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**EMPLOYMENT, LABOUR AND SOCIAL AFFAIRS COMMITTEE**

**DELSA/ELSA/WP1/HS(2004)9**
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## Working Party on Social Policy. Health Policy Statistics.

# ESTIMATING EXPENDITURE ON LONG-TERM CARE

**to be held at the Château de la Muette, Paris, 30 September and 1 October 2004, starting at 14.00 on the first day**

*Following the Meeting of OECD Health Data National Correspondents, starting at 09:30 on 29-30 September 2004 - DEELSA/ELSA/WP1/HS/A(2004)1/REV1*

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## NOTE BY THE SECRETARIAT

1. Differences in estimation methods applied in member countries for expenditure on long-term care are a prime source for data comparability problems in health accounts collected for *OECD Health Data*. Estimation methods have also been found to differ among countries which have implemented the OECD manual *A System of Health Accounts* (SHA), illustrating the need for improved definitions of this expenditure category and better guidelines for sources and estimation procedures (see DELSA/ELSA/WD/HEA(2004)7).

2. Two projects that will address this issue have received high ranking by administrations in member countries in reply to a questionnaire of the Secretariat on priorities for future health work at OECD. One is a project on refined expenditure classifications which is presented at this meeting (see DELSA/ELSA/WP1/HS(2003)5), another one is a project in 2005 on improving data on expenditure and recipients of long-term care services. There will be considerable overlap between the future conceptual work for expenditure on long-term care and the issues addressed in the paper on data for recipients and services (DELSA/ELSA/WP1/HS(2003)3), for which definitions should be harmonised as far as possible.

3. This paper reviews current accounting practice on expenditure on long-term care for the 19 OECD countries that have participated in the S*tudy on long-term care* under the *OECD Health Project*. It summarises main issues to be addressed for the proposed follow-up work in 2005 on definitions and estimation guidelines, which will have implications for, and will need to be co-ordinated with the project on refined expenditure classifications.

4. The Secretariat invites participating experts to:

- COMMENT on the conclusions from data work on long-term care expenditure from the *Long-term care study*, presented in this paper.

- NOTE the planned project of an improved data collection on long-term care services and expenditure in 2005;

- EXPRESS their interest to participate during 2005 in the project of improving long-term care expenditure estimates; e.g. by input and comments on draft papers and by investigating the feasibility of estimates from national sources.

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# ESTIMATING EXPENDITURE ON LONG-TERM CARE

## Introduction

5. Comprehensive information systems on long-term care expenditure that bring together data from all public and private sources are largely absent in OECD countries and comparability over time and across countries is often limited. Consequently, there are important information gaps for health and long-term care policy. On a more positive note, the data situation on long-term care expenditure has improved substantially for several countries which implemented the SHA manual. However, even where SHA-based accounts are now available, important comparability issues remain for long-term care (see DELSA/ELSA/WD/HEA(2004)7).

6. Two projects to improve the methodology, data availability and comparability on long-term care expenditure have been proposed for inclusion in the OECD Programme of Work and Budget for 2006/2006 (SG/ADHOC/HEA(2004)8). One is a project on data and methodology for long-term care services, recipients and expenditure. The other a project on refining expenditure classifications for a second edition of the manual *A System of Health Accounts* (see DELSA/ELSA/HS(2004)6).

7. This paper analyses and compares estimates for long-term care expenditure from different sources. These estimates have been brought together as part of work under the *Long-term care study* (see Annex 1). This component of the *OECD Health Project* compared trends in long-term care policy in 19 OECD countries, with a focus on recent reforms of long-term care, trends in monitoring quality of care, and policies for a continuum of care (OECD, 2004a).The following candidates/sources for estimates were analysed:

- National sources, such as strategic papers on long-term care policy, which usually include the most comprehensive account of available sources for countries where long-term care is covered only partially in health accounts, or where national health accounts are not available.
- Expenditure on long-term care as reported to *OECD Health Data 2004*.
- Expenditure on long-term care reported in SHA pilot implementations.
- Secretariat estimates from replies to the questionnaire for the *Long-term care study*.

8. The numbers estimated from replies to the questionnaire of the *Long-term care study* are mostly expenditure aggregates derived from data provided on individual programmes, based on the replies to the questionnaire of the study. For some countries, these estimates are based on additional research and data work by the Secretariat, from original national publications and data sources, such as from recent government or research reports which aimed at drawing a comprehensive picture of long-term care services, often with the goal to provide a basis for the assessment of expected future trends and options for reform.

9. The basic concepts used have been developed and tested for the *Long-term care study* under the *OECD Health Project* with the help of a network of experts on long-term care who co-operated with the Secretariat on this project. Definitions proposed for the Long-term care study have been harmonised as far

as possible with definitions on long-term care services and recipients used in this study. These are discussed in a related paper (DELSA/ELSA/WP1/HS(2004)3), which further elaborates on some aspects of these definitions, such as how definitions might in the future be the linked to concepts of the WHO *International Classification of Functioning, Disability and Health* (ICF). Annex 1 shows the basic data tables on expenditure collected for the Long-term care study.

**A working definition of "long-term care" to describe data used for the *Long-term care study***

10. Within the framework of the *System of Health Accounts* (SHA), the functional component of the International Classification for Health Accounts (ICHA) includes an expenditure component for long-term care in the functional component of the ICHA, under total expenditure on health (*ICHA-HC.3: Long-term nursing care*).

**Box 1. Definition of long-term care in the ICHA classification (ICHA-HC.3)**

Long-term health care comprises ongoing health and nursing care given to in-patients who need assistance on a continuing basis due to chronic impairments and a reduced degree of independence and activities of daily living. In-patient long-term care is provided in institutions or community facilities. Long-term care is typically a mix of medical (including nursing care) and social services. Only the former is recorded in the SHA under health expenditure.

11. The SHA manual also gives some examples of which services should be included: long-term care in institutions, community facilities or in patients' homes, hospice and palliative care, long-term care for mental health and substance abuse patients where the care need is due to chronic or recurrent psychiatric conditions. And it gives some examples of what should *not* be included: for example, residential facilities like homes for the elderly, homemaking and meals-on-wheels.

12. From its inception, the SHA manual intended a definition of long-term care which covers a fairly broad range of services, following best practice of actual accounting practice of a number of well developed national health accounts (e.g. Canada, Germany, Netherlands, and the USA). There has also been an agreement among experts who provided advice during the time of drafting of the SHA manual to include a broadly defined spending item on long-term care. The decision to include long-term care prominently under a health accounting framework was also made in response to the growing policy relevance of long-term care issues and the need to analyse both acute and long-term care services with the help of a single, consistent data set, covering both public and private expenditure.

13. Having both health and long-term care spending in the same accounting framework can serve a number of analytical purposes. It allows comparing spending on a continuum of care needs, and – when additional, more detailed data are matched to health accounts -, about an improved mix of services of rehabilitation, prevention and long-term care.

14. However, for health accounting and for the purposes of the *Long-term care study*, the definitions provided in the SHA manual have found to lack needed detail and provided only limited guidance for implementation. For this reason, the data work for the *Long-term care study* has experimented with alternative, more detailed definitions, and compared these with actual data availability and scope of expenditure estimates in countries participating in the study.

***Defining "long-term care" by levels of care needs in national eligibility assessment***

15. The comparative study of national eligibility criteria for "long-term care" for the 19 countries in the *Long-term care study* shows that criteria for long-term care services are usually linked to the notion of dependency, which is frequently defined by levels of functional limitations with activities of daily living (ADL). This is done with or without explicit reference to this concept.

*16.* *Activities of daily living* usually refer to self-care activities that a person must perform every day, such as eating, dressing, bathing, transferring between the bed and a chair, using the toilet, and controlling bladder and bowel. These are distinct from services of support towards i*nstrumental activities of daily living*, which refer to activities that enable a person to live independently in a house or apartment, such as preparing meals, performing housework, taking drugs, going on errands, managing finances and using a telephone.

17. Long-term care recipients are usually characterised in national information systems as persons who need ongoing help over an extended period of time due to chronic medical problems and ADL restrictions (with or without additional help provided with IADL restrictions), where the care need in order to meet eligibility criteria of public programmes is often required to be above a certain threshold which can vary across countries.

