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DIRECTORATE FOR EMPLOYMENT, LABOUR AND SOCIAL AFFAIRS
HEALTH COMMITTEE

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LONG-TERM CARE WORKFORCE AND FINANCING: INITIAL FINDINGS AND PROGRESS

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NOTE BY THE SECRETARIAT

1. The 2009-2010 programme of work and budget of the OECD Health Committee and the Employment, Labour and Social Affairs Committee includes a project addressing the workforce and financing challenges confronting long-term care (LTC) systems in OECD countries [DELSA/ELSA/WP1(2008)1 and DELSA/HEA(2008)14. The main outcome of the project will be an OECD publication on *Long-term care work and financing for future generations*, foreseen for early 2011. An expert meeting to discuss draft chapters of the publication is planned for the 15 and 16 of November 2010. The project received voluntary contributions from Belgium, France, the Netherlands, Japan and the European Commission (DG SANCO).

2. A fact financing and policy questionnaire was sent to all OECD and accession countries in June 2009. Most responses, initially due for mid September 2009, have been received by the Secretariat in waves, between the second half of 2009 and the first months of 2010. As of 23 March 2010, all OECD countries and Slovenia (with the exception of Turkey, Iceland, Denmark and the United States) have submitted their replies to the questionnaire. However, due to the late responses, the Secretariat could start compiling partial replies only from early 2010. This document and Annex DELSA/HEA(2010)13/ANN do not take full account of countries' replies for this reason.

3. An extended outline of the putative publication was sent to delegates of the Health Committee and the Working Party on Social Policy in December 2009, via the Electronic Discussion Groups. The OECD Secretariat has also carried out policy missions to Belgium and France. A mission to the United States is scheduled for the week of 19-23 April 2010, one to Japan for the week of 20-24 of May 2010, and one to the Netherlands in June 2010 (dates to be confirmed).

4. In parallel, the OECD Secretariat has drafted a background chapter on demographic and societal changes affecting the demand for and the supply of long-term care. It has carried out initial econometric analysis on the impact of caring on the mental health and labour-market participation of informal carers. It has mapped public coverage arrangement for long-term care in OECD countries. Finally, it has developed long-term care expenditure projection for 5 non EU countries, to complement estimates recently published by the European Commission for EU member states (EC, 2009 Ageing Report).

5. This document reviews initial findings from ongoing work on the project. The annex [DELSA/HEA(2010)13/ANN] includes more extensive text analyses, which will feed into various chapters of the final publication.

6. Delegates are invited to:

- **COMMENT** on the initial findings;
- **NOTE** the ***31 May 2010*** deadline for providing written comments on Annex DELSA/HEA(2010)13/ANN;
- **NOTE** that an expert meeting to discuss the draft publication is planned for ***15-16 November 2010***.

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1. Introduction

7. Pressures on long-term care systems (LTC, see Box 1 for definitions) are expected to grow in the future, for at least three reasons. First, although the speed at which populations are ageing varies considerably across countries, and despite uncertainties about future trends in disability among the population,[1] demographic transformations will increase demand for LTC services in all societies. Second, changing societal models – such as declining family size, changes in residential patterns of people with disabilities and rising female participation in the formal labour market – are likely to contribute to a decline in the availability of informal caregivers, leading to an increase in the need for paid care. Third, as societies become wealthier, individuals demand better quality and more responsive social-care systems. People want care systems that are patient-oriented and that can supply well co-ordinated care services. This raises pressures for improving the provision of care services, their performance, and, therefore, their cost.

8. These changes will create upward pressure on the demand for long-term care services and, as a consequence, the human and financing resources necessary to provide LTC services. This is apparent in the ranking of policy priorities towards long-term care systems in OECD countries (see Figure 1).

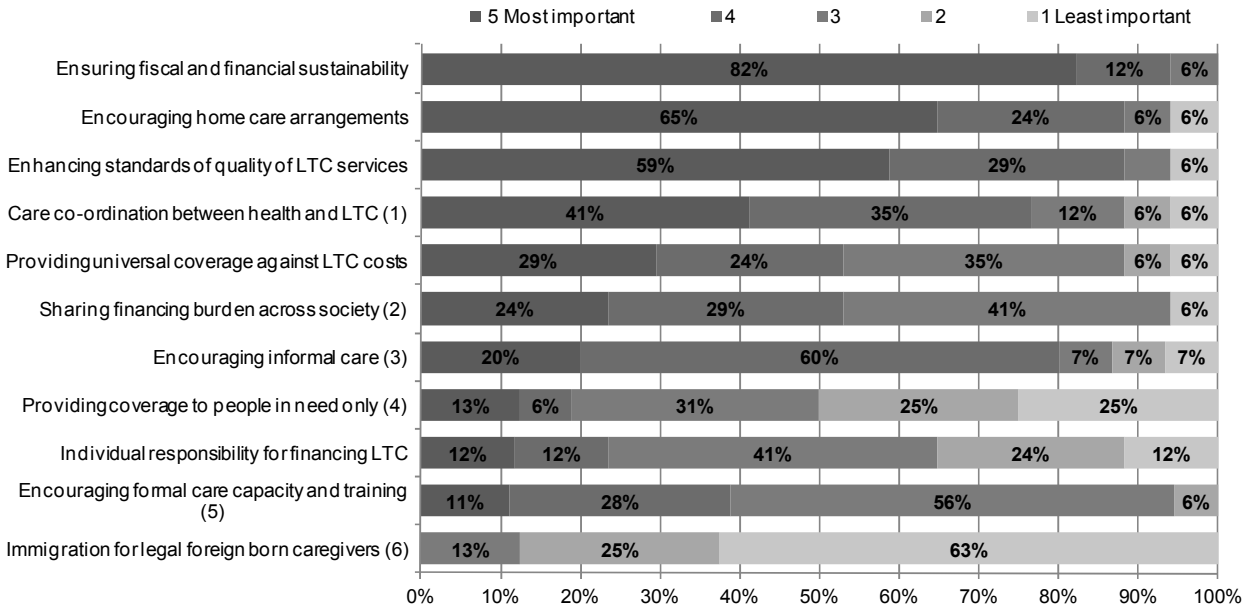
9. This document summarises preliminary findings from OECD analysis into these varied issues. After providing some background statistics on long-term care systems in section 2, section 3 takes a closer look at informal caregivers, who can be considered as the backbone of any LTC system, and the impact of caring on their employment and health status. Section 4 reviews the broad range of coverage arrangements for LTC across countries, while section 5 explores future trends in LTC use and expenditure as well as the demand for LTC workers. Section 6 concludes.

Box 1. What is long-term care?

Long-term care consists of a wide set of services to people who, due to their reduced degree of functional capacity, physical or cognitive, have prolonged difficulties with performing Activities of Daily Living (ADLs) such as washing, eating, getting in and out of bed. Furthermore, in many cases Instrumental Activities of Daily Living (IADLs) (such as housework, meals, shopping and transportation) are also hampered and require assistance. People most affected by a need for long-term care are those with (multiple) chronic illnesses, with (mental) disabilities, and older people.

[1] Elderly and non-elderly population. Users of long-term care services are predominantly found in older population groups, but another target group of LTC policies are younger disable people including those with physical and cognitive handicaps.

Figure 1. Policy priorities for LTC systems, 2009-2010



Notes: Includes responses from 23 OECD countries. 4 countries identified other policies and reforms than the ones listed above, including: improving functional needs assessments and international co-operation.
1) Harmonising LTC and health systems, support care co-ordination;
2) Sharing the burden of LTC financing across society as a whole, including seniors or retired high-income individuals;
3) Encouraging informal care and support for informal carers (including family members);
4) Providing coverage to eligible categories of people in need only;
5) Encouraging formal care capacity and training to caregivers, for example in order to reduce the burden on informal caregivers;
6) Encouraging or facilitating the immigration of legal foreign-born caregivers.
Source: OECD Questionnaire on LTC workforce and financing, 2009-2010.

2. Who uses LTC services? Who provides care? At what cost?

The over 80 years old are the main users of LTC services

10. The use of formal LTC services – measured in terms of recipients of LTC -- varies across OECD-countries. Use is very low in Korea (0.3% of the population) and Poland (0.2%). High use is seen in Norway (4.3%), the Netherlands (3.7%), Sweden (3.4%) and Switzerland (3.8%). On average 2.2% of the population in the OECD countries for which data are available, use formal LTC-services (2007). Except for Poland and Hungary, with relatively large shares of LTC recipients younger than 65 years, in most OECD-countries those aged over 80 years represent the biggest share of LTC-users.

11. Between half and three quarters of all LTC is provided at home.[2] This is in line with a tendency across nearly all OECD countries to encourage caring in home-care settings.

[2] Except in Australia, where less than a third (29%) of the LTC-users over 65 years or older receive home-care services according to data reported in OECD Health Data.

