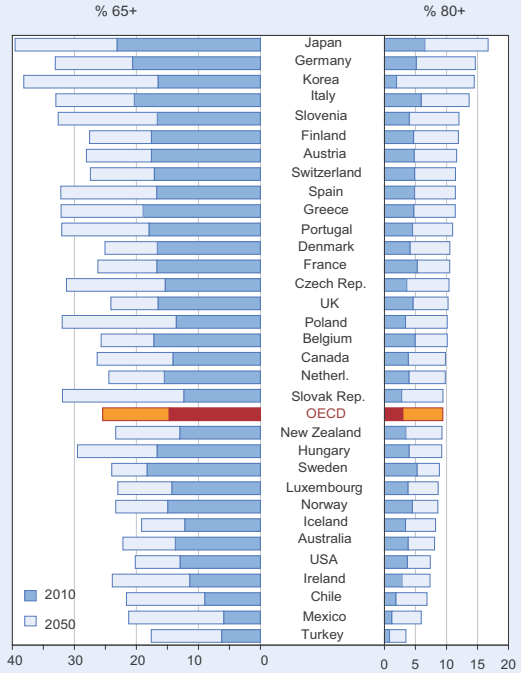
# Long-term Care Cost Projections for OECD Countries

In the field of long-term care (LTC), policymakers around the world face the triple challenge of ensuring high quality care and high rates of inclusion while upholding financial viability. Changes in the demographic composition and social organization of societies as well as technological advancements make meeting these goals increasingly challenging. Firstly, population ageing increases the number of people that require long term care and reduces the working share of the population that provides the economic basis for transfers to long-term care recipients. The growth in the population shares of individuals age 65 and over, and 80 and over, in OECD countries between 2010 and 2050 shown in the Figure reflects this development. Secondly, technological change and, in emerging countries in particular, income growth change the cost of LTC provision to individuals with a given need for LTC. Thirdly, declining family size and increasing female labor market participation reduce the share of LTC recipients that receive formal care services at home or are cared for informally by family members.

The formulation of innovative LTC policies requires mid- and long-term projections of LTC care cost that take the aforementioned developments into account. A recent OECD report (Colombo et al. 2011) provides such projections for the year 2050 for three types of scenarios. The Table summarizes its main findings.

**Figure**

Development in Shares of Population Aged Over 65 and 80 Years in the OECD Countries and Selected Other Areas




Source: Colombo et al. (2011).

The first column of the Table shows LTC spending as a percentage of GDP for 2006/07 for the 30 OECD countries under study. On average, the EU-members in the sample currently spend 1.5 percent of their Gross Domestic Product (GDP) on LTC, a share that is similar to that in the industrialized non-EU OECD countries.

Columns 2 and 3 show cost projections for two scenarios with different assumptions on the ageing of societies. The first scenario in column 2 builds on the conservative expectation that the share of elderly people who will require LTC will remain constant in the future. This pure ageing cost projection therefore extrapolates the current demographic development while treating the prevalence of disabled people in 2007 as a constant. The OECD contrasts the pure ageing scenario with a healthy ageing scenario in column 3. Here, population ageing will coincide with a delay in the occurrence of disability, i.e., it is assumed that the health status of elderly people of a given age will improve over time. Moreover, both scenarios assume that the relationship of a country's cost of providing a given amount of LTC and its GDP will remain constant over time. The results in column 2 and 3 suggest that the LTC share in GDP will, on average, almost double in the OECD until 2050. The healthy ageing scenario only leads to marginal reductions in this steep increase.

Columns 3 and 4 show projection results for scenarios with different assumptions on the development of costs per unit of LTC provided. For instance, if a given type of LTC becomes less expensive because of technological advancements that permit equal or higher quality care at lower cost, the LTC costs per unit decrease. The scenario in column 3 expects that LTC costs will increase at a rate that is 1 percent below the growth of the real GDP per working member of the population. Column 4, in contrast, assumes LTC cost to grow at a rate that is 1 percent above this ratio. The projections suggest that for the EU OECD-countries, the LTC expenditure shares in GDP will by 2050 have grown to 2.2 percent in the column 3 scenario and to 2.7 percent in the column 4 scenario by 2050.