18. Data work for the *Long-term care study* has reviewed the ICHA definitions versus data availability in countries and found that the number and severity of activity restrictions as measured by functional limitation with activities of daily living is the most common concept by which long-term care needs are characterised. Help with ADL restrictions has therefore be taken as starting point for defining expenditure on long-term care for the *Long-term care study*. A threshold of at least one or two ADL restrictions, which also corresponds to the most frequently definition for "dependency" or "disability" in population health surveys would seem to be a reasonable threshold, but both data systems and formal definitions are currently not developed and harmonised sufficiently to test this hypothesis under the *Long-term care study* (see also the discussion in DELSA/ELSA/HS(2004)3 for more details about this question).

***A working definition on long-term care services***

19. From the discussion above it follows that for long-term care services a patient centred "treatment episode" should be considered for long-term care services in following national accounting practice. This means that patient characteristics should be used as the first principle of classification, in the sense of defining the type and level or care needs to which services respond.

20. The following working definition summarises the experiences with data work on the *Long-term care study* and from comparisons of national data sources in that it comes closest to a common denominator of a range of services for which data can both be found and estimates calculated.

**Box 2. A working definition for long-term care services (*Long-term care study*)**

Long-term care is a range of services needed for persons which are depended on help with basic activities of daily living (ADL), such as bathing, dressing, eating, getting in and out of bed or chair, moving, around and using the bathroom, because of physical or mental disability. This central personal care component is frequently provided in combination with help with basic medical services such as help with wound dressing, pain management, medication, health monitoring, prevention, rehabilitation or services of palliative care.

Long-term care is provided in a variety of settings. It can be provided at home and in the community, or in various types of institutions, including nursing homes and assisted living facilities, for which a wide range of national

arrangements and national labels exist.

Depending on the setting in which long-term care is provided and/or national programme design, long-term care services can include lower-level care of home help or help with instrumental activities of daily living (IADL) more generally, such as help with activities of home making, meals etc., transport and social activities. Following the recommendation in the ICHA, an attempt was made to exclude these, where accounted for separately.

For care provided in a nursing-home setting, cost of accommodation is included in long-term care expenditure.

In some cases, long-term care services are supported, and provided in combination with assistive aids, tele-links, and home adaptations to allow dependent persons to live in their own homes, or increase their independence an institutional setting.

For persons with ADL restrictions who are cared for at home, long-term care expenditure include spending on consumer-choice programmes, care-allowances and other social benefits to care assistants, including family and friends, that are granted to care recipients or their households for the primary purpose to support care activity at home. Services for persons cared for at home may include community care services such as day care centers and respite care to support informal carers.

21. The definition above differs from the one original proposed in the questionnaire of the *Long-term care study* in at least one important aspect. The original definition drew a boundary line between help with ADL restrictions versus help with IADL restrictions as delimiting line for accounting. However, national data systems usually include all nursing home expenditure, where these are part of health accounts, which also is in accordance with the principle of taking "episodes of care" as units of measurement. This basic distinction, therefore, seems only to apply to care provided at home.

22. But countries also differ in the division of labour between different professionals that are involved in the care process, and in the extent to which lower-level versus higher-level of care is regarded as two distinct services, and/or are covered by different social programmes. Also, the original definition did not clearly spell out the need to include basic medical services in long-term care expenditure estimates, where these are provided as a package of care, often by the same person which also administers the personal care component.

**Conclusions from the work on expenditure data under the *Long-term care study***

23. This section summarises issues of data availability and national definitions and concepts used for long-term care expenditure from data work for the *Long-term care study*. Data comparability of data in *OECD Health Data* and in SHA tables is currently limited for several reasons. The main are differences in concepts and differences in estimates that are due to limited availability of data that would allow including important spending components in estimates, or, alternatively, draw better harmonised boundaries of overall spending.

24. The following seems to be a rough ranking of the factors limiting international comparability of data currently reported in *OECD Health Data* and (for several cases) in SHA tables in descending order by (numerical) importance:

1. Inclusion of public expenditure for institutions which predominantly or exclusively provide residential services, possibly in combination with some low-level care, but without a substantial component of help with ADL restrictions and with only a small number of residents with such needs.
2. Exclusion of cost of accommodation in nursing homes.

3. Exclusion of expenditure on long-term care at home and on community care.
4. Differences in the coverage of age-groups in the estimates (older persons versus all age groups).
5. Lack of estimates of expenditure on long-term care recipients outside of specifically tailored facilities and programmes, such as persons receiving long-term care type services in hospitals.
6. Differences in the level-of care needs and boundaries of services included in expenditure estimates on home and community care (different treatment of home-help, meals-on-wheels, transport, etc.)
7. Lack of estimates of private out-of-pocket expenditure on long-term care.

***Data availability and scope of "long-term care" included in current estimates***

25. Early implementations of the SHA manual, such as for Denmark, Germany and Switzerland seemed to follow the originally intended boundaries of long-term care more closely than some of the other implementations which followed since then (this is also illustrated in the recent paper on *SHA-based national health accounts in 13 OECD countries* (DELSA/ELSA/WD/HEA(2004)7, Box.8), which, among others, reviews spending levels on long-term care and differences in estimation methods.

26. There are a number of reasons why actual accounting practice found is difficult to implement the proposed definitions for long-term care categories in the ICHA-HC. Many of the comparability problems that are currently abound are not due to problems with definitions or insufficient estimation guidelines but are caused by incomplete data or missing resources to establish estimation strategies to bridge gaps. Data systems for long-term care expenditure are usually less well developed than other items covered in health accounts and this fact greatly contributed to the less than satisfactory results of estimates of long-tem care expenditure in many cases.

27. Consequently, there is the need to document the contents of items covered under the estimates, of data sources used and estimation principles applied, to make the final results transparent. This is all the more important for long-term care, because – as detailed work under the *Long-term care study* has shown - much of the differences in spending levels on long-term care is real, due to the fact that long-term care systems greatly vary across countries in programme design and scope of services.

***Estimating expenditure on long-term care services provided in an institutional setting***

28. For long-term care provided in institutions, special dedicated institutions for the care of dependent persons (often, but not necessarily, with multiple or severe ADL and IADL restrictions), so-called nursing homes are still the predominant model of providing institutional care in many countries. Besides, there exists a variety of assisted living facilities that provide a mix of residential services, and help with IADL (or even ADL) restrictions together with other social services.

29. For persons living in assisted living facilities or similar facilities and who receive only limited help with ADL restrictions, the rule-of-thumb under the *Long-term care study* was that cost of accommodation (of the dominating residential care component) should be excluded, in analogy to the treatment of housing costs for persons receiving long-term care in a home-based setting. Expenditure on residential facilities where few if any long-term care services are provided should in total have been excluded, but this is not currently the case in all available estimates, which may for this reason show higher expenditure values than an adjusted estimate done for the *Long-term care study*. An example where such an adjustment was done for the *Long-term cares study* is Switzerland.

30. The questionnaire for the *Long-term care study* recommended that it would be desirable to show expenditure on accommodation in long-tem care facilities separately for analytical purposes. This would have helped shed more light on country cases, where there is a split responsibility for financing, with private households responsible for contributing to accommodation cost. The data collection undertaken so far suggests that there are wide variations in expenditure per nursing home inhabitant, both within and between countries, which are partially due to significant differences in the quality of accommodation (single room, privacy, amenities). However, no such data set could be completed due to gaps in data and lack of resources.

31. Cost of accommodation in nursing homes covered by out-of-pocket spending and/or social assistance programmes was however estimated in some cases where these are separate cost components financing a substantial part of nursing home care. Omissions in this cost component can substantially limit the international comparability (and comparability over time in countries).

***Estimating expenditure on long-term care services provided at home***

32. Home and community care may include a range of supportive functions, such as respite care, other day care, transport, and a range of supportive services for informal care givers. The model of modern community care, which includes a continuum of services between acute health care and social support services, poses a challenge to the estimation of long-term care services under health accounts and under other functions of social expenditure. The estimation process is further complicated by the spread in OECD countries of specific models of consumer choice, such as care allowances, direct payments and care budgets.

33. Expenditure on services of home help, for recipients who receive this type of lower care only, should, in principle, be separated from long-term care expenditure. The same should be the case for medical care provided at home (acute, post-acute care). In some cases these are financed separately, therefore these should be easily identifiable. Other care packages (programmes) which combine these three may need to be allocated according to the predominant component, which typically could be help with ADL restrictions, which means the programme (package) would be allocated to "long-term care" expenditure, without separating out medical services that are at the boundary between health and long-term care, such as help with medication or providing injections on a regular basis.