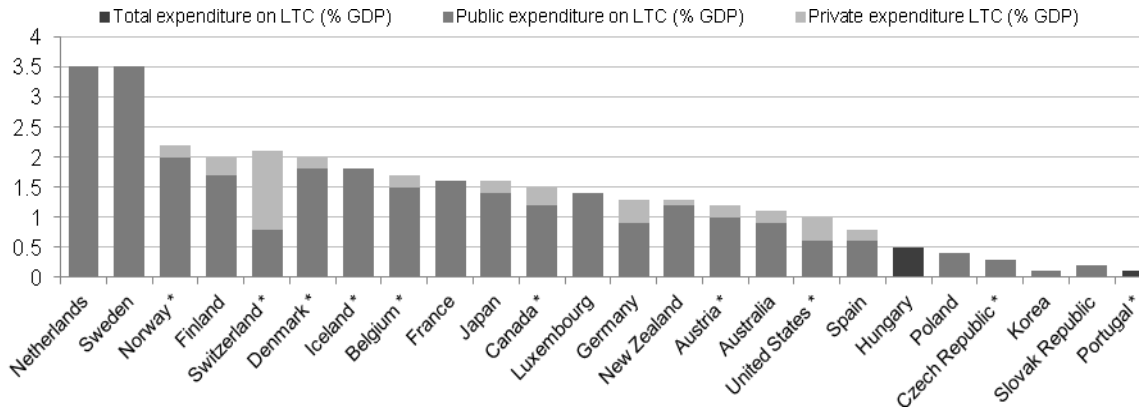
Significant cross-country variation in LTC workers, but informal care arrangements prevail

12. Although data are often lacking, long-term care is provided first and foremost by informal carers, of which most are adult daughters and spouses/partners. The most intense form of informal care is provided within the same household (see section 3). The share (head counts) of mostly female LTC workers in the working-age population tends to be small and varies from 0.2% in Poland to 3.8% in Switzerland.[3] A large number of LTC-workers work part-time, both in home care and residential care, although in the Czech Republic most workers work full-time. Part-time work arrangements are not uncommon in the health sector, for example they are prevalent in the hospital sector. However, data suggest that hospital employees in OECD-countries work more hours per week than LTC-workers.

LTC expenditure

13. Sweden and the Netherlands spend 3.5% of GDP on long-term care, whereas countries such as Portugal, the Slovak Republic and Korea, spend no more than 0.2% or 0.3% of GDP. Although there is underreporting of the private share, most expenditure on LTC is public (Figure 2).

Figure 2. Expenditure on long-term care, share of GDP, 2007



Note: * data for Norway, Switzerland, Denmark, Iceland, Belgium, Canada, Austria, United States, the Czech Republic and Portugal refer solely to the health component of LTC (so-called nursing long-term care expenditure).

Source: *OECD Health Data*, 2009

14. Significant cross-country differences in cost structures, as well as in occupancy rates in institutions, are reflected in relative expenditure per residential care user. Relative annual cost per user is 18 times higher in the US (US$ PPP 92,178) than in Poland (US$ PPP 5,028). Other countries with high residential care expenditure per user are Norway, Iceland and Luxembourg (> US$ PPP 80,000). On the other side of the scale, expenditure per residential care user is small in some eastern European countries (e.g., Hungary, Poland).

15. Unsurprisingly, expenditure per home-care user is substantially lower than for a residential care user, although in Denmark home-care costs reach three quarters of the level of residential care cost (2007). For Eastern European countries and Korea, per home-care user cost are extremely low, which may be a reflection of relatively lower wage levels, the occupational status of the carers, or the type of care provided at home.

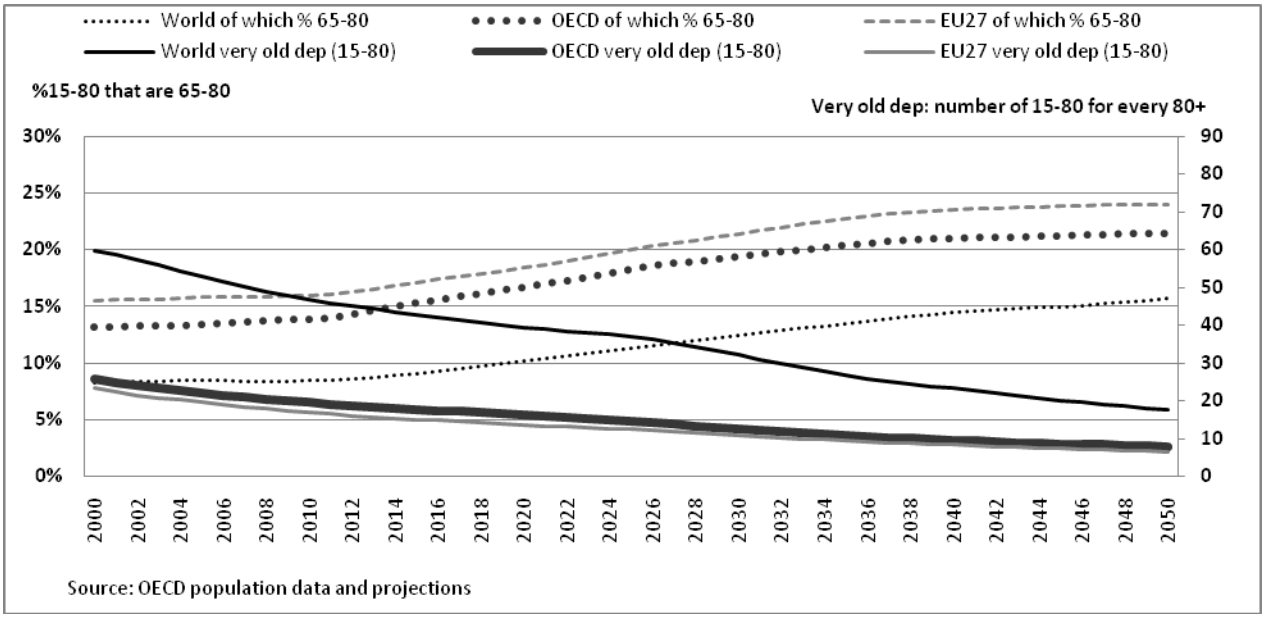
[3] In comparison, the share of professional and licensed nurses in the working-age population is highest in Norway (4.8%, 2007). Next highest share is found in Denmark (2.2%). Shares below 1% are found in Greece, Korea, Poland, Portugal and Hungary.

Growing demand and dwindling supply

16. The share of those aged 80+ in the OECD-30 is expected to increase from 4% in 2010 to 9,4% in 2050 (OECD Demographic and Labour Market Database). In Japan, but also in Germany, Korea and Italy, projected shares of those aged 80+ will be significantly higher, beyond one in eight people. Korea will experience both the biggest absolute and most rapid growth of the share of the very old people, but the share of those aged 80+ will be biggest in Japan in 2050 (16.7%). Some Nordic-European countries will reach their ageing peak – at a lower level – before 2050, but for most OECD countries, this peak will occur later. Although theories suggest different relationships between ageing societies and the expected need for long-term care, evidence does not show consistent trends of declining disability in all OECD countries (Lafortune et al., 2007; Bernd et al, 2009).

17. The ageing of societies will not only affect the future demand for long-term care, but also the potential supply of individuals available to provide both formal and informal long-term care. Given the substantial role of informal carers older than 65 years of age and the possible increase in retirement ages across the OECD, it is relevant to seek data beyond the usual working-age population. While in 2000, in the OECD30-countries, there were 20 persons between 15 and 80 years of age for every person older than 80 years of age, by 2050 the share of those aged 15-80 per person over 80 years old will shrink to 8 (Figure 3, continued lines referring to the right y-axis). Within the population aged between 15 and 80 years, which can be seen as an 'extended LTC-human resources pool', the share of those aged between 65 and 80 years old will increase from about 15% in 2000 to more than 20% in 2050 (Figure 3, dotted lines referring to the left y-axis). This implies that in 2050 close to one in every four of this 'extended LTC human resource pool' will be older than 65 years of age.

Figure 3. The potential care supply is decreasing rapidly and ageing as well



18. The availability of informal carers is also projected to decline as a result of societal changes such as a decrease in family size, increased childlessness and growing female labour market participation. The projected decline may be alleviated by the expected increase in the availability of "older" males to provide informal care, as the difference in life expectancy between men and women continues to narrow and as pressures on men to step into caring roles increase. However, it is unlikely that this will suffice to compensate *in toto* for the effects of demographic changes.

19. In some countries, for example in Southern Europe, the growing demand for care has been met by an increasing inflow of low-skilled migrant carers. In Italy, for example, following a national campaign of regularisation in 2002, the share of foreign carers has increased rapidly, to reach an estimated 82% of all home carers in 2005 (Lamura, et al., 2008a).

