

Around 1.5% of GDP is allocated to long-term care across OECD countries

As societies age, pressure grows to ensure the provision and affordability of long-term care (LTC) services for all people in need. In many OECD countries, a substantial share of the economy is already allocated to a range of medical and nursing care, personal care and assistance services for people dependent on others for activities of daily living (Box 1). On average, 1.5% of Gross Domestic Product (GDP) was spent on all LTC services in 2018. This equates to around USD 760 per capita (adjusted for differences in price levels across countries).

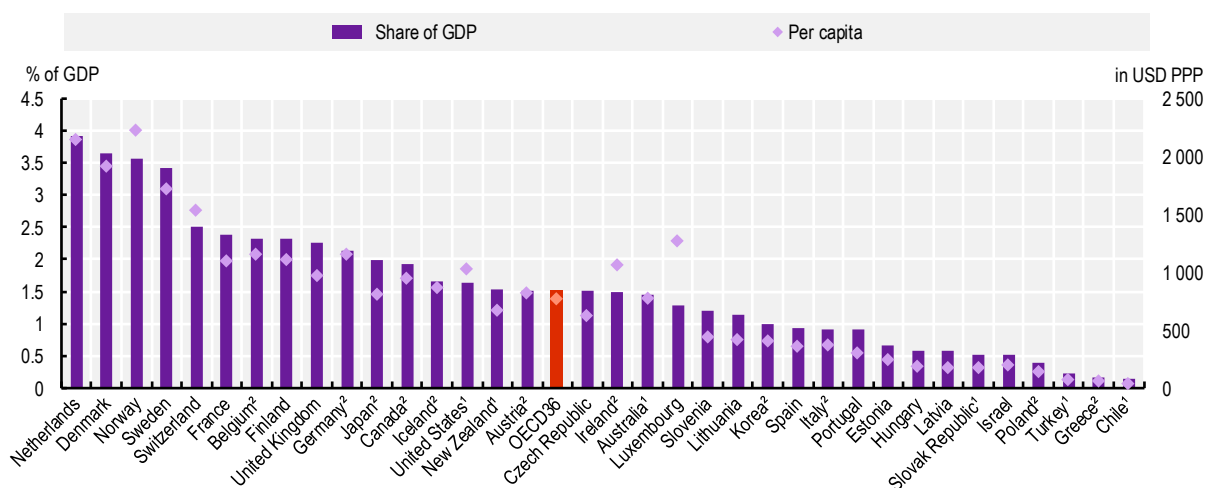
Spending data presented in this brief generally covers both the health and social components of LTC but for some countries the social part of LTC spending is missing (although in some cases it is implicitly included under health LTC). In some countries, various elements of private spending on LTC are not reported. For countries with completely missing data or significant underestimations, LTC figures have been estimated.

The Netherlands and Scandinavian countries (Denmark, Norway and Sweden) are by far the highest spenders on LTC (Figure 1), with around 3.5% of GDP or more dedicated to caring for people with LTC needs. The elevated levels of spending reflect the more developed formal LTC systems in these countries. A second group of high-income countries, including Switzerland, France, Belgium, Finland, the United Kingdom, Germany and Japan, allocate between 2-2.5% of their national wealth to LTC.

In some South-Eastern European or Latin American countries – which tend to have younger populations, formal provision of care is less comprehensive and people with LTC needs rely to a greater extent on (unpaid) family members. As a result, LTC spending levels are comparably low in Greece, Turkey, Chile and Mexico among others.

Among countries able to report both health and social components of LTC, spending on health LTC is typically the dominant part of total LTC, accounting for about 70% of overall LTC spending on average.

Figure 1. Total LTC expenditure as share of GDP and per capita, 2018 (or nearest year)