34. All expenditure on programmes of care allowances and other direct payment schemes should be included in health accounts. "Paid for" care by families and funds should be regarded as a direct substitute for formal care services. The justification for this is that persons who mainly rely on informal carers under these schemes seem to receive a broad range of services, including help with ADL restrictions, which tend to be at least of the same standard that could be bought for in the formal home care market.

35. All social services expenditure to informal care-givers providing long-term care should be regarded as cost of care provision and thus be included for the same reason as above. This should include special social protection rights, such as pension entitlement for time spent on informal care. Counselling and training of care recipients and (informal) care-givers should be included. There is, however, the boundary case where cash-allowances to carers are very small amounts spread to a large number of carers, many of which look after persons with lower-level of care needs.

***Additional methodological issues for further investigations***

36. For further work both on data and on methodology, the following additional questions have emerged from data work under the *Long-term care study*:

*Should day services (semi-stationary care) of long-term care be accounted for separately?*

37. This distinction was not used for work under the *Long-term care study* in order to keep the scope of data work manageable. For the purposes of the *Long-term care study*, both categories have been estimated together under the label of "care provided in a home-based setting", or *Home care* for short. This decision is also supported by the fact that spending on day care services is not a big spending category under long-term care services and its main purpose is usually to support care primarily provided at home. Currently only one country (Denmark) reports this spending category separately in SHA tables.

*The treatment of expenditure for "long-term care" recipients in hospital wards*

38. A difficult issue are dependent persons who's main care needs are due to ADL restrictions, but which reside in hospital wards for an extended period of time for lack of alternative care options. There are two ways of accounting for these patients in health accounts. The first is to include these spending in hospital inpatient spending under "acute and rehabilitative", the second is to try to separate a spending component for long-term care, which is effectively, what these patients receive in most cases. However, this could also be considered a boundary case between original accounting and secondary data analysis. Moreover, there are usually serious issues of data gaps for original estimates.

*The need for a basic age breakdown*

39. Monitoring trends in long-term care services provided to older persons is a policy concern which calls for a recording of aggregate data for at least two distinct age brackets: (0-64; 65+). However, the amount of extra work needed to do so should not be underestimated. Although recipient data are usually broken down by age groups, the cross-classification with expenditure data is not always available. E.g., for programmes of consumer choice and care allowances, the way how these benefits are actually spent or retained by households on different types of care may not be cross-classified by age categories.

**Limitations of data sources for spending on long-term care from private sources**

40. The original questionnaire asked for information on total out-of-pocket spending on long-term care. Only limited information could be gathered on this important item. It is difficult for the Secretariat to do estimates on private spending based on available reports and surveys in countries, which tend to differ in methodology and provide only rough total estimates. A more demanding task would be to reconcile overall production of the long-term care industry with expenditure by public and private sources. This is usually only possible as a team effort in member countries, but could well become a special sub-task of the project of implementing the SHA manual (complemented with more detailed definitions from this study). In some countries, such an effort is already under way.

41. Private long-term care insurance does not, as yet, play a significant role as source of funding in most countries. It accounts for around 11% of all spending in the USA. Complementary long-term care insurance on top of public coverage is a growing market in several countries, but these contracts are typically marketed to consumers that will not become recipients in the near future, so do not result in much current expenditure on services (other than on insurance administration). The bulk of spending on these contracts is therefore not part of current health expenditure in the definition of expenditure of the SHA manual. Premium payments and number of contributors to such policies, would, however, be relevant as complementing information, and in addition collecting such data on a routine basis could be envisaged.

**Proposed next steps for work on long-term care expenditure data and methodology in 2005**

42. As part of the *Long-term care study*, sources and proposed estimation methods for long-term care expenditure data have been tested and will be documented for 19 countries until end of 2004. As an

outcome, at least partial data sets are currently available for these countries. The following next steps are suggested for continuing work in 2005:

- Documentation and description of the initial data set will be published in the health policy Technical Working Paper Series.

- Draft refined definitions and estimation methods will be produced for discussions with experts in member countries, including teams in charge of SHA pilot implementations.

- A new pilot data set and a proposal for definitions and estimation methods, as well as documentation of data sources will be gathered by end of 2005 with recommendations on implementation to be discussed as input to the wider process of refining expenditure classifications of the SHA manual.

- Administrations in countries that are not among the 19 countries studied under the *Long-term care* study and countries which currently do not report long-term care expenditure separately in health accounts for *OECD Health Data* will be contacted and invited to join a pilot data project on long-term care expenditure.

- Feasibility of time series data needs to be further explored beyond the data points collected so far under the *Long-term care study*, in order to fill gaps for the countries currently covered.

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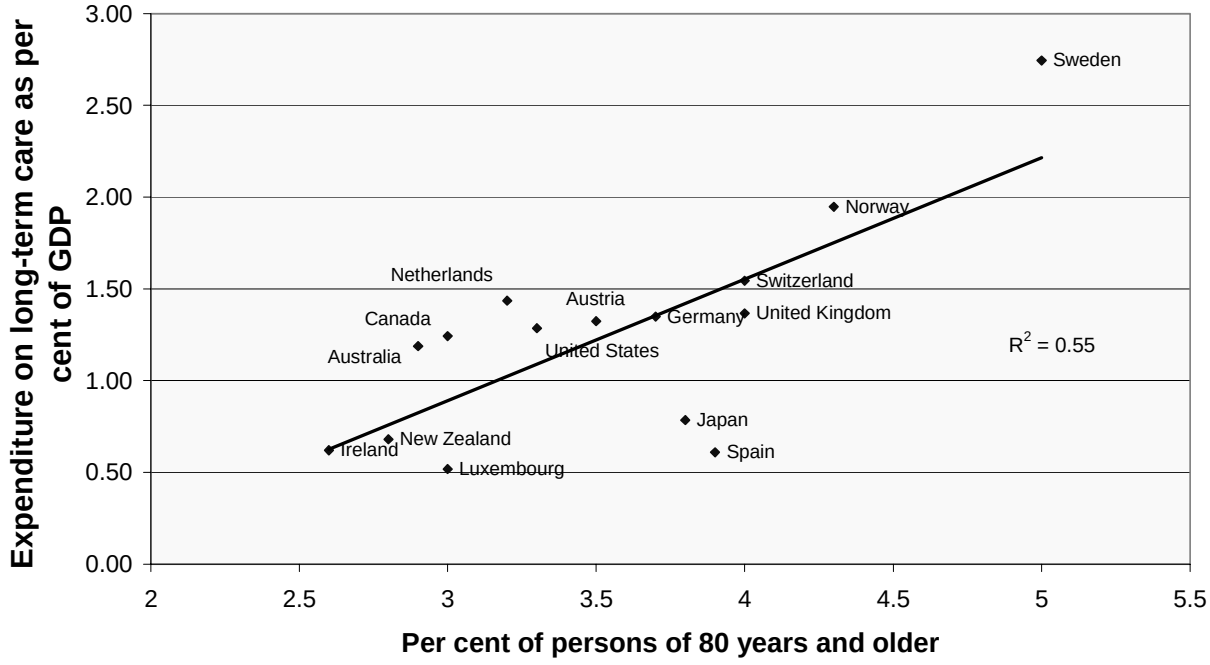
## ANNEX 1. EXPENDITURE ON LONG-TERM CARE FOR NINETEEN COUNTRIES

This annex shows an overview of the current data set on long-term care expenditure that has been compiled for the *Long-term care study* (Table 1 and 2). Annex 2 provides explanations on sources and estimation methods. Among the different estimates, the one highlighted in light grey is the one chosen for use in the policy analysis of the *Long-term care study*.

One of the main results from this data work is that countries vary widely in spending levels. Programme design and the stage of development of long-term care systems is the predominant factor explaining differences in spending level. Countries with significant differences in the share of the oldest age groups in the population can consequently have similar spending levels (Figure 1).

**Figure 1. Figure 1. Countries vary widely in spending levels**




Source: Table1; Figure 1 excludes countries were reported spending levels are small and/or long-term care services could only partially be identified in public and private expenditure (Hungary, Korea, Mexico, and Poland).