Key findings on demographic and LTC use

20. The increased shares of those aged over 80 years old will likely lead to higher need for LTC-services, while at the same time the pool of those potentially available to provide care will shrink and become older. Currently, formal LTC-provision is a small sector in OECD economies, in which the workforce tends to work part-time. Some countries have constructed comprehensive systems, associated with high GDP expenditure, others have systems in their infancy. Demographic trends suggest not only that long-term care can be seen as a 'growth market', but also that systems will be under pressure to provide for an increased demand for LTC. This further development of LTC-systems may, however, require additional workforce and financial resources than currently. Both may become scarce.

3. Addressing caring responsibilities: impact on informal carers

21. In all OECD countries, informal carers (family, friends, and other uncompensated workers) supply the bulk of care (defined as help with personal care, i.e. with basic activities of daily living, ADL) to seniors and disabled persons. Not only do they provide the majority of care hours, but also the number of informal carers far outweighs headcounts and fully-time equivalent formal LTC workers. On average, around 70 to 90% of those who provide care either formally or informally, are informal carers (Fujiwara and Colombo, 2009). There are clear advantages to informal care. It allows disabled or frail people to receive care in their homes/community from individuals they are familiar with. It also allows LTC systems to keep cost down, for example by substituting for or complementing formal care.

22. While informal carers play a prominent role in the provision of LTC, overreliance on informal caregivers may have undesirable social consequences. Using two household surveys from Australia and United Kingdom,[4] and two surveys for individuals aged over 50 (the European Survey on Health and Ageing (SHARE) and the United States Health and Retirement Survey), this section provides a snapshot of who are the carers of individuals with functional limitations. It also analyses the impact of caring on the carer's employment and mental health status. This overview provides insightful information to shape policy reforms in relation to 1) helping carers combine caring responsibilities with paid work, particularly by setting the right incentives for informal care to continue to play a role; and 2) improving carers' physical and mental wellbeing.

23. The analysis shows that caregivers are a diverse group, with different care intensity, providing help to individuals with different care needs and in different settings (e.g., within or outside the household). Caregiving is associated with a significant reduction in employment and hours of work, especially for individuals providing a high intensity of care. Wages of carers do not appear to be lower relative to those of non-carers, once other characteristics are taken into account. On the other hand, there is an increased risk of poverty for carers of working age. Finally, caregivers are more likely to be affected by mental health problems, even after controlling for pre-existing mental health problems.

[4] The Household, Income and Labour Dynamics in Australia (HILDA) and the British Household Panel Survey (BHPS) are used for the analysis of informal carers in Australia and the United Kingdom respectively.

Most carers are women, care for close relatives and provide limited hours of care

24. More than one in 10 adults is involved in informal caregiving of people with functional limitations across the OECD. There are significant variations in the percentage of the population involved in caregiving across OECD countries. Part of the country differences could be attributed to the differences in the definition and interpretation of caring across countries (Box 1).

Box 2. Defining carers: complexity and focus of this study

There is little comprehensive or comparable international evidence on carers. The definition and measurement of unpaid care present significant challenges, especially in a study which attempts to make international comparisons. Many carers do not see themselves as such and, even if questioned, would not declare that they were carers. Society's attitudes towards family responsibilities and the availability of services to support both carers and people with health limitations vary widely between countries, influencing the pattern and statistics on informal caring. Studies use different definitions of carers, which differ depending on the caring activities and on who is the caree, leading to the inclusion or exclusion of so-called Instrumental Activities of Daily Living (IADL, that is help with shopping or with paperwork for instance), and the inclusion or exclusion of young carees and people with ill-health. Glendinning et al. (2009) draws attention to how differences in definitions and complex causal relationships threaten generalisations.

To assess the characteristics of carers and the impact of informal caring, different national and cross-country surveys are used in this chapter. No threshold is used in the general definition of carers and all individuals with caring responsibilities of at least one hour per week are included. All definitions focus on personal care inside or outside the household, but there are differences in the scope of the definition. The descriptive analysis on the characteristics of carers is limited to the sample of individuals aged 50 and above. The choice is partly driven by data limitations and partly by the fact that this group is more likely to be involved in caring responsibilities for elderly people and more at risk of labour market exit. Data from Australia and the United Kingdom reveals that 75% to 80% of carers of individuals with a long-term health condition, elderly or with a disability are aged 45 and above. This is confirmed by other published studies (Johnson and Wiener, 2006; Eurofarmacare, national reports). Older workers between 50 to 64 are also more prone to early retirement, particularly in the case of family responsibilities.

25. Carers are more likely to be female but more males become carers at older ages. Across the 13 OECD countries reviewed in this study, close to two-thirds of informal carers over 50 years old are women. Caregiving tends to decrease at older ages with a smaller percentage of carers at age 75 and above, probably being related to health limitations. At the same time, the gender distribution of carers changes with age. Relatively more males are carers among the 75-years-old and above: less than 50% of carers are women in that age category.

26. On average, unpaid carers are more likely to devote time to close relatives, such as their parents or their spouse.[5] Yet, there is a non-negligible proportion of carers who also report helping a friend or neighbor (18%) or taking care of other relatives such as brothers/sisters or aunts/uncles (13%). Male carers are more likely to be taking care of their spouse but are less often providing help to other relatives.

27. Overall, most informal carers provide limited hours of care but there is wide variation in hours provided across countries. Generally, more than 50% of carers are involved in caring activities involving less than 10 hours per week on average. This low intensity of caring is particularly prevalent in Northern European countries and Switzerland. In such countries, less than 20% of carers provide an intensive level of caring of more than 20 hours per week. This may reflect the fact, that in these countries, a relatively greater proportion of elderly receive formal care either at home or in institutions. In contrast, in Southern

[5] Care for children is excluded to avoid confusion between child care and care for dependent children.

Europe and the United States, more than 30% of carers provide intensive caring, reaching even slightly over 50% in Spain.[6]

28. Caring responsibilities are largely influenced by the health status of carees. While 11% of adults aged 50 years old and above with one limitation of daily activities receive informal care, this proportion doubles in the case of two or more limitations. The proportion of those receiving informal care does not vary greatly among those with two or more activity limitations. Individuals with ADL limitations are more likely to receive unpaid care in Southern Europe irrespective of the number of limitations. This result is consistent with other studies on geographic patterns of caring in Europe (Lamura et al., 2008b).

High-intensity caring can lead to reduced rates of employment and hours of work

29. Caring has a negative impact on labour-force participation even after controlling for employment status in the previous year and other individual observed and unobserved characteristics.[7] Such lower employment rates can be explained by the fact that providing personal care can be a demanding task that is incompatible with a full-time job or with any type of paid employment. The results show however differential impact depending on intensity of care. Results also show that the impact of caring on employment is less important than other factors: low education or the presence of a disability have a much larger effect on reducing employment rates. It is also possible to identify some geographical patterns.

30. The impact of care on *labour force participation*[8] appears only when individuals provide a high intensity of care: at least 20 hours per week. Similarly, the impact is significant only in the case of care towards co-residents. Co-residential living arrangements might reflect the high needs of the person being cared for and/or low availability of formal care. Conversely, caring does not lead to reduced work hours in case of low caring responsibilities. Less intensive caregivers may find it easier to combine work and care. They may also be more likely to provide care to more autonomous individuals or as a complement to a primary caregiver, giving them more flexibility. Staying at work can also help carers to cope with increased expenditures and a reduction in their disposable income.

31. While different definitions of informal carers limit the significance of cross-country comparisons on the impact of caring, certain rough patterns emerge. In particular, being an informal carer is not associated with a significant reduction in employment in Northern European countries. At the other extreme, Southern European countries exhibit a greater decrease in employment for informal carers. This geographic variation could be explained by the higher labour force attachment in Northern European countries and policies which might encourage a better combination of work and family responsibilities. Another explanation of the association between caring and labour force participation can be found in the already observed differences in the intensity and location of care across countries.

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6 The distribution of care hours across countries may however be influenced by the definitions of caring, by recall and reporting problems affecting the reliability of the actual hours spent.

7 When estimating the impact of caregiving on employment, is important to control for other factors because carers have different socio-demographic characteristics and human capital levels which might influence participation choices. Decisions within families as to who will be a carer or whether to use formal care instead of informal care might be related to the different labour market opportunities and earnings potential.

