

Long-term care spending and unit costs

Compared to other areas of health care, spending on long-term care (LTC) has seen the highest growth in recent years (see indicator on “Health expenditure by function” in Chapter 7). 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 cost pressures, and substantial further increases in LTC spending in OECD countries are projected for the coming years.

A significant share of the spending on LTC services is covered by 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 2017 (Figure 11.28). At 3.7% of GDP, the highest spender was the Netherlands, followed by Norway (3.3%) and Sweden (3.2%). In these countries, public expenditure on LTC was around double the OECD average. At the other end of the scale, Hungary, Estonia, Poland, and Latvia all allocated less than 0.5% of their GDP to the delivery of LTC services. This variation partly reflects 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. Generally, the health component of LTC represents the vast majority of all LTC expenditure, but some issues remain around properly distinguishing between health and social LTC in some countries.

The way LTC is organised in countries affects the composition of LTC (health) spending and can also have an impact on overall LTC spending. Across OECD countries, around two-thirds of government and compulsory spending on LTC (health) was for inpatient LTC in 2017. These services are mainly provided in residential LTC facilities (Figure 11.29). Yet in Poland, Finland, Denmark, Lithuania, Austria and Germany, spending on home-based LTC accounted for more than 50% of all LTC spending. Spending for home-based LTC can be on services provided by either professional LTC workers or informal workers, when a care allowance exists that remunerates the caregiver for the LTC services provided.

The important role public schemes play in the financing of LTC can be explained by the substantial costs for care that older people with LTC needs face. These costs vary widely between countries but are always high relative to median incomes among elderly people. For institutional care, for example, the costs for a person with severe LTC needs represent between just under one the median disposable income for individuals of retirement age and more than four times that income (Figure 11.30), depending on the country or region. Compared to the average income, costs are higher in Finland, Ireland and the Netherlands and lower in

Hungary, Slovenia and Croatia. Only in Slovenia and Croatia would an older person with median income be able to afford the costs of institutional care from their income alone. All OECD countries have some form of social protection against these high financial risks, and out-of-pocket costs that older people ultimately face tend to be lower in countries where public expenditure on LTC is higher, such as in the Netherlands and Finland (Muir, 2017[1]).

Definition and comparability

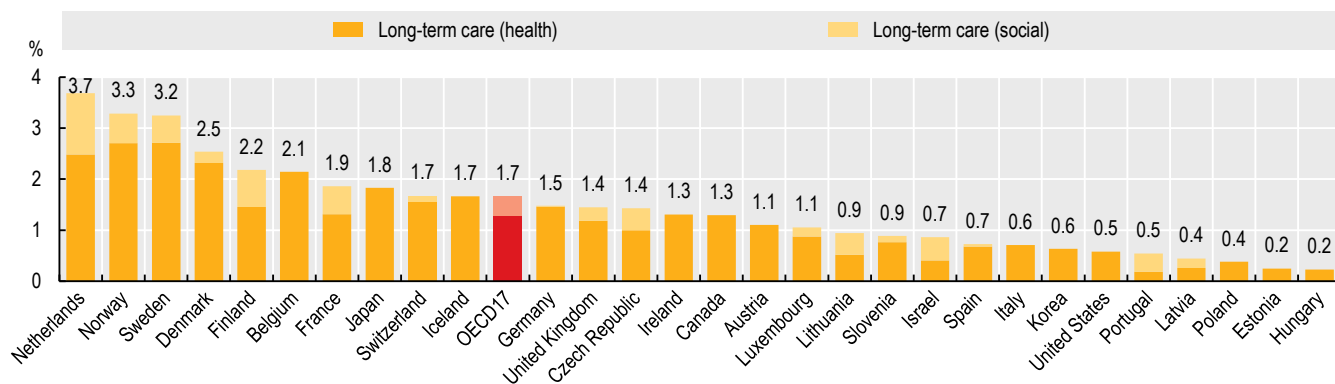
LTC spending comprises both health and social services to LTC dependent people who need care on an ongoing basis. Based on the System of Health Accounts, the health component of LTC spending relates to nursing care and personal care services (i.e. help with activities of daily living). It also covers palliative care and care provided in LTC institutions (including costs for room and board) or at home. LTC social expenditure primarily covers help with instrumental activities of daily living. 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 for some LTC activities in some countries. Currently, LTC expenditure funded by governments and compulsory insurance schemes is more suitable for international comparison as there is more variation in the comprehensiveness of reporting of privately funded LTC expenditure across OECD countries. Finally, some countries (e.g. Israel and the United States) can only report spending data for institutional care, and hence underestimate the total amount of spending on LTC services by government and compulsory insurance schemes.

