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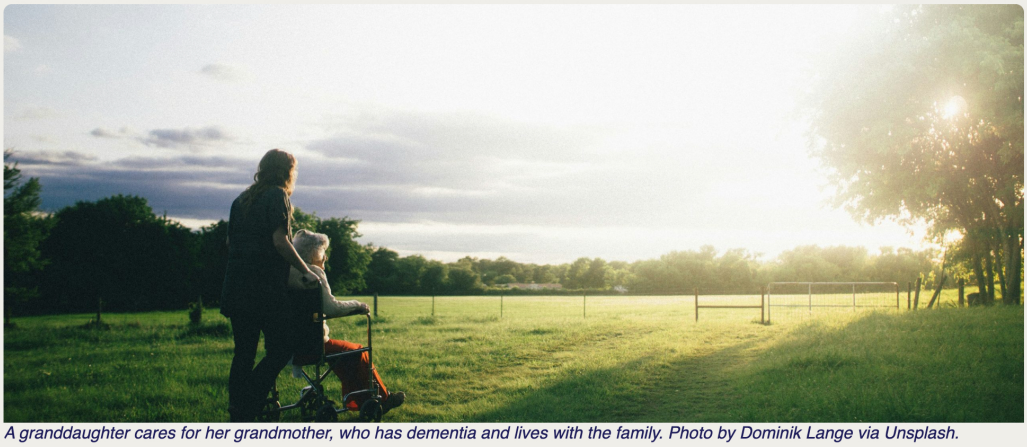
How Is Long-Term Care Handled by OECD Countries?

June 21, 2024

HIGHLIGHTS

OECD countries spent on average 1.8% of total GDP on long-term care in 2021, ranging from 4.4% in the Netherlands to as low as 0.5% or less in Greece, Poland and Latvia.



A granddaughter cares for her grandmother, who has dementia and lives with the family. Photo by Dominik Lange via Unsplash.

Executive Summary

The world's population is getting older very quickly, and the need for long-term care is projected to rise precipitously in the coming years.[1] The percentage of the population aged 65 or over in Organization for Economic Cooperation and Development (OECD) countries is expected to increase from 17.3% in 2019 to 26.7% by 2050.[2]The demand for long-term care (LTC) is rapidly increasing alongside the rate of aging: within the Americas alone, the number of adults over 60 who need LTC will more than triple between 2019 and 2050, from around 8 million to 30 million.[3]

Informal care provided by family members has historically been the primary form of LTC in many countries. With changing demographics, economies, and other factors, traditional reliance on informal care provided by relatives may not be sustainable indefinitely, and many countries lack sufficient infrastructure to provide LTC as demand rises and available informal care wanes.[4][5]

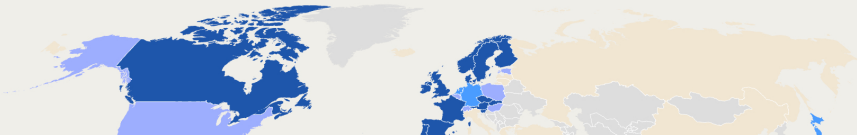
In recent decades, LTC has become a significant public policy concern, particularly in industrialized countries such as those in the OECD.[6] But, as improved living standards and quality healthcare are helping people live even longer, LTC demand is increasing and straining public budgets. Anticipating future need, long-term care has become one of the fastest growing healthcare sectors in most countries: the global LTC market was estimated at $1.1 trillion in 2023 and is expected to reach $1.74 trillion by 2030.[7] This report examines the organization of LTC across OECD countries, LTC spending, and whether LTC systems effectively provide accessible care in a way that is financially sustainable.

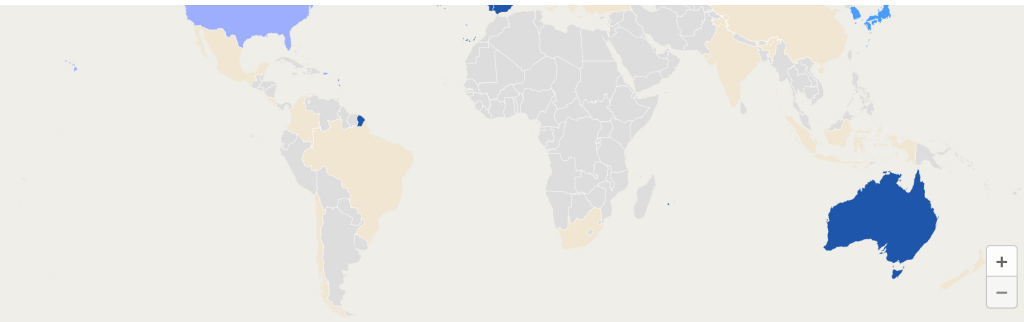
Most OECD countries fund LTC with taxes or health insurance programs and control public expenditure through means-testing, meaning only those below certain income limits are eligible, or the amount of public support is based on the care recipient's financial resources.[8] [9] Despite the fact that means-testing can provide support to those less able to afford LTC, those with lower incomes can still face unaffordable out-of-pocket costs.[10]This can force some needing LTC to go without care or rely only on informal care from family and friends, who, in turn, may face increased stress and financial hardship as they may stop working to care for a loved one. [11] [12] Unmet LTC needs can drive up healthcare spending. According to a study published in the Health Economics Review, "unmet needs for LTC have been associated with increased risk of hospital admission, hospital readmission, emergency department admission for falls and injuries, and mortality."[13]

Most OECD countries finance long-term care through taxation

Although many countries use a mixed form of financing, the main resource for financing long-term care in most OECD countries is taxation. Other forms are a dedicated long-term care insurance and general health insurance.

Taxation | Long-term Care Insurance | Health Insurance | Not available





Map: A-Mark Foundation • Source: Lee et al. (2023) • Get the data • Created with Datawrapper

In contrast, Nordic countries, including Denmark, Norway and Sweden, have universal tax-funded LTC programs where a comprehensive range of services are available based only on a person's care needs.[14] [15]Countries with universal systems generally perform best regarding accessibility, but this comes at a higher public cost. LTC spending in these countries is nearly double the OECD average.[16] Moreover, rising demand and mounting financial pressure have culminated in benefit restrictions and care responsibilities are increasingly shifting back to families.[17] Consequently, growing numbers of people need care but are not receiving it, and increasing public funding enough to meet demand may not be feasible.