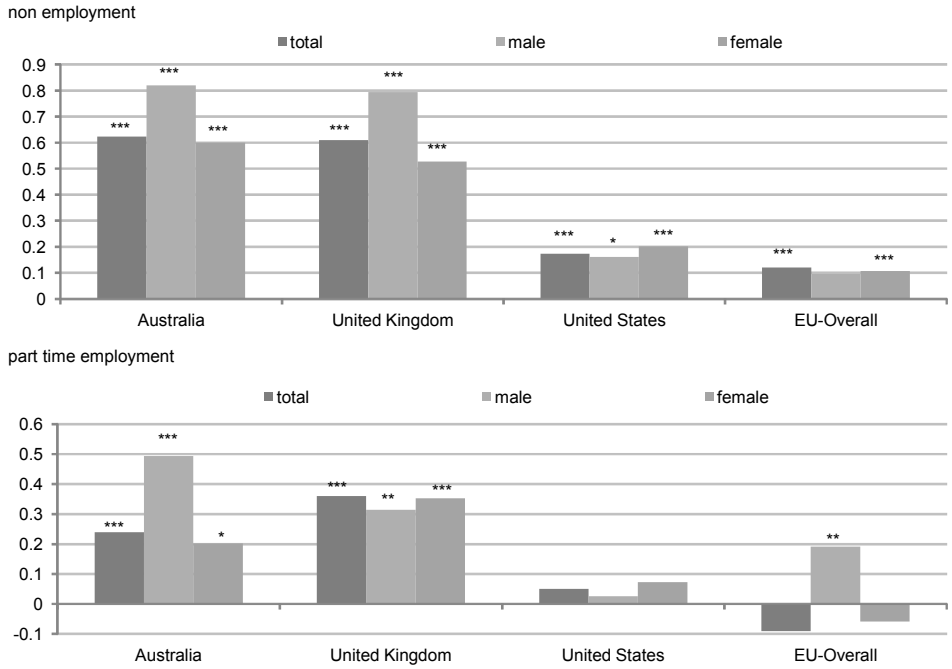
8 Using a lagged dependent variable model (dynamic probit model). This model estimates the probability of being in employment as a function of previous employment status, caring and demographic characteristics as well as work characteristics, controlling for initial conditions.

32. Caregiving also leads *to reduced working hours*[9] across all countries except in Northern Europe. It leads to a greater reduction in working hours in Southern Europe than in Central Europe. Hours of work are sensitive to a change in hours of care: a one percent increase in hours of care translates, on average, into slightly more than one percent decrease in hours of work. Other socio-demographic factors, such as education and marital status, are important predictors of working hours.

33. Caring can be attenuated by flexibility of working hours. However, carers are much more likely to stop working than to reduce work hours (Figure 4).[10]

Figure 4. Carers are more likely to stop work rather than working part-time

Coefficients from a multinomial logit



*, **, ***: statistically significant at the 10%, 5%, 1% level, respectively.

a) A positive coefficient indicates a higher probability with respect to full-time employment

b) Samples include persons below age 65 in Australia and the United Kingdom, aged 50 to 65 in other European countries and the United States.

c) The following years are considered for each country: 2005-07 for Australia; 1991-2007 for the United Kingdom; 2004-2006 for other European countries; and 1996-2006 for the United States.

d) The sample includes individuals present in at least three consecutive waves in Australia, the United Kingdom and the United States.

e) All regressions include the following controls: age, number of children, marital status, education, house ownership and other non-labour income if available, health status and regions (in Australia and the United Kingdom). The United States includes care provide to parents only.

Source: OECD estimates based on HILDA for Australia, BHPS for the UK, SHARE for other European countries, and HRS for the US.

9 Using random effect tobit. Hours of work is a continuous variable.

10 Using a simplified estimation procedure where a full-time worker chooses between non-employment and part-time work. Most workers will face a decision-making process where both options, i.e. whether to stop working or whether to work shorter hours, are considered simultaneously. Such decision depends on multiple factors, in particular the socio-economic situation of the carer as well as the opportunities to reduce working time.

For those of working age, caring is associated with higher risk of poverty but not with lower wages

34. Another possible economic outcome associated with unpaid care is lower wages. For instance, it could be argued that informal carers might experience a wage penalty as a result of career interruptions, which lead to a deterioration of human capital or skills depreciation, or the loss of opportunities for career advancement. The wage penalty might also be the result of signalling low career commitment towards employment as a result of long leaves out of work. However, lower wages for carers might not necessarily reflect a wage penalty as they could also be the result of self-selection into lower paid-jobs or occupations which provide a better balance between work and family obligations. After controlling for individual characteristics[11] and the decision to participate in the labour market, there is little evidence that caregiving leads to lower hourly wages.[12]

35. That said, working-age carers are at higher risk of poverty. For this group, caregiving is associated with a higher probability of experiencing poverty across all countries, except in Southern Europe. Women carers appear to be especially vulnerable to poverty risks. Because of career interruptions due to caring responsibilities women are also penalized with respect to pension benefits in many OECD countries. Since poverty is measured at the household level and includes income from different sources (equivalised by household size and composition), several reasons could explain such findings. Higher poverty may be linked to lower employment rates and lower working hours for carers, which leads to reduced total annual income. Another possible explanation is that the household composition of carers is different, with fewer household members having earnings from work. The results could also partly reflect the higher risk of dependency and health problems associated with lower socio-economic status.

Intensive caring has a negative impact on mental health

36. While unpaid carers provide a valuable service to society and looking after family members or friends brings great rewards, there is growing concern about increased psychological stress, strain and overall health deterioration endured by informal carers. Isolation and lack of support might prove a high burden and result in distress or mental health problems. However, relatively few studies have explored this topic and, those who did, rarely rely on nationally representative or longitudinal data sources.

37. Results from regression analysis[13] confirm that being an informal carer leads to a higher probability of mental health problems.[14] Caring has an important effect and a higher impact on mental troubles than do other socio-demographic variables, with the exception of other indicators of health status such as the presence of a long-standing illness. A higher probability is observed in all countries for both males and females, except for men in Australia. The impact of caring is more serious for females, with the exception of those living in Southern European countries. An important result is that being the recipient of

11 Such as age, education, marital status, number of children.

12 Unpaid care is associated with lower wages in the case of the United Kingdom only. Wages of carers are only 5% to 7% lower and there is no significance difference between carers and non-carers for men. In addition, if job characteristics are taken into account, the difference in wages between carers and non-carers is even further limited (amounting to 3-4%).

13 Using the same estimation method as for the probably of employment.

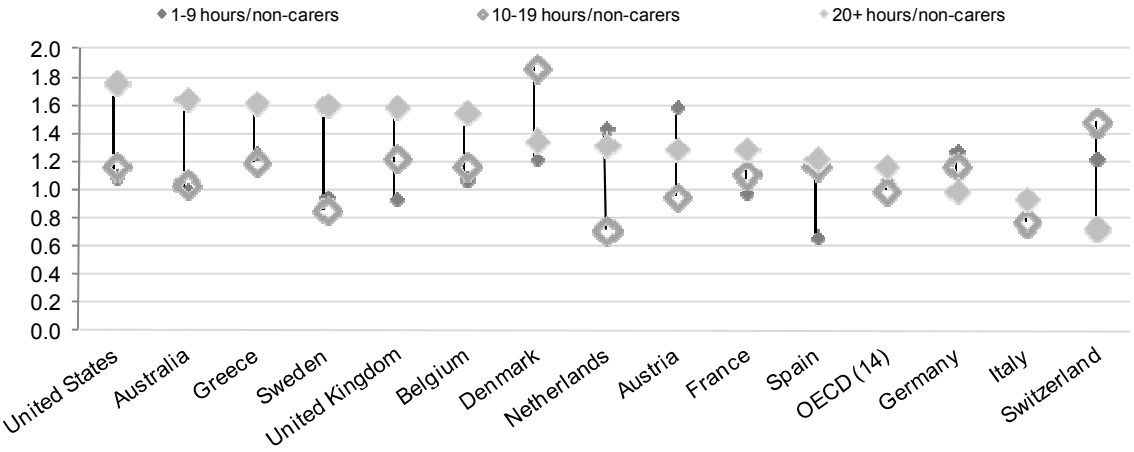
14 Mental health problems are measured through the use of symptom scales which are used as screening instruments to detect current diagnosable psychiatric disorders. The analysis focuses on mental health because the indicators capture the level of psychological distress of carers and because of the lack of availability of other cross-country indicators of physical health.

a carers' allowance does not significantly alter the negative impact on mental health in Australia and the United Kingdom (where information on allowances exists).

38. The impact of caring on mental health is stronger in the case of intensive and co-residential care. In Australia and in most European countries, significant worsening effects on mental health are only found when carers activity involves at least 20 hours per week (Figure 5). In the United Kingdom, worsening effects on mental health begins earlier at a medium level of caring intensity (10-19 hours/week) but the impact is smaller. The United States shows a clear gradient on worsening mental health by care intensity for women. Similarly, co-residential care is associated with a higher probability of mental health problems across all countries.

Figure 5. Mental health problems depend on the intensity (hours per week) of caring

Relative prevalence (1 corresponds to non-carers)



a) Numbers presented correspond to the relative prevalence of mental health problems among carers by intensity of caring with respect to non-carers. Above 1 means that mental health problems are more prevalent among carers relative to non-carers.

b) Samples include persons aged 50 and above. The United States includes care provide to parents only.

b) The following years are considered for each country: 2005-07 for Australia; 1991-2007 for the United Kingdom; 2004-2006 for other European countries; and 1996-2006 for the United States.