Finally, the scenarios in columns 5 and 6 address the effects of the ongoing reduction in the share of LTC that is provided informally, e.g., through unpaid family members. OECD's scenarios cover the extreme

**Table**

**Public LTC expenditure expected to rise significantly by 2050 (percentage of GDP, in base year prices)**

| | Base year | Prevalence of dependency | | Changes to the LTC cost structure | | Decline in the availability of family care | |
|---|---|---|---|---|---|---|---|
| | | Pure ageing | Healthy ageing | –1% of GDP per worker | +1% of GDP per worker | All home care | All residential care |
| | | (1–Baseline) | –2 | –3 | –4 | –5 | –6 |
| EU 2009[a] | 2007 | 2050 | | | | | |
| Austria | 1.3 | 2.5 | 2.4 | 2.3 | 2.7 | 2.6 | 2.6 |
| Belgium | 1.5 | 2.9 | 2.8 | 2.6 | 3.2 | 3.1 | 3.5 |
| Czech Republic[a] | 0.2 | 0.6 | 0.5 | 0.6 | 0.6 | 0.6 | 0.7 |
| Denmark | 1.7 | 3.4 | 3.2 | 3.1 | 3.7 | 3.7 | 3.4 |
| Finland | 1.8 | 4.2 | 4.2 | 3.8 | 4.7 | 4.5 | 5.3 |
| France | 1.4 | 2.2 | 2.1 | 1.9 | 2.5 | 2.3 | 2.6 |
| Germany[b] | 0.9 | 2.3 | 2.2 | 2.1 | 2.5 | 2.4 | 2.7 |
| Greece | 1.4 | 3.3 | 3.2 | 2.9 | 3.7 | 3.5 | 3.9 |
| Hungary | 0.3 | 0.5 | 0.5 | 0.4 | 0.6 | 0.7 | 0.9 |
| Ireland | 0.8 | 1.8 | 1.8 | 1.6 | 2.0 | 1.9 | 2.2 |
| Italy | 1.7 | 2.9 | 2.8 | 2.6 | 3.2 | 3.3 | 3.9 |
| Luxembourg | 1.4 | 3.1 | 3.0 | 2.8 | 3.4 | 3.3 | 3.8 |
| Netherland | 3.4 | 8.2 | 7.7 | 7.5 | 9.0 | 8.4 | 9.2 |
| Norway | 2.2 | 4.5 | 4.3 | 4.1 | 4.9 | 4.6 | 5.3 |
| Poland | 0.4 | 0.9 | 0.9 | 0.8 | 1.0 | 1.1 | 0.9 |
| Portugal | 0.1 | 0.2 | 0.2 | 0.2 | 0.2 | 0.2 | 0.2 |
| Slovak Republic | 0.2 | 0.5 | 0.5 | 0.5 | 0.5 | 0.6 | 0.5 |
| Spain | 0.5 | 1.4 | 1.3 | 1.3 | 1.5 | 1.4 | 3.0 |
| Sweden | 3.5 | 5.5 | 5.3 | 5.0 | 6.1 | 5.8 | 6.3 |
| United Kingdom | 0.8 | 1.3 | 1.2 | 1.2 | 1.4 | 1.3 | 1.3 |
| OECD-EU average | 1.3 | 2.4 | 2.3 | 2.2 | 2.7 | 2.5 | 2.9 |
| Case study | 2006 | | | | | | |
| Australia | 0.8 | 1.8 | 1.6 | 1.7 | 2.0 | 2.0 | 2.4 |
| Canada | 1.2 | 2.7 | 2.4 | 2.4 | 2.9 | 2.7 | 3.4 |
| Japan | 1.4 | 4.0 | 3.5 | 3.6 | 4.4 | 4.0 | 4.4 |
| New Zealand | 1.4 | 3.9 | 3.6 | 3.5 | 4.3 | 4.6 | 6.2 |
| United States | 1.0 | 1.9 | 1.7 | 1.7 | 2.1 | 2.2 | 2.6 |
| **Case study average** | **1.2** | **2.9** | **2.6** | **2.6** | **3.2** | **3.1** | **3.8** |
| OECD projections | 2006 | | | | | | |
| Iceland | 1.9 | 2.8 | 2.5 | – | – | – | – |
| Korea | 0.2[c] | – | – | – | – | – | – |
| Mexico | – | – | – | – | – | – | – |
| Switzerland | 0.8 | 1.6 | 1.3 | – | – | – | – |
| Turkey | – | – | – | – | – | – | – |

[a] Data for the Czech Republic only reflect expenditures of the public health insurance funds and do not include expenditures on the attendance allowances. – [b] For the projection, unit costs are indexed to GDP per worker and do not reflect the current German legislation under which all long-term care benefits are indexed to prices. – [c] 2007.

Source: Colombo et al. (2011).

case of an entire disappearance of informal care. In column 5 it is assumed that this gap is filled exclusively by formal, paid home care. Column 6 assumes that the LTC that is now provided informally will be fully replaced by residential care in the future. The projected 2050 LTC spending share in the EU OECD countries is 2.5 percent in the home care scenario and 2.9 percent in the residential care scenario.

In summary, all scenarios see the GDP share of LTC expenditure doubling in the coming 40 years, highlighting an urgent need for financially viable LTC systems that provide a growing number of elderly citizens with high quality care.

S. N./E. D.

## Reference

Colombo, F. et al. (2011), Help Wanted? Providing and Paying for Long-Term Care, OECD Health Policy Studies, OECD Publishing. http://dx.doi.org/10.1787/9789264097759-