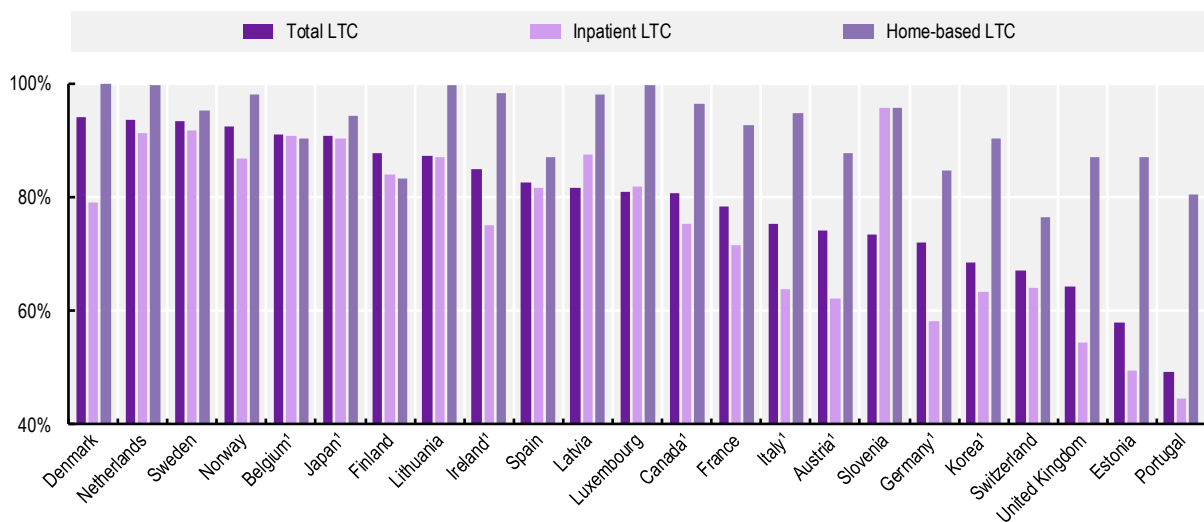
1. Estimated by the OECD Secretariat. 2. Countries not reporting spending for LTC (social). In many countries this component is therefore missing from total LTC but in some countries it is partly included under LTC (health). Colombia became an OECD member after the 2020 data collection and is missing from the chart.

Source: OECD Health Statistics 2020, <https://doi.org/10.1787/health-data-en>; Mueller, Bourke and Morgan. (2020^[1]) "Assessing the comparability of Long-Term Care spending estimates under the Joint Health Accounts Questionnaire", <https://www.oecd.org/health/health-systems/LTC-Spending-Estimates-under-the-Joint-Health-Accounts-Questionnaire.pdf>.

Governments and social insurance cover the bulk of the costs of long-term care provision

The two main modes of provision for LTC are either inpatient care in a residential facility or care provided in the patient's home. In most OECD countries, the costs for both types of care are covered to a great extent (4 out of every 5 dollars spent on LTC on average) by either a government scheme (such as a National Health Service or regional health boards) or through compulsory insurance (mainly social insurance), with inpatient care generally less well covered by government or compulsory insurance than home care (Figure 2).

Figure 2. Share of public spending for different LTC services, 2018 (or nearest year)



1. Countries that do not report LTC (social).

Source: OECD Health Statistics 2020, <https://doi.org/10.1787/health-data-en>.

Box 1. What is included in LTC spending?

A *System of Health Accounts 2011* defines total long-term care expenditure as the sum of **long-term care (health)** and **long-term care (social)** (OECD/Eurostat/WHO, 2017^[1]).

LTC (health) includes *medical or nursing care* (e.g. wound dressing, administering medication, health counselling, palliative care, and medical diagnosis with relation to a LTC condition), and *personal care services* which provide help with activities of daily living (ADL), such as support with food intake, bathing, washing, dressing, getting out of bed, and managing incontinence.

LTC (social) consists of *assistance services* that enable a person to live independently. They relate to help with instrumental activities of daily living (IADL) such as shopping, cooking and performing housework. It also includes subsidies to residential services in assisted living facilities (as well as expenditure on accommodation).

LTC (health) can be further broken down into the key modes of provision: inpatient LTC (mainly in nursing homes) and home-based LTC (when care is delivered at people's homes).

LTC services can be provided by a range of health professionals and institutions but also by family members in case a *care allowance* is paid. Uncompensated work by informal carers is excluded.

Countries with high LTC spending overall – Denmark, Sweden, the Netherlands and Norway – also tend to be those with the highest public share (at 92-94%). At the other end of the scale, public financing in Estonia and Portugal only covers around 60% or less of overall LTC spending.

In all but three countries (Belgium, Finland and Slovenia), public financing covers a higher proportion of home-based care costs compared with inpatient care, typically because some or all of the costs for room and board are borne by residents themselves. On average across the OECD, 75% of inpatient LTC is financed by public or compulsory schemes compared to more than 90% for home-based care. The gap is more pronounced in Estonia, Portugal, the United Kingdom and Italy, where there is a 30-percentage point difference or more between the two.

The public share of inpatient LTC costs is less than half in Estonia and Portugal and below 60% in the United Kingdom and Germany. By contrast, more than 90% of inpatient spending is publicly covered in Slovenia, Sweden, Belgium and the Netherlands. Without adequate social protection, the high costs for LTC can represent a significant financial burden for people with LTC needs (Oliveira Hashiguchi and Llena-Nozal, 2020^[1]).