Source: OECD estimates based on HILDA for Australia, BHPS for the UK, SHARE for other European countries, and HRS for the US.

Key findings and preliminary policy discussion on the impact of caring

39. Caring can have important impacts on one's work effort and health, especially for individuals providing a high intensity of care. Since caring does not seem to affect work decisions at low care intensity (below 10 hours/week) and for extra-residential caring, intensive caregiving and co-residential carers should be the primary targets of policy interventions. Extra-residential care and less intensive caregiving show some modest effects in terms of mental health outcomes, too.

40. The analysis has shown that many individuals provide low levels of care, although some might underreport hours. This suggests that there may be some scope for an increase in the availability of informal care, as low intensity caregivers could increase their hours of care with only a limited impact on work effort and mental health status. However, with population ageing, it is likely that a greater share of carers will be involved in high intensity care. Without the adequate support, informal caregiving might exacerbate employment and health inequalities for these groups of carers. It may also reduce the chances of working-age carers to re-enter the labour market during or at the end of the caring spell.

41. Policies for carers should be designed bearing in mind these negative outcomes of caregiving. For those combining work and care, the analysis suggests that flexible working arrangements could mitigate reductions in working hours for carers, and should be promoted. For those who opt for temporarily leaving the workforce for caring purposes, training and employment support programmes might facilitate their transition back into the workforce. Payments towards caregivers and care recipients (such as cash allowances) should also take into account the possible economic incentives for certain groups to leave the labour market. As to the impact of caring on one's mental health, this could be alleviated by policies or programmes, ranging from respite care to physiological support and practical help for carers. Existing studies suggest that combinations of such interventions, and targeting support to specific categories of carers, might work best in supporting carers (Glendenning et al., 2009). The final report will take a closer look at policies put in place by countries to support informal carers and, where it exists, evidence of their effectiveness in reconciling caring with work and in reducing the burden on carers. The OECD Secretariat will also complement this analysis with a review of policies to recruit and retain formal LTC workers, expanding past OECD work on formal LTC workers (Fujiwara and Colombo, 2009).

42. Finally, while promoting options to combine care and work and provide support to carers are crucial, the availability of formal care is also important. Differences in access to formal care services are likely to influence the possibility of carers to chose the amount and intensity of caregiving provided. As examined in the next section, most OECD countries have formal LTC coverage arrangements complementing informal care, although approaches vary across countries.

4. Coverage of long-term care systems in OECD countries is very diverse

43. There are significant uncertainties, in one's life time, about the need, duration, intensity and cost of long-term care. This provides a powerful rationale in favour of creating collective coverage mechanisms for long-term care to complement informal care arrangements. Such mechanisms can ensure protection against the potentially catastrophic cost of care, which can place a significant burden on users, more specifically those living on low-income or with high levels of dependency. They can also respond to demand for intergenerational equity and risk pooling across today's and tomorrow societal groups.

44. The formal LTC sector is still relatively small in OECD countries (as a share of GDP) (Figure 2). However, in recent years, it has been a sector in evolution. LTC expenditure – particularly public LTC spending -- has shown a faster upward trend than health care spending.[15] The expected increases in formal LTC use are pushing ahead discussions about how to improve equity and efficiency in the financing of long-term care. These discussions often concern public systems. Private pooling mechanisms -- such as LTC insurance – still play a relatively small role in financing LTC expenditure.[16]

45. This section intends to inform those discussions by offering an overview of public LTC coverage mechanisms in OECD countries. For illustrative purposes, countries are clustered into three main groups, and new directions and challenges ahead are discussed.

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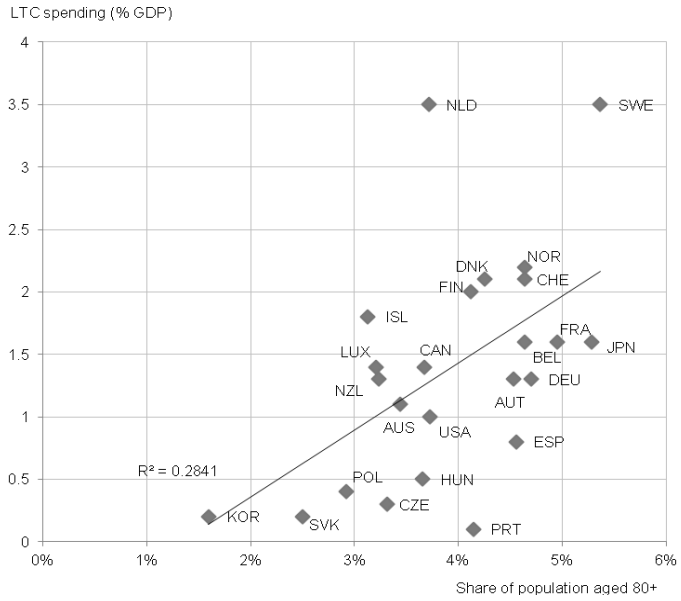
15 In the past decade, the health component of total long-term care has increased, in per capita terms, at an annual average of over 7% in real terms across 22 OECD countries, compared to an average of real per capita health spending growth of slightly over 4%.

16 A number of factors explain the relatively small size of the private LTC insurance market including individuals myopia in planning for the risk of dependency and the cost associated with it, as well as information asymmetry about the risk of needing care into the future, which generates problems of adverse selection.

Public long-term care coverage in OECD countries: three main groups

46. The share of GDP that countries devote to long-term care varies significantly across OECD countries. While some of the variation can be attributed to the fact that some countries are older than others (Figure 6), this also reflects differences in the comprehensiveness of public LTC systems. For instance, the Netherlands and Sweden allocate relatively more resources to LTC than the OECD average and more than could be expected given the share of the elderly population, while the United States and Hungary allocate less.

Figure 6. Share of the population aged over 80 and spending on long-term care in OECD, 2007



Note: Data for Japan, Portugal and the Slovak Republic refer to 2006; data for Australia and Luxembourg refer to 2005.
Source: OECD Social and Demographic Database, 2009 and OECD Health Data 2009

47. Analysing public LTC coverage models is complex. First of all, the ***comprehensiveness*** of the system varies with respect to *eligibility rules* (i.e. the care-dependency and, in some cases, the income levels triggering public support); the *breadth* of services (e.g., nursing care, personal care, IADL support, board and lodging) and of settings covered (e.g., home and institutional care); and the extent of *private cost-sharing* on public coverage. Second, views of LTC as a ***health or social risk*** have lead countries to the set up coverage arrangements that may in part overlap with health coverage, but the health-social boundaries are not uniform across the OECD. Third, not all OECD countries have set up ***dedicated financing mechanisms***[17] or entitlements[18] for long-term care, partly reflecting the policy priority assigned to public LTC coverage. In a large number of countries, LTC coverage is rather fragmented across different funding sources and coverage mechanisms. Fourth, LTC programmes are often operated and/or funded by ***lower levels of governments***/authorities.

48. Bearing in mind these difficulties, it is still possible to distinguish clusters of countries with similar LTC coverage approaches (countries with no or very little public LTC coverage, e.g., Mexico, are not discussed). The taxonomy focuses on variation in support for personal care (i.e. help with daily activities), and uses two main criteria to distinguish across country types: the scope of entitlement to long-

17 Such as LTC insurance financed from earmarked payroll taxes.

18 Such as obligations to provide LTC coverage written into specific laws or Act (Merlis, 2004).

term care benefits – whether there is universal or means-tested entitlement to public funding; and whether LTC coverage is through a single or multiple programmes. Three broad country clusters can be identified.

- Universal coverage within a single programme;
- Mixed systems;
- Means-tested systems.

49. In all countries, LTC benefits are adjusted to long-term care needs through a care-need assessment. Assessment systems and dependency levels on which benefits eligibility is determined are not uniform across countries and, in some cases, across sub-national jurisdictions.

Universal coverage within a single programme

50. Under this cluster, the LTC coverage is provided through a *single system*, whether this is separate from health systems, or part of health coverage. Systems with single universal LTC coverage provide publicly funded nursing and personal care to all individuals assessed as eligible due to their care-dependency status. They may apply to the elderly population only (e.g., Japan), or to all people with assessed care-need regardless of the age-group (e.g., the Netherlands). Co-payments, user charges or up-front deductibles can apply even in universal coverage systems. They are typically subject to income thresholds, with partial or full exemption from payments, or social-assistance mechanisms for the poor, resulting, effectively, in a comprehensive coverage of LTC costs through collective public mechanisms. Three main sub-models can be distinguished: i) *Tax-based models* (e.g., Nordic countries); ii) *Public long-term care insurance models* (e.g., Germany, Japan, Korea, the Netherlands, and Luxembourg); iii) *Personal care and nursing care through the health system* (e.g., Belgium).