Alternatively, Germany, Japan, Luxembourg, the Netherlands and South Korea operate mandatory public long-term care insurance (LTCI) programs financed through social contributions, typically via payroll deductions.[18] Eligibility for care under LTCI programs is needs-based and these programs have been found to have the highest coverage rate for those aged 65 and older.[19] Government spending and out-of-pocket spending on LTC vary widely between these countries. In 2018 for example, the Netherlands spent 3.9% of its GDP on LTC, with 6.7% of total spending on LTC coming from out-of-pocket payments, while in South Korea, just 1% of GDP was spent on LTC and 31.5% of spending came from out-of-pocket payments.[20] Increasing demand for LTC has led to considerable premium increases in most countries with LTCI in the past two decades, and some have restricted benefits, increased copayments, and shifted responsibility to informal caregivers to contain public spending.[21]

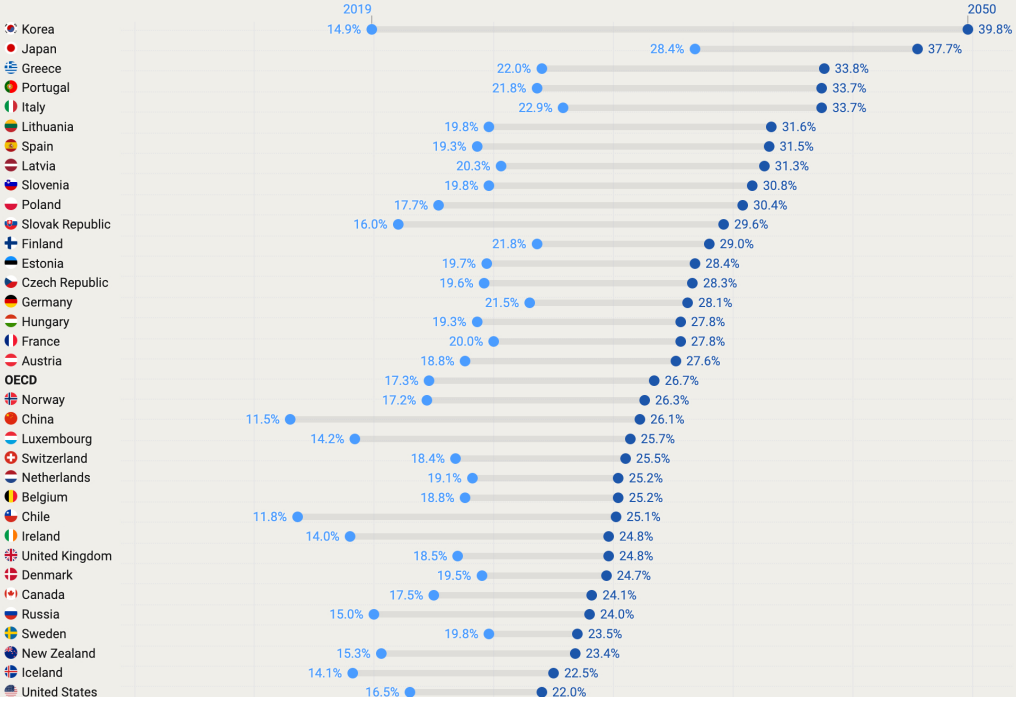
Ultimately, this report finds that no single formula exists for creating a financially sustainable LTC system, and most countries are struggling to provide accessible care as demand increases. LTCI programs and tax-based systems are both vulnerable to the economic pressures caused by population aging, regardless of whether care is means-tested or universal. Instead, the path forward likely involves investing in prevention and rehabilitation services to delay or prevent the need for LTC.

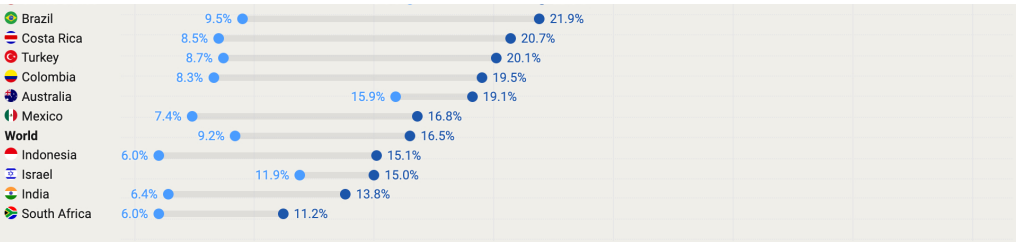
Long-Term Care in an Aging Population

As improved living standards and quality healthcare help people live longer, and, simultaneously, fertility rates are falling, the world's population is aging rapidly. However, the trend is more pronounced in industrialized countries, such as those in the Organization for Economic Cooperation and Development (OECD), where life expectancy is eight years higher than the global average (79 v. 71), and 18% of the population is over 65, compared to 10% of the world population. In OECD countries, the percentage of the population aged 65 or over is expected to increase to 27% by 2050.[22] [23] In the United States, an OECD member, life expectancy at birth is 76 years, and 17% of the population are over 65.[24]

Over a quarter of the population will be older than 65 years

The OECD population will have 26.7% of people older than 65 years by 2050. Currently the share is about 17%. In Korea the group of elderly will reach almost 40%. World estimates for 2050 are about 16.5%





Future estimate for World is by the United Nations, Department of Economic and Social Affairs, Population Division.
Chart: A-Mark Foundation • Source: OECD • Get the data • Created with Datawrapper

As people age, many face functional decline and disease and rely on others for long-term care.[25] LTC encompasses medical care, such as nursing and physical therapy, as well as personal, assistance, and social services that support people who cannot care for themselves independently due to disability or age-related limitations.[26] Personal care supports daily activities such as bathing, eating, and using the bathroom, while assistance and social services help with practical household tasks like shopping, cooking, and housekeeping, as well as activities that promote quality of life.[27]

