

Help Wanted?

Providing and Paying for Long-Term Care

Demographic ageing and social changes will make it harder to care for older people who cannot cope without help. Based on a recently published OECD report, this policy brief calls for a comprehensive approach to long-term care and addresses the following questions:

- ▶ Who uses long-term care, in which settings and at what cost?.....2
- ▶ What will be the effects of growing need for long-term care?3
- ▶ How can family carers be supported?.....4
- ▶ How can job quality in LTC labour markets be improved?.....5
- ▶ How will countries finance growing care needs?.....6
- ▶ How to improve value for money in the long-term care sector?7

Addressing the growing need for long-term care requires a comprehensive vision



With population ageing, no clear signs of a reduction in disability among older people, family ties becoming looser and growing female

labour-market participation, it is not surprising that the need for care for frail and disabled seniors is growing.

Growth in the number of old people is the main driver of increased demand for long-term care (LTC, Box 1) across OECD countries. Indeed, policy discussion around LTC reforms is often presented as being all about population ageing. In fact, this is not the only problem that LTC systems must address.

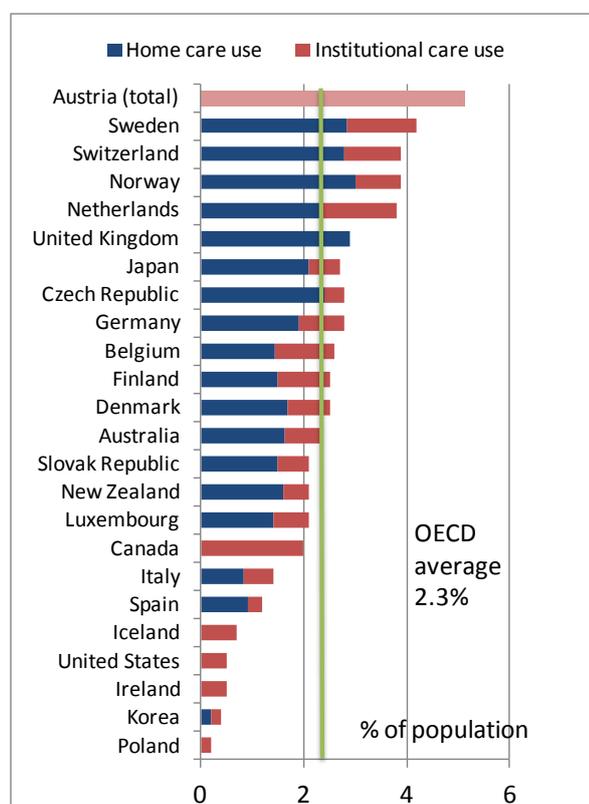
In many countries, LTC policies being developed in a piecemeal manner, responding to immediate political or financial problems, rather than being constructed in a sustainable, transparent manner. Yet, the future of LTC is more demand, more spending, more workers (see Box 2), and above all, higher expectations that the final few years of life must have as much meaning, purpose and personal well-being as possible. Facing up to this challenge requires a comprehensive vision of LTC. Addressing future LTC challenges needs to focus on both formal and family care arrangements, as well as their coordination. Going on in a disordered manner is not good enough. This study examines policies for family (and friends) carers, as well as the formal provision of LTC services and its financing.

Most care recipients are old women living at home, but most LTC cost occurs in institutions

The probability of needing care increases with age. Less than 1% of those younger than 65 years use LTC, while 30% of the women aged 80 years old or over use LTC services, on average across the OECD. Across the OECD, one in five LTC users is younger than 65 years, while around half of all users are aged over 80 years.

In nearly all OECD countries, between half and three quarters of all formal LTC is provided in home-care settings (Figure 1), with a substantial share of these suffers from dementia-related problems.