51. Single-programme universal arrangements are good for access. They are typically comprehensive in relation to both the share of the cost publicly reimbursed and the spectrum of services covered in institutional and home settings, thereby reducing the out-of-pocket cost born by users. In some cases, coverage also includes the cost of support/domestic care, home adaptations and assistive devices (e.g., some Nordic countries). These systems do not discriminate access based on income or assets of users (or that of their families), although these may be taken into account to determine individual cost-sharing up to a ceiling (e.g., Norway, Sweden). Often, care provision by nurses or caregivers is regulated to ensure minimum standards for the care purchased through public funds (e.g., Japan). In addition, the separation between health and long-term care budgets in nearly all these countries reduces utilisation of more expensive health care services and professionals (e.g., hospital care, doctors) for long-term care needs.

52. On the down-side, these systems generally cost a larger share of national income and domestic budgets, in line with the relatively larger share of people eligible to receive care supports, the range of services covered and the relatively higher reimbursement rates compared with other systems. Comprehensive single-programme systems may replace informal carers unless specific incentives, services and benefits for informal carers are implemented. The separation of health and long-term care budgets may also impede the continuum of care and lead to cost-shifting incentives.

Mixed systems

53. Under mixed systems, LTC coverage is provided through a mix of different universal programmes and benefits operating alongside, or a mix of different universal and means-tested LTC

entitlements. It is difficult to give a proper account of the variety and complexity of institutional arrangements belonging to this group. Nevertheless, one possible way to group countries -- in decreasing order of universality of the LTC benefit -- is the following:

i) *Parallel universal schemes*, with different coexisting coverage schemes, each providing universal coverage of a type of care. The health care elements of LTC are free at the point of use in the United Kingdom. In addition, personal care (i.e., ADL support) for older people, which is part of the social-care system, is free in Scotland in both institutions and at home. Some eastern European countries provide universal LTC benefits for nursing care (often via the health systems) and for personal care (often cash benefits under the social system) although the share of the cost that is covered can be low.

ii) *Income-related universal benefits or subsidy* (e.g., France, Austria, Australia), where all those assessed as eligible on care-need grounds receive a public benefit, but the amount is adjusted to recipient's income and the adjustment can be very steep.

iii) *Mix of universal and means-tested (or no) benefits***.** Generally, universality tends to apply to nursing-care cost (either at home or in institutions) (e.g., Switzerland) and/or to home-care arrangements (e.g., many Canadian provinces, New Zealand). There are also countries where there is universal institutional care but no formal home-care supply (e.g., Greece).

54. The level of the public subsidy relative to total LTC cost varies significantly across countries, and, in some case, within country. Even if entitlement to some form of LTC benefit is universal, income and, sometimes, assets of the care recipient can be taken into account to determine the subsidy level or the personal contribution to the cost of care. In addition, the universal benefit or entitlement may refer to only one component of the care cost (e.g., home care), but not to others (e.g., care in institutions). As for systems with single universal coverage, mixed systems generally do not cover long-term care cost in their entirety. Rather they leave a share at the charge of individuals. This cost is met by a number of different arrangements including funding from social-assistance and income-support mechanisms, personal contributions and, in some countries, private insurance.

55. Mixed systems provides coverage for at least a share of LTC cost for all people needing care, and, therefore, provide a stable source of support for LTC dependent people. Generally, those systems have been developed in recognition that long-term care can lead to catastrophic cost for users. Providing a universal entitlement is viewed as desirable both for equity reasons (i.e., sharing of cost across societal groups) and for efficiency reasons (e.g., providing insurance, especially those living on low-income or with high LTC need).

56. On the other hand, these systems can still leave a significant share of the cost to be paid out of pocket. As they often combine coverage through different mechanisms, benefits or entitlements, it can sometimes be more difficult to quantify the overall support received by a user relative to the cost incurred. Even if there is some degree of universality, there is also a certain fragmentation in some such countries: across services governed by different programmes; across providers financed from different sources; between health and social-care administrations; across users entitled to different benefits depending, for example, on their age. In some cases, sharing of LTC cost across different government budgets can also mean that decisions affecting one budget (cost restraint/benefit expansion) may have spill-over effects on another budget in a different area of government. Some countries have set up mechanisms to facilitate coordination and help users navigate through the system.

Means-tested systems

57. Under means-tested systems, LTC coverage is provided through programmes of last resort (e.g., social assistance).[19] In these systems, only those falling below a set threshold would be entitled to publicly-funded LTC personal-care services or benefits, with care being prioritised to those with the highest care needs. This approach offers a safety net to those individuals otherwise unable to pay for the care themselves. The criteria for eligibility (e.g., personal and/or family income and assets; availability or not of informal care), care-managers' flexibility in assessing needs, and thresholds for eligibility differ markedly and may or not overlap with social-assistance norms. The United States belongs to this category. Current policy discussions about reforming the social-care system in England are around the means-tested arrangements for personal care, although there is a universal benefit for persons with disabilities in the United Kingdom.[20]

58. Means-tested arrangements offer a safety net to those individuals that are otherwise unable to pay for the care themselves. Typically, coverage extends to support for daily living activities, while domestic care, board and lodging in nursing homes, and other LTC services (assistive devices, rehabilitation) are not covered. By targeting public funds to the poor, this approach is effective at limiting cost. But it may also create inequities and incentives to use health care, particularly where there are universal health-care services and targeted social-care services. Means assessment can also be administratively expensive. Importantly, these systems can result in unmet needs and leave many families above the assets threshold vulnerable to catastrophic LTC spending.

Convergence of policy discussions on public long-term care coverage

59. Looking over time, long-term care systems in OECD countries are evolving in some common directions. The level of public coverage of long-term care cost is increasing in many low-coverage or strict-targeting countries, but there is also greater targeting of public funding in the most comprehensive LTC-coverage systems.

60. At one end of the spectrum, means-tested, some safety-net approaches have been called into question, mostly on grounds of fairness and growing need. The use of asset testing for accessing a nursing home is being phased out in New Zealand, while Ireland introduced in 2010 a system of "tailored universalism" for coverage of institutional care. Similar proposals have been made as part of the current policy debate about reforming social-care coverage in England (UK DoH, 2009), where, despite universal disability benefits, means-tested social care leaves many people above the income eligibility threshold vulnerable to catastrophic LTC spending. The United States is considering introducing a voluntary government LTC insurance programme as part of new health-care legislation (so-called, Community Living Assistance Services and Supports, CLASS Act). At the opposite end of the spectrum, in comprehensive universal coverage countries, the range of services eligible for coverage has also been the object of scrutiny. Sweden has increased targeting of public services to the most sick and disabled (OECD,

[19] Note: Several OECD countries providing some publicly-funded LTC benefits take income and, in some cases, assets into account to determine the amount of user cost-sharing. But in some countries, income and asset tests are actually used to set thresholds for eligibility to any publicly funded personal care.

[20] Subject to parliamentary approval, personal care at home is not means-tested in England also for people with very high needs. As already mentioned, the health components of LTC is also free at the point of use.

2005). France has – at least in the medium-term – set aside discussion of creating a new social-security LTC pillar and is considering, among others, steeper targeting of APA.[21]

61. Overall, these trends result in a certain convergence in the "breadth'' of eligible services covered and the "depth" of public coverage (share of costs covered) in universal systems belonging to the first and second category. Ultimately, in a context of limited public funding, there can be trade-offs between the breath of eligible services, the depth of coverage and the stringency of need assessment mechanisms.

62. It is important to note that universal coverage for some share of the LTC cost does not mean that access to care is always provided in a prompt way. Even in universal benefit systems, eligibility can in practice be targeted to those with the highest care need, relative to those with milder care needs. There can still be deviations from the universal model due to shortage of providers in semi-urban and rural areas and of special institutions (e.g. nursing homes, institutions of rehabilitation). If LTC programmes are funded through fixed budgets or if budgets are constrained (e.g., in lower-income OECD countries), service coverage is limited to what public services can provide given their budget, even when there is entitlement to some universal LTC benefit. Waiting lists -- especially for access to nursing homes -- are a way to match service supply with available resources. This means that there can be de-facto targeting of access to care based on (implicit or explicit) access and prioritisation rules.

63. Coverage arrangements can be used to encourage other desirable policy goals. For example, one way to promote home care has been to push for more comprehensive/universal care provided at home (e.g., Canada). Consumer choice and flexibility is another major goal of modern LTC care systems. There is growing demand for better tailored and more responsive care. Within both universal and safety-net systems, several OECD countries have opted for providing LTC benefits in the form of cash entitlements or personal budgets, sometimes at the choice of user (e.g., Netherlands, Germany, Eastern European countries, Italy, England). These direct payments bring more choice over alternative providers (including, in some cases between formal and informal carers) and can strengthen the role of households in the care-management process (Lundsgaard, 2005). Yet, it can be more difficult to exert control over the way cash benefits are utilised. If the value of benefits is not adjusted for cost inflation, it leads to a real loss in purchasing value of the benefit, exposing recipients to higher out-of-pocket expenses.