Most LTC is informal, usually involving children or spouses helping with personal and practical tasks at home.[28] As fertility rates fall, however, there will be fewer informal caregivers, and demand for formal services will grow.[29] Professional caregivers, such as nurses and home aides, can provide formal LTC at home, in community settings, or in residential or institutional facilities like assisted living or nursing homes.[30] But, most people want to continue living at home as they age - and home and community-based LTC makes this possible.[31] On average across OECD countries, 69% of those receiving formal LTC benefits receive care at home (versus in institutional care). Portugal has the lowest proportion of LTC recipients receiving care at home at 34%, and Israel has the highest proportion at 95%. [32]

The demand for long-term care (LTC) is rapidly increasing alongside the rate of aging. Within the Americas alone, the number of adults over 60 who need LTC will more than triple between 2019 and 2050, from around 8 million to up to 30 million.[33]

Formal care is expensive, though. In the United States, for example, average costs for formal home or residential care can range from two to almost four times higher than older Americans' median income, and the U.S. has no dedicated national LTC program.[34] Medicare, the public healthcare program for older adults, does not cover most LTC services, nor does private health insurance.[35] Instead, Medicaid, the public health insurance program for low-income households, primarily finances LTC, and many Americans with care needs exhaust their savings to become eligible.[36] [37]Moreover, Medicaid only covers nursing home support and limited home-based care, and long waitlists are common. Recent estimates suggest that 38 states had waiting lists for home care with an average wait list of 3 years. [38]

Ultimately, the majority of Americans (59%) who need LTC receive only informal care, which can lead to extreme stress, depression, and financial hardship among informal caregivers, as they may stop working to provide care or pay care-related expenses out-of-pocket.[39] [40]Nearly 40% of people who provide informal care or help pay for formal care report that it depletes most or all of their savings.[41] In 2021, the estimated economic value of informal care reached $600 billion, exceeding Medicaid, Medicare, and out-of-pocket spending combined.[42] Total spending on LTC in 2021 was estimated to be $467.4 billion.[43]

Informal care is prevalent, and formal care is expensive everywhere, with costs reaching one to six times higher than older adults' median disposable income across the OECD.[44] But, unlike the United States, many OECD countries have developed public LTC programs or integrated LTC services into their healthcare systems. Looking ahead, understanding how these countries organize care and what makes an LTC system effective may offer valuable insight.[45]

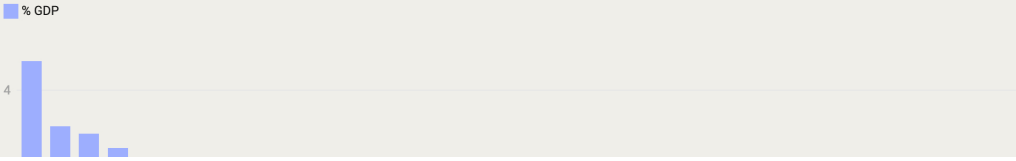
Long-term care systems across the OECD

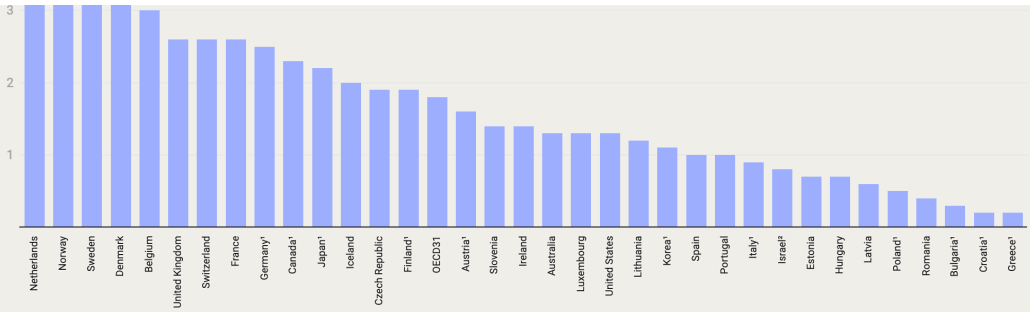
Approaches to LTC vary widely across OECD countries, and there are dramatic differences in how much each spends on LTC. In 2021, LTC spending amounted to 1.8% of gross domestic product (GDP) across the OECD, ranging from 4.4% in the Netherlands to 1.3% in the United States and 0.5% or less in Greece, Latvia and Poland.[46] Mexico, who last reported in 2019, spent just 0.1% of GDP on LTC. [47] However, countries report LTC spending differently, so comparing expenditures can be challenging and potentially misleading. Many countries report only health and medical LTC spending or exclude certain types of care services. For example, some personal care and assistance services, including food preparation and housekeeping, are not reported as LTC expenditures in Austria, Bulgaria, Canada, Croatia, Italy, Finland, Germany, Greece, Japan, Poland and South Korea.[48]

Still, spending trends can be informative when considering factors like the organization and scope of a country's LTC system and how much they rely on informal care.[49] For example, Mexico has no dedicated public LTC programs, and the private market is underdeveloped. Consequently, 97% of care recipients receive only unpaid help, explaining Mexico's low LTC expenditure.[50] In contrast, Nordic countries, including Denmark, Norway, and Sweden, have developed robust LTC programs over several decades. Caretaking for older people and those with disabilities is broadly considered a government responsibility in Nordic countries, while informal care is mainly supplemental.[51] After the Netherlands, the highest LTC spenders were Norway (3.5% GDP), Sweden (3.4%), and Denmark (3.2%).[52]

Total long-term care spending as a share of GDP, 2021 (or nearest year)

In 2021(most recent available data), 1.8% of gross domestic product (GDP) was allocated to LTC (including both the health and social components) across the OECD countries.





1. 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).
2. Country not reporting spending for LTC (health).

