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, with population ageing leading to more people needing ongoing health and social care, rising incomes leading to higher expectations of quality of life in old age, the supply of informal care potentially shrinking and productivity gains difficult to achieve in such a labour-intensive sector (De La Maisonneuve and Oliveira Martins, 2013).

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 1.7% of GDP on average across OECD countries in 2013 (Figure 11.21). The highest spender was the Netherlands, where public expenditure on long-term care was two and a half times greater than the OECD average, at 4.3% of GDP. At the other end of the scale, the Slovak Republic, Greece, Estonia, Hungary, the Czech Republic, Poland and Israel allocated less than 0.5% of their GDP to public provision of long-term care. This variation partly reflects differences in 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 the problems of underreporting, privately-funded LTC expenditure plays a relatively large role in Switzerland (0.6% of GDP), Germany (0.6%) and Belgium (0.4%). As a share of total spending on LTC (including private and public health and social components), private spending accounts for more than a third in the United States (43%), Germany (37%) and Spain (36%). Most private spending is out-of-pocket, since private LTC insurance does not play an important role in any country.

The boundaries between health and social LTC spending are not fully consistent across countries, with some reporting particular components of LTC as health care, while others view it as social spending. The Netherlands, Sweden, Norway and Denmark spend over 2% of GDP on the health part of LTC, which is double the OECD average. Finland has the highest level of public spending on social LTC, reaching 1.6% of GDP, much higher than the OECD average of 0.5%. The Netherlands and Japan spend more than 1% of GDP on social LTC, but this accounts for less than 0.1% of GDP in Korea, Spain and Luxembourg.

Public spending on LTC has grown rapidly in recent years in some countries (Figure 11.22). The annual growth rate in public expenditures on LTC was 4.0% between 2005 and 2013 across OECD countries, which is above the growth in health care expenditures over the same period. Countries such as Korea and Portugal have implemented measures to expand the comprehensiveness of their LTC systems in recent years and so have among the highest public spending growth rates since 2005, although spending in both countries remains relatively low as a share of GDP.

Many OECD countries have expanded the availability of home care services in order to allow people receiving LTC to remain more independent and part of their community. Between 2005 and 2013, the annual growth rate of public spending on home care matched spending growth for care in institutional care settings – at 4.3% per year (Figure 11.23). However, there were significant increases in home care spending of more than 7% per year in Korea, Estonia, Japan and France.

Projection scenarios suggest that public resources allocated to LTC as a share of GDP could 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 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 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.

Data for the United States refer to institutional care only, so underestimate the total amount of public spending on long-term care services.

**References**


11. AGEING AND LONG-TERM CARE

Long-term care expenditure

11.21. Long-term care public expenditure (health and social components), as share of GDP, 2013 (or nearest year)

Note: The OECD average only includes the eleven countries that report health and social LTC.
1. Figures for the United States refer only to institutional care.

11.22. Annual growth rate in public expenditure on long-term care (health and social), in real terms, 2005-13 (or nearest year)

Note: The OECD average excludes Korea (due to the extremely high growth rate).

Information on data for Israel: http://oe.cd/israel-disclaimer

11.23. Annual growth rate in public expenditure on long-term care (health), by setting, in real terms, 2005-13 (or nearest year)

Note: The OECD average excludes Korea (due to the extremely high growth rate).

StatLink: http://dx.doi.org/10.1787/888933281455