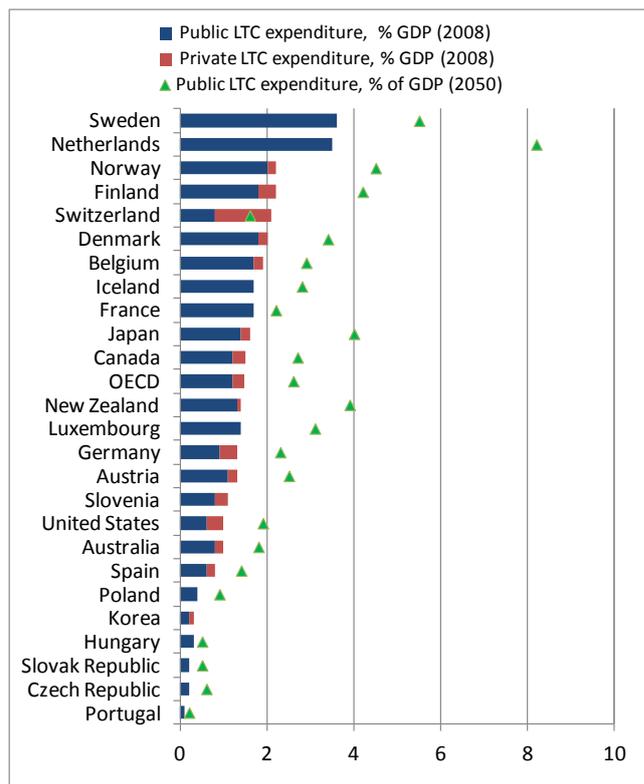
Figure 1. LTC users as share of the population, 2008 or latest available year



Source: *Help Wanted?*

Very old users are less likely to receive home care than younger ones. Nevertheless, more than half of the care recipients aged 80 years or over receives care at home in most countries, and only a third of all LTC users receives care in institutions.

Figure 2. Public and private LTC expenditure in the OECD, 2008 and 2050



Source: *Help Wanted?*

In contrast, 62% of total LTC expenditure occurs in institutional settings. LTC spending accounted for 1.5 % of GDP on average across 25 OECD countries in 2008 (Figure 2). This variation reflects differences in care needs, the comprehensiveness of formal systems, and family caring cultures.

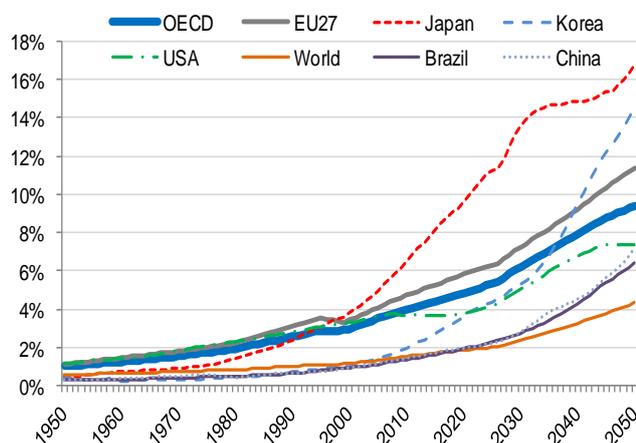
Box 1. What is Long-term care?

A range of services required by persons with a reduced degree of functional capacity, physical or cognitive, and who are dependent for an extended period of time on help with basic activities of daily living (ADL). This *personal care* component is frequently provided with basic medical services, *nursing care*, prevention, rehabilitation or palliative care. LTC services can also be combined with lower-level care related to help with so-called instrumental activities of daily living (IADL) (e.g., domestic help, help with administrative tasks, etc).

Box 2. Demand for more and better care will have major financial and labour-market implications

Over the next decades, OECD countries will continue to age, leading to unprecedented shares of their population being 80 years and over. In 1950, less than 1 % of the global population was aged over 80 years old. By 2050, the share is expected to increase from 4 % in 2010 to nearly 10 % across the OECD (Figure 3).