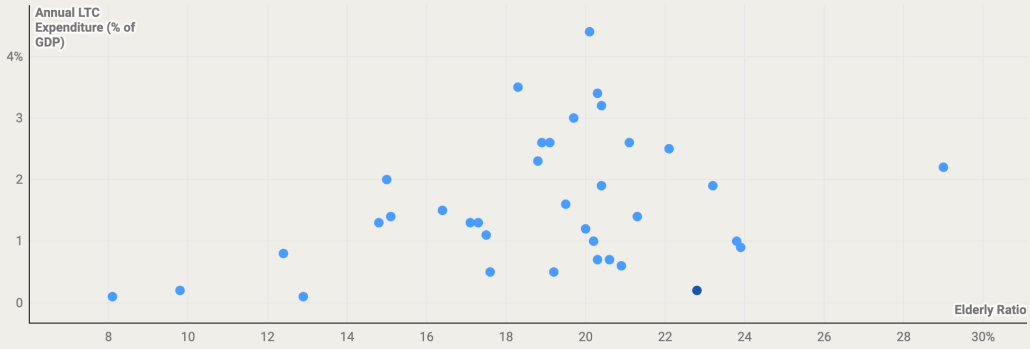
Chart: A-Mark Foundation • Source: OECD • Get the data • Created with Datawrapper

Ultimately, social values and economic capacities influence LTC spending and shape the organization of care, the benefits available, eligibility criteria, and financing arrangements.[53] [54] Generally, the social and healthcare sectors organize public LTC, and multiple levels of government are often involved.[55] OECD countries have traditionally organized formal LTC around institutional care. But, given the high costs of institutional care for both care recipients and the government and most people's desire to live at home as they age, most OECD countries are increasingly prioritizing home-based LTC.[56]

In any case, LTC systems can be universal, where a person's care needs are typically the only eligibility criteria, or selective, where only select groups are eligible, often based on social or financial resources. Systems are also considered universal if everyone over a certain age, usually 65, is eligible.[57] In Nordic countries, for example, eligibility is universal, and municipalities organize a comprehensive range of affordable services.[58] In contrast, public LTC is a "safety net" for those with limited financial resources in the United States and England, and eligibility is means-tested: only those below certain income or asset limits qualify for public support.[59] Alternatively, mixed or hybrid systems blend elements of universal and selective programs. In Australia, for example, eligibility is universal, but support is adjusted to the care recipient's income, and some pay all costs out-of-pocket.[60]

Elderly ratio can drive LTC expenditure

Generally, a higher ratio of elderly in the population means more of the GDP is spent on long-term care. However, this is not a fixed rule. Greece, for example, has a elderly ratio of almost 23% but spends only 0.2% of the GDP on long-term care.



**LTC Expenditure does not include social LTC (primarily Instrumental Activities of Daily Living (IADLs) and other social activities).*

Chart: A-Mark Foundation • Source: OECD, The World Bank Gender Data Portal • Get the data • Created with Datawrapper

Benefits

Benefits generally fall under two categories: in-kind services and cash. In-kind benefits are those that are provided directly as a service, such as home-based nursing or care provided in an LTC institution. However, in-kind benefits can also include goods, such as necessary medical or assistive devices, e.g., wheelchairs. Most countries offer both, but one type may be prioritized.[61] Sweden, for example, offers both but prioritizes in-kind home care, and services like nursing and personal care, and home modification grants are widely available.[62] By contrast, LTC in Austria is organized around a cash allowance, which recipients can use to arrange care at home or in residential settings. Austria's LTC allowance is a national program and eligibility is universal based on care needs. Regional governments organize and provide access to in-kind services, including home and residential care, that care recipients can pay for with the cash allowance.[63]

Most countries also offer benefits for informal caregivers, including cash allowances, temporary work leave, and respite services to provide short-term relief for informal caregivers.[64] OECD countries are also increasingly offering benefits like counseling and caregiver training. For example, in Germany, informal caregivers can enter a contract with a care recipient to receive compensation, respite, flexible work options, counseling, and skills training.[65]

Financing care

LTC funding can come from multiple sources, including general tax revenues, health insurance, and private payments, but LTC is primarily tax-funded in most countries.[66] Alternatively, LTC is financed through mandatory long-term care insurance (LTCI) in Germany, Japan, Korea, Luxembourg, and the Netherlands. LTCI systems are primarily financed through earmarked social contributions, usually via payroll deductions, which creates a dedicated funding stream.[67] However, each country organizes LTCI differently.

In Germany, for example, LTCI insurance contributions are shared equally between employee and employer and are set at 3.05% of income for workers with children and 3.3% for workers without children. Eligibility for benefits is based solely on care needs, and LTCI covers home and institutional care, cash, and informal caregiver benefits. However, benefits received sometimes do not cover the whole cost of LTC services a person needs, leading to out-of-pocket costs. Those who cannot afford additional services can apply for

whole cost of LTC services a person needs, leading to out-of-pocket costs. Those who cannot afford additional services can apply for means-tested assistance.[68] [69]

Contrastingly, the Netherlands, Korea, Japan, and Luxembourg fund LTCI through a combination of contributions and taxes.[70] In Japan, for example, contributions provide 50% of LTCI funding, and taxes finance the remaining 50%. Only those over 40 pay contributions in Japan, and eligibility is generally restricted to those over 65.[71] In-kind services are comprehensive but require copayments, which may be waived for low-income beneficiaries, and cash benefits are unavailable.[72]

In the Netherlands, LTC is offered through three separate schemes. LTCI mainly covers institutional care, and social health insurance provides home-based personal care and nursing.[73] LTCI and social health insurance are financed by social contributions of nearly 10% of income up to a limit, and eligibility is needs-based.[74] The third scheme, the tax-funded social welfare sector, is responsible for home help and social care, and eligibility for these services is means-tested.[75]

Elements of effective LTC

Long-term care systems must balance competing priorities. Promoting health and well-being requires accessible and affordable services, but universal coverage may not be financially sustainable. This section considers how effectively OECD countries tackle these priorities based on the accessibility of care, support for informal caregivers, and financial sustainability.