64. Maintaining cost growth within sustainable limits will be a key goal for the future. As the available pool of informal carers is likely to shrink, much in line with the overall working-age populations, there will be pressure to increase formal provision of LTC in OECD countries. Population ageing is pushing up public LTC expenditure, probably at faster rates than the growth in government revenues. Legitimate demands for better quality and responsive care systems are likely to continue. Although some goals of an LTC system such as wide access and good equity outcomes are achieved by expanding the comprehensiveness of coverage arrangements, these can rapidly lead to higher costs, and may have unintended negative impacts on the supply of (already shrinking) informal carers. If costs grow more rapidly than the economy, this means that governments will either need to give up on spending in other areas or raise contributions/taxes to pay for higher LTC cost. Alternatively, and especially in the current economic and fiscal environment, governments will need to consider ways to ensure value from LTC spending. This means that private collective financing arrangements could have a role in complementing public coverage, at least in some countries. This also means that reforms in the delivery of long-term care services may need to consider improvements in productivity.

65. During the rest of 2010, the analysis will concentrate on policies to ensure financial sustainability for public coverage arrangements. Beside looking more specifically at recent reform discussions about

[21] Allocation the Allocation Personalisée d'Autonomie (APA) is a cash benefit available to disabled people aged 60 or older living either at home or in a nursing home.

ways to encourage intergenerational solidarity and risk pooling, it will consider the role of private financing and coverage mechanisms.

5. Looking into the future: LTC cost will at least double and possibly triple by 2050

66. There is concern across OECD countries that the demographic and societal changes described in section 2 will lead to higher future ageing-related cost. One of the main tools to assess potential trends of age-related spending is to undertake projections as a share of GDP. These projections help to frame policy discussions and debates by providing an indication on the magnitude (size) or urgency (timing) of the challenge ahead.

67. LTC expenditure projections typically serve to demonstrate where an existing set of policies or programmes are likely to lead. As shown in table 1, most OECD countries currently allocate between 1 and 1.5 per cent of their GDP to long-term care, with some countries allocating more (e.g., the Netherlands, Sweden and Norway) and others less (e.g., Portugal, Czech Republic, Hungary).

68. According to the 2009 European Union projection scenarios, public LTC spending of OECD-EU member states, as a share of GDP, is expected to at least double by 2050. LTC expenditure are expected to fall in the range of 2.2 to 2.9 per cent of GPD in 2050 relative to about 1.2 per cent in 2007 (EC, 2009). Complementary projections elaborated by the OECD for a selected number of non-European OECD countries are consistent with those findings. As results are sensitive to certain assumptions, projection scenarios examine how results might change relative to certain eventualities, such as a change in the disability/dependency profile of the population, a change to the cost structure of LTC services, as well as a potential shift from informal to formal care (see Table 1). Taken together, these scenarios provide a potential range within which a country's public LTC expenditure may fall in the future.[22]

Healthy ageing and productivity gains mitigate some of the rise in LTC spending

69. The first two scenarios relate to changes in disability across the population. The projected change in functional status of the population (i.e., the prevalence of dependency/disability overtime) is indeed at the heart of any LTC-related forecast. Under the first scenario (baseline), the future demand of long term care is projected according to the prevalence of dependency/disability in the reference year. This is equivalent to assuming that the number of years with disability will increase in line with future gains in life expectancy. This is often referred to as the pure demographic scenario. While there is no consensus regarding the extent to which disability could change in the future, the second scenario examines the benefit of "healthy ageing" on projected LTC cost by assuming that half of the increase in lifespan will be years with lower dependency. The results show that "healthy ageing" could reduce total public LTC cost by about 5 to 10 percent by 2050.

70. Under the first two scenarios (pure ageing and healthy ageing), the cost of providing LTC is assumed to grow in line with wages in the rest of the economy (i.e., GDP per worker). Since LTC is a labour-intensive sector, it is reasonable to assume that wages in the sector will grow in line with wages in the rest of the economy. The third and fourth scenarios examine the sensitivity of expected public LTC

[22] The results discussed below consider both the results of the EC 2009 Ageing Report and the results of OECD estimates for five non-EU countries applying the methodology used in the EC 2009 Ageing Report. This methodology allows for an assessment of the organisation of LTC services across care settings as well as providing for a direct examination of the impact of a shift from informal to formal care. Results are consistent with aggregate projection results presented by the OECD in 2006, which were elaborated using a slightly different methodology (Oliveira Martins and de la Maisonneuve, 2006).

expenditure to a change to the LTC cost structure. For instance, the implementation of a new reform or the introduction of new technologies could bring about productivity gains, allowing for more care being provided for the same cost. Under this scenario, it is assumed that the cost of providing LTC grows at a rate (i.e., 1 percentage point) below real GDP per worker over the first ten years of the projection (see scenario 3 in Table 1).[23] Results suggest that such a change could bring a reduction of about 10 per cent in projected public LTC expenditure.

Declining informal care exacerbates the rise in LTC spending, while demand for LTC workers increases

71. There is a great deal of uncertainty with respect to the future availability of informal care and the consequences this will have on increased demand for formal care (as seen in section 2). As mentioned earlier, the availability of informal carers is projected to decline as a result of population ageing and societal changes. The fifth and sixth projection scenarios examine the sensitivity of projected LTC expenditure to a shift from informal to formal care by assuming that the number of dependants relying on informal care (or no care) will decline at a rate of 1 per cent per year over the first ten years of the projection period. Depending on whether new beneficiaries would receive care at home or in an institution, this shift is expected to increase public LTC cost in the range of about 5 to 35 per cent across OECD countries.

Table 1 Public LTC Expenditure Expected to Rise Significantly by 2050

(% of GDP, in base year prices)

		2050					
	Base Year	**Prevalence of Dependency**		**Changes to the LTC Cost Structure**		**Decline in the Availability of Informal Care**	
		Pure Ageing (1 - Baseline)	Healthy Aging (2)	-1% of GDP per Worker (3)	+1% of GDP per Worker (4)	All Home Care (5)	All Residential Care (6)
EU 2009*	**2007**						
Austria	1.3	2.5	2.4	2.3	2.7	2.6	2.6
Belgium	1.5	2.9	2.8	2.6	3.2	3.1	3.5
Czech Republic	0.2	0.6	0.5	0.6	0.6	0.6	0.7
Denmark	1.7	3.4	3.2	3.1	3.7	3.7	3.4
Finland	1.8	4.2	4.2	3.8	4.7	4.5	5.3
France	1.4	2.2	2.1	1.9	2.5	2.3	2.6
Germany**	0.9	2.3	2.2	2.1	2.5	2.4	2.7
Greece	1.4	3.3	3.2	2.9	3.7	3.5	3.9
Hungary	0.3	0.5	0.5	0.4	0.6	0.7	0.9
Ireland	0.8	1.8	1.8	1.6	2.0	1.9	2.2
Italy	1.7	2.9	2.8	2.6	3.2	3.3	3.9
Luxembourg	1.4	3.1	3.0	2.8	3.4	3.3	3.8
Netherlands	3.4	8.2	7.7	7.5	9.0	8.4	9.2
Norway	2.2	4.5	4.3	4.1	4.9	4.6	5.3
Poland	0.4	0.9	0.9	0.8	1.0	1.1	0.9
Portugal	0.1	0.2	0.2	0.2	0.2	0.2	0.2
Slovak Republic	0.2	0.5	0.5	0.5	0.5	0.6	0.5
Spain	0.5	1.4	1.3	1.3	1.5	1.4	3.0
Sweden	3.5	5.5	5.3	5.0	6.1	5.8	6.3
United Kingdom	0.8	1.3	1.2	1.2	1.4	1.3	1.3

[23] Consistent with the methodology used in the EC 2009 Ageing Report. This is a reasonable assumption since such a change to the LTC cost structure would not be expected to apply over the whole projection period.

OECD-EU Average	**1.3**	**2.4**	**2.3**	**2.2**	**2.7**	**2.5**	**2.9**
Case Study	**2006**						
Australia	0.8	1.8	1.6	1.7	2.0	2.3	2.5
Canada	1.2	2.7	2.4	2.4	2.9	2.7	3.4
Japan	1.4	4.0	3.5	3.6	4.4	4.0	4.4
New Zealand	1.4	3.9	3.6	3.5	4.3	4.6	6.2
United States	1.0	1.9	1.7	1.7	2.1	2.2	2.6
Case Study - Average	**1.2**	**2.9**	**2.6**	**2.6**	**3.2**	**3.2**	**3.8**
OECD 2006 Projections	**2006 (Actual)**						
Iceland	1.9	2.8	2.5	-	-	-	-
Korea	0.1	-	-	-	-	-	-
Mexico	-	-	-	-	-	-	-
Switzerland	0.8	1.6	1.3	-	-	-	-
Turkey	-	-	-	-	-	-	-

Source: OECD calculations based on EU (2009), *Ageing Report: Economic and budgetary projections for the EU-27 Member States (2008-2060) – Statistical Annex* and OECD (2006), *Projecting OECD Health and Long-term Care Expenditure: What are The main Drivers* .
Notes:
*Public LTC expenditure level as presented in the EU 2009 Ageing Report. Figures, for 2007, may differ from figures found according to the OECD Health Database, as information from the EUROSTAT database was used to complement it. As such, public LTC expenditure may reflect a broader range of expenditures including support in-cash or in-kind for some IADL services.
**In the projection, unit cost are indexed to GDP per worker or GDP per capita and does not reflect the current German legislation under which all long-term care benefits are indexed to prices. Based on this rule, Germany's public share of LTC expenditure is projected to reach about 1.1 per cent of GDP by 2050.

