

OECD Health Policy Studies

The Economic Benefit of Promoting Healthy Ageing and Community Care



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Foreword

Growing demand for health and long-term care and the associated cost present a significant challenge for OECD countries. Populations are ageing at a rapid pace across the OECD, with the share of those 80 and above expected to double by 2050, and populations not ageing as healthy as they could. This will have large consequences for health and long-term care systems. Previous OECD work has shown that health spending as a share of GDP will reach 8.6% of GDP by 2040 as a result of change in incomes, productivity constraints, demographic changes, and the impact of new technologies. Similarly, on average, LTC spending is projected to at least double by 2050.

Investing in healthy ageing policies is therefore not only an important human prerogative but also a social and economic imperative. Improvements in health and life expectancy not only help to attenuate growing health costs but can also lead to greater savings and facilitate economic growth. Recent estimates suggest that without a significant improvement in productivity gains, GDP per capita growth would slow down by about 40% in the OECD area due to ageing.

Yet living longer in good health requires concrete actions. A healthier longevity requires policies to improve the health of people across the life course and addressing health inequalities to ensure healthier ageing for all. This report focusses on four key pillars to promote healthy ageing close to people's home: prevention, health system adaptation, home care and the continuum of care in the community. The report assesses to what extent countries are focussing on improving prevention at older ages and what interventions are cost effective, together with stressing the importance of reablement to help recover functions. It highlights that spending in prevention is low: in 2023, OECD countries spent 3% of their total spending on health on prevention. It points to slow changes in health systems to adapt their care towards older people by bringing care closer to where people live and make it more integrated. Older people have complex care needs, with one in two people aged 65 to 74 having at least two chronic conditions and 22.5% of those age 65 and above having some limitations in ADLs or IADLs. Care is often poorly co-ordinated: according to the OECD's *Patient-Reported Indicator Surveys* (PaRIS), less than half of patients aged 65 and above perceive their practice to be well-prepared to co-ordinate with long-term care providers. As a result, older people frequently experience avoidable hospital admissions, which have large financial and human resources implications. In 2022, the average costs of one inpatient stay exceeded the average total health expenditure per capita by a factor of 2.23. It also discusses the importance of housing policies to help people age in their homes and current gaps in housing adaptation and in home care services. Finally, the report highlights the potential of adult day care and community housing options which are currently underdeveloped or rely extensively on private funding.

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Table of contents

Foreword	3
Acknowledgements	4
Executive summary	8
1 Assessment and policy recommendations for healthy ageing and community care	10
Introduction	13
1.1. Populations are not ageing as healthily as they could	14
1.2. The economic benefits of healthy ageing	22
1.3. Better prevention and health system adaptation	27
1.4. Promoting ageing close to people's homes	30
References	33
Notes	39
2 Are people ageing healthily?	40
2.1. Ageing is currently not as healthy as it could be	42
2.2. Ageing unequally is driving the lower gains in life expectancy	48
2.3. What is preventing healthy longevity?	52
References	57
Notes	65
3 Promoting healthy ageing from the outset	66
3.1. Harnessing the potential of prevention and reablement at older age	68
3.2. Helping people live healthy lives	71
3.3. Promoting public health measures and preventive care	79
3.4. Identifying people at risk	83
3.5. Supporting rehabilitation and reablement after health shocks	87
References	92
4 Adapting health systems to an ageing population	104
4.1. Making health systems meet older people's needs	106
4.2. Preparing the health workforce for an ageing population	108
4.3. Increasing the supply of and access to healthcare services	111
4.4. Providing care where it is best	112
4.5. Ensuring patient-centred care	121
References	130

5 How to ensure better ageing in place?	144
5.1. Introduction	146
5.2. Being able to afford a home is the first step towards ageing in place	146
5.3. Adequate housing is crucial for age-friendly communities	151
5.4. Building age-friendly communities calls for rethinking urban and rural planning	157
5.5. Enhancing access and affordability of home care services can facilitate ageing in place	164
References	172
Notes	179
6 Promoting the continuum of care in the community	180
6.1. Adult day care can promote healthy ageing and ageing in place, but it is far from fulfilling its potential	182
6.2. Services and quality requirements for adult day care remain very heterogenous across the OECD	189
6.3. Innovative residential solutions are emerging as an option to make communities more age-friendly	197
References	205
Notes	214

FIGURES

Figure 1.1. A consistent quarter of life expectancy at age 60 is spent living with disability	15
Figure 1.2. Health literacy is lower for older people	16
Figure 1.3. Only a quarter of older people met physical activity guidelines in 2019 (or nearest available year)	17
Figure 1.4. More people aged 65-74 are experiencing chronic conditions than a decade ago	18
Figure 1.5. Old-age disability is declining over cohorts, but midlife disability remains unchanged	19
Figure 1.6. Fewer than 1 in 5 older people reside in homes that support mobility and independence	20
Figure 1.7. Are there limitations in the maximum number of hours funded for personal care and care for household chores?	21
Figure 1.8. Less than 1% of the population aged over 65 years uses day-care in three-quarters of 16 countries surveyed	22
Figure 1.9. A 10% increase in prevention can reduce health spending on chronic diseases by 0.9% on average	24
Figure 1.10. Many congestive heart failure hospital admissions in adults can be avoided	25
Figure 1.11. A 1% increase in spending on long-term care at home can reduce overall long-term care spending by 0.5% on average	26
Figure 2.1. The growth in life expectancy has slowed in the mid-2010s, with a temporary drop during the pandemic	42
Figure 2.2. The gap between life expectancy and healthy life expectancy is growing	44
Figure 2.3. Improvement in activity limitations in old age varies across countries	46
Figure 2.4. Generational health gains have mainly benefited older people rather than midlife adults	48
Figure 2.5. The narrowing gender gap masks women's lesser gains in life expectancy	49
Figure 2.6. Despite the progress, women are still more likely to experience activity limitations	50
Figure 2.7. People with a lower socio-economic status are expected to have lower life expectancy	51
Figure 2.8. Most OECD countries do not meet the recommended vaccination rates for older people	53
Figure 2.9. One in two older people have experienced polypharmacy consistently over the past decade	54
Figure 2.10. Dementia has had a considerable negative impact on life expectancy	55
Figure 3.1. Spending on prevention remains low across OECD countries	70
Figure 3.2. Four policy areas of prevention and reablement to improve Healthy Ageing	71
Figure 3.3. Pharmacists can now perform seasonal flu vaccinations in 18 countries (by year of introduction)	81
Figure 3.4. Rehabilitation and reablement involves a multitude of different professions	89
Figure 4.1. Four areas of health system adaptation for an ageing population	107
Figure 4.2. Status of geriatrics as specialty across OECD countries	108
Figure 4.3. The Japanese Community-based Integrated Care System Model	129
Figure 5.1. Housing cost overburden rates have been rising for older people in latest years in EU countries	147

Figure 5.2. Most responding countries have programmes to make housing more affordable for older people	148
Figure 5.3. Over 80% of older people live in housing lacking mobility and independence support	152
Figure 5.4. The type of housing adaptations whose cost can be covered by public funds varies across countries	154
Figure 5.5. National funds are the most common source of funding for housing adaptations, but out-of-pocket contributions seem significant	155
Figure 5.6. Age-friendly features are available in the majority of countries	159
Figure 5.7. One in ten older people reside in a neighbourhood of low quality in Europe	160
Figure 5.8. Green spaces and hospitals are scarcely available within walking distance	161
Figure 5.9. 0.5 hospitals are accessible within a 15-minute walk across 30 OECD and EU countries	162
Figure 5.10. Formal care systems meet less than 30% of long-term care needs across the OECD	165
Figure 5.11. Most countries do not actively enforce policies to reduce or monitor a waiting list for services	166
Figure 5.12. Personal care and support with household activities are the most commonly funded services	168
Figure 5.13. The public share of costs covered tends to be higher at home	170
Figure 5.14. Public financial support for informal home care is limited	171
Figure 6.1. Day care represents a small fraction of overall long-term care expenditures	186
Figure 6.2. Many countries have few healthcare staff in adult day care centres	188
Figure 6.3. More than 40% of countries have no requirements or only registration for adult day care	193
Figure 6.4. Quality regulations focus on the environment and staff qualifications	195
Figure 6.5. Quality standards are the most prevalent mechanism while audits and public reporting exist less often	196
Figure 6.6. Evaluation of adult day care is often not very user-centric	197
Figure 6.7. Help with ADLs and IADLs are the most common services provided in assisted living facilities	202
Figure 6.8. Public funds are a common of funding for assisted living facilities, but out-of-pocket contributions are often needed	203

TABLES

Table 1.1. This report's framework for healthy ageing close to people's home	14
Table 3.1. Several structured, evidence-based physical exercise programmes are now available	74
Table 3.2. Duration, referral pathways and services offered in rehabilitation and reablement programmes across selected OECD countries	88
Table 4.1. Overview of key characteristics of hospital-at-home programmes across OECD countries	114
Table 4.2. Overview of care pathways for older people across several OECD countries	122
Table 4.3. Integration of different health sectors in integrated care programmes	125
Table 6.1. Adult day care is fully or partially financed from public resources	187
Table 6.2. Services offered in adult day care are heterogeneous but tend to focus on basic needs	192
Table 6.3. Co-housing and intergenerational housing are available in one-third of countries	197

Executive summary

While healthy ageing holds the potential to lower projected health and long-term care expenses, countries are not fully reaping its potential. Life expectancy increased between 2001 and 2011 across the OECD, but improvements have slowed down over the past decade: Over the period of 2012 to 2023, life expectancy at age 60 increased by 1.0 year compared to 1.7 years between 2001 and 2011. Not all of these additional years gained are lived in good health. The gap between life expectancy and healthy life expectancy has widened slightly from 5.2 years in 2000 to 5.7 years in 2021. Trends in limitations in (instrumental) activities of daily living for older people confirm that people are not necessarily living in better health in more recent years: younger cohorts show stable trends in activity limitations compared with older cohorts where the share of people with limitations was declining.