The majority of spending on long-term care is in residential facilities

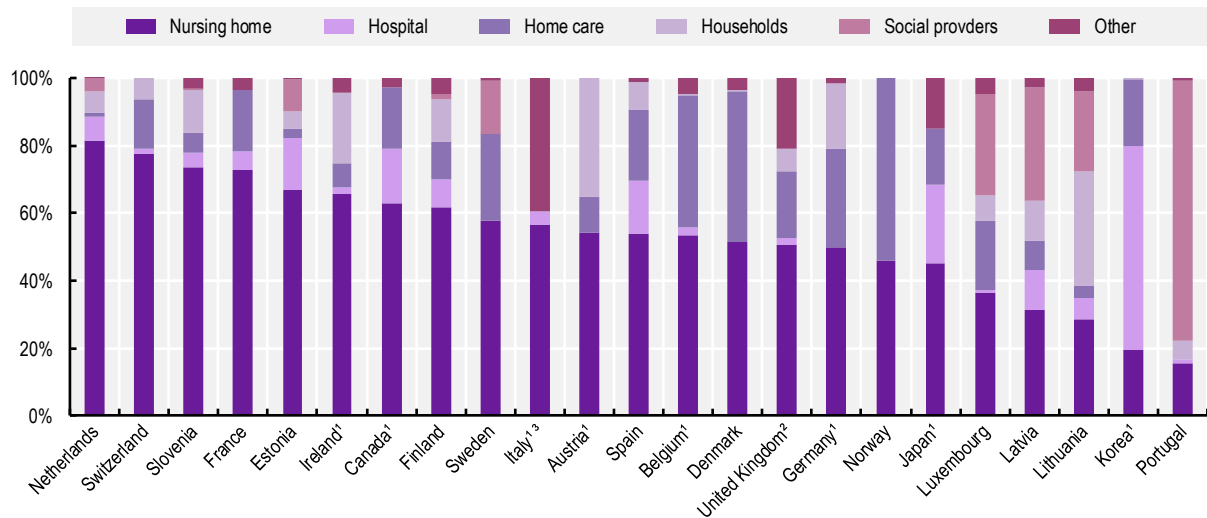
Residential facilities such as nursing homes constitute the major provider of LTC in nearly all OECD countries, mainly delivering inpatient LTC services but also offering home-based LTC or help with instrumental activities of daily living in some countries (Figure 3). They account for around 80% of all LTC spending in the Netherlands, the highest overall LTC spender. The share is above 70% in Switzerland, Slovenia and France. In Korea and Portugal, which spend much less overall on LTC, less than 20% is related to care in residential facilities. Three-quarters of LTC spending in Portugal is linked to providers predominantly from the social care sector.

Almost two-thirds of LTC spending in Korea is on hospital-based care. Hospitals are also a non-negligible LTC provider in Japan (24% of all spending), Canada, Spain, Estonia and Latvia (12-16%). While hospital-like facilities play a historical role in the organisation of LTC in Japan and Korea, a high share could point to shortages in alternative lower-level care facilities for people with inpatient LTC needs in some countries.

In Norway, Denmark and Belgium, all with very high LTC spending levels, ambulatory home care providers play an important role in LTC provision. They account for around 40% or more of total LTC spending. By contrast, this type of provider plays only a minor role in LTC provision in Estonia and Lithuania.

Many countries have specific policies to finance informal LTC provision at home. In these countries, LTC-dependent persons can choose to be cared for by friends or family members and receive a care allowance for this purpose. This makes up more than a third of all LTC spending in Lithuania and Austria and stands at around 20% in Ireland and Germany.

Figure 3. Total long-term care spending broken down by provider, 2018 (or nearest year)



1. Countries not reporting social LTC. 2. Countries where social LTC cannot be allocated to providers (included in "Other"). 3. No breakdown of ambulatory service providers (included in "Other").

Source: OECD Health Statistics 2020, <https://doi.org/10.1787/health-data-en>.

LTC spending has outpaced overall health spending and GDP growth in most OECD countries

The share of LTC spending in total health spending or as a share of GDP has gradually increased over the last 15 years in many OECD countries as demand for care grows with population ageing and the extension of publicly financed services.