Figure 3. Rapidly increasing share of the population aged over 80 years



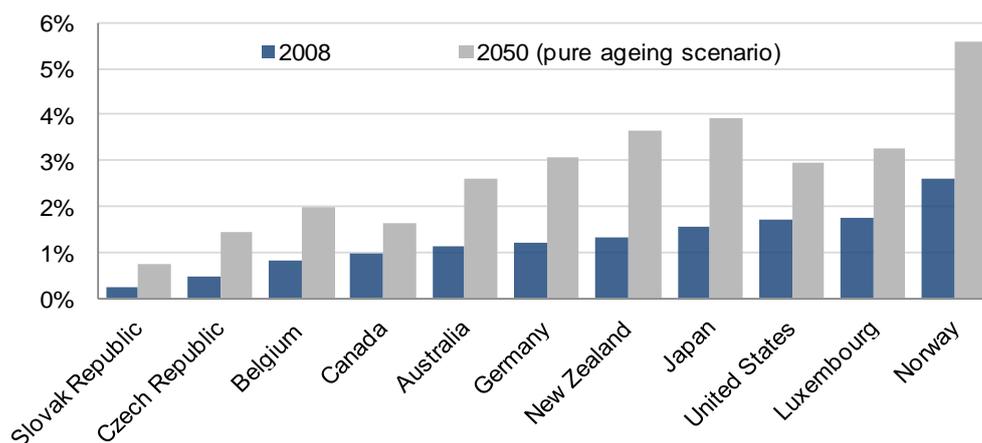
Source: *Help Wanted?*

Population ageing will challenge long-term care services. The pool of potential family carers is likely to shrink because more women are working, and social policies no longer support early retirement. Meeting the expected demand for LTC services by increasing the supply of workers may be difficult, given that it will take place in the context of a shrinking workforce. To maintain the current ratio of family carers to the number of individuals with ADL restrictions, the total number of family carers would need to increase by about 20 to 30% in some countries.

Between 1 and 2% of the total workforce is employed in providing LTC. In many countries, this share will more than double by 2050 (Figure 4). Recruiting and retaining LTC workers may be a challenge and exacerbate pressures on wages in the sector. Spending on LTC will double or even triple between now and 2050, a result of growth in volumes and prices of formal care, as individuals demanding better quality and more responsive, patient-oriented social-care systems.

Figure 4. The demand for LTC workers expected to at least double by 2050.

Share of Full-Time-Equivalent nurses and personal carers to projected working population.

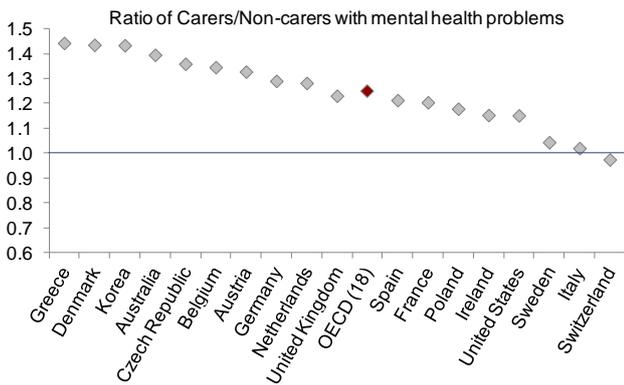


Source: *OECD Help Wanted?*

Three ways to support the health of people who provide care and those working

Family carers are the backbone of any LTC system. Across the OECD, more than one in 10 adults aged over 50 years provides (usually unpaid) help with personal care to people with functional limitations. Close to two-thirds are women. Support for family carers is often tokenistic, provided as recognition that they perform a socially useful and difficult task.

Figure 5. More mental health problems among carers



Source: *Help Wanted?*

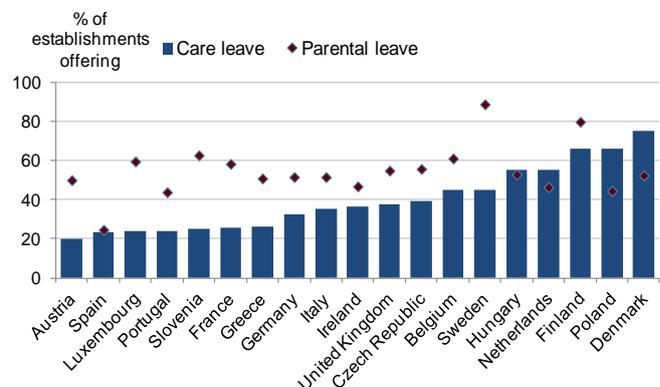
But supporting family carers effectively is a **win-win-win solution**. It is beneficial for carers. Without support, high-intensity care-giving is associated with a reduction in labour supply for paid work, a higher risk of poverty, and a 20% higher prevalence of mental health problems among family carers than for non-carers (Figure 5). It is beneficial for care recipients, because they generally prefer to be looked after by family and friends. And it is beneficial for public finances, because it involves far less public expenditure for a given amount of care than if it was provided in the formal sector. Governments can support family carers by:

- *Providing cash*, although if badly designed, such policies can become counter-productive. Both carers' allowances and cash benefits paid to the care recipients, for example in the Nordic and all English-speaking countries, increase the supply of family care, but the state will pay for many cases that would have been provided even

in the absence of any financial incentive. Carers also risk being trapped into low-paid roles in a largely unregulated part of the economy, with few incentives for participating in the formal labour market.