More emphasis on prevention and community care improves economic returns to healthy behaviours. Unhealthy behaviours can increase the likelihood of poor health in older adults. Physical inactivity has a strong impact on obesity, falls and cognitive decline which can be detrimental in older ages. Just under three-quarters (74%) of people aged 65 and above across the OECD do not meet the recommended minimum level of physical activity per week. Strategic investment in health and long-term care spending can help reverse these trends. Investment in prevention helps people to age more healthily, for example by delaying, reducing, or outright preventing chronic diseases. OECD estimates show that a 10%-increase in spending on prevention is associated with a decrease in the share of people with chronic conditions by 0.9% after a period of five years. Similarly, countries could spend more on helping people to age independently at home and delay a transfer to long-term care facility, for example through housing adaptation and a greater supply of home-based services. Home-based care is generally less expensive for people with low and moderate needs than care in facilities and supporting them to age at home not only meets the preferences of older people but is also cost-effective. OECD calculations show that an increase in the ratio of spending on long-term care at home over long-term care in facilities by 10% can lead to a decrease in the overall long-term care spending by 4.9%.

A lack of adapted homes, easy access and affordable home and community care services limits the ability for older people to age in the community. Housing adaptation can support people's autonomy at home by reducing the probability of falls and of needing help with activities of daily living and by delaying admissions to nursing homes. Yet only 20% of older people have introduced adaptations to their homes and bigger modifications such as ramps and solutions for stairs are even less common, with only 5% having them. Across OECD countries, 60% of countries reported that public transportation is easy to access for people with mobility limitations and affordable for older people. Older people do not always benefit from sufficient hours of home care services for independent living: more than 40% of countries have limitations in the number of hours provided for home care and one-third of countries do not provide public funding for help with some important instrumental activities of daily living such as support for grocery shopping and attending appointments. In addition, there are gaps in the generosity of care especially for people with severe needs: in 16 countries, out-of-pocket costs exceed 50% of median income while they are above median income itself in seven countries. While community care options have shown a range of benefits in terms of health, quality of life and loneliness, their supply is limited. The number of adult day-care users is below 1% of the older population and less than one-fourth of countries make health screening

and rehabilitation mandatory components of day care. Shared living arrangements such as co-housing or co-operatives are not common and were reported in about one-third of OECD countries, a similar proportion to intergenerational housing options.

Such shortcomings call for greater policy priority and measures to incentivise healthy ageing close to older people's homes.

First, a stronger focus on **improving prevention and reablement and identifying older people at risk of health deterioration** is key to promoting healthy ageing. While early intervention at younger ages is key to building healthy lives throughout the life course, prevention and improvements in healthy lifestyles in older ages can still materialise in significant health gains. Health literacy campaigns equip people with the skills to make healthy choices. Physical activity is key to healthy ageing, but because adherence remains challenging, group exercise programmes offer the benefit of improving it while helping to fight isolation. Early identification of people is key to allow for early and targeted interventions. An important number of countries (16), such as Australia, Denmark, Mexico, Norway and Switzerland, have introduced dedicated home visit schemes which have demonstrated effectiveness in reducing hospital admissions and delaying entrance to a long-term care facility. More specific screening for conditions such as dehydration, inappropriate medication, and the risk of falls seems to be beneficial, as undertaken in Finland, Hungary, the Netherlands, Portugal and Sweden. Finally, reablement as offered in Australia, Denmark, Japan, New Zealand and the United States helps people maintain or recover their functions, with some evidence that it is cost-effective and linked to a reduction in the use of home care services in Denmark.

Providing care closer to people's homes by a workforce with greater expertise on older people's needs and in a **more integrated** manner will be paramount to further promote healthier ageing. Addressing shortages of geriatricians and enhancing primary care centres with different professionals can help better address complex needs, as in Canada or France. Promoting nurse-led outreach teams, especially with advanced nurse practitioners to offer assessments and simple interventions can reduce the risk of emergency admissions, as seen in Australia, Canada, Denmark and Finland. Similarly, *hospitals at home* have proved effective in replacing or shortening inpatient stays and are in place in at least 22 OECD countries, such as in Chile, England, France and Spain. The introduction of specific care pathways for older people or integrated care programmes, such as in Canada (Québec), and in Japan with multidisciplinary teams, and changing payment structures appear to have good results in terms of quality of life of older people.

There is room **to expand the range of services and affordability of long-term care services at home and in the community, while also ensuring adapted homes and age-friendly environments**. To ensure that older people can remain at home, changes in long-term care systems could be considered, including lifting or loosening restrictions on hours of home care, considering a more comprehensive view on the type of limitations people need help with in order to live independently, and looking into 24-hours care options, as in Finland, especially for people without informal care support. The generosity of home care system currently leaves a high share of people in many OECD countries at risk of poverty and aligning benefits and services to enhance the affordability of home care for people with severe needs would be important as done in Nordic countries, Luxembourg and Japan. More funding and support to adapt the housing environment to make age-friendly modifications which reduce the risk of falls, such as is Norway, can significantly impact autonomy of older people and impact long-term care needs. A broader variety of long-term care models are also essential for healthy ageing, including promoting high-quality adult day care as in Japan and shared-living or intergenerational options, as in the Netherlands.

1

Assessment and policy recommendations for healthy ageing and community care

This introductory chapter provides an overview of the entire publication, drawing on the analyses carried out in the four subsequent chapters. It documents the state of healthy ageing and community care across OECD countries and quantifies the benefits of further investment in preventive policies and community care. The chapter flags effective preventive policies as well as policies to adapt the health system better to population ageing. The chapter concludes with policy options to improve long-term care at home and in the community.

Key findings

People are ageing less healthily than they could

- **The trend of population ageing across the OECD is set to persist in the coming decades.** As fertility rates remain below replacement levels and life expectancy continues to rise, the proportion of older adults in the population is projected to grow steadily. By 2060, there will be more than 50 older people aged 65 and over for every 100 working-age people (20-64) in most OECD countries.
- **Gains in life expectancy are slowing down and not every additional year lived is a year lived in full health.** Life expectancy at age 60 increased by 1.0 year between 2012 and 2023 while it increased by 1.7 years between 2001 and 2011. In 2021, the gap between life expectancy and healthy life expectancy at age 60 stood at 5.7 years, meaning that 25% of the last years of people's lives are characterised by poor health and limitations. This gap has increased by 0.5 years over the past two decades from 5.2 years in 2000. The rate of people aged 65 to 74 with chronic conditions has increased from 44% to 50% between 2011 and 2021 across the OECD.
- **Part of the reasons behind this trend is that health systems are not well adapted to older people.** Older people have complex health needs. But they often do not receive the care they need, and in the setting that is best for them. Many are not sufficiently adopting healthy lifestyles. For example, only one in four people aged 65 and above meets the physical activity recommendations of at least 150 minutes of moderate-intensity physical activity per week. A lack of prevention and primary care, poor co-ordination and integration with other providers can lead to worsening health among a certain segment of the population. Data from the OECD's *Patient-Reported Indicator Surveys (PaRIS)* shows that only 47% of patients aged 65 and above perceive their primary care practice as well-prepared to co-ordinate with long-term care providers.
- **At the same time, home and community care provision is not meeting current needs.** Currently, 40% of 25 OECD countries have ceilings set on the hours of care, while care for instrumental activities for daily living is not covered in 20% of the surveyed countries and only 30% of OECD countries provide 24 hours of long-term care help at home. Lack of adequate and affordable home care services can promote an overreliance on informal or family caregivers. In many countries, options for community care are limited: the number of adult day-care users is below 1% of the population aged 65 or above. Shared living arrangements such as co-housing or co-operatives are reported in about one-third of OECD countries.

Besides the health benefits, there is a strong economic imperative to better supporting healthy ageing

- **Insufficient healthy ageing drives health and long-term care expenditures amid financial scarcity and workforce shortages.** Spending on health is expected to grow by an average annual rate of at least 2.6% per year over the period from 2019-2040, and long-term care expenditures are projected to nearly double by 2050. In parallel, the working age populations in OECD countries is projected to shrink by 8% in the OECD area by 2060, and by more than 30% in more than a quarter of OECD countries. This is projected to reduce GDP per capita growth in the OECD area by almost two-thirds from 1.1% per year in the 2010s to 0.4% per year on average over the period 2024-2060. Lower GDP growth rates make it more difficult for countries to meet rising demand for health and long-term care, and reductions in the working-age population reduce the pool from which to recruit health and long-term care sector, adding to already existing scarcities of a health and long-term care workforce that is ageing. With other

sectors forecasted to face shortages, attracting further workers to the health and long-term care sector will be even more challenging.

- **Promoting healthy ageing would help freeing up resources.** Poor health among older people drives up healthcare consumption due to more frequent outpatient consultations, avoidable hospitalisations and hospital readmissions. Better prevention, such as policies to improve healthy lifestyles and early detection of diseases helps curb the burden of chronic diseases. Estimations by the OECD find that on average, a 10%-increase in spending on prevention leads to a reduction in the number of chronic diseases that would translate into reductions in healthcare spending by 0.9% within a period of five years. Similarly, OECD calculations suggest that an increase in spending on long-term care at home could lead to a decrease in the overall long-term care spending by around 0.5%.
- **Further evidence from a broader set of countries is needed to close evidence gaps.** A review of the evidence from policies in OECD countries identified some main policies that show the greatest potential for promoting healthy ageing, discussed below. However, significant gaps in the evidence based on the impact of certain policies remain. Furthermore, the degree of policy implementation of promising policies remains sometimes limited to a handful of countries or it is sometimes in initial stages. Policy emphasis and resources seem to be placed more on providing care services and reacting to worsening care needs than on preventing or slowing disability or anticipating proactively the evolution of older people's care needs.

Three main policy options around better prevention and health system adaptation promise to reduce the impact of ageing on health expenditures

- **Identify people at risk.** While early intervention is desirable, prevention can still be effective in old age, and older people might benefit more from targeted interventions. Home visits can improve health outcomes, quality of life, reduce hospitalisations, and delay admissions to long-term care facilities. For example, preventive home visits in Norway were found to lead to a reduction in admissions to long-term care facilities by 7%, in hospital admissions among those aged 80 and above by the same rate, in the average number of hospital days by 11%, and in mortality of those aged 80 and above by 4%.
- **Offer care closer to people.** Hospital stays are costly, remove people from their familiar surroundings, and can have negative side effects on patients' health. To avoid this, countries are successfully shifting the delivery of care from hospitals to home and community settings. Hospitals-at-home shorten or entirely replace hospital stays. They result in similar or better health outcomes and evidence from several OECD countries, such as England (United Kingdom) and Israel, found that they are 10-50% less costly than the in-patient stay.
- **Foster co-ordination and integration of providers.** Care pathways and integrated care programmes harmonise the delivery of care and formalise team structures. Across the OECD, 20 countries have already introduced integrated care programmes for an older population, with another three planning to do so. In England, increases in emergency admissions were up to 70% lower in integrated care programmes compared to the control group.