**Table 1. Expenditure on long-term care, % GDP, 2000**

| | | | Total expenditure | | | Public expenditure | | | Private expenditure | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Source | Year | Home care | Institutions | Total | Home care | Institutions | Total | Home care | Institutions | Total |
| Australia | Health Data | 2000 | | 0.62 | 0.62 | | 0.51 | 0.51 | | 0.11 | 0.11 |
| | SHA tables | 2000 | | 0.61 | 0.61 | | 0.50 | 0.50 | | 0.11 | 0.11 |
| | Prod. Commission | 2001 | 0.38 | 0.81 | 1.19 | 0.30 | 0.56 | 0.86 | 0.08 | 0.25 | 0.33 |
| | LTC Study | 2000 | | | | 0.26 | 0.53 | 0.79 | | | |
| Austria | Core Study | 2000 | | | | 0.82 | 0.51 | 1.32 | | | |
| Canada | Health Data | 2000 | 0.17 | 1.06 | 1.23 | 0.17 | 0.82 | 0.99 | 0.00 | 0.24 | 0.24 |
| | SHA tables | 1999 | 0.17 | 1.07 | 1.24 | 0.17 | 0.83 | 1.00 | 0.00 | 0.25 | 0.25 |
| Germany | Health Data | 2000 | 0.47 | 0.67 | 1.14 | 0.43 | 0.52 | 0.95 | 0.04 | 0.15 | 0.20 |
| | LTC Study | 2000 | 0.47 | 0.88 | 1.35 | 0.43 | 0.52 | 0.95 | 0.04 | 0.36 | 0.40 |
| | SHA tables | 2001 | 0.46 | 0.66 | 1.12 | 0.42 | 0.51 | 0.93 | 0.04 | 0.15 | 0.19 |
| Hungary | Health Data | 2000 | 0.01 | 0.14 | 0.15 | 0.01 | 0.12 | 0.13 | 0.00 | 0.01 | 0.01 |
| | SHA tables | 2001 | | | | 0.00 | 0.12 | 0.12 | | | |
| Ireland | Core Study | 2000 | 0.19 | 0.43 | 0.62 | 0.19 | 0.33 | 0.52 | 0.00 | 0.10 | 0.10 |
| Japan | Health Data | 2000 | 0.02 | 0.76 | 0.78 | 0.02 | 0.69 | 0.71 | 0.00 | 0.07 | 0.07 |
| | LTC Study | 2000 | | | | 0.25 | 0.51 | 0.76 | | | |
| | SHA tables | 2000 | 0.02 | 0.76 | 0.78 | 0.02 | 0.69 | 0.71 | 0.00 | 0.07 | 0.07 |
| Korea | Core Study | 2000 | | | | 0.00 | 0.01 | 0.01 | | | |
| Luxembourg | Health Data | 2000 | 0.15 | 0.37 | 0.52 | 0.15 | 0.37 | 0.52 | 0.00 | 0.00 | 0.00 |
| Mexico | LTC Study | na | | | | | | | | | |
| Netherlands | HD 2003 | 2000 | 0.60 | 0.81 | 1.41 | 0.56 | 0.78 | 1.34 | 0.05 | 0.02 | 0.07 |
| | LTC Study | 2000 | 0.60 | 0.83 | 1.44 | 0.56 | 0.75 | 1.31 | 0.05 | 0.08 | 0.13 |
| | SHA tables | 2001 | | | 0.86 | | | | | | |

**Table 1. Expenditure on long-term care, % GDP, 2000 (cont.)**

| | | | Total expenditure | | | Public expenditure | | | Private expenditure | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Source | Year | Home care | Institutions | Total | Home care | Institutions | Total | Home care | Institutions | Total |
| New Zealand | LTC Study | 2000 | 0.12 | 0.56 | 0.68 | 0.11 | 0.34 | 0.45 | 0.01 | 0.22 | 0.23 |
| Norway | LTC Study | 2000 | | | | 0.65 | 1.30 | 1.95 | | | |
| Poland | Health Data | 2000 | | | | | 0.04 | | | | |
| | SHA tables | 1999 | 0.35 | 0.03 | 0.38 | 0.35 | 0.03 | 0.37 | 0.00 | 0.00 | 0.00 |
| Spain | Health Data | 2000 | | 0.14 | 0.14 | | 0.12 | 0.12 | | 0.01 | 0.01 |
| | Marin/Casaovas | 1998 | 0.23 | 0.37 | 0.61 | 0.05 | 0.11 | 0.16 | 0.18 | 0.26 | 0.44 |
| | SHA tables | 2001 | 0.00 | 0.14 | 0.14 | 0.00 | 0.12 | 0.12 | 0.00 | 0.02 | 0.02 |
| Sweden | LTC Study | 2000 | 0.82 | 2.07 | 2.89 | 0.78 | 1.96 | 2.74 | 0.04 | 0.10 | 0.14 |
| Switzerland | Health Data | 2000 | 0.21 | 1.82 | 2.03 | 0.16 | 0.60 | 0.76 | 0.05 | 1.22 | 1.27 |
| | LTC Study | 2000 | 0.20 | 1.34 | 1.54 | 0.16 | 0.52 | 0.68 | 0.04 | 0.82 | 0.86 |
| | SHA tables | 2001 | 0.21 | 1.79 | 2.00 | 0.16 | 0.59 | 0.75 | 0.05 | 1.20 | 1.25 |
| United Kingdom | UK exper. HA | 1999 | | | 0.42 | | | 0.38 | | | 0.03 |
| | LTC Study | 2000 | 0.41 | 0.96 | 1.37 | 0.32 | 0.58 | 0.89 | 0.09 | 0.38 | 0.48 |
| United States | Health Data | 2000 | | 0.96 | 0.96 | | 0.57 | 0.57 | | 0.39 | 0.39 |
| | LTC Study | 2000 | 0.33 | 0.96 | 1.29 | 0.17 | 0.58 | 0.74 | 0.16 | 0.39 | 0.54 |

**Table 2. Expenditure on long-term care, NCU, 2000**

| | | | Total expenditure | | | Public expenditure | | | Private expenditure | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Source | Year | Home care | Institutions | Total | Home care | Institutions | Total | Home care | Institutions | Total |
| Australia | Health Data | 2000 | | 4,153 | 4,153 | | 3,416 | 3,416 | | 737 | 737 |
| | SHA tables | 2000 | 0 | 4,124 | 4,124 | 0 | 3,362 | 3,362 | 0 | 762 | 762 |
| | Prod. Comm. | 2001 | 2,690 | 5,797 | 8,487 | 2,146 | 3,997 | 6,144 | 543 | 1,800 | 2,343 |
| | LTC Study | 2000 | | | | 1,746 | 3,536 | 5,282 | | | |
| Austria | Core Study | 2000 | | | | 1,687 | 1,050 | 2,737 | | | |
| Canada | Health Data | 2000 | 1,773 | 11,243 | 13,016 | 1,773 | 8,692 | 10,465 | 0 | 2,551 | 2,551 |
| | SHA tables | 1999 | 1,637 | 10,390 | 12,027 | 1,637 | 7,994 | 9,631 | 0 | 2,397 | 2,397 |
| Germany | Health Data | 2000 | 9,584 | 13,655 | 23,239 | 8,700 | 10,514 | 19,214 | 884 | 3,141 | 4,025 |
| | LTC Study | 2000 | 9,584 | 17,801 | 27,385 | 8,700 | 10,514 | 19,214 | 884 | 7,287 | 8,171 |
| | SHA tables | 2000 | 9,583 | 13,655 | 23,239 | 8,699 | 10,514 | 19,214 | 884 | 3,141 | 4,025 |
| Hungary | Health Data | 2000 | 1,317 | 17,839 | 19,156 | 1,313 | 15,929 | 17,242 | 4 | 1,910 | 1,914 |
| | SHA tables | 2000 | | | | 0 | 15,929 | 15,929 | | | |
| Ireland | LTC Study | 2000 | 196 | 441 | 637 | 196 | 341 | 537 | 0 | 100 | 100 |
| Japan | Health Data | 2000 | 118,656 | 3,891,886 | 4,010,542 | 107,436 | 3,523,100 | 3,630,536 | 11,220 | 368,786 | 380,006 |
| | LTC Study | 2000 | | | | 1,265,050 | 2,605,675 | 3,870,725 | | | |
| | SHA tables | 2000 | 118,657 | 3,891,886 | 4,010,542 | 107,436 | 3,523,100 | 3,630,536 | 11,220 | 368,786 | 380,006 |
| Korea | Core Study | 2000 | | | | 9,318 | 35,040 | 44,358 | | | |
| Luxembourg | Health Data | 2000 | 32 | 78 | 110 | 32 | 78 | 110 | 0 | 0 | 0 |
| Mexico | LTC Study | na | | | | | | | | | |
| Netherlands | HD 2003 | 2000 | 2,425 | 3,242 | 5,667 | 2,241 | 3,150 | 5,391 | 184 | 92 | 276 |
| | LTC Study | 2000 | 2,425 | 3,349 | 5,774 | 2,241 | 3,011 | 5,252 | 184 | 338 | 522 |
| | SHA tables | 2001 | | | 3,679 | | | | | | |