- *Promoting a better work-life balance* through more choice and flexibility, for example about care leave (Figure 6). A one percent increase in hours of care is associated with a reduction in the employment rate of carers by around 10%. Flexible work arrangements in the United Kingdom, Australia and the United States attenuate the risk of a reduction in working hours associated with caring.
- *Introducing support services*, such as respite care, training and counselling. These ensure quality of care at the same time as improving carers' wellbeing. Such services can be arranged for a relatively low cost, including by leveraging upon the widespread and invaluable contribution of the voluntary sector, as is done in some countries

Figure 6. Care leave is less frequently available than parental leave



Source: *Help Wanted?*

Carers and the people cared for are heterogeneous groups with different needs. This calls for flexibility in designing support measures. Coordination with formal care systems is desirable, too. Further evidence on the cost effectiveness of policies to support carers is badly needed.

It is possible to attract more care workers and to retain them

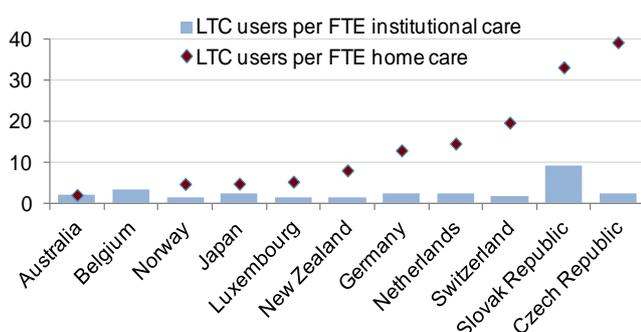


Over-reliance on family carers is not desirable, and many countries need to strengthen the formal – highly labour intensive – LTC sector. Some workers get considerable satisfaction from working in the LTC sector. However, relatively low pay and difficult working circumstances discourage many others. High turnover and low retention endanger both access and quality of services.

Who are the LTC workers?

Ninety percent of LTC workers are women and many are relatively old. Typically, the required qualifications are low -- and lower in home care settings. Between 16% (Japan) and 85% (Hungary) of all LTC workers are nurses, but in most countries fewer than half are nurses. While most care users receive care at home, the majority of care workers are found in institutional care settings, but (Figure 7). The number of LTC workers per 100 people aged over 80 years varies from slightly over 0.5 in the Slovak Republic to over 3.5 in Norway, Sweden and the United States.

Figure 7. Higher ratio of LTC users per full time equivalent (FTE) worker in home care



While many countries struggle to meet the challenge, ensuring an adequate supply of LTC workers is, on balance, a manageable goal. Countries can use the following strategies:

- *Improving recruitment efforts by expanding recruitment pools and recruiting migrant LTC*

workers. Measures to expand existing recruitments pools and create new pools (e.g., young people in Norway and the United Kingdom, long-term unemployed in Japan and Finland) have however met with mixed success. There are many new migrant LTC workers in Italy, Israel and the United States, among others. Only a few countries, including Australia and Canada give work permits specifically for LTC workers; more countries should consider doing so.

- *Increasing retention.* High staff turnover is costly: turnover costs have been calculated to be USD 2 500 per vacancy in the United States. Valuing the LTC workforce by improving the pay and working conditions will have immediate positive spin offs if retention rates increase. There is evidence of good results from measures aimed at upgrading LTC work, for example in Germany, the Netherlands, Sweden and Norway.
- *Seeking options to increase the productivity of LTC workers.* The main avenue has been from reorganisation of work processes (e.g., the Netherlands), the use of ICT to reduce indirect workload (e.g., Finland and the United States), and the delegation to nursing assistants of tasks that were previously the responsibility of nurses (e.g., the United States). However, evidence on productivity improvements in LTC labour markets remains sparse.