Adequate housing, age-friendly environments and a continuum of care are effective at supporting people ageing in their community

- **Adapt houses and communities to an ageing population.** The current housing stock is not always well-adapted for older people and home modifications are associated with lower likelihood of being admitted to nursing homes and lower need of help with activities of daily living. However, the evidence reviewed also showed a need to simplify the process for housing adaptation and ensuring that it is sufficiently generous to cover modifications. In several

countries like the Netherlands, Sweden and Norway municipalities provide advice on housing adaptation. There are also gaps in accessibility, with urban infrastructure often not designed with an age-friendly perspective to further promote independence for older adults. An offer of activities to enhance social participation is also effective: In Japan, municipalities have implemented salons for older people on educational programmes and social activities, which has halved the incidence in long-term care needs.

- **Make home care services more comprehensive.** Just under 30% of people report having long-term care needs and have access to formal services due to waiting times, complex eligibility requirements, high out-of-pocket costs and countries not always providing enough hours and services for home care in line with older people need. Personal budgets as introduced in England and the Netherlands could provide flexibility to users in deciding the home care services that they need or countries could expand the service offer to better meet help with instrumental activities of daily and the number of hours available such as in Australia and Spain, respectively. Digital technologies as implemented in Nordic countries and Japan can help contain the costs of monitoring and free workers time for providing other type of care to older people while also seeking options to improve the affordability for users.
- **Improve access to adult day care and innovative community living options.** Day care services for older adults have substantial benefits with reduced social isolation, improvement in health outcomes and a reduction in health costs and delay nursing home admission. While looking for options to expand access, improving the offer of health services in adult day care, such as in Japan, where health screening is included, could have a stronger impact on health outcomes. Beyond adult day care, some countries are promoting innovative housing models for older people in order to reduce social isolation and delay the severity of health and long-term care needs. France is considering options for co-operative housing and intergenerational housing whereby people could benefit from the allowance for long-term care and there is also a special allowance for inclusive housing, the so-called “allowance for shared living” (*aide à la vie partagée*). In the United States, Green House care facilities include Medicaid and Medicare residents and offer small home-like environment with higher quality of care, resulting in lower hospitalisation.

Introduction

Population ageing is one significant demographic trend necessitating changes in social and health systems throughout the OECD. Between 1980 and 2020, the ratio of older people aged 65 or over to younger people of working age (ages 20-64) increased from 20 to 30 for every 100, reflecting sustained low fertility rates and rising life expectancy (OECD, 2024^[1]). This structural change has already contributed to an annual increase of 2.6% in per capita spending on healthcare across the OECD before the pandemic (OECD, 2024^[1]). Projections indicate that the old-age-to-working-age ratio will climb up to 45% or more for most OECD countries through 2060, with Japan and Korea exceeding 80% (OECD, 2024^[1]). In light of these trends, maintaining health in old age has become increasingly important due to both individual and social implications. Successful policies that support healthy ageing can improve health outcomes, reduce health costs and can also delay the need for longer-term care for older people. OECD countries have recognised the need to adapt their health, social and long-term care systems to accommodate an ageing population. Out of 29 countries that participated in the *OECD Questionnaire on Healthy Ageing and Community Care*, 25 had a healthy-ageing-strategy in place.

This chapter provides an overview of the policies that countries are undertaking in terms of healthy ageing, concentrating on healthcare and long-term care for those 65 and above. The focus is to document as much

as possible whether interventions are cost-effective interventions and document innovative approaches. With such an economic angle in mind, the report drew on national healthy ageing plans and strategies, as well as research on long-term care, to identify key principles for the four priorities, which can help promote healthy ageing in place (Table 1.1). The four priorities and relevant policies are discussed in detail in each of the analytical chapters. The current chapter is a summary of the key findings of these analytical chapters, focussing on a selection of promising policy options.

Sections of this chapter are organised as follows. Section 1.1 discusses trends in healthy ageing, followed by Section 1.2, which presents how healthy ageing can contribute to reducing health and long-term care spending and better cost-effectiveness by outright preventing chronic diseases, rearranging the delivery of care, and promoting ageing at home. Section 1.3 focusses on better prevention and health system adaptations to prepare for an ageing population and to shift the delivery of care from hospitals to outpatient and community care. Long-term care at home that is directed towards housing adaptations, home care services that promote longer and more independent living at home, are discussed in Section 1.4, together with long-term care in communities and day care.

Table 1.1. This report's framework for healthy ageing close to people's home

Prevents health deterioration and emphasises recovering functioning	Has a health system adapted to the needs of older people and integrated	Ensures adequate housing and comprehensive home care	Promotes a continuum of care in the community
Promotes healthy lifestyles: People are empowered to make healthy choices at older ages thanks to investments in health and adequate support from the healthcare system	Has workers with the right skills: People have wider access to workers with specialised knowledge in geriatric care in the community	Establishes affordable and adequate housing: People have housing which accommodates the limitations of older age and has comprehensive policies for affordable rental options	Improves access to day care: People have sufficient availability of adult day care, close to their home, with adequate transportation options and opening times
Identifies people at risk: People can have access to screening for specific risks in old age, in particular falls, and benefit from referral to lifestyle services	Delivers care closer to older people: People have healthcare closer to their homes and avoid extended hospital stays thanks to innovations in care delivery	Stimulates age-friendly environments: People live in an environment that supports their autonomy as they can easily access the services they need	Enhances the service offer and quality of adult day care services: People have adult day-care centres with staff offering health services to improve or maintain their physical and cognitive health, and of high quality
Invests in rehabilitation and reablement: People benefit from timely access to rehabilitation and reablement services to maintain or recover their functional capacity	Integrates across health and long-term care: People have access to co-ordinated care for their health and long-term care needs	Delivers comprehensive and affordable home care services: People have sufficient variety and hours of home care services, which are affordable	Supports innovative communal living options: People who no longer wish to stay at home have home-like housing options with services and do not feel lonely

1.1. Populations are not ageing as healthily as they could

1.1.1. Gains in life expectancy do not fully translate into healthy life expectancy

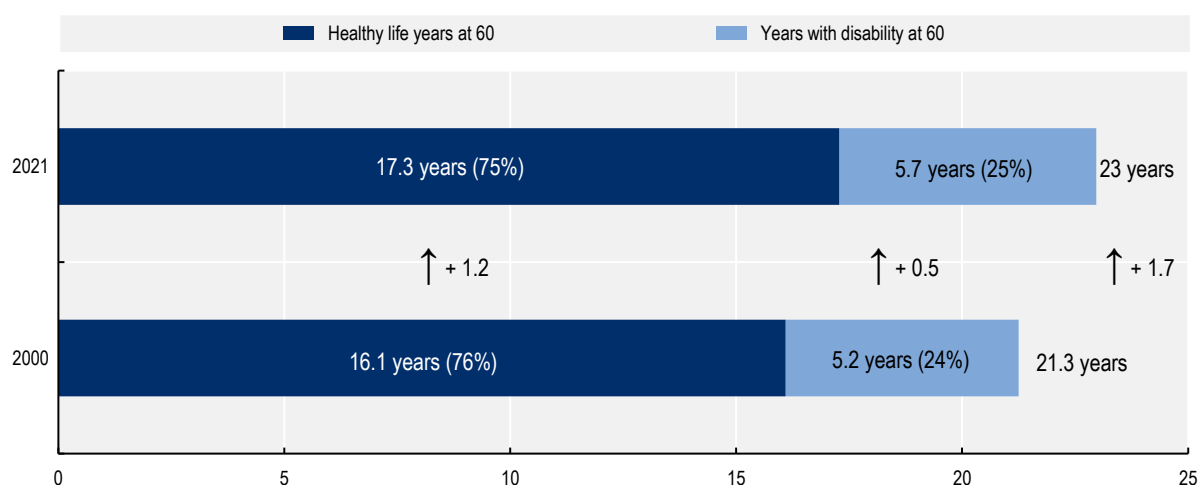
Over the past decades, OECD countries have recorded impressive gains in the number of years people can be expected to live, but gains in life expectancy have slowed down. Life expectancy at birth increased from 74.4 to 81.1 between 1990 and 2023 due to advances in health and living standards and this has led to large increases in the share of the population aged 65 and above. While life expectancy has increased steeply over the period from 1990 to 2011, the rate of increase has slowed down since 2011: life expectancy at age 60 increased by 1 year between 2012 and 2023,¹ while it increased by 1.7 years between 2001 and 2011 (see Chapter 2). While there was a strong decline during and recovery after the

COVID-19 pandemic, the reduction in growth in life expectancy started already prior to the pandemic. The reason for the stalling is that many OECD countries are seeing slower reductions in deaths from circulatory diseases and a rise in deaths from dementia and respiratory diseases among older people (Raleigh, 2019^[2]). Widening inequalities in life expectancy by socio-economic status have also contributed in some countries to halting improvements in life expectancy.

Not every additional year of life is spent in good health. Countries have already achieved considerable gains in healthy ageing. Out of the 1.7 years in increase in life expectancy at age 60 from 2000 to 2021, the majority of 75% was an increase in disability-free “healthy life years”, although another 25% remains in years with disability (Figure 1.1). However, trends do not suggest that countries are closing the difference between healthy life expectancy and life expectancy. From 2000 to 2021, the difference between life expectancy and healthy life expectancy at age 60 has increased slightly from 5.2 years to 5.7 years, on average. Similarly, less than half of the population aged 65 and above rate their own health as good or very good (OECD, 2023^[3]), all of which only highlight the potential for further gains in healthy ageing.

Figure 1.1. A consistent quarter of life expectancy at age 60 is spent living with disability

Share of Healthy and Disabled Life Years at Age 60



Note: Estimates are based on 38 OECD countries.

