8.9. Long-term care expenditure

Long-term care (LTC) expenditure has risen over the past few decades in most OECD countries and is expected to rise further in the coming years due mainly to population ageing and a growing number of people requiring health and social care services on an on-going basis.

A significant share of LTC services is funded from public sources. Total public spending on LTC (including both the health and social care components) accounted for 1.6% of GDP on average across OECD countries in 2011 (Figure 8.9.1). The highest spenders are the Netherlands and Sweden, where public expenditure on long-term care was two-times greater than the OECD average (at 3.7% and 3.6% of GDP). On the contrary, Greece, Portugal, Estonia, Hungary, the Czech Republic and Poland allocated less than 0.5% of their GDP to public spending on long-term care. This variation reflects both differences in population structure but especially the development of formal long-term care systems, as opposed to more informal arrangements based mainly on care provided by unpaid family members. Despite the problems of under-reporting, privately-funded LTC expenditure plays a relatively large role in Switzerland (0.8% of GDP), Germany, the United States, Finland and Spain (about 0.4% of GDP). Most of the private spending comes from out-of-pocket spending, since private health insurance for long-term care does not play an important role in any country.

The boundaries between health and social LTC spending are not fully consistent across countries (see box on "Definition and comparability"), with some reporting particular components of LTC as health care, while others view it as social spending. The Netherlands, Denmark and Norway spent over 2% of GDP on the health part of LTC, which is double the OECD average. Regarding the social part of public LTC expenditure, Sweden has the highest share, reaching 3% of GDP, much higher than the OECD average of 0.7%. The Netherlands, Finland and Japan reported more than 1% of GDP on this spending component. Poland, Spain, New Zealand and Korea reported less than 0.1% of GDP on social public LTC spending.

Public spending on LTC has grown rapidly in recent years in some countries (Figure 8.9.2). The annual growth rate in public expenditures on LTC was 4.8% between 2005 and 2011 across OECD countries, which is above the growth in health care expenditures during this period. Countries such as Korea and Portugal, which have implemented measures to expand the coverage of their LTC systems in recent years, have had the highest public spending growth rates between 2005 and 2011. On the other hand, countries with high spending levels and those with a longer history of public LTC coverage tend to record below-average growth rates in recent years.

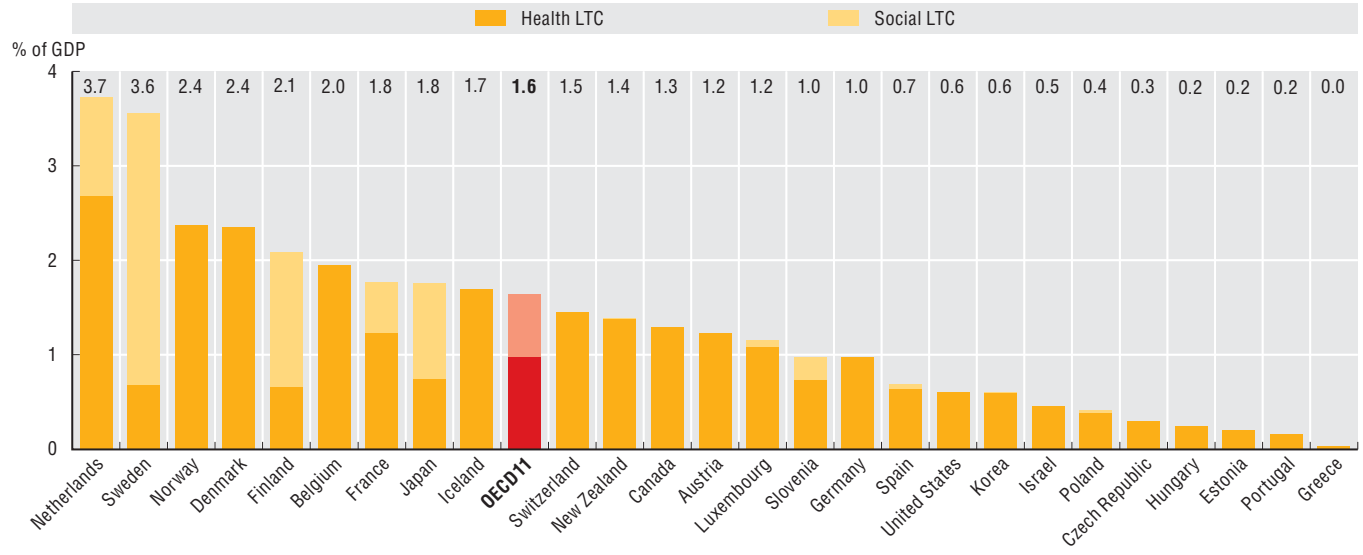
Although a high proportion of LTC expenditure continues to be allocated for institutional care, many OECD countries have expanded the availability of home care services. Between 2005 and 2011, the annual growth rate of public spending on home care was about 5% compared with 4% for institutional care (Figure 8.9.3). There were significant increases in home care spending in Korea, Estonia and Spain, while public spending on institutional care was reduced in Finland and Hungary.