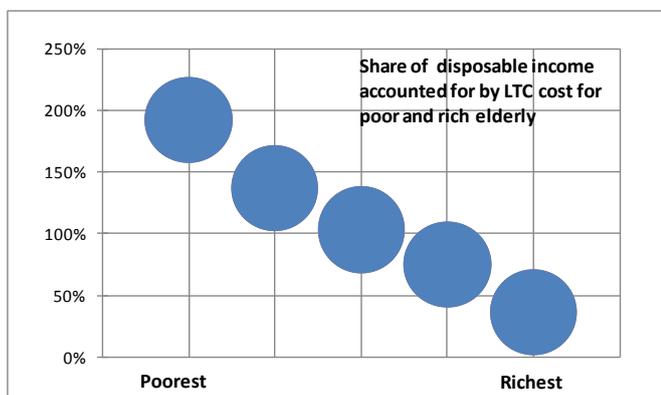
In the long-run, improving job quality will be important. High turnover, low quality and low pay are unsustainable strategies, which can lead to not enough workers willing to provide care. The flip side of the coin is that ‘professionalising’ a still relatively easy-to-enter sector may raise entry barriers, increasing rigidity in a sector that is regarded by workers as being highly flexible. These measures require investment of resources, too. Costs will go up. This can only be justified if productivity is improved.

A toolkit of policies to strike a balance between access to care and financial sustainability

Most OECD governments have set up collectively-financed schemes for personal and nursing-care costs. One third of the countries have universal coverage either as part of a tax-funded social-care system, as in Nordic countries, or through dedicated social insurance schemes, as in Germany, Japan, Korea, Netherlands and Luxembourg, or by arranging coverage mostly within the health system, as in Belgium. While not having a dedicated “LTC system”, several countries have universal personal-care benefits, whether in cash (e.g., Austria, France, Italy) or in kind (e.g., Australia, New Zealand). Finally, two countries have ‘safety-net’ or means-tested schemes for LTC costs, namely the United Kingdom (excluding Scotland, which has a universal system) and the United States.

Private LTC insurance has a potential role to play in some countries, but unless made compulsory will likely remain a niche market. In the United States and France, the largest markets in the OECD, respectively 5% and 15% of the over 40 years old have an LTC policy.

Figure 8. The cost associated with high-care need is a large share of income for most seniors



Source: *Help Wanted?*

Moving towards universal LTC benefits is desirable on access grounds. Uncertainty with respect to *whether, when, and for how long* an individual might need LTC services suggests that

pooling the financial risk associated with long-term care is a more efficient solution than relying on out-of-pocket payments. Otherwise, the cost of LTC services and support is unaffordable for most people: average LTC expenditure can represent as much as 60% of disposable income for those in the bottom 80% of the income distribution (Figure 8).

However, to maintain control over expenditure, it will be important to:

- *Implement targeted universalism, i.e. target universal care benefits where needs are the highest*, for example via cost-sharing policies, and a better definition of the need levels triggering entitlement and of the services included in the coverage. Even in universal LTC schemes, more stringent assessment criteria can be in place, as is the case in Korea and Germany, in contrast, for example, to Japan. All countries have user cost-sharing for LTC, although the extent varies from a flat fee in Korea (11% of LTC costs) to a capped share based on disposable income in Sweden. Maintaining flexibility to adjust benefit coverage to changing care needs is desirable on adequacy and quality grounds.
- *Move towards more forward-looking financing policies*, involving better pooling of financing across generations, broadening of financing sources beyond payroll contributions, and introducing elements of pre-funding. Japan, the Netherlands, Belgium and Luxembourg complement payroll contributions with alternative revenue sources. In Germany, retirees are required to contribute premia to social LTC funds, as well as those of working age. Innovative voluntary funding schemes based on automatic enrolment with opting-out options exist in Singapore and are being implemented in the United States.
- *Facilitate the development of financial instruments to pay*, especially, for the board and lodging cost of LTC in institutions. This cost can be twice or three times as large as

personal care and nursing costs taken together. Home ownership can provide means to help users mobilise cash to pay for such cost, for example via bonds/equity release schemes (as in Australia, Ireland), public measures to defer payments (United States, United Kingdom), and private-sector products, such as reverse-mortgage schemes and combinations of life and LTC insurance policies.

With rising costs, seeking better value for money in long-term care must be a priority