**Table 2. Expenditure on long-term care, NCU, 2000 (cont.)**

| | Source | Year | Total expenditure | | | Public expenditure | | | Private expenditure | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Home care | Institutions | Total | Home care | Institutions | Total | Home care | Institutions | Total |
| New Zealand | LTC Study | 2001 | 137 | 637 | 774 | 130 | 387 | 517 | 7 | 250 | 257 |
| Norway | LTC Study | 2000 | | | | 9,590 | 19,027 | 28,617 | | | |
| Poland | Health Data | 2000 | | | | | 263 | | | | |
| | SHA tables | 1999 | 2,267 | 198 | 2,465 | 2,267 | 179 | 2,446 | 0 | 19 | 19 |
| Spain | Health Data | 2000 | | 834 | 834 | | 747 | 747 | | 87 | 87 |
| | Marin/Casaovas | 1998 | 1,239 | 1,975 | 3,214 | 290 | 579 | 869 | 949 | 1,396 | 2,345 |
| | SHA tables | 2001 | 0 | 931 | 931 | 0 | 805 | 805 | 0 | 127 | 127 |
| Sweden | LTC Study | 2000 | 18,082 | 45,338 | 63,420 | 17,178 | 43,071 | 60,249 | 904 | 2,267 | 3,171 |
| Switzerland | Health Data | 2000 | 890 | 7,564 | 8,454 | 683 | 2,477 | 3,160 | 207 | 5,087 | 5,294 |
| | LTC Study | 2000 | 844 | 5,577 | 6,421 | 683 | 2,147 | 2,830 | 161 | 3,430 | 3,591 |
| | SHA tables | 2000 | 889 | 7,564 | 8,453 | 683 | 2,477 | 3,160 | 206 | 5,087 | 5,294 |
| United Kingdom | UK exper. HA | 1999 | | | 3,756 | | | 3,447 | | | 309 |
| | LTC Study | 2000 | 3,870 | 9,125 | 12,995 | 3,000 | 5,475 | 8,475 | 870 | 3,650 | 4,520 |
| United States | Health Data | 2000 | | 93,790 | 93,790 | | 56,131 | 56,131 | | 37,659 | 37,659 |
| | LTC Study | 2000 | 31,729 | 93,784 | 125,513 | 16,344 | 56,175 | 72,519 | 15,385 | 37,609 | 52,994 |

## ANNEX 2. SOURCES AND ESTIMATION METHODS BY COUNTRY

### Introduction

This annex documents the data sources and estimation methods currently in use for expenditure on long-term care services for the 19 countries analysed in the *Long-term care study*. Each country section first starts by saying which estimate (either a Secretariat estimate of a national source) has been found to be the closest proxy to the proposed definition of long-term care.

Details are given per country on estimation methods for public and private expenditure and for services for users at home versus users residing in an institution. The feasibility of estimating a breakdown of expenditure by age is briefly discussed, although not all possible sources and estimation strategies for an age breakdown may have been explored in the scope of the *Study on Long-term Care*. Known deviations from the "closest-proxy" estimate from the proposed definition of long-term care and its sub-categories are listed next.

### Australia

For the Long-term care study a comprehensive and fairly detailed account of long-term care expenditure in Australia by programmes and source for funding was used, which has recently been estimated by the *Productivity Commission*. The content of this estimate is reviewed below.

#### *Public expenditure*

Public expenditure on home/community care services comprise assessment services, Home and Community Care (HCC), Community Aged Care Packages (CACP), Respite Care and Carer Payment and Allowances, and other community care (including so-called "Flexible Care"). Care in institutions corresponds to the budget item *Residential Aged Care*.

#### *Private expenditure*

Private expenditure comprises user contributions to the programmes listed under public expenditure plus an estimate for "informal care", which needs to be further investigated. The estimate includes charitable donations to long-term care.

#### *Estimation of breakdown by age and coverage of age groups in estimates*

Not all items listed under public expenditure can currently be broken down by age. Around 5.6% of persons covered by *Residential Aged Care* are persons younger than 65, and are included in the current estimate. About 45 percent of total carer payments and allowances are paid to carers looking after the aged. This share has been used to estimate the aged care share of total HACC expenditure included in the estimate.

***Deviations from proposed long-term care definition***

Some lower-level care is included in the *Productivity Commission* estimates. The estimate of privately funded care in institutions is only indicative of the magnitude.

***Deviations from OECD Health Data and SHA tables***

*OECD Health Data* currently only includes spending on *Residential Aged Care*. Care provided at home is not included. The same is the case for SHA tables.

***References and data sources***

Productivity Commission (2003) Productivity Commission Submission to the Review of Pricing Arrangements in Residential Aged Care, Melbourne.

AIHW (2002a) Community Aged Care Packages in Australia 2000-01: A Statistical Overview, Aged Care Statistics Series no.12, Canberra.

AIHW (2002b) Residential Aged Care in Australia 2000-01: A Statistical Overview, Aged Care Statistics Series no.11, Canberra.

Lindy Ingham (2004) SHA-BASED HEALTH ACCOUNTS IN THIRTEEN OECD COUNTRIES, COUNTRY STUDIES: AUSTRALIA: NATIONAL HEALTH ACCOUNTS, 2000, OECD HEALTH TECHNICAL PAPERS NO. 1

**Austria**

For Austria, no national expenditure estimate is available that includes long-term care in a consolidated account. Estimates for private spending on long-term care are are missing.

***Public expenditure***

The bulk of public funding is provided as care allowance from federal and regional budgets (Bundesländer). Expenditure estimates from administrative sources have been roughly allocated to home versus institutional care based on numbers of recipients of care allowances in the absence of further detail in available administrative records. Numbers on public subsidies to long-term care providers are available for both home care and nursing homes.

***Private expenditure***

Aggregate information on private expenditure on long-term care is largely missing. It is currently not possible to include an estimate of private spending not covered by the care allowances (user contributions to long-term care programmes) or from social assistance.

***Estimation of breakdown by age and coverage of age groups in estimates***

Information on age breakdown of spending is missing. The estimates include some 10-15% of care recipients below the age of 65.

***Deviations from OECD Health Data***

Expenditure on long-term care is currently not included in Austrian health expenditure estimates which follow *National Accounts* classification principles.

***References and data sources***

Bundesministerium für soziale Sicherheit und Generationen (2001) Long-term care in Austria (in German: Pflegevoersorge in Österreich, Wien). Internet: www.bmsg.gv.au

**Canada**

For long-term care expenditure, *OECD Health Data*, and SHA tables provide a comprehensive picture for long-term care expenditure. Aggregate numbers from both data systems are identical. Own estimates based on the *Long-term care study* questionnaire, on the other hand, were only able to calculate partial estimates, therefore, not shown in Table 1.

***Public expenditure***

Public sources cover around 75% of all long term care in-patient expenditure. It covers expenditure for care in homes for the aged, institutions for persons with physical disabilities, developmental delays, psychiatric disabilities, alcohol and drug problems, and for emotionally disturbed children. Consist of expenditures from Ministries of Health or combined ministries of health and social services (depending on the province). Only health related expenditure is included where it is possible to distinguish between health and social care. A small amount relating to these institutions is allocated to Inpatient curative care where appropriate. In addition an estimate of in-patient long term care in hospitals is also made.

Included are all expenditures by the public sector for home care programs. This may include some expenditure for curative and rehabilitative care which could not be separated.