Accessibility

Care is accessible when the amount and type of services needed are available, and out-of-pocket costs are affordable. There are no widely accepted measures of LTC affordability, but, in healthcare, out-of-pocket spending exceeding 25% of income is deemed "catastrophic."[76] Borrowing this standard, out-of-pocket LTC costs exceeding 25% of income can be considered unaffordable.

For a typical older person with moderate care needs and no net wealth, out-of-pocket costs for home care represent less than 25% of income in Finland, Germany, Iceland, Ireland, Japan, Luxembourg, the Netherlands, the Slovak Republic and Sweden.[77] All these countries finance home-based LTC through tax-based systems or LTCI.[78] [79] In contrast, out-of-pocket home care costs for moderate needs exceed 50% of income among older adults with no net wealth in France, Spain, and the United States.[80] While home-based LTC is financed through tax-based systems in France and Spain, the United States operates its LTC programs within a health insurance system.[81] Put simply, after paying for home care, an older person with moderate care needs in these countries is left with less than half their income to pay for food, housing, and other living costs.

In most countries, out-of-pocket costs are set by income, however in some countries (such as France, Spain and the US), the amount of assets a person has is also considered.[82] For those with average net wealth living in these countries, 60% to 100% of income goes toward home-based care costs.[83]

Affordability does not always mean accessibility, though. For example, while home-based LTC is affordable in Ireland, there are pervasive shortages of available services because the home care sector is underfunded.[84] In 2021, for example, home care only represented 9% of Irish LTC spending, versus 18% of LTC spending across the OECD. The rest of LTC spending was divided among hospitals, social care providers, spending LTC allowances, and other services[85] In Ireland, 22% of those with LTC needs report not using formal home care because services are unavailable, compared to 10% across other European countries.[86]

Complicating matters, staffing shortages pose another barrier to accessible care as LTC demand is increasing faster than the number of formal LTC workers in most countries. Staff recruitment and retention are major challenges. LTC jobs are often part-time, low-wage, labor intensive, and therefore unattractive to most workers. In Germany, for example, 70% of LTC jobs are part-time, and wages are only 60%-70% of the economy-wide average.[87] A recent study found that personnel shortages forced 80% of German home care providers to reject client requests for services for three months, while another found that lack of staff retention led some programs to new clients or place them on waitlists.[88] In the United States, only 34% of LTC jobs are part-time but wages are 51% of the economy-wide average, the lowest in the OECD.[89]

Long-term care jobs are often part-time and low-wage

About a third of LTC jobs in the OECD are part-time and hourly wages are below three quarters of the economy-wide average. On the edges of the spectrum are the Netherlands, where 77% of the jobs are part-time, and the United States, where payment is 51% of the average wage.

Country with Code	Part-time percentage	Hourly wage (% of average)
Netherlands	77%	95%
Norway	30%	88%
Iceland	68%	88%
Luxembourg	31%	85%
Austria	50%	85%
Czech Republic	7%	83%
Denmark	40%	83%
Sweden	50%	80%
Finland	28%	80%
Switzerland	61%	76%
Belgium	58%	74%
OECD26	**32%**	**72%**
France	39%	71%

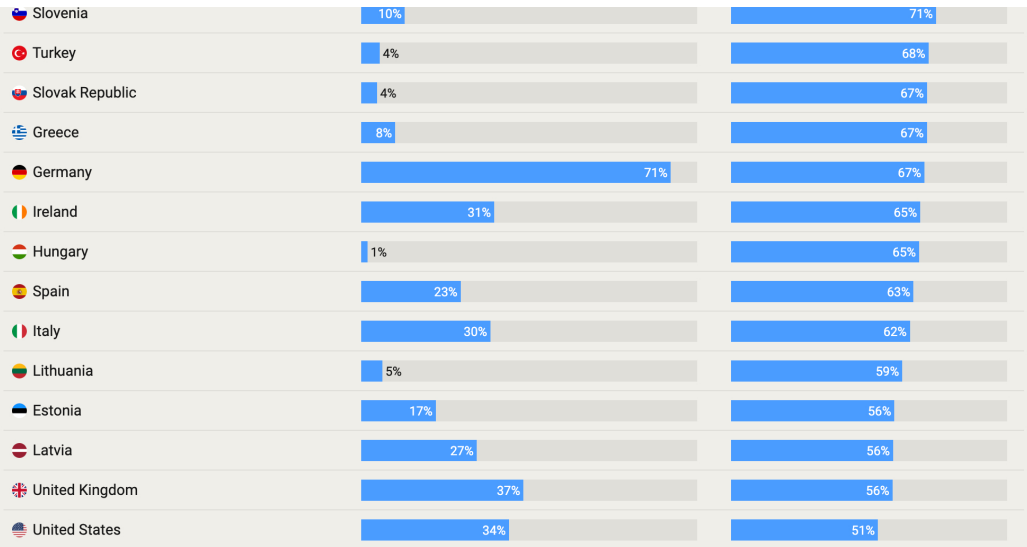


Table: A-Mark Foundation • Source: OECD • Get the data • Created with Datawrapper

Although LTC worker shortages are generally less severe in countries with universal tax-based systems, increasing demand is still impacting accessibility.[90] In Sweden and Denmark, for example, age-related functional limitations are increasingly prevalent, but the share of older people receiving LTC is decreasing. In Denmark, the proportion of older people with disabilities reporting that they received formal LTC help decreased from 45.8% in 2013 to 29.9% in 2017. In Sweden, the proportion fell from 35.8% to 28.9% over the same period.[91] Nordic countries have traditionally prioritized universal coverage with some level of care, but as increasing demand strains public resources, benefits are now reserved for those with the highest care needs, and care responsibilities are increasingly shifting back to families.[92] In Denmark, the proportion of all older people aged 65 and older reporting that they received LTC help either at home or in institutions, decreased from 19.4% in 2011 to 14.3% in 2021. In Sweden, the proportion fell from 17.2% to 15.7% over the same period.[93]

Supporting informal caregivers

Informal care plays a critical role in every OECD country, regardless of accessibility concerns and eligibility requirements. For example, informal caregiving is as common, if not more, in Sweden, Norway, and Denmark, as it is in England, Ireland, and Spain. Intensive caregiving, however, involving 11 hours or more of weekly caregiving, is significantly less prevalent in countries with universal systems compared to hybrid and safety-net systems. In Denmark, Norway, and Sweden, for example, less than 5% of the population reports providing intensive care to a loved one. In contrast, approximately 9%-10% of the total population are intensive caregivers in England, Ireland, and Spain.[94]

Intensive caregiving is less prevalent with universal systems of long-term care

Intensive care involves 11 hours of more of weekly caregiving. The analyzed European countries fall into one of two groups: the population share that givers intensive care is either higher than 8.6% or lower than 6.8%.