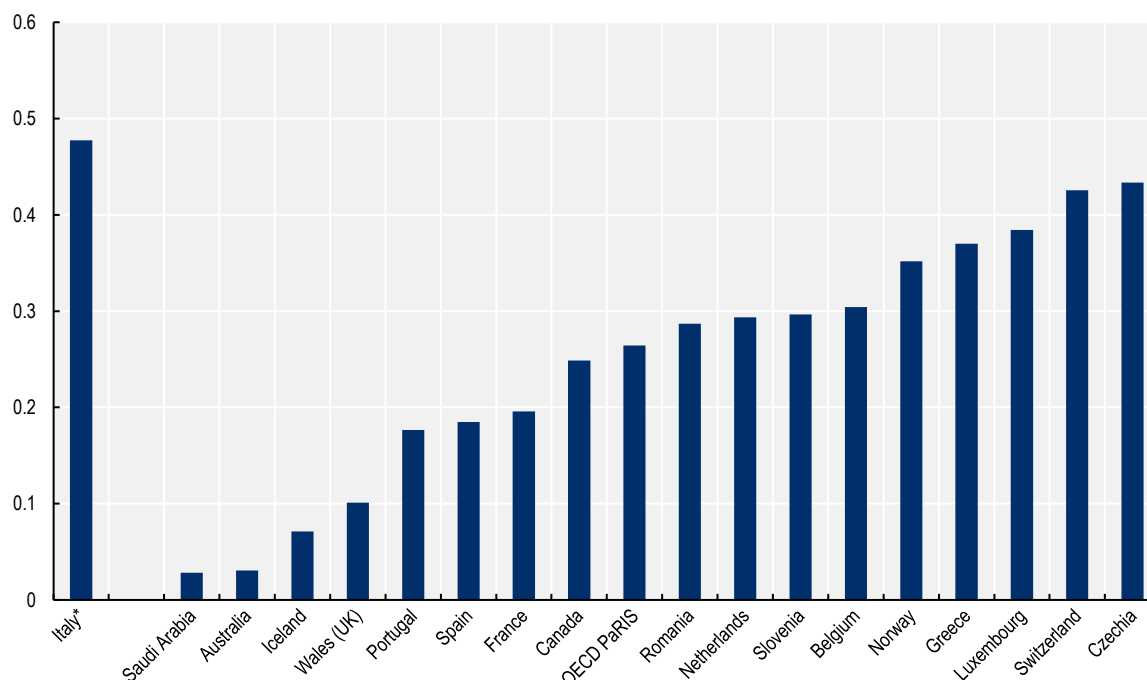
Source: WHO Global Health Observatory (2024^[4]), “Healthy life expectancy (HALE) at 60 (years)”, <https://www.who.int/data/gho/data/indicators/indicator-details/GHO/gho-ghe-hale-healthy-life-expectancy-at-age-60>.

1.1.2. Health and lifestyle indicators show room for further progress

Older people’s limited health literacy presents a barrier to the adoption of healthy lifestyles and effective management of chronic conditions. Health literacy enables people to make healthy lifestyle choices and to manage complex chronic diseases better concurrently. However, data from the OECD’s *Patient-Reported Indicator Surveys* (PaRIS) shows that people aged 75 and above have lower levels of health literacy than people aged 45-55 (OECD, 2025^[5]) (Figure 1.2). Similarly, levels of digital health literacy are also lower among older people than younger people, indicating that the use of digital tools and online sources for health information is more difficult for older people (OECD, 2025^[5]).

Figure 1.2. Health literacy is lower for older people

Comparison of the average of a 5-point health literacy index across education and age groups. Difference in the 5-point health literacy index across age groups over 75 and 45-54



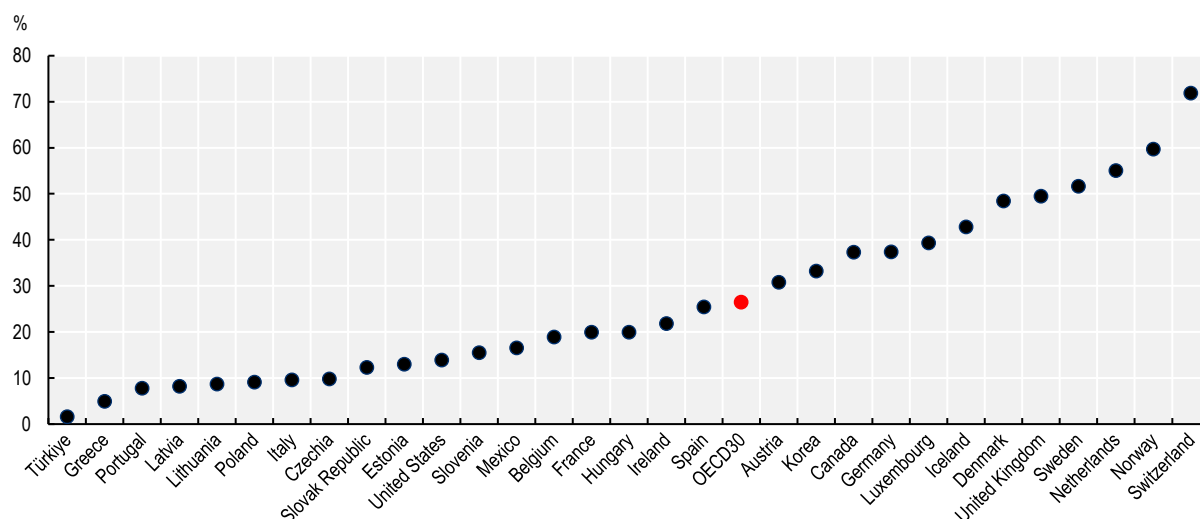
Note: *Data for Italy refer to patients enrolled in outpatient settings for specialist visits in selected regions. **United States sample only includes people aged 65 years or older. Results are age and sex-standardised across countries. Gaps between education groups are statistically significant ($p < 0.05$) for Belgium, Canada, Czechia, Greece, Italy, Luxembourg, the Netherlands, Norway, Slovenia and Switzerland.

Source: OECD PaRIS 2024 Database, <https://stat.link/qdehr0>.

Many older people do not display a lifestyle that is conducive to ageing healthily. Physical activity has consistently been identified as a successful strategy to reduce cognitive decline and falls. It can reduce the number of people aged 65 and above who experience at least one fall by 15%, and the incidence of falls by 38% (Sherrington et al., 2019^[6]). However, in 2019, just over one in four people aged 65 and above met the WHO recommendations on at least 150 minutes of moderate-intensity exercise per week. Levels of physical activity varied greatly across OECD countries. In eight countries of the OECD (Czechia, Greece, Italy, Latvia, Lithuania, Greece, Portugal and Türkiye), less than one in ten people aged 65 and above met the recommendations, compared to one in two in the Netherlands, Norway, Sweden and Switzerland (Figure 1.3). Similarly, in Australia less than 11% of the population aged 65 and above performed less than 30 minutes of physical activity in at least 5 days per week (AIWH, 2024^[7]).

Figure 1.3. Only a quarter of older people met physical activity guidelines in 2019 (or nearest available year)

Share of adults 65 and over meeting WHO physical activity recommendations

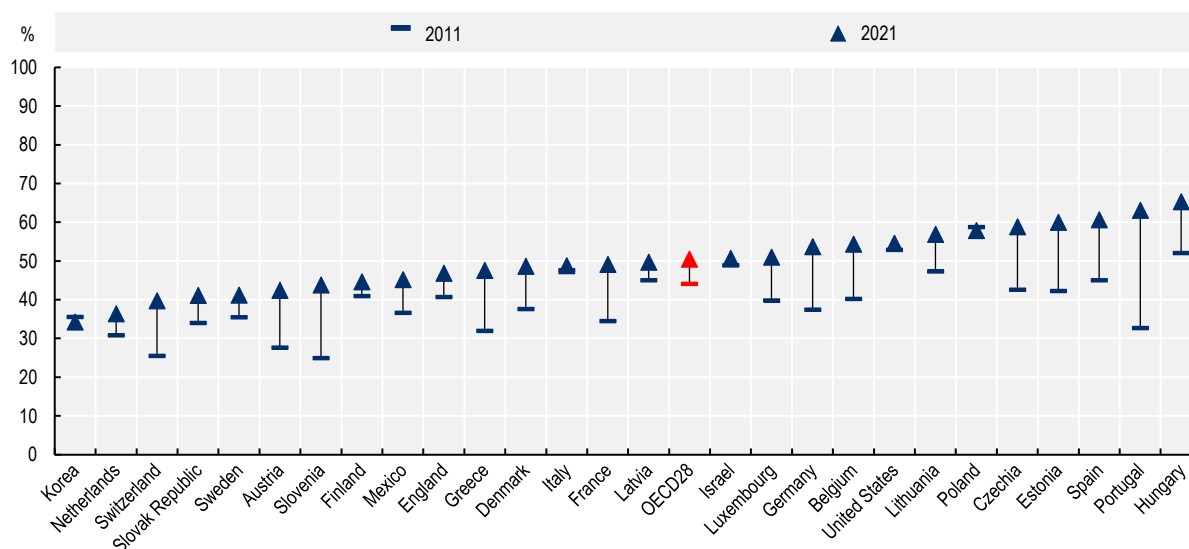


Source: Canada: 2018 Canadian Community Health Survey (CCHS), European OECD countries: Eurostat (online data code: hlth_ehis_pe2e); Korea: Seo et al. (2022^[8]) based on the Korean National Health and Nutrition Examination Survey; Mexico: 2019 Encuesta Nacional sobre Confianza del Consumidor, Módulo de Práctica Deportiva y Ejercicio Físico (MOPRADEF); Switzerland: 2017 BFS – Schweizerische Gesundheitsbefragung [Swiss Health Survey]; United Kingdom: May 2018-May 2019 Active Lives Survey; United States: 2020 National Health Interview Survey.

Older people have greater, more complex, and different needs than younger people. In 2021, one in two people aged 65 to 74 had at least two chronic conditions (Figure 1.4), representing an increase of almost 6 percentage points (p.p.) over the past 10 years. Rates are heterogeneous across OECD countries, ranging from 34% in Korea to 65% in Hungary in 2021. Rates have increased across most OECD countries. Only Korea and Poland show a slight decline in the rate of people with at least two chronic conditions aged 65-74 over that time period. Some countries have recorded only small increases, such as England, the Netherlands and Finland, while increases have been the largest in Portugal. People with chronic conditions often encounter additional limitations and thus require care from different providers within the health sector, along with extra support from the social and long-term care sectors. This makes them vulnerable to health system deficiencies, such as a lack of primary care and care fragmentation (OECD, 2023^[9]). Living with a chronic disease can negatively affect people's well-being, physical and mental health and social functioning, and drive up health expenditures (OECD, 2025^[5]).