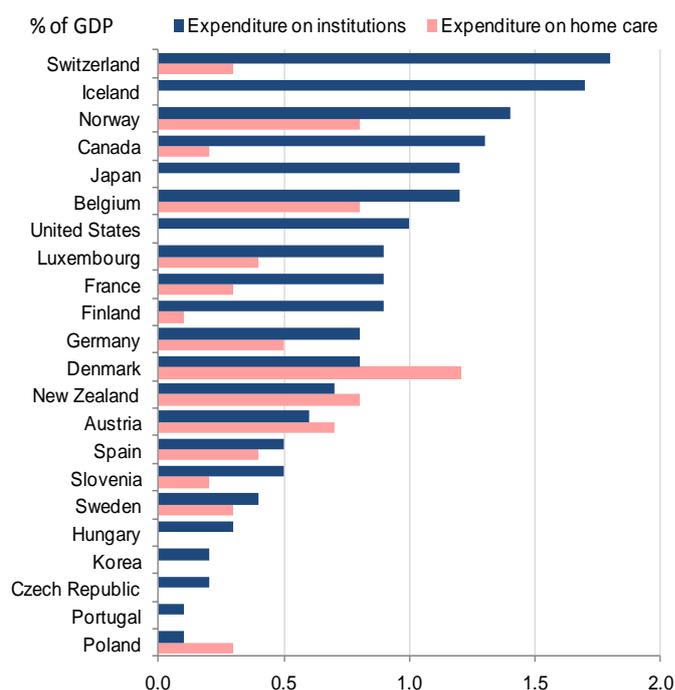
Not enough attention is being paid to achieving value for money. Possible areas for action are:

- *Encouraging home and community care* is desirable for users and spending is lower (Figure 9), but there are questions about the appropriateness or cost-effectiveness of home care for high-need users requiring round-the-clock care and supervision, and for users residing in remote areas with limited home-care support.
- *Improving productivity in long-term care.* Pay-for-performance initiatives in long-term care are limited to a few examples in the US Medicaid program. Sweden, Denmark and Finland have vouchers, enabling LTC users to choose freely among accredited competing providers. Competitive markets have the potential to drive efficiency improvements in care delivery, although evaluation on productivity impact remains sparse. Positive correlation between the introduction of ICT, job satisfaction and productivity was found in Australia and Finland.
- *Encouraging healthy ageing.* The most obvious way to reduce LTC spending would be to reduce the need for it through lifelong health promotion. In 2006, the Japanese government introduced a community-based, prevention-oriented LTC benefit targeted at low-care-needs seniors. In 2008, Germany introduced carrot-and-stick

financial incentives to sickness funds that are successful at rehabilitation and moving LTC users from institutions to lower-care settings.

- *Facilitating appropriate utilisation across health and long-term care settings and care coordination,* for example by arranging for adequate supply of services outside hospitals, changing payment systems and care pathways to steer LTC users towards appropriate settings, and setting up coordination tasks to guide users through the care process.
- *Addressing institutional efficiency,* such as by establishing good information platforms for LTC users and providers, setting guidelines to steer decision-making at local level, the use of care planning processes, and data sharing within government administrations.

Figure 9. Spending on LTC in institutions is higher than spending at home



Source: *Help Wanted?*

Did you know? Key Facts about Long-term Care in OECD countries

- The share of those aged over 80 years will increase from 4 % in 2010 to nearly 10% in 2050, with the highest share of very old people in Japan (about 17%), followed by Germany (about 15%).
- More than one in 10 adults provides care to frail people. The highest shares are found in Italy and Spain. Two-thirds of informal carers aged over 50 years are women. Most provide fewer than 10 hours of care per week and are unpaid.
- Compared to non-carers, family caregivers are 50% more likely to be homemakers, work 2 hours less per week, and have a 20% higher chance of developing mental health problems.
- Half of all LTC users are over the age of 80, and about 61% are women. 67% of LTC users receive services at home, but spending in institutional care accounts for 62% of total LTC expenditure.
- Nine in ten formal LTC workers are women. The highest density of LTC workers is found in Sweden and Norway (over 40 LTC workers per 100 people aged over 80).
- LTC workers (nurses and personal carers) account for about 1.5 % of the working-age population. The demand for LTC workers is expected to at least double by 2050.
- In 2008, public LTC expenditure accounted for 1.2% of GDP, while private LTC expenditure for another 0.3%, on average across the OECD. Public LTC expenditure is expected to at least double and possibly triple by 2050.
- Private LTC insurance accounts on average for less than 2% of total LTC spending, across OECD countries. The largest markets (in terms of population covered) are the United States and France.
- The average length of stay for dementia and Alzheimer's patients in acute care has decreased by 23 days on average across OECD, between 1994 and 2008, showing that it is possible to deliver more appropriate care at lower cost.

Further reading

Colombo, F. et al (2011), *Health Wanted? Providing and Paying for Long-Term Care*, Paris, OECD, <http://dx.doi.org/10.1787/9789264097759-en>

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