72. A projected increase in the level of LTC expenditure would necessarily translate into an increase in the number of LTC workers. For the OECD countries on which information is available, the total number of full-time equivalent LTC workers (nurses and personal carers) currently represents about 1 to 2 per cent of the total workforce. This share is set to increase significantly and for many countries could more than double by 2050, assuming no changes in the current ratio of LTC workers per recipient. This projected increase reflects the expected rise in the number of dependents requiring formal care (demand for care) as well as the expected stagnation and even decline of the total workforce in certain OECD countries, as indicated in section 2.

For LTC users, the mix of public/private financing of LTC services matters

73. The mix between public and private financing determines how much individuals have to pay for LTC services. Because of data limitations and concerns regarding governments' fiscal sustainability, most international studies tend to focus solely on the public share of LTC expenditure. In recent years, however, many OECD countries have introduced policies that might alter the mix of public and private coverage of LTC cost. For example, some countries have increased public coverage (e.g., France, Japan, Spain, Korea) while others have reduced the share of LTC spending financed publicly or increased targeting of public spending (e.g., Germany, Sweden, Netherlands).

74. Public coverage pools the risk of dependency over a large share of a country's population, thereby significantly reducing the cost incurred by LTC users. On the other hand, universal public schemes inevitably reduce cost incurred by some users who could afford to fully or partially pay for care on their own.

75. A shift in the public/private financing mix can have significant repercussion on the budget of LTC users. For instance, for the selected number of non-European OECD countries for which projections are elaborated, the impact of a 5 per cent decrease/increase in public LTC spending could translate in an increase/decrease ranging from 15 percent in the United States to about 65 per cent in New Zealand in the aggregate level of expenditure incurred by LTC users. Their ability to pay for this expenditure will depend on their existing and future income situation.

Preliminary policy discussion on LTC projections

76. Overall, the analysis points to a significant rise in LTC use and expenditure by 2050. *Ceteris paribus*, this would also translate in higher demand for LTC workers.

77. Policies aiming at delaying the onset of disability (so-called " healthy ageing" policies such as increasing community activities, improving lifestyles and health literacy, or better adapting health care systems to the needs of the elderly) have the potential to mitigate demand for care. However, policies/programmes aimed at keeping individuals in good health as they age, rarely appear to be cost-effective, or lead to overall reductions in health-care costs. There can also be long time-lags between the time of the intervention and the time benefits can be obtained (Oxley, 2008). This suggests the importance of future analysis to investigate what healthy ageing and prevention interventions would offer the highest returns.

78. Projected demand for LTC and its cost are very sensitive to potential shifts from the informal to formal care sector. The expected decline in both the working-age and the caregiver's populations suggests that addressing future LTC challenges will require a multi-pronged approach focussing on both formal and informal care arrangements, as well as their coordination. For instance, increasing the supply of LTC workers may be difficult to achieve in a context of a shrinking workforce. Recruiting and retaining LTC workers in the future will be a greater challenge and will likely exacerbate future pressures on wages (see scenario 4 in Table 1). This suggests the importance of initiatives directed at the formal LTC workforce, with a view to improve recruitment, retention and productivity. Complementary policies to support and help caregivers would better recognise and encourage the availability of informal carers.

79. The final publication will consider policies to achieve more or better care for each dollar spent on LTC system. It will also take a closer look at household income and expenditure in a context of ageing, examining the potential linkages between private LTC spending and pension income as well as the risk for catastrophic LTC expenditures.

6. Conclusion

80. Designing sustainable long-term care systems is a policy priority of many OECD countries seeking to provide adequate response to well-known demographic and societal changes. In designing LTC-system policies, workforce and financing issues rank among the top areas of concern. The initial findings of this work highlight the importance of complementing formal LTC arrangements with policies to foster work/care balance as well as to mitigate the impact of caregiving on the health of informal carers. Creating predictable sources of funding for long-term care is a desirable policy goal in light of the potentially catastrophic consequences of LTC costs on household budgets and the need to finance higher formal-care utilisation. Most OECD countries have indeed established or are working to create (mainly public) LTC-coverage mechanisms. Yet the initial findings of OECD work show that providing adequate coverage and, linked to that, establishing formal delivery mechanism, can well result in a significant increase in public cost. Although LTC systems still account for a small share of government spending, this is likely to grow significantly into the future.

81. During the rest of 2010, ongoing LTC work at OECD will look at these policy issues. The analysis will build upon country responses to the LTC questionnaire, the findings from selective OECD-country missions, a review of the published literature, and OECD work in other ELS divisions, for example work on migration and retirement income.

BIBLIOGRAPHY

Bernd, B. Doyle, Y. Grundy, E. and M. Mc Kee (2009), "How can health systems respond to population ageing?", *Policy Brief* No. 10, European Observatory on Health Systems and Policies, Copenhagen, WHO Regional Office for Europe.

Glendenning, C. , Arksey, H. and Tjadens, F. (2009), *Care Provision within Families and its Socio-Economic Impact on Care Providers - Policy Briefing*, Working Paper No. BRF 2350, The University of York, Social Policy Research Unit.

Eurofamcare national and pan-European Report, accessed at: http://www.uke.de/extern/eurofamcare/publikationen.php?abs=1

European Commission and the Economic Policy Committee (2009), *The 2009 Ageing Report: Economic and budgetary projections for the EU-27 Member States (2008-2060),* Joint Report prepared by the European Commission, DG ECFIN and the Economic Policy Committee (AWG), Brussels, European Communities. http://ec.europa.eu/economy_finance/publications/publication14992_en.pdf

Lafortune, G. and G. Balestat et al. (2007), "Trends in Severe Disability among Elderly People: Assessing the Evidence in 12 OECD Countries and the Future Implications", *OECD Health Working Paper* No. 26, Paris, OECD. http://www.oecd.org/dataoecd/13/8/38343783.pdf

Fujiwara, R. and Colombo, F. (2009), "The Long-Term Care Workforce: Overview and Strategies to Adapt Supply to a Growing Demand", *OECD Health Working Paper No. 44, Paris, OECD,* http://www.olis.oecd.org/olis/2009doc.nsf/LinkTo/NT00000F0A/$FILE/JT03261422.PDF

Lamura, et al. (2008a), « Les travailleurs immigres dans le secteur des personnes agées : l'example de l'Italie », Retraite et société, No. 55, Octobre 2008, pp. 72-82.

Lamura et al. (2008b), "Family Carers' Experiences Using Support Services in Europe: Empirical Evidence From the EUROFAMCARE Study", The Gerontologist, Vol. 48, No. 6, pp. 752–771.

Lundsgaard, J. (2005), "Consumer Direction and Choice in Long-Term Care for Older Persons, Including Payments for Informal Care: How Can it Help Improve Care Outcomes, Employment and Fiscal Sustainability?" *OECD Health Working Paper* No. 20, Paris, OECD. Accessed http://www.oecd.org/dataoecd/53/62/34897775.pdf

Merlis, M. (2004), *Long-term care financing: Models and issues,* Paper prepared for the National Academy of Social Insurance Study Panel on Long-term Care, April 30, 2004. Accessed at: http://www.nasi.org/usr_doc/Merlis_LongTerm_Care_Financing.pdf

OECD (2005), *Long-term care for Older People*, Paris, OECD.

OECD Health Data 2009, Paris, OECD.

OECD, 2009-2010 Questionnaire on the long-term care workforce and financing project. Country replies, Paris, OECD.

Oliveira Martins M. J. and C. de la Maisonneuve (2006), "The Drivers of Public Expenditure on Health and Long-Term Care: An Integrated Approach", *OECD Economic Studies*, No. 42 (OECD: Paris).

Oxley. H. (2009), "Policies for Healthy Ageing: An Overview", *OECD Health Working Paper* No. 42, Paris, OECD, http://www.olis.oecd.org/olis/2009doc.nsf/LinkTo/NT00000BDE/$FILE/JT03259727.PDF

Johnson, R.W., Wiener J. et al (2006), *A profile of frail older Americans and their caregivers. The retirement project*, Occasional paper number 8, The Urban Institute.