Figure 1.4. More people aged 65-74 are experiencing chronic conditions than a decade ago

Share of people aged 65-74 with at least two chronic conditions, 2011 vs. 2021 (or nearest)



Note: First observations include 2010 for England, Korea, and the United States; 2012 for Mexico; 2013 for Israel and Luxembourg; 2015 for Greece; and 2019 for Finland, Latvia, Lithuania, and the Slovak Republic. Last observations include 2018 for England and Mexico, and 2020 for Korea and the United States. Japan has a single wave and, therefore, is not displayed in the figure.

Source: Survey of Health, Ageing and Retirement in Europe (European Union and Israel), Health and Retirement Study (United States), English Longitudinal Study of Ageing (England), Korean Longitudinal Study of Aging (Korea), Mexican Health and Aging Study (Mexico).

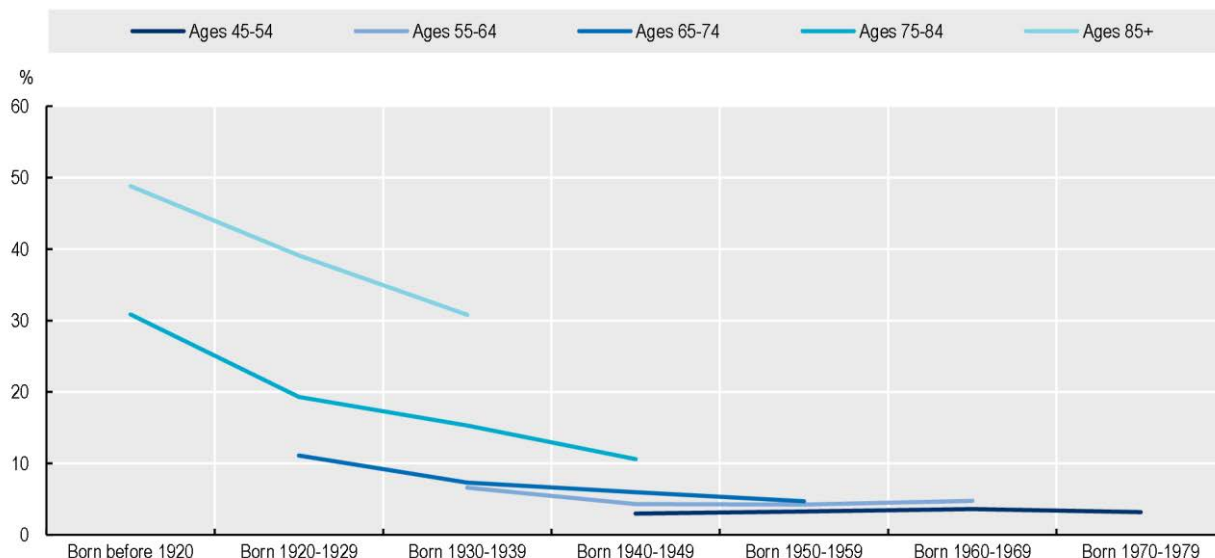
Insufficient management and support for older people with complex needs can further exacerbate these issues and negatively affect healthy ageing. Responses from the OECD's *Patient-Reported Indicator Surveys* (PaRIS) show that only 47% of patients aged 65 and above perceive their Primary Care practice as well-prepared to co-ordinate with long-term care providers (OECD, 2025^[5]).

Functional disability has not improved across generations

Improvements in old-age disability have not been equally distributed across generations in OECD countries. Functional limitations in old age have declined over the past two decades (Figure 1.5) but this is primarily focussed on the older population. Substantial gains are observed among these middle-old (ages 75-84) and old-old (ages 85+), with marked declines in limitation rates for the 85+ groups across later-born cohorts. In contrast, among people aged 45 to 74, the prevalence of limitations shows little evidence of generational improvements. This suggests that, despite advances in healthcare and living conditions, young-old (ages 65-74) and midlife functional health have not experienced the same progress seen in older age groups. Some countries have seen an increase in limitations among younger cohorts, including the United States, Canada, and the United Kingdom (Beller and Epping, 2021^[10]; Zajacova and Montez, 2018^[11]). In addition, across the OECD on average, there has been an increase in the share of people in the younger cohorts reporting limitations in instrumental activities of daily living over time (Chapter 2).

Figure 1.5. Old-age disability is declining over cohorts, but midlife disability remains unchanged

Share of people aged 45 or over having any functional disability by birth cohort, 1999-2021



Note: Functional disability includes activities of daily living and instrumental activities of daily living. The estimates are weighted estimates pooled across available datasets between 1999 and 2021.

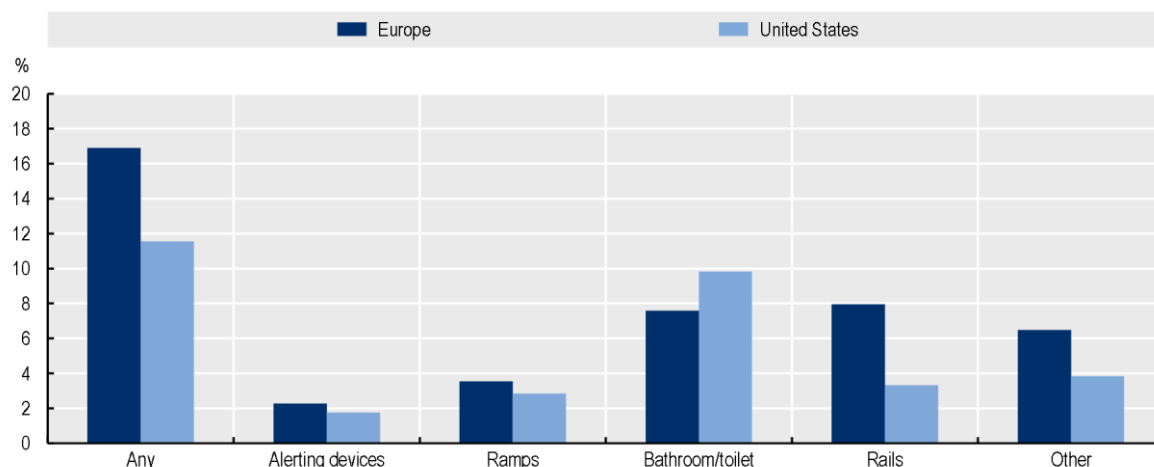
Source: Survey of Health, Ageing and Retirement in Europe (European Union and Israel), Health and Retirement Study (United States), English Longitudinal Study of Ageing (England), Korean Longitudinal Study of Aging (Korea), Mexican Health and Aging Study (Mexico), Japanese Aging and Health Dynamics (Japan).

1.1.3. Current living environments are not sufficiently age-friendly

The current housing stock is not always well-adapted for older people to stay at home as they age and public funding for housing adaptation is often insufficient. Data from the United States and Europe highlights that less than 20% of homes had the most basic features to be considered ageing-ready (Figure 1.6). As people age, moving around the house, taking the stairs and living in a place that is not adapted to people with physical limitations can lead to fear of falling and increased risk of falls and injuries (Chen et al., 2023^[12]; Braubach, 2011^[13]). Across the OECD, just over half of the countries provide public subsidies while two countries have funds available as part of the insurance, four countries offer tax credits, and others offer loans or grant to providers. Still, housing adaptation remains costly as the generosity of these types of support varies across countries and means-testing is common. Out-of-pocket are required in one-third of countries to cover the cost of housing adaptations. In half of the countries for which information is available, people who need to perform housing adaptations will need to contract out the adaptation work, before receiving partial or total reimbursement of expenses.

Figure 1.6. Fewer than 1 in 5 older people reside in homes that support mobility and independence

Share of people living at home with specific features for older people or people with physical impairments



Note: Alerting devices include button alarms, detectors, a call system, or other systems to get help when needed. Ramps include street-level entrances, and bathroom and toilet modifications include grab bars or shower seats. Data for Europe and the United States is based on SHARE Wave 9 (2021-2022) and HRS 2022, respectively. The SHARE data includes 28 European countries.

Source: Survey of Health, Ageing and Retirement in Europe (European Union and Israel) and Health and Retirement Study (United States).

Housing affordability is decreasing, calling for better support to ensure affordable housing for older people. While older people are mostly homeowners, the housing market is becoming increasingly unaffordable and more recent generations of older adults might be less likely to be homeowners. Between 2020 and 2022, the housing cost overburden rate² has been growing considerably for people aged 65 or older, moving from 7.8 in 2020 to 9.7 in 2022 on average in the European Union (EU). Evidence from Australia, the United States and European countries shows that people in older ages might also face difficulties in paying rent as the incomes of older people (aged 65 or older) tend to be lower than that of the general population (OECD, 2023^[14]). Research has highlighted growing housing insecurity and rent unaffordability, together with lower quality of housing among older people.

Essential services, green spaces and social activities are not always readily accessible to older people either walking or with public transport. Being able to reach the main services and social activities that a person might need on a daily or weekly basis within walking distance makes those activities and services more accessible and improves the chances that people remain in their own homes. In cities, on average, a person can reach 16 food shops and 34 restaurants by walking 15 minutes in some of the major cities across 30 OECD and EU countries, yet only 0.2 green areas are available within the same distance and only 0.5 hospitals are reachable within that walking time. Across 27 OECD countries with available information, only 16 countries reported that public transportation is easy to access for people with mobility limitations and affordable for older people. While 83% of the urban population across the OECD's cities can access a bus stop and 31% a metro or tram stop within a ten-minute walk, promoting mobility and accessibility for peri-urban and non-urban populations is much less available and people often require individual cars (OECD, 2024^[15]).