***Private expenditure***

Private expenditures on residents who require personal care for a minimum of 1.5 hours per day with medical and nursing supervision in the following three types of facilities: homes for the aged, institutions for persons with physical disabilities and institutions for persons with psychiatric disabilities. This is estimated from an annual *Residential Care Facilities Survey* and relates to a defined Type II or above category of care. A small estimate relating to higher type care may be allocated in In-patient curative care.

***References and data sources***

G. FORTIN (2004) SHA-BASED HEALTH ACCOUNTS IN THIRTEEN OECD COUNTRIES, COUNTRY STUDIES: CANADA: NATIONAL HEALTH ACCOUNTS 1999, OECD HEALTH TECHNICAL PAPERS NO. 2

CIHI (2003) National Health Expenditure Trends, 1975-2003, Ottawa.

http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=PG_104_E&cw_topic=104&cw_rel=AR_31_E (accessed August 2004)

Hicks, V., G. Fortin, and I. Button (2002) Long-term residential care in national health expenditures, Feasibility study, Canadian Institute for Health Information, Ontario.

http://www.hc-sc.gc.ca/english/care/expenditures/expenditure_stats.htm

**Germany**

A comprehensive data set on long-term care spending with time series from 1992 onward is available in *OECD Health Data*. These data are identical to results from SHA tables. Own estimates under the LTC study had the purpose to better understand the breakdown of services. In addition, they increased the private expenditure estimate.

***Public expenditure***

Two thirds of public expenditure on care in institutions is funded from social long-term care insurance, another third from social assistance (for households not able to cover their private cost-sharing). Around 3% is spending in specialised institutions for disabled persons.

Around half of public spending on home-care is in the form of care allowances (cash benefits only). Over a quarter is in the form of home care services. The next biggest item is in the form of social insurance premiums (e.g. pension rights) for family carers. Minor cost-components are respite care (carers' leave), day/night care and other forms of short-term care to support care provided at home.

Not included are technical aids and medical goods to support home care and administrative cost of the social long-term care insurance system (both components would add some 5 and 6% to public spending, respectively.

***Private expenditure***

The biggest spending item under private expenditure is cost-sharing for care received in nursing homes, including cost of accommodation and a small number of persons funded under private mandatory long-term care insurance. This spending component has been estimated as residuum between total production of the nursing home industry minus public spending. A specialised survey of private household spending on long-term care suggests an estimate that is considerably higher and this has tentatively added to the estimate used for the long-term care study. The rest is out-of-pocket spending on home-care, which is around 10% of total home care spending.

***References and data sources***

Natalie Zifonun (2004) SHA-BASED HEALTH ACCOUNTS IN THIRTEEN OECD COUNTRIES, COUNTRY STUDIES: GERMANY: NATIONAL HEALTH ACCOUNTS 2001, OECD HEALTH TECHNICAL PAPERS NO. 4

Statistisches Bundesamt (2003) Health care: expenditure and employment (in German: Gesundheit: Ausgaben und Personal 2001), Bonn, http://www.destatis.de/presse/deutsch/pk/2003/gbe_2003.pdf (accessed November 2003)

**Hungary**

For Hungary, two data sources are currently available: *OECD Health Data* and SHA tables from 1998 to 2001. Both show the same aggregates. However there is no breakdown of private expenditure into LTC categories in the SHA

At present the Hungarian Health Accounts have been compiled for four years (1998-2001). The calculation of expenditures based on the SHA resulted in substantial change to previous estimates. The

Hungarian Health Accounts provide public expenditure data on health care that are more reliable than before and comparable on an international level. As for private expenditures, Household expenditure data have been taken from the National Accounts. At present tables do not contain data on private insurance.

***Public expenditure***

Public expenditure on long term care represented less than 2 % of total expenditure on health in 2000 (1.6% in 2001). Long-term nursing care provided in residential care homes are estimated based on manpower costs of medical personnel. All day-care expenditure is reported under HC.1.2. Long term nursing home care includes curative and rehabilitative home care. Payments for households' production are not included

***Private expenditure***

In the SHA tables there is no separation of private expenditure into curative-rehabilitative and long-term care for institutional long-term care.

***References and data sources***

Maria Manno and Mihalyne Hajdu (2004) SHA-BASED HEALTH ACCOUNTS IN THIRTEEN OECD COUNTRIES, COUNTRY STUDIES: HUGARY: NATIONAL HEALTH ACCOUNTS 2001, OECD HEALTH TECHNICAL PAPERS NO. 5

**Ireland**

The Irish expenditure data is collected from the Irish reply to the questionnaire and from the website of the Department of Health and Children, Health Statistics. (www.doh.ie/statistics/stats/section1.htm) *OECD Health Data* does not include data on long-term nursing care in Ireland.

***Public expenditure at home***

Four social programmes are included under public spending on long-term care at home: home nursing services; home help services; and two cash programmes: *Carer's Benefi*t and *Carer's Allowance*.

Expenditure data on "Home nursing services" and "Home help services" is available from the website of Department of Health and Children. From Table L1 "Estimated non-capital health expenditure 1990 to 2003 categorised by programme and service", Item 2.4 "Home nursing services" and Item 3.7 "Home help services" have been included as long-term care services. The data on Carer's Benefit and Carer's Allowance were taken from the long-term care questionnaire.

***Public expenditure on care in institutions***

Three items are included from the Ministries' spending accounts as long-term care expenditure: welfare homes for older people (Item 3.14); contributions to patients in private nursing homes (Item 3.15); services in health board long-stay hospitals (Item 6.5); and expenditure on the nursing home subvention scheme from the long-term care questionnaire.

**Private expenditure**: a rough estimate for private spending on nursing home care from a study of Mercer Lmt,, commissioned by the Irish Department of Social & Family Affairs was included as the only private spending item for which estimates are currently available.

***References and data sources***

Department of Social and Family Affairs (2002) Study to Examine the Future Financing of Long-Term Care in Ireland, Dublin.

Eamon O'Shea (2002) Review of the nursing home subvention scheme, Dublin.

Department of Health and Children, Health Statistics www.doh.ie/statistics/stats/sectionl.htm

**Japan**

For Japan, a comprehensive data set on long-term care spending is available for recent years in *OECD Health Data*. These data are identical to available SHA tables.

Additional estimates under the *Long-term care study*, served the purpose to better understand the exact breakdown and contents of services included in these data. All numbers for *Long-Term Care Insurance* in 2000 are monthly average from April 2000 to February 2001. The overall level of public spending corresponds roughly with the estimates reported in *OECD Health Data* and in SHA tables but the split between home care and care in institutions is somewhat different.

***Public expenditure on home care***

This includes home help, home-visit bathing, visiting nursing, home-visit rehabilitation, day care, rehabilitation at day centres, and rental service of welfare equipments; Short term stay in long-term care institutions (respite care). Moreover, it includes home-visit medical consultation by physician or dentists, medical goods such as wheelchairs. Also includes subsidies for home improvement, such as adding handrails, eliminating steps, etc. to the recipient's house.

***Public expenditure in institutions***

This includes group homes for demented elderly people, care at fee-charging homes for the elderly, and care management (coordination of care services). Fee-charging homes for the elderly do not provide long-term care services themselves.

Certain types of social service institutions are not included in this study because they are primarily facilities for economic protection rather than provision of long-term care. There may be some frail elderly people in these institutions, but they are in principle recommended to move into long-term care institutions as there are not adequate staff and equipments. Examples are: Yougo-roujin-home (Care home for the elderly (established in accordance with Elderly Welfare Law)) and Kyuugo shisetsu (Relief facility (established in accordance with Daily Life Security Law).

Also excluded is spending on long-stay patients in general hospitals who receive little care in additional to basic long-term care services and reside in hospital wards mainly for social reasons (because no nursing home place is available and/or no informal carer available among family or friends.

***References and data sources***

Report on Service Provision on Long-Term Care Insurance (kaigo-hoken-jigyou-houkoku), 2000

Hiroyuki Sakamaki, Sumie Ikezaki, Manabu Yamazaki and Koki Hayamizu (2004) SHA-BASED HEALTH ACCOUNTS IN THIRTEEN OECD COUNTRIES, COUNTRY STUDIES: JAPAN, OECD HEALTH TECHNICAL PAPERS NO. 6

**Korea**

There exists no comprehensive public long-term care system in Korea that would provide basic coverage of long-term care to all older persons. Benefits for long-term care services analysed below all belong to services under the Older Persons Welfare Act, and expenditure on long-term care for Korea used for the *Long-term care study* and described below include only items under this budget.