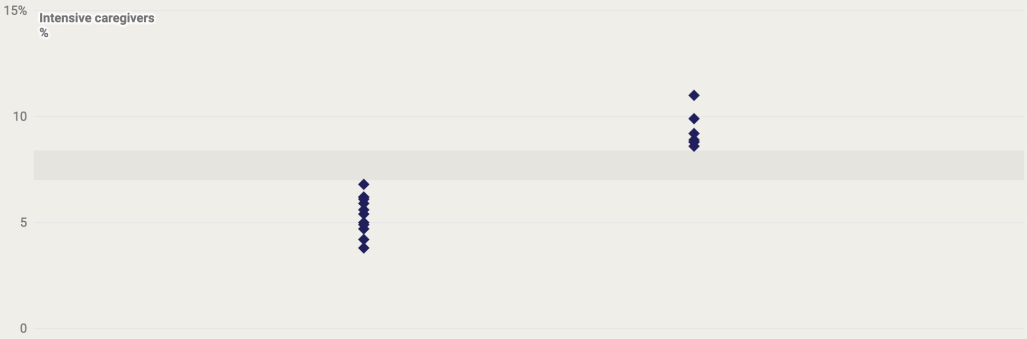


Chart: A-Mark Foundation • Source: Verbakel (2017) • Get the data • Created with Datawrapper

Intensive caregiving is linked to the availability of formal care, specifically personal care services that help with bathing, using the bathroom, eating, and meal preparation. These activities are time-consuming and required during the day, making it more difficult for informal caregivers to remain employed and placing them at greater risk of financial hardship. Further, intensive caregiving is strongly associated with stress, depression, and burnout.[95] In other words, informal caregivers are best supported in countries with widely accessible formal LTC.

However, facing strained public budgets, several countries, including the Netherlands and Germany, offer benefits to support informal caregivers and stimulate informal care as a substitute for formal services, thereby reducing public burden.[96] Cash benefits are most common, offered by 33 OECD countries either as a direct payment to a carer or the care recipient, or both. Cash benefits are usually means-tested and can impose limits on formal working hours for the caregiver.[97] However, most informal caregivers are already low-income, and allowances are typically modest amounts, meaning cash benefits can inadvertently trap informal caregivers in poverty if they cannot increase their income by working additional hours.[98]

Beyond cash, most countries also offer respite care, but these services are often inaccessible due to lack of service provision.[99] However, informal caregivers say that regularly scheduled respite can help prevent burnout, especially when combined with other benefits, including caregiver training, education, and counseling services, all of which are associated with improvements in informal

caregivers' physical and mental well-being.[100]

Nonetheless, few countries offer sufficient support for informal caregivers, and rigorous data on the effectiveness of various caregiver benefits is scant.[101] As growing demand strains LTC systems, strengthening informal caregiver benefits is critical. But, at the same time, shifting caregiving responsibilities back to families may be infeasible as the pool of potential informal caregivers dwindles. In Germany, for example, by 2060, there may be as many as 400,000 more people in need of informal care than who can provide it.[102]

High levels of informal care show less intensive care

Overall, countries with a high share of informal caregivers have lower levels of intensive care (11 hours per week or more). Austria and Lithuania are exceptions where both shares are low.

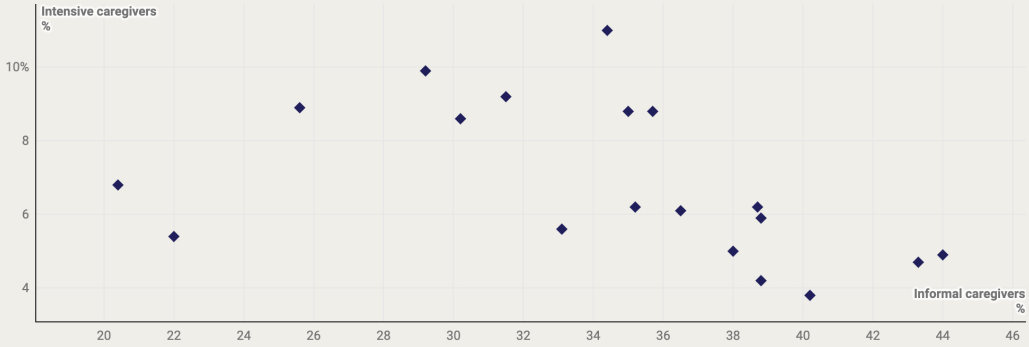


Chart: A-Mark Foundation • Source: Verbakel (2017) • Get the data • Created with Datawrapper

Financial sustainability

Financial sustainability may be the most challenging aspect of designing an LTC system. Universal, comprehensive systems may provide accessible and affordable care, but this comes at a high cost. The Netherlands, for example, spent more than double the OECD average on LTC in 2021, and the next highest spenders, Norway, Sweden, and Denmark, each allocated over 3% of GDP to LTC.[103] Yet, these countries are still struggling to meet demand, and fiscal pressure has already led to benefit restrictions.[104] As demand continues growing, additional restrictions or further increasing funding may be necessary.