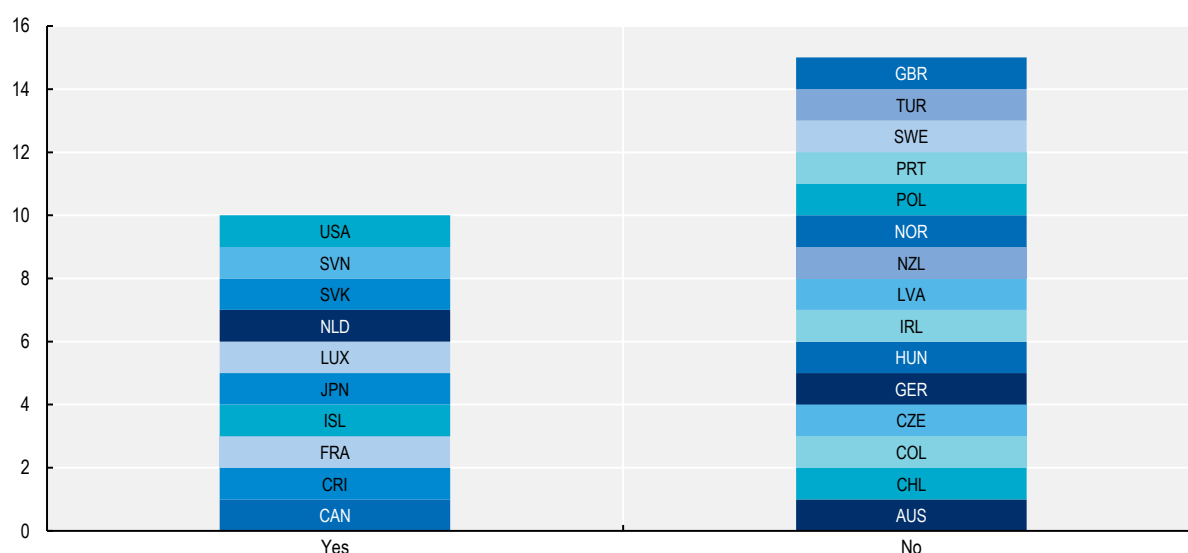
1.1.4. Home and community care services remain limited

The offer of home care services in several OECD countries falls short of ensuring that people can lead an independent life at home for as long as they wish. Currently, 40% of countries have some limitations in the hours of care which can lead to unmet needs or out-of-pocket costs for individuals and incentivise the use

of institutional care (Figure 1.7). While care for activities of daily living, such as eating and bathing, is included across OECD countries, not all instrumental activities of daily living, like shopping for groceries and managing one's finances, are well-catered for. Financial support with grocery shopping and going to appointments and administration was not included in 20% and 30% of the countries respectively. In addition, only 30% of countries in the OECD provide continuous long-term care help at home, the so-called 24-hour-care. Given people's preferences for ageing at home for as long as possible, limitations in the number of hours and services can put a strain on older people at home, both financially and physically and precipitate the decision to move into a nursing home earlier than what would be desirable. Inadequate or unaffordable home care services can also promote an overreliance on informal or family caregivers, while demographic changes with families becoming smaller and living further away from their parents are likely to limit the availability of family caregivers.

Figure 1.7. Are there limitations in the maximum number of hours funded for personal care and care for household chores?

Proportion of OECD countries with limits on hours funded for personal and household care



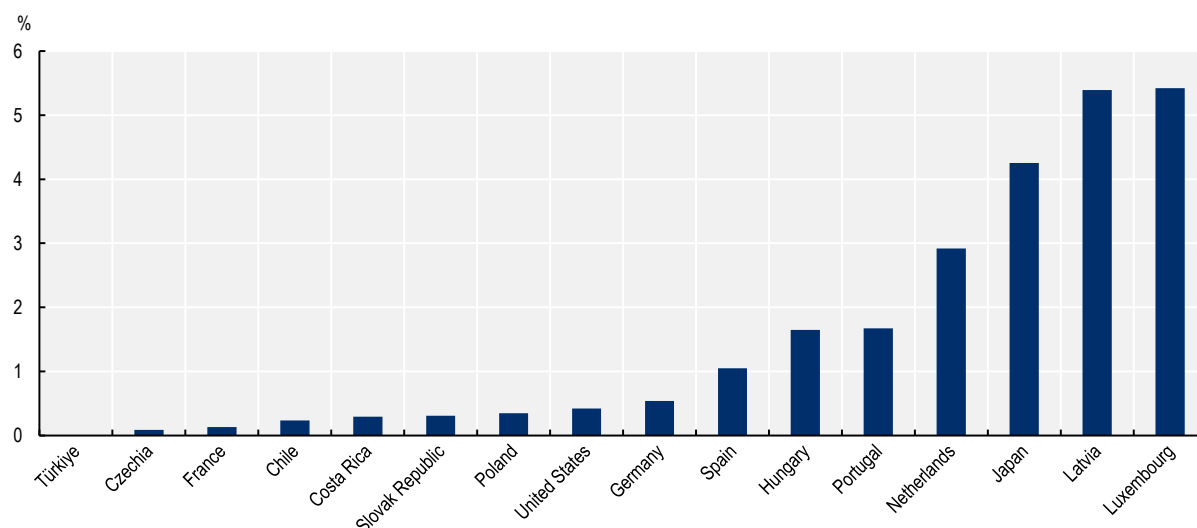
Note: Data for Canada refer to New Brunswick.

Source: OECD Questionnaire on Healthy Ageing and Community Care (2023_[16]).

Day-care use among older adults is limited in most OECD countries for which data are available. In most countries, the number of adult day-care users is below 1% of the population aged 65 or above (Figure 1.8). There are some exceptions, with day care being a vital component in long-term care delivery in Latvia and Luxembourg where the share is above 5%, as well as in Japan and the Netherlands to some extent. Lack of awareness about adult day care, transportation challenges and costs limit the overall use of day care. Communities and professionals do not often have sufficient knowledge about the availability of day care options nearby (STIMA, 2023_[17]). Day care services for older adults are not always available within a reasonable distance and countries do not always provide appropriate funding or reimbursement for transportation (EHESP, 2019_[18]). While public funding for adult day care is available, it remains low in comparison to other long-term care services, representing only 3% of the total long-term care budget on average. In 17 OECD countries, out-of-pocket costs are required, and this can limit the number of participants. In other countries such as France and Israel, limited funding results in low availability, waiting times or in a limited number of hours.

Figure 1.8. Less than 1% of the population aged over 65 years uses day-care in three-quarters of 16 countries surveyed

Number of day-care users as share of the population aged 65+, 2021 or latest year



Source: OECD Questionnaire on Healthy Ageing and Community Care (2023^[16]).

1.2. The economic benefits of healthy ageing

1.2.1. Better healthy ageing improves the sustainability of health and long-term care systems

Population ageing takes place amid declines in GDP growth and a shift in spending priorities. The shift in the demographic composition leads to a reduction in the working-age population, which can negatively affect GDP growth rates. By 2060, the working-age population will have declined by 8% in the OECD area, and by more than 30% in more than a quarter of OECD countries. The OECD old-age dependency ratio increased from 19% in 1980 to 31% in 2023 and is projected to rise further to 52% by 2060 (OECD, 2025^[19]). A lower projected share of employed persons in the total population implies that GDP per capita growth in the OECD area will be reduced by almost two-thirds, falling from 1.1% per year in the 2010s to 0.4% per year on average over the period 2024-2060 (OECD, 2025^[19]). Reductions in GDP growth limit the amount to which health and long-term care spending can be increased to cover rising demand from population ageing. Migration can contribute to lessen the challenge of ageing, but migration rates would need to increase well above historical values to have a substantial impact in the labour market. The largest contribution to offsetting the effects of demographic change on growth would come from mobilising further labour market participation and employment of older people in good health.

Health and long-term care expenditures are projected to increase as populations age. Population ageing is having a profound impact on societies and on healthcare and long-term costs. Health spending from public sources across the OECD is projected to grow at an average annual rate of 2.6% for 2019-2040 for the base scenario and projected to reach 8.6% of GDP, an increase of 1.8 p.p. from 2018 (OECD, 2024^[20]). Long-term care expenditures are projected to near double by 2050 (OECD, 2024^[21]).

Health conditions, which tend to increase with age, drive the increase in health expenditures. Older people tend to have higher expenditures mostly because of their morbidity status and preventable diseases, long-

term care conditions and proximity to death are core drivers (Breyer and Lorenz, 2020^[22]; Howdon and Rice, 2018^[23]; Maynou, Street and García-Altés, 2023^[24]). It is estimated that a 65 year-old with a serious chronic illness in the United States spends USD 1 000 to 2 000 more per year in healthcare services than a similar adult without the condition (Joyce et al., 2005^[25]). This is leading to higher health expenditures as people age, but a healthy old person enjoys lower spending than a young person with chronic conditions. In addition, health-system-related factors, such as increases in benefit levels and changes healthcare production, especially pharmaceutical spending and innovation, have been found to outpace the effect of ageing in driving up health expenditures (Dormont, Grignon and Huber, 2006^[26]; Hagist and Kotlikoff, 2005^[27]).

An increase in demand for health and long-term care services compounds with already existing workforce shortages, and an ageing health and long-term care workforce. In the European Union, over one-third of doctors and a quarter of nurses are aged over 55 and expected to retire in the coming years while countries already have an estimated shortage of approximately 1.2 million doctors, nurses and midwives in 2022 (OECD/European Commission, 2024^[28]). In addition, many countries already face existing shortages of health workers and OECD has identified the need for more training, as well as improving working conditions to retain staff (OECD, 2023^[29]). Likewise, recruitment and retention of long-term care workers faces severe difficulties. Salaries of long-term care workers and job recognition are low and working conditions are difficult, dissuading people from choosing these professions and contributing to further mismatches between demand and supply (OECD, 2023^[30]). This is occurring in a context where other economic sectors are experiencing shortages and can offer more attractive salaries and working conditions than the long-term care sector.

Healthy ageing and changes in the way care is provided can help reduce increases in spending and improve the effectiveness and productivity of health and long-term care systems. Three policy options stand out in effectively supporting healthy ageing and their economic impact are discussed in the next sub-sections. Firstly, more prevention, such as policies to support healthy lifestyles and participating in public health measures, the identification of people at risk, and rehabilitation and reablement help reduce the effect of morbidity, such as the number and severity of chronic diseases and limitations (Section 1.2.1). Secondly, changes in the way care is provided, such as a shift in care provision from the inpatient to the outpatient, home and community setting can ensure that people receive the same or better care that is less disruptive care and takes place in a less costly setting (Section 1.2.2). Thirdly, supporting people to age at home is generally cost-effective and meets people's preferences to live as home for as long as possible. Housing adaptations, more affordable comprehensive home care and day care that allows people to age at home without having to fully move towards institutional care, are two promising policy options countries have at their disposal to support ageing at home and in the community (Section 1.2.3).