Long-term care institutions refer to nursing and residential care facilities that provide accommodation and long-term care 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[1]).

References

- [1] 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>.

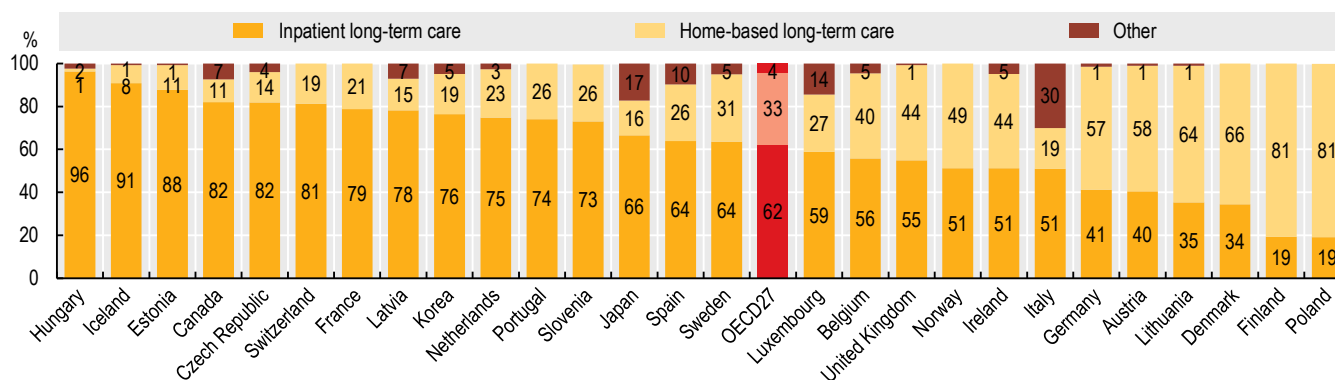
Figure 11.28. Long-term care expenditure (health and social components) by government and compulsory insurance schemes, as a share of GDP, 2017 (or nearest year)



Note: The OECD average only includes 17 countries that report health and social LTC.
Source: OECD Health Statistics 2019.

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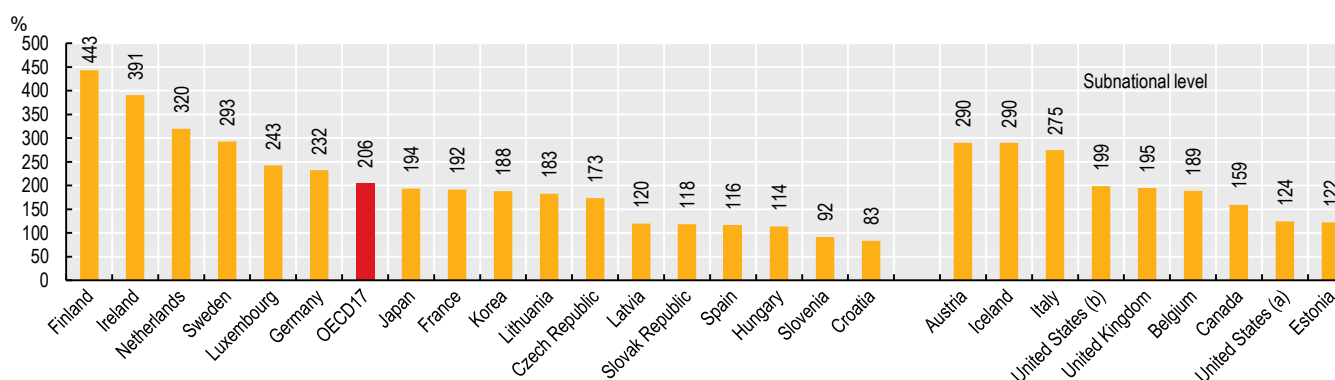
Figure 11.29. Government and compulsory insurance spending on LTC (health) by mode of provision, 2017 (or nearest year)



Note: "Other" includes LTC in day care and outpatient settings.
Source: OECD Health Statistics 2019.

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Figure 11.30. Costs of institutional long-term care for an older person with severe needs, as a share of the median income among people of retirement age and older, 2018 (or nearest year)



Note: Belgium refers to Flanders, Iceland refers to Reykjavik, Canada refers to Ontario, Estonia refers to Tallinn, Austria refers to Vienna, the United States refers to (a) California and (b) Illinois, Italy refers to South Tyrol, and the United Kingdom refers to England.
Source: OECD Long-Term Care Social Protection questionnaire (2018) and OECD Income Distribution Database (2018).

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