The Netherlands' uniquely high expenditure reflects the country's generous and widely available benefits, but fragmentation and inefficient resource allocation are also significant factors. The Netherlands' three separate schemes have created a fragmented system that generates excessive administrative costs, poorly coordinated care, and inefficient uses of resources.[105] For example, the differences in personal care and home help provided by LTCI, social health insurance, and the social welfare sector can be unclear and overlapping. In turn, care recipients may receive redundant services, or a more extensive package of services may be provided when the individual's care needs may not require it.[106]

In other words, inefficient resource allocation can balloon LTC expenditure. For example, home care has long been underfunded compared to institutional care in Canada, which has led to widespread shortages of high-quality home-based services and unnecessary nursing home admissions. In 2022, for example, as many as 10% of those admitted to nursing homes could have been adequately cared for at home if services were available. However, in 2021-2022, the Ministry of Health in Ontario, Canada, expanded access to home care for 131,180 people who were eligible for residential care.[107] In doing so, the Ministry of Health saved more than 5 billion Canadian dollars, which represents over 10% of national public LTC spending. The public cost of supporting 79,000 people in LTC institutions in Ontario, Canada, would have cost the Ontario Ministry of Long-term Care more than CA$6.4 billion, and the Ontario Ministry of Health spent CA$1.3 billion to provide home care to people who were eligible for residential care.[108] [109]

Alternatively, many countries impose strict means-testing to limit public LTC expenditure. However, strict means-testing often leads to higher rates of informal care and unmet need, which can strain public budgets in other sectors.[110] For example, most OECD countries anticipate shrinking workforces as people age out of the workforce and fertility rates fall, which may stifle economic productivity.[111] Countries with inaccessible LTC already face comparatively high rates of unemployment related to informal caregiving, potentially making them more vulnerable to these economic changes.[112]

Means-tested LTC can also increase pressure on healthcare, especially in countries with universal health coverage. When people are ineligible for public LTC and unable to afford private services, those with LTC needs may turn to hospitals for care when hospitalization is not medically necessary, leading to higher healthcare spending and shortages in available hospital beds.[113]

Low workforce participation and pervasive LTC hospitalizations were key issues motivating Japan to implement LTCI in 2000.[114] Before then, eligibility for LTC was means-tested, and services were often unavailable. But, older people had access to free healthcare, which resulted in such frequent unnecessary LTC hospitalizations that many hospitals essentially functioned as nursing homes.[115] [116] Since introducing LTCI, workforce participation among informal caregivers has increased, access to LTC has become more equitable, home care has dramatically expanded, and out-of-pocket costs have remained relatively low.[117] [118]

Moreover, excluding the Netherlands, countries with LTCI spend significantly less on LTC than countries with universal tax-based systems, ranging from 1.1% of GDP in Korea to 2.5% in Germany in 2021.[119] Several countries with hybrid and safety-net systems spend comparable amounts, or more. The United Kingdom and France, for example, each spent 2.6% of GDP on long-term care in 2021.[120]

LTCI programs also benefit from having dedicated funding streams, meaning funding cannot be diverted to other programs. In contrast, most countries fund LTC through general tax revenues, which provides flexibility and allows governments to quickly respond to supply and demand changes.[121] But, this also allows funding to be diverted based on competing political priorities.

Further, the public may find high LTCI premiums more acceptable than tax increases. Eligibility criteria and benefits are often vague in tax-based programs to allow flexibility for policy changes, while, in contrast, LTCI creates entitlements to care with clearly defined benefits, eligibility, and financing.[122] For many, the relative transparency of LTCI programs makes premium increases tolerable.

However, LTCI programs are highly vulnerable to demographic and labor market changes, like fluctuations in workforce size and average earnings, because funding is primarily derived from worker contributions.[123] For example, rising demand and lagging economic growth have forced Japan to restrict benefits, develop stricter needs assessments, and increase copayments in the past two decades.[124] In Korea, the contribution rate has almost doubled since its introduction in 2008, and LTCI has operated in an increasing deficit since 2018. Korea's LTCI deficit is partly explained by rapidly increasing demand, as Korea is the fastest aging country in the world. However, the LTCI contribution rate is substantially lower in Korea than other countries with LTCI, at only 0.68% of wages. Consequently, LTCI funding has struggled to keep pace with population aging.[125]

Put simply, LTC demand is increasing everywhere, and costs are rising, too, regardless of the financing arrangement. Shrinking workforces will result in a smaller pool contributing to LTCI but will also impact tax revenues and economic activity, straining LTCI and tax-based systems alike. Ultimately, no clear formula exists to create a financially sustainable LTC system.

Solutions

Increasing LTC demand is a global challenge. There is no single solution to the mounting crisis, but some clear options to improve LTC systems stand out. For example, many countries' LTC systems remain skewed toward institutional care. These countries could reduce reliance on informal care, expand LTC coverage, and prevent costly unnecessary institutional care admissions by reallocating resources to sufficiently develop home care. While shifting resources to home care may not reduce public expenditure overall, spending would be more efficient and potentially rise at a slower rate.

Expanding access to formal care also requires investing in LTC workers. Recruitment initiatives like grants for new workers to complete training programs have shown promise in the Netherlands, the U.S. and Israel. Other potentially effective strategies include wage increases and creating career development pathways.[126] Yet, even if every country expanded home care and improved LTC working conditions, many would still be ineligible for LTC in countries with hybrid and safety-net systems.

Private insurance

To expand coverage without raising public expenditure, some countries have explored options to develop a private LTC insurance market.[127] The United States, for example, has offered tax credits and deductions to incentivize the purchase of private LTCI since the 1990s.[128] Nonetheless, as few as 3% of Americans aged 50 and older hold private LTCI today.[129] Coverage remains low largely because insurers can reject applicants with pre-existing conditions and set high premiums based on health and lifestyle, which can be unaffordable and cost significantly more than the value of the expected benefits.[130] Average monthly premiums cost $185 to $439, or more depending on the policyholder's age and health.[131] Further, many people never need LTC. Facing high premiums and uncertainty, purchasing LTCI can be unappealing, at least in part because around 30% of Americans over age 65 never require LTC services.[132]

In contrast, France has developed a significant private LTCI market. The French government incentivizes group purchasing through employer-based plans, which can spread risk and help keep premiums low. However, benefits are also low, and insurers can reject applicants with pre-existing conditions. Consequently, private LTCI is mainly supplemental, and most still pay LTC costs out-of-pocket or rely on public benefits.[133] In short, private LTCI cannot substitute a robust public system.