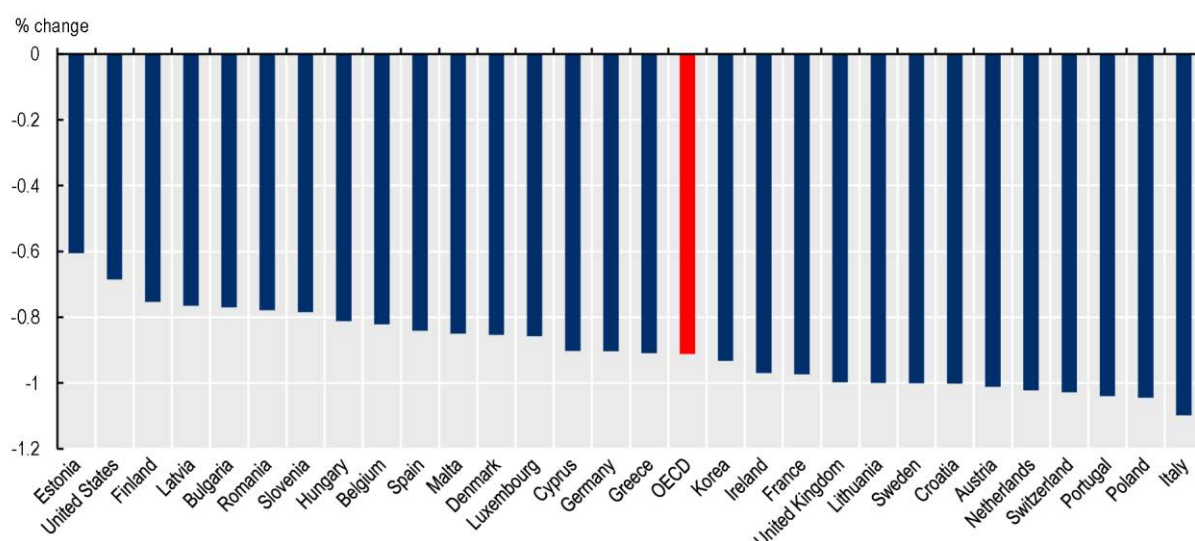
1.2.2. More spending on prevention and health system adaptation can reduce health expenditures

Better prevention reduces morbidity as well as health expenditures. Spending on prevention supports people in living a lifestyle and participating in public health measures that contribute to healthy ageing. Unhealthy lifestyle factors, such as excessive alcohol consumption and smoking, low levels of physical activity and unhealthy diets increase the burden of chronic diseases and negatively affect life expectancy and healthy life expectancy (OECD, 2021^[31]). More prevention efforts, such as public health campaigns to reduce alcohol consumption and smoking, and policies to improve physical activity reduce chronic diseases, prolongs life expectancy and healthy life expectancy, and offers cost-effective returns (Devaux et al., 2023^[32]; OECD/WHO, 2023^[33]; OECD, 2024^[34]). Participation in public health measures, such as screening campaigns and preventive home visits allow to reduce the burden of certain diseases, to identify people at risk to intervene as early as possible, and to target those that benefit the most from health and long-term care interventions (Bannenberg et al., 2021^[35]; OECD, 2024^[34]).

Investments in such preventive measures can lead to reductions in the share of older people with chronic conditions. OECD estimations show that a 10%-increase in spending on prevention was associated with a decrease in the share of people with chronic conditions, which is associated with lower overall health spending by 0.9% after a period of five years (see Box 1.1 for the methodology) (Figure 1.9).

Figure 1.9. A 10% increase in prevention can reduce health spending on chronic diseases by 0.9% on average

Changes in healthcare spending due to changes in the ratio of people with two or more chronic conditions to those with one or no diseases out of five conditions



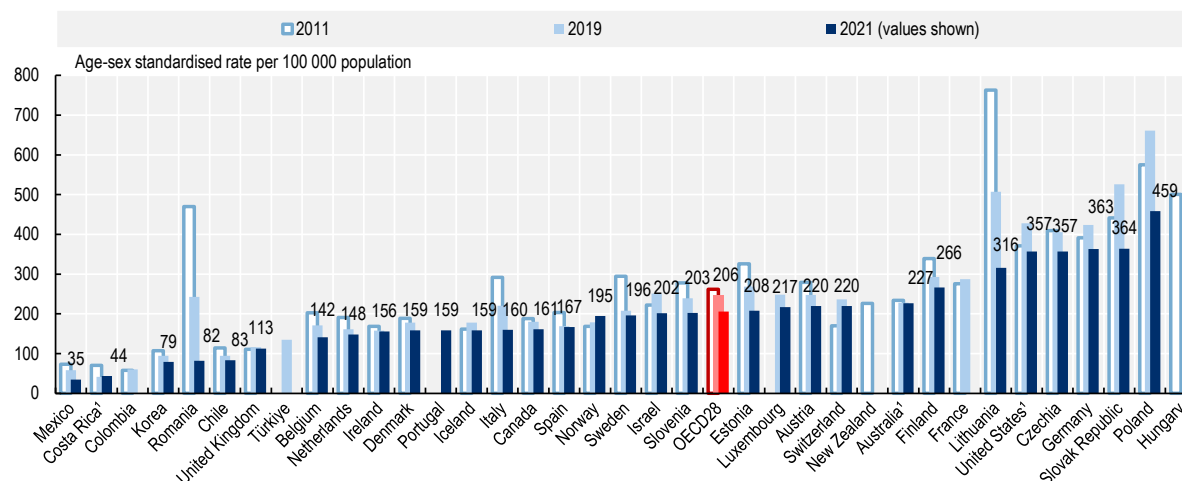
Source: Survey of Health, Ageing and Retirement in Europe (European Union and Israel), Health and Retirement Study (United States), English Longitudinal Study of Ageing (England), Korean Longitudinal Study of Aging (Korea).

Health system adaptation can shift care to settings that offer better value for money. Older people often do not receive the care they are most in need of, nor the most suitable setting, which contributes to driving up costs due to avoidable hospitalisations and exacerbations of their conditions. Avoiding hospitalisations can free financial and human resources. Hospitalisations are costly and bind healthcare resources amid workforce shortages and waiting time concerns. While a large part of the population never experiences a hospital stay in a calendar year, or is only hospitalised for a mild condition, one average hospitalisation equates the annual per capita health expenditures of more than one person. In 2022, average costs per inpatient stay for curative and rehabilitative care exceeded total health expenditures per capita by a factor of 2.23 across 27 OECD countries for which data was available.

Hospitalisations can be risky for older people. Taking people out of their familiar surroundings may disrupt care provision, require informal carers to take time off and make rearrangements to accommodate them in the hospital. For older patients, hospital stays can often be stressful and expose them to risks. They can lead to an increase in limitations of (instrumental) activities of daily living (hospital-associated disability) (Lloyd et al., 2020^[36]), delirium after operations, which can exacerbate cognitive decline (Kunicki et al., 2023^[37]; Saczynski et al., 2012^[38]), and expose them to hospital-acquired infections (Bates et al., 2023^[39]; OECD, 2023^[40]). As a result, the benefits of hospitalisations do not always outweigh the risks.

Figure 1.10. Many congestive heart failure hospital admissions in adults can be avoided

Congestive heart failure hospital admission in adults, 2011, 2019 and 2021 (or nearest years)



1. Latest data from 2020 (and for Costa Rica from 2022) instead of 2021.

Source: OECD Health Statistics 2023.

A share of hospitalisations can be avoided through health system rearrangements. For example, congestive heart failure is highly prevalent among older people and can lead to unnecessary hospitalisations, as can be deduced from the heterogeneity in hospital admissions due to congestive failure (Figure 1.10) (OECD, 2023^[40]). Better prevention, access to primary care, a good relationship between physicians and patients and care integration can help reduce the rate of hospitalisations for these conditions among older people (Barrenho et al., 2022^[41]; van Loenen et al., 2014^[42]; OECD, 2023^[9]).

1.2.3. Supporting ageing at home can reduce long-term care spending

Ageing at home meets people's preferences while reducing health and long-term care expenditures. Older people across OECD countries prefer to age at home and in their community. According to evidence from the United States, 77% of adults 50 and above wish to age at home (Binette and Farago, 2021^[43]). While this might be preferable in terms of quality of life and well-being, in some cases, it might also be a more cost-effective option than institutional care, depending on the system.

Long-term care at home is less expensive for people with low and moderate levels of need. People with low and moderate needs that have a limited number of (instrumental) activities of daily living and only need a few hours of care per week. They do not need the constant presence of a long-term care worker that institutional care provides, but rather some help in the morning and evening for personal hygiene, or for shopping groceries several times a week. Often, they either own the place they live in, or rent it at lower cost than the costs for boarding charged by institutional care. Long-term care provided in institutions can be cost-effective for people with severe needs that need a high number of hours of care thanks to economies of scale, where long-term care workers can provide care to several people with severe needs at the same time instead of providing intense care to a single person in their home. For people with lower levels of need, however, long-term care at home and in communities is generally more cost-effective and uses human resources more effectively, also freeing out expensive beds for those with more severe needs.