***Public expenditure***

Available data all refer to administrative budget data. They likely underestimate the total amount of services and expenditure on long-term care in Korea. The Ministry of Health and Welfare is on central government level responsible for governing publicly provided long-term care. However, local governments have the main responsibility for implementing and also shared budget responsibility.

*Institutional care*

Two types of institutional care have been provided; general and special nursing home care. General nursing homes provide care for the disabled elderly with minor or no chronic diseases and special nursing home for the elderly with severe chronic conditions such as stroke or dementia. In addition, geriatric hospitals have provided specialized services for the elderly with the most severe diseases.

Institutional care provides only for the elderly aged 65 and over. Moreover, care services by publicly financed institutions are limited to relatively poor elderly. Only older persons who receive social assistance benefits are entitled to care in nursing homes free of charges, while older persons in marginal income brackets are entitled for care in nursing homes which partially subsidized by the government.

*Home Care*

There is an emerging supply of home care services including home help, day care, short-stay services. Home help covers domestic support and personal care services. Day care centers provide rehabilitative care services for recovering ADLs, wheels-on-meals, bathing and recreation services. The older persons can stay at the short-stay facilities for 45 days at a time and a maximum of 90 days a year.

As for institutional care, public coverage for home care is income tested. Recipients for social assistance benefits are only eligible for home care services free of charge. The elderly with marginal income are obliged to pay the actual cost while upper and middle income elderly have to pay the whole costs.

***Private expenditure***

Information on private expenditure is currently not available.

***References and data sources***

Hyoung-Sun Jeong (2004) SHA-BASED HEALTH ACCOUNTS IN THIRTEEN OECD COUNTRIES COUNTRY STUDIES: KOREA, NATIONAL HEALTH ACCOUNTS 2001, OECD HEALTH TECHNICAL PAPERS NO. 7

Ministry of Health and Welfare (2003), “Manual for home care services”, Seoul.

**Luxembourg**

*OECD Health Data* is currently the only data source for aggregate spending estimates. Expenditure estimates for Luxembourg are confronted with difficulties of calculating data that accrue to the year in question (budget data can differ from actual spending by more than 40%). For this reasons, no own estimate has been calculated for the *Long-term care study*. Information on private spending is missing.

***Public expenditure***

Public expenditure comprises only spending under the new *Long-term care insurance*.

***References and data sources***

Inspection Générale de la sécurité sociale, Rapport general sur la sécurité sociale (IGSS) (2001), Luxembourg.

**Mexico**

For Mexico, there are currently no estimates for long-term care services available, although some spending items in specialised hospitals and the like are probably covering some services that resemble long-term care as defined in other countries. The total amount of these spending items, however, suggests that "long-term care" spending as a percentage of GDP is very small in Mexico.

Both *OECD Health Data* and available SHA tables for Mexico do not include information on long-term care expenditure.

**Netherlands**

A preliminary data set of comprehensive data on long-term care was provided with *OECD Health Data*. This data set is currently under revision, and the most recent estimate provided in SHA tables and *OECD Health Data 2004* at the moment is not able to disaggregate total expenditure numbers calculated. For the *Long-term care study*, data from *OECD Health Data* were used, complemented with additional information from the *Long-term care study* questionnaire on private expenditure.

It should be noted that these estimates show a share of GDP for long-term care which is much smaller than total aged care spending reported in the Netherlands, and much smaller than the total spending under the AWBZ scheme, which are sometimes used as national reference in discussions about "long-term care". The main difference between the estimates presented here and the data received with questionnaire replies is the exclusion of care homes, which are considered residential homes following the proposed definition of the *Long-term care study*.

***Public expenditure***

Expenditure on care in institutions comprise most of the spending under the care industry items "nursing homes" and "large dwelling units" plus a smaller share of expenditure on institutions for the mentally handicapped. Expenditure on home care mainly comprise around half of the spending on the care industry item "home help services", and all spending on the (minor) items "home care shops", "household cure and care", and services for households with mentally handicapped person.

***Private expenditure***

Private expenditure is calculated as residuum of total production of industries minus public funding. For the estimates under the Long-term care study, however, additional information has been used from the questionnaire, which indicates a substantial higher amount of private funding for care in institutions.

***References and data sources***

Cor van Mosseveld (2004), SHA-BASED HEALTH ACCOUNTS IN THIRTEEN OECD COUNTRIES, COUNTRY STUDIES: THE NETHERLANDS, NATIONAL HEALTH ACCOUNTS 2001, OECD HEALTH TECHNICAL PAPERS NO. 9, Paris.

Cor van Mosseveld and J.M. Smit (2004) Health and Social Care Accounts, 1998-2002, CBS Working Papers, Voorburg.

Financieel Overzicht Zorg (several years), Tweede Kamer, vergaderjaar (several years)

CBS (2001) Zorgnota 2001, CBS Statline

**New Zealand**

For New Zealand, only few data were available from both the questionnaire and health accounts (including statistics on disability services). Care in institutions corresponds to "long-term nursing homes and the like".

***Public expenditure***

For home care, expenditures on two budget items were included: "home support services" and (as smaller item) "support to informal carers".

***Private expenditure***

Private expenditure was used as reported in the "health expenditure trend" publication.

***References and data sources***

Ministry of Health (2004) Health Expenditure Trends in New Zealand, 1990–2002, Wellington, New Zealand, www.moh.govt.nz

**Norway**

For Norway, expenditure on long-term care are not reported separated in *OECD Health Data 2004*, From the *Long-term care study* questionnaire, highly aggregated spending items were available, complemented with a breakdown by age. No information on private expenditure was available.

***Public expenditure***

From the budget item "public long-term care expenditure", expenditure on the population aged 65+ were included, which was provided separately for care provided at home and for care in institutions.

**Poland**

A pilot project of health accounts for Poland was carried out for 1999 expenditure data in accordance with the requirements of the System of Health Accounts. The difference between pre-SHA and SHA estimates was estimated at around 7.7%. The differences were mainly due to the incorporation of additional sources and well as identifying expenditure related to the wider boundaries of the health care sector.

***Public expenditure***

Long term care accounted for around 6% of Total Expenditure on Health, which is almost exclusively publicly funded. However most of this (5.5%) is accounted for from the home care element. In-patient long term care is underestimated due to the limited reporting practices, resulting in the combining of long term care with curative care in hospitals. Moreover, in the functional structure of nursing and residential facilities, only 28% is allocated to long-term care – the majority of the expenditure relating to curative/rehabilitative care in spas, sanatoria etc. Data on residential centres for mental health and community care facilities for the elderly are not available, underestimated or included under Hospitals.

The home care element is almost exclusively provided by households but financed through various types of social assistance benefits (permanence allowance, nursing allowance and specialist care services, mainly cash, according to certain income and health criteria. These are financed by government through the Social Assistance Law or other laws such as the Law on Family, Nursing and Child-care Allowances. This part may be overestimated due to boundary definition problems and may include expenditure normally allocated to HC.R.7 (Administration and provision of health related cash benefits).

***Private expenditure***

Less than 1% of long term care expenditure is reported to come from private sources (out of pocket household expenditure) in institutional settings. This again will likely be underestimated for the reasons above.

***References and data sources***

Ministry of Labour and Social Policy – MPiPS 03 Annual report of provided social assistance benefits, in cash, in kind and services for the period I-XII 1999

Office for Health Insurance Supervision (UNUZ), Summary Financial Plan of Health Insurance Funds (statement of revenue and costs of all 17 Sickness Funds)

Social Security fund - Information concerning cash benefits from the Social Insurance Fund and the Alimony Fund and „Quarterly Statistical Information of the Agricultural Social Insurance Fund

Central Sstatistical Office GUS - Classification of Individual Consumption by Purpose for Household Budget Surveys (COICOP/HBS). (division 06 – health and 12 – Miscellaneous goods and services)

Dorota Kawiorska (2004) SHA-BASED HEALTH ACCOUNTS IN THIRTEEN OECD COUNTRIES, COUNTRY STUDIES: POLAND, NATIONAL HEALTH ACCOUNTS 1999, OECD HEALTH TECHNICAL PAPERS NO. 10, Paris.