Reablement

Ultimately, addressing the mounting LTC crisis may require finding ways to slow demand. While most countries' LTC systems are reactionary, responding to needs as they arise, public health and social experts are increasingly advocating for a more proactive approach that promotes healthy aging and reablement.[134] Reablement is a short-term, intensive rehabilitation program involving social care professionals, occupational and physical therapists, and nurses working with older people to improve functional ability and regain independence through exercise and lifestyle adjustments.[135] In turn, reablement can reduce or delay the need for LTC.

Reablement is already offered in several OECD countries, but it is most developed and widely implemented in Denmark.[136] Under Danish law, anyone requesting home care must first be considered for a 12-week home-based reablement program provided free of charge. Home care is only offered if reablement does not restore the individual's functional abilities or if they physically or mentally cannot complete reablement.[137]

Determining the effectiveness of reablement is challenging, though, because comprehensive data is not yet available due to the fact that this is a relatively new approach to healthcare. Still, several small-scale studies have linked reablement programs to improved quality of life and functional abilities.[138] For example, in some Danish municipalities, 60% of reablement participants no longer needed permanent home care.[139] Further, short-term rehabilitative interventions are likely more cost-effective than traditional home-based LTC, which is often provided until the end of a person's life. Although reablement may not lower LTC demand or expenditure in absolute terms, effective programs may slow the pace. Nonetheless, rigorous data on costs is scant.[140]

While research remains limited, advocates indicate that effective reablement programs engage with older people to set unique personal goals to improve their physical, emotional, and social well-being.[141] If successful, reablement can help older people become more independent and socially connected, and less reliant on others for care.[142]

Promoting healthy aging

Public health and social care experts envision reablement and rehabilitation services that prevent functional decline and restore autonomy as critical components of a "life-cycle approach" to promote healthy aging and prevent the need for LTC. Ultimately, expanding access to high-quality and affordable rehabilitation, prevention, and primary care services for all ages costs the same or less than providing intensive care services later in life and will reduce the need for LTC for many. As such, according to the International Labour Organization (ILO), the costs of rehabilitation, prevention, and primary care should be viewed as a public investment to enable more people to remain working and living independently as long as possible, prevent financial hardship, and reduce the demand and associated costs of LTC.[143]

The future of care in the United States

Given the importance of health services in preventing functional decline and promoting healthy aging, the World Health Organization

emphasizes that universally accessible LTC will not be possible unless a country has already achieved universal health coverage.[144] Most OECD countries have universal health coverage, so a life-cycle approach could provide a blueprint to strengthen LTC for countries that have the political will and economic capacity. However, the United States is an outlier as the only wealthy OECD country without universal health coverage.[145]

Although a life-cycle approach may not be possible without substantial healthcare reforms, the United States could build on Medicare, the public healthcare program guaranteeing coverage for adults over 65. Medicare already covers some services related to reablement, such as home-based occupational and physical therapy, if an individual is deemed "homebound," or unable to leave their home without help.[146] As such, the U.S. could consider allowing Medicare beneficiaries to access these services and improve their functional abilities before becoming housebound. But, this does little to expand access to traditional LTC.

In 2010, the U.S. tried expanding coverage by passing the Community Living Assistance Services and Supports (CLASS) Act, a voluntary public LTCI plan that would provide beneficiaries a modest cash benefit of at least $50 a day to pay for LTC. However, actuarial analysts indicated that monthly premiums would be costly, ranging from $235 to $391, likely leading to low enrollment.[147] The plan was eventually repealed after being deemed "financially unsound."[148]

Nonetheless, some progress has been made at the state level. For example, in 2019, Washington passed the "WA Cares Fund," a statewide mandatory LTCI program funded by worker contributions, which will start providing benefits in 2026. Eligibility will be needs-based, and benefits include a comprehensive range of home-based services, institutional care, and informal caregiver benefits. However, benefits are limited to a lifetime maximum equal to around one year of home-based care or approximately six months of institutional care.[149] Washington's LTCI program is the most comprehensive state program to date, but other states have passed limited means-tested LTC programs outside of Medicaid, including West Virginia, Minnesota, Hawaii, New Jersey, and New York.[150]

Ultimately, however, there is insufficient political will to invest in long-term care at the federal level. In 2021, for example, the U.S. House of Representatives passed the Build Back Better Act, which contained significant Medicaid funding increases and reforms to expand access to home care.[151] However, the LTC provisions were later dropped due to concerns about public spending.[152]

Conclusion

As the number of people needing LTC increases, and the number of potential informal caregivers decreases, governments are grappling with the challenge of making care accessible and affordable. Relying on private financing or imposing strict means-testing is unsustainable, as the high costs of care drive unmet need and an overreliance on informal care, which, in turn, may cause excessive healthcare spending. Moreover, relying on informal care as a substitute for formal services decreases informal caregivers' workforce participation and places them at high risk of poor health outcomes. Some countries already invest heavily in LTC and provide universally accessible and affordable care. But, as more people need LTC, the mounting financial pressure has led to benefit restrictions and initiatives to shift care responsibilities back to families.

While the United States lags behind most wealthy countries in protecting older people from the financial hardship that arises from needing long-term care, accessibility and affordability issues exist virtually everywhere. Ultimately, this report concludes that there is no single formula for creating a financially sustainable LTC system that provides adequate, accessible care. Neither tax-based systems nor LTCI programs are immune to the economic pressures caused by population aging, regardless of whether care is means-tested or universal. Instead, the path forward likely involves investing in prevention and rehabilitation services, including reablement, to delay or entirely prevent the need for LTC.

Instead of continually debating the relative merits of various financing arrangements and eligibility criteria, the findings in this report suggest that a more useful and hopeful frame for thinking about the future of care involves identifying ways to make health and social care services more accessible for all ages, which will take pressure off long-term care systems while also helping people remain independent, stay socially connected, and overall, have a better quality of life as they age.

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