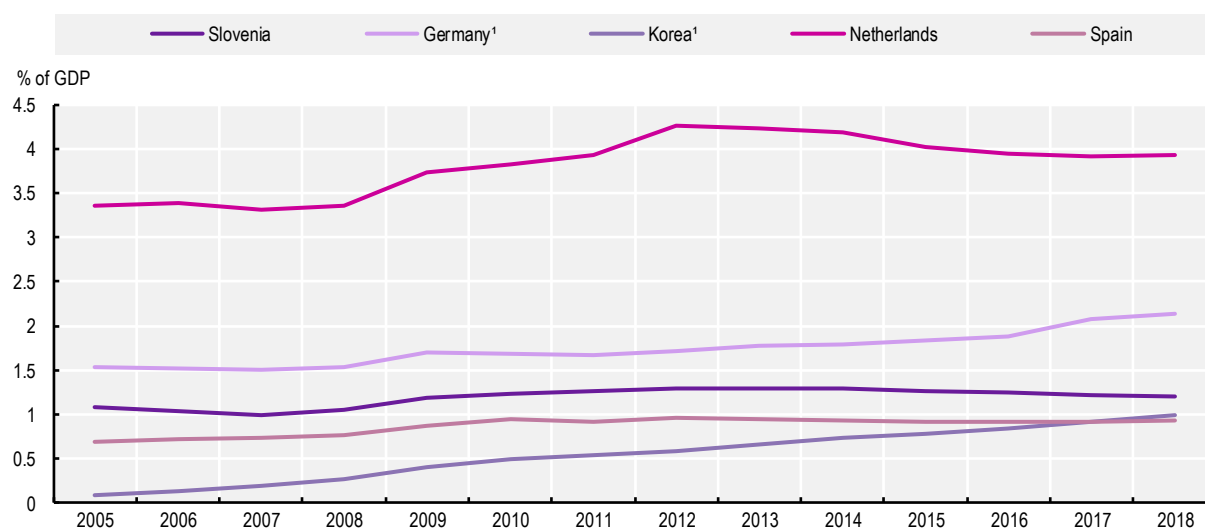
In Germany, for example, LTC spending as a share of GDP has increased from 1.5% in 2005 to 2.1% in 2018 (Figure 4). In parallel with population ageing, the frequent adjustment of LTC benefits and a widening of the definition of LTC dependency has expanded the entitlement for services for people with dementia in particular.

The situation in Korea has been even more dynamic. From a very low base, the share of LTC in GDP grew sharply, from 0.1% to 1.0% between 2005 and 2018, now close to the OECD average. This reflects specific efforts to move away from informal LTC provision in a relatively short period of time. Spending on LTC has been increasing by more than 25% per year (in real terms) over this period.

In some countries, spending on LTC has not grown much faster than the economy as a whole. In Slovenia and Spain, for example, the shares of LTC relative to GDP in 2018 were only 0.1-0.2 percentage points above those in 2005, at 1.2% and 0.9% of GDP, respectively. In Slovenia, the share increased between 2006 and 2011 and has remained mainly flat since. In Spain, the share of LTC spending has been stagnating since 2009, with LTC spending tracking GDP growth.

In the Netherlands, LTC spending has historically been very high, reflecting the very generous benefit basket for LTC-dependent people. It already stood at 3.4% of GDP in 2005 but has been increasing further to reach 3.9% by 2018, despite a drop of this share in 2015 corresponding to an important LTC reform in the country. Financing responsibilities for LTC were transferred from central authorities to the local level in 2015, services re-oriented towards home care and expenditure adjusted. This led to a 8% drop in inpatient LTC spending (in real terms). Since then, spending on inpatient LTC has returned to positive growth.

Figure 4. Share of total long-term care spending in GDP, selected countries, 2005-18



1. Country does not report LTC (social).

Source: OECD Health Statistics 2020, <https://doi.org/10.1787/health-data-en>. Data for Slovenia 2012 estimated by the OECD Secretariat.

References

- Mueller, M., E. Bourke and D. Morgan (2020), “Assessing the comparability of Long-Term Care spending estimates under the Joint Health Accounts Questionnaire”, *Technical report*, OECD, Paris, <https://www.oecd.org/health/health-systems/LTC-Spending-Estimates-under-the-Joint-Health-Accounts-Questionnaire.pdf>. [3]
- OECD/Eurostat/WHO (2017), *A System of Health Accounts 2011: Revised edition*, OECD Publishing, Paris, <https://dx.doi.org/10.1787/9789264270985-en>. [1]
- Oliveira Hashiguchi, T. and A. Llana-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://dx.doi.org/10.1787/2592f06e-en>. [2]

Useful Links

OECD Health Statistics 2020: , <https://doi.org/10.1787/health-data-en>

OECD work on LTC: <http://www.oecd.org/health/long-term-care.htm>

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