Projection scenarios suggest that public resources allocated to LTC as a share of GDP may double or more by 2060 (Colombo et al., 2011; De La Maisonneuve and Oliveira Martins, 2013). One of the main challenges in many OECD countries in the future will be to strike the right balance between providing appropriate LTC protection and ensuring that this protection is fiscally sustainable in the long run.

Definition and comparability

LTC spending comprises both health and social support services to people with chronic conditions and disabilities needing 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. assistance 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). Countries' reporting practices between the health and social components of LTC spending may differ. In addition, publicly-funded LTC expenditure is more suitable for international comparisons as there is significant variation in the reporting of privately-funded LTC expenditure across OECD countries.

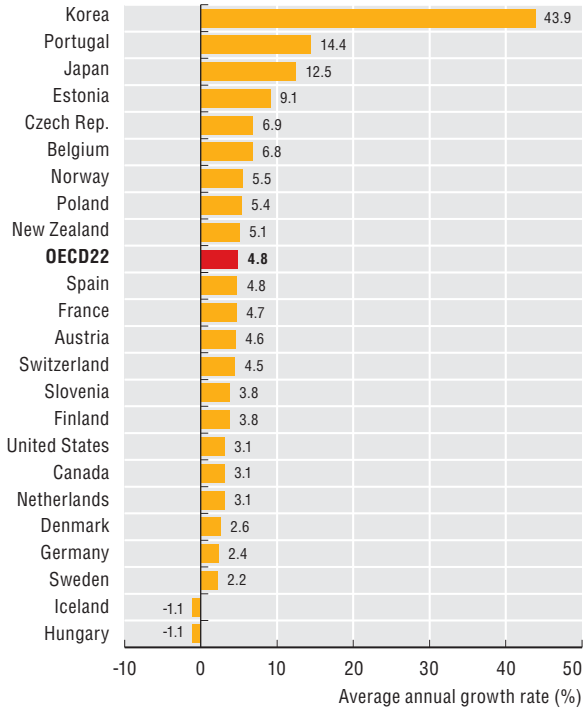
8.9.1. Long-term care public expenditure (health and social components), as share of GDP, 2011 (or nearest year)



Note: The OECD average only includes the 11 countries that report health and social LTC.
Source: OECD Health Statistics 2013, http://dx.doi.org/10.1787/health-data-en.

StatLink http://dx.doi.org/10.1787/888932919498

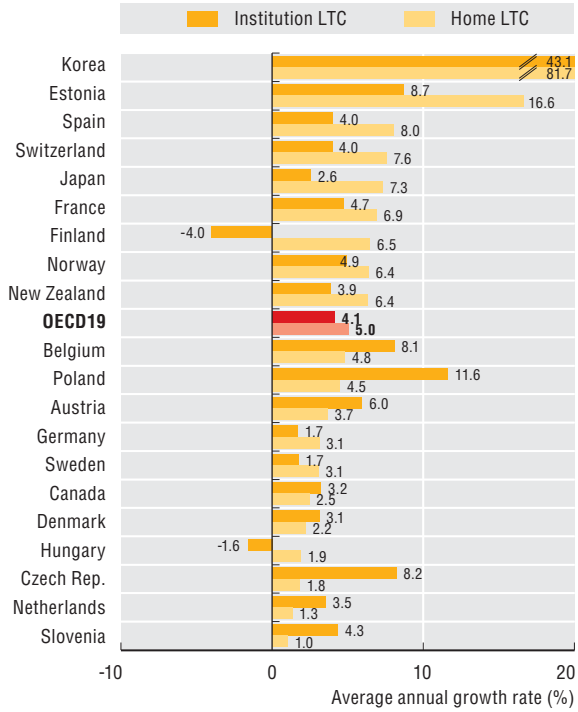
8.9.2. Annual growth rate in public expenditure on long-term care (health and social), in real terms, 2005-11 (or nearest year)



Note: The OECD average excludes Korea (due to the extremely high growth rate).
Source: OECD Health Statistics 2013, http://dx.doi.org/10.1787/health-data-en.

StatLink http://dx.doi.org/10.1787/888932919517

8.9.3. Annual growth rate in public expenditure on long-term care in institutions and at home, in real terms, 2005-11 (or nearest year)



Note: The OECD average excludes Korea (due to the extremely high growth rate).
Source: OECD Health Statistics 2013, http://dx.doi.org/10.1787/health-data-en.

StatLink http://dx.doi.org/10.1787/888932919536