is social protection reducing the risk of poverty associated with care needs?”, *OECD Health Working Papers*, No. 117, OECD Publishing, Paris, https://doi.org/10.1787/2592f06e-en. [1]

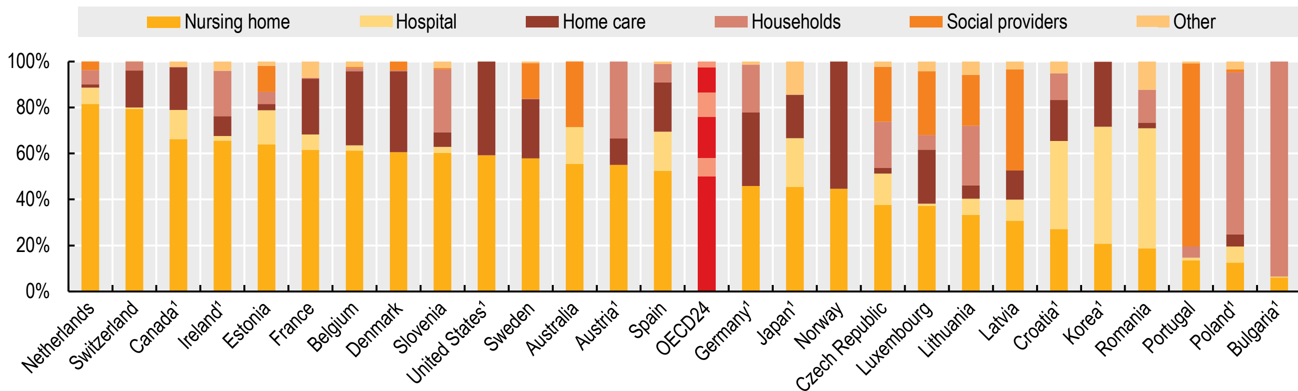
Figure 10.23. Total long-term care spending as a share of GDP, 2021 (or nearest year)



1. Countries not reporting spending for LTC (social). In many countries this component is therefore missing from total LTC, but in some countries it is partly included under LTC (health). 2. Country not reporting spending for LTC (health).
Source: OECD Health Statistics 2023.

StatLink https://stat.link/fobxem

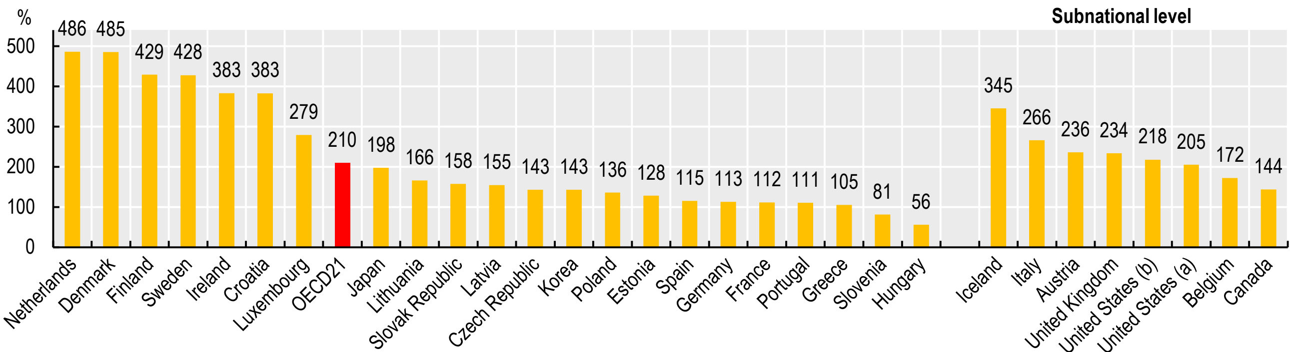
Figure 10.24. Total long-term care spending by provider, 2021 (or nearest year)



1. Countries not reporting social LTC. The category "Social providers" refers to providers where the primary focus is on help with IADL or other social care.
Source: OECD Health Statistics 2023.

StatLink https://stat.link/dgi1tf

Figure 10.25. Costs of institutional long-term care for people aged 65 and over with severe needs, as share of median income, 2022 (or nearest year)



Note: Subnational data for Belgium refer to Flanders, for Iceland refer to Reykjavik, for Canada refer to Ontario, for Austria refer to Vienna, for the United States refer to (a) California and (b) Illinois, for Italy refer to South Tyrol, and for the United Kingdom refer to England.
Source: OECD Long-Term Care Social Protection Questionnaire (2022) and OECD Income Distribution Database (2022).

StatLink https://stat.link/tnxm9o

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