**Spain**

For Spain, both *OECD Health Data* and SHA tables cover long-term care services only partially, mainly showing public long-term care spending in a hospital based setting. No estimates are currently included for a growing home care industry, which has attracted considerable private funding in recent years. In addition, for private expenditure it is not possible to separate long term care provided by General Hospitals.

The data used for the long-term care study are based on a detailed study on future options for long-term care policy in Spain which includes a stock taking of different types of spending and a comprehensive range of funding. (see Martin and Casasnovas, 2001). It should, however, be noted that these estimates are only available for the year 1998.

***Public expenditure***

Public spending for care provided in institutions is about twice as high as spending on home care. According to these estimates, public spending does only account for less than 30% of total spending on long-term care.

***Private expenditure***

Private spending levels are roughly equal for home care and care in institutions, and private sources seem to be the predominate sources of funding in both cases. Given the difficult data situation, these estimates should be seen as preliminary, providing rough magnitudes of spending.

***References and data sources***

Marín, D.C. and G.L. I Casasnovas (2001) Vejez, dependencia y cuidados de larga duración, Situación actual y perspectivas de futuro, Colección Estudios Sociales, Num.6, Fundación “la Caixa’, Madrid.

**Sweden**

For Sweden, estimates are based on public budget items plus additional information on private cost-sharing.

***Public expenditure***

Expenditure data for home care provided to different estimates to the Long-term care questionnaire: spending on “home and day care” and “social care”, which refers to help with IADL restrictions. Only the former has been included in the estimates, and only the spending for persons 65+. This includes municipal expenditure for home-based services (kommunale utgifter til hjemmebaserede tjenester), and municipal expenditure for adjusted housing (kommunale utgifter til tilrettelagte boliger).

Expenditure long-term care in institutions comprises both the budget item “permanent living” (permanent boenden) and a (much smaller) item on long-term care provided in a hospital setting. Again, only expenditure for persons aged 65+ were included.

***Private expenditure***

According to the questionnaire replies, around 5% of public spending (gross) are recuperated as user-charges. Public (net) and private spending have been allocated accordingly.

***References and data sources***

Svenska Kommunförbundet (2003) Swedish Elderly Care 2003, Stockholm.

**Switzerland**

Following the adoption in 2000 of the OECD methodology on health accounting, the boundaries of the health system and sources and methods were revised to create a series now covering the period 1995 to 2002.

In patient long term care is provided by nursing homes for elderly and institutions (nursing and residential facilities) for handicapped persons.

Estimation is based on the annual statistical survey of all homes for elderly and other institutions providing nursing and residential facilities. In these institutions the expenditure for nursing care, surveillance and assistance for daily life represents at least half of the total expenditure ("majority rule"). The expenses of the institutions taken into account cover nearly all the basic needs of a dependent person, except very small items such as TV and telephone fees or taxes, special contributions for leisure activities, etc - "pocket money".

All expenditure on home health care is considered as long term nursing care. The institutional classification of SHA mentions private households as providers of home care if social allowances are paid. This is not currently integrated in the Swiss health accounts.

***Public and private expenditure***

Private out of pocket household payments account for almost twice the expenditure by public sources for institutional long-term care, through cost-sharing or direct financing.

80% of home health care is provided through general government funding – the remainder through household payments and non profit institutions.

***References and data sources***

Raymond Rossel and Yves-Alain Gerber (2004), SHA-BASED HEALTH ACCOUNTS IN THIRTEEN OECD COUNTRIES, COUNTRY STUDIES : SWITZERLAND, NATIONAL HEALTH ACCOUNTS 2001, OECD HEALTH TECHNICAL PAPERS NO. 12, Paris.

Office fédéral des assurances sociales (2002) Statistique de l'aide et des soins à domicile (Spitex statistics) 2000, Bern.

Statistiques de la sécurité sociale, OFCL.

Statistique de l'AVS, bénéficiaires de rentes et sommes versées, dans leurs contextes démographique, économique et juridique. OFCL.

Statistique des prestations complémentaires à l'AVS et à l'AI. OFCL.

Statistique de l'AI. Contenu : nombre de personnes invalides, au bénéfice d'une rente ou d'une allocation pour impotents AI ou AVS, selon différents critères, tels que infirmité, âge, degré d'invalidité ou canton. OFCL.

Statistique de l'aide et des soins à domicile (Spitex). Offre de prestations, personnel, postes, heures d'engagement, clientèle, recettes et dépenses par canton. OFAS.

Santé publique, Statistique de l'assurance-maladie. Statistique administrative et statistique de la morbidité des caisses-maladie reconnues par la Confédération, OFCL.

Statistique des franchises à option dans l'assurance-maladie 1997 – 2001.

Assurances sociales en Suisse. Comptes d'exploitation AVS, AI, APG, PC; comptes prévoyance professionnelle, assurance-maladie, assurance-accidents (CNA), assurance-chômage et allocations familiales. OFCL.

www.publicationsfederales.ch.

**United Kingdom**

For the Long-term care study, estimates have been provided from a study of the *Personal Social Services Research Unit*, London School of Economics (PSSRU). This estimate covers England only, and has been "scaled-up" by the relative GDP values of England and the UK. The two main sources of public funds are the National Health Services (NHS) and Personal Social Services (PSS).

***Public expenditure at home***

Expenditure at home, or "non-residential spending" in the UK terminology covers spending on community health services and day hospital care for older people by the NHS and home, day care, meals and professional support from PSS.

***Public expenditure in institutions***

This includes NHS residential expenditure on continuing care in hospitals and nursing homes plus PSS expenditure on PSS-funded residential and nursing home care.

***Private expenditure***

Public expenditure estimates are "net", excluding out-of-pocket payments which are accounted as private spending. Estimates of out-of-pocket services on home care and nursing homes, which would roughly double the private spending share, have not been included and need further checking, in particular as these have been estimated for England only.

***References and data sources***

Comas-Herrera, A. et al. (2003) Future Demand for Long-Term Care, 2001 to 2031: Projections of Demand for Long-Term Care for Older People in England, PSSRU Discussion Paper 1980.

Comas-Herrera, A. and Wittenberg, R (eds.) (2003) European study of long-term care expenditure, report to the European Commission, Employment and Social Affairs DG., PSSRA Discussion Paper 1840, Personal Social Services Research Unit, London School of Economics and Political Science.

Office of National Statistics (2003) Experimental UK Health Accounts, London.

http://www.statistics.gov.uk/healthaccounts/experimental_health_accounts.asp

**United States**

***Public expenditure on long-term care***

Over 60 percent of expenditure for long-term care services are paid for by public programs, primarily Medicaid and Medicare, with Medicaid funding over 40% of all (public and private) spending. There are several challenges for statistically delineating long-term care (as defined here) from other spending:

- Many nursing homes are open for short or medium-term stay, often for rehabilitative services.
- "Home care" is a budget umbrella term for a wide range of services, including a large share of post-acute services and services of medical attention at home, as well as long-term care services of home care.

The current estimates only partially have succeeded in separating long-term care under these spending items. In addition, long-term care pending estimates currently do exclude some expenditure for nursing home and home health services provided by hospital-based entities, which are counted generally with other hospital services.

The main spending items of Medicaid on institutional care are nursing facilities and Intermediate care facilities for the mentally retarded. Medicaid home care expenditure include home health, home and community-based waivers, personal care services and home and community-based services for functionally disabled elderly.

***Private expenditure on long-term care***

Out-of-pocket is the predominant private source of funding long-term care, about twice as high as private insurance payments. In the US health accounts private spending are recorded under analogue expenditure headings than public spending that is "home health care" and "nursing home care".

***References and data sources***

CMS (2002), "2002 Data Compendium" II. Expenditures "CMS Benefit Payments by Major Program Service Categories Fiscal Year 2000" www.cms.hhs.gov/researchers/pubs/datacompendium

CMS (2002), "2002 Data Compendium" V. Utilization "Medicare Use of Selected Types of Long-Term Care: Calendar Years 1982-2000" http://www.cms.hhs.gov/researchers/pubs/datacompendium/

Brian Burwell, Steve Eiken and Kate Sredl (2002) "Medicaid Long Term Care Expenditures in FY 2001" The MEDSTAT Group, Inc.

GAO (2002) Long-term care, Aging Baby Boom Generation Will Increase Demand and Burden on Federal and State Budgets , United States General Accounting Office, GAO-02-544T, Washington.