Countries can support a larger part of people to age at home. Between 2011 and 2021, the proportion of long-term care recipients who received care at home increased slightly, from 67% to 69%. Still, on average,

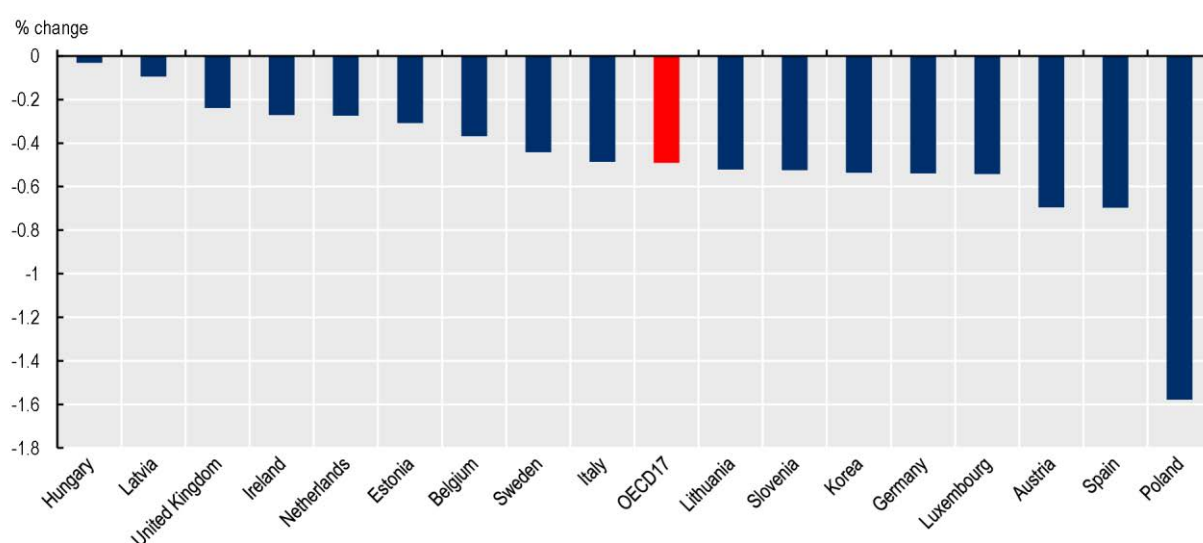
only 29% of older people in institutional care in OECD countries have severe needs, indicating that a considerable part of people that receive long-term care support in institutions could receive long-term care at home and in communities, that reduces expenditures, helps reduce shortages of long-term care workers through a more effective use of their time, and better responds preferences of older people (see (OECD, 2024^[21])).

Spending on long-term care remains geared towards institutions. In 2021, more than two-thirds of long-term care beneficiaries received long-term care at home, but countries spent half of their total long-term care spending on long-term care in institutions (OECD, 2023^[40]). An increase in spending on long-term care at home could help long-term care recipients to prolong ageing at home and to postpone the transition to a long-term care institution. Spending on long-term care at home can be directed towards housing adaptations to enable people to live at home as independently as possible and towards cash and in-kind benefits to ensure that long-term care needs are met to avoid a deterioration of a person's health and limitations.

Based on OECD estimations, a shift from spending on long-term care in facilities towards spending long-term care at home, expressed through an increase ratio of spending on long-term care at home over long-term care overall expenditures by 1%, can lead to a decrease in the overall long-term care spending by 0.49% (Figure 1.11).

Figure 1.11. A 1% increase in spending on long-term care at home can reduce overall long-term care spending by 0.5% on average

Ratio of spending on long-term care at home over overall long-term care



Note: United Kingdom refers to England.

Source: Survey of Health, Ageing and Retirement in Europe (European Union and Israel), Health and Retirement Study (United States), English Longitudinal Study of Ageing (England), Korean Longitudinal Study of Aging (Korea), The Irish Longitudinal Study on Ageing (Ireland).

Box 1.1. OECD estimations on the impact of healthy ageing

OECD estimates the impact of healthy ageing policies on health and long-term care expenditures. Estimates are based on data from the *Survey of Health, Ageing and Retirement in Europe* (SHARE), the *English Longitudinal Study of Ageing* (ELSA) for England, the *Health and Retirement Survey* (HRS) for the United States and the *Korean Longitudinal Study of Ageing* (KLoSA) and on OECD data on health expenditures. The OECD has analysed the impact of two policies to support healthy ageing: (1) a policy that promotes health prevention and (2) a policy that promotes home care as an alternative to institutional care.

Model 1 was estimated to assess the impact of the first policy on health expenditures. Specifically, it examines how changes in the spending on health prevention compared with total hospital spending – affect the ratio of people with two or more chronic conditions to those with one or no diseases out of a total of five chronic diseases (high blood pressure, diabetes, heart problems, arthritis and lung diseases). The analysis draws on data from 23 OECD countries and 3 accession countries (Bulgaria, Croatia and Romania), covering the time-period from 2006 to 2021. The estimated impact of increasing health prevention expenditures is expressed in terms of changes in overall healthcare spending associated with changes in the prevalence of chronic conditions.

In the second model (Model 2), the impact of the second policy on long-term care expenditures is assessed. This model examines how changes in spending on home care – expressed as spending on home care divided by the spending on overall expenditures in long-term care – affects the ratio of people with severe long-term care needs to those requiring fewer or no hours of care. The model parameters are estimated using data for 18 OECD countries over the time span from 2006 to 2021. The estimated impact of increasing home care expenditures is expressed in terms of changes in overall long-term care spending associated with changes in the prevalence of long-term care needs.

The impact of both policies is assessed with a five-year time lag to account for the delay between changes in spending and measurable health outcomes. Both models control for the share of the population aged 80 and above relative to those aged 65 to 79, to account for changes in population age structure. They also include GDP per capita as a control variable to account for the overall effect of wealth on health spending and the demand for health and long-term care services. The models estimate how changes in spending affects the prevalence of chronic conditions and long-term care needs *within each country*. This approach avoids imposing any assumptions related to in cultural and social norms or other environmental factors, such as preferences for long-term care at home over institutions.

1.3. Better prevention and health system adaptation

Better prevention can drive healthy ageing by reducing or outright preventing a deterioration in older people's health and by recovering people's health and functioning after health shock (pillar 1 of the *OECD framework on Healthy Ageing close to people's home*). Health system adaptation focusses on ensuring that health systems meet the needs of older people and offer the right care at the right place by the right people in a people-centred and integrated manner (pillar 2 of the framework). This section looks at policy options countries have to ensure that health systems support prevention and reablement and successfully and effectively accompany populations as they age.

1.3.1. Implementing targeted interventions to better identify people at risk of health decline can be effective if properly designed

Outright promoting healthy lifestyles remains challenging. While early intervention is desirable, there are still benefits to invest in preventive policies at an older age, but this comes with additional challenges. Older people that have spent several decades following unhealthy behaviours will find it difficult to change established patterns. While the benefits of prevention are clear, policies to sustainably improve healthy behaviours often yield mixed results at best. Policies to identify people at risk, which allows to effectively direct interventions towards them, has returned positive results and several evaluations of rehabilitation and reablement point at cost-effectiveness.

Health literacy campaigns are important to support healthy choices. Despite their well-known benefits, health behaviours and the uptake of public health measures remain challenging to realise. Firstly, people might not possess the levels of literacy that enable them to make healthy lifestyle choices and might also not be aware of offers that exist on a community level. Secondly, behaviours are sticky, and a share of people aged 65 and above have already spend several decades with unhealthy behaviours, making them resistant to change. Health concerns, such mobility restrictions, chronic pain, and fear of falling can further defer older people from being physically active. Countries are using information campaigns and counselling to improve health literacy and to inform and remind people of the benefits of healthy behaviours. France offers Nutri-Scores that improve health literacy and was found to reduce the calorie intake of purchased labelled food products by 3%, contributing to increases in life years and disability-free life-years gained (OECD, 2022^[44]).

Countries could use targeted strategies to identify people at risk of a certain condition or people that have already developed it. Australia, Finland, Norway and the Netherlands have introduced dedicated preventive home visits to older people to assess their health status and to check whether their surroundings are age friendly. Denmark had mandatory preventive home visits to older people, but since 1 July 2025 these visits have been voluntary for municipalities to provide. Home visits were found to improve health outcomes, quality of life, reduce hospitalisations, delay admissions to long-term care facilities, and were cost-effective (Kronborg et al., 2006^[45]; Liimatta et al., 2019^[46]; Sahlen et al., 2008^[47]). For example, the introduction of preventive home visits in Norway was found to lead to a reduction in admissions to long-term care facilities by 7%, in hospital admissions among those aged 80 and above by the same rate, in the average number of hospital days by 11%, and mortality of those aged 80 and above by 4% (Bannenberg et al., 2021^[35]). Countries also use sector-specific screening to identify people at risk. For example, policies to prevent falls were only effective when they targeted people at risks, but showed no effect for people that were not at risk of falling (Sherrington et al., 2019^[6]). In the Netherlands, fall prevention measures have been introduced and will be covered under the basic benefits package for older people at elevated risk for falls. Changing health behaviours might also be more challenging for people from a lower socio-economic status who are also more constrained by their income levels and living environment in terms of healthy choices. Targeted interventions such as group exercises and screening for specific conditions might be beneficial.

Rehabilitation and reablement aim at restoring a person's independence and functions after an accident or illness by optimising their functioning and reducing disability, in the case of rehabilitation and by increasing or maintaining independence in (instrumental) activities of daily living and reducing long-term care needs in the case of reablement (Gough et al., 2025^[48]). Evaluations of general and disease-specific rehabilitation, such as cardiac rehabilitation and pulmonary rehabilitation, were largely cost-effective (Shields et al., 2018^[49]; Mosher et al., 2022^[50]; Candio et al., 2022^[51]). Evidence is much more limited and heterogeneous for reablement, but some programmes have managed to generate positive results (Aspinal et al., 2016^[52]). For example, in Australia, people that underwent a home-based reablement programme were less likely to have an unplanned emergency admission or unplanned hospital admission, required 40% fewer hours of home-based care and had 35% lower total home-based costs and 20% lower total

health and home-care-related costs than those receiving standard care in a follow-up period of two years (Lewin, Alfonso and Alan, 2013^[53]; Lewin et al., 2014^[54]). In Norway, reablement was also found to lead better performance of and satisfaction with daily activities while requiring 25% fewer home visits, and costs being 17% lower than standard care (Kjerstad and Tuntland, 2016^[55]).

1.3.2. Bringing care closer to people's homes reduces inpatient expenditures

Policies that shift the delivery of care from the in- to the outpatient sector by shortening or outright replacing a hospital stay are largely effective in reducing costs while being less disruptive to older people's lives. Hospitals-at-home and intermediate care structures to shorten or replace hospital stays are now well-established, and newer policies, such as outreach teams, show promising results in keeping people in their homes rather than admitting them to hospitals.

Hospitals at home offer hospital-type care in a patient's home or long-term care facility to outright replace or shorten inpatient stays and are dominant in at least 22 OECD countries, such as Chile, France, Spain and the United Kingdom. A generous body of evidence indicates that hospitals-at-home lead to similar or better health outcomes while being 20-30% less costly than the in-patient stay (Singh et al., 2021^[56]; Yehoshua et al., 2024^[57]). For example, in England, hospital-at-home stays were (GBP 2 840) less expensive after inclusion of informal care costs (Singh et al., 2021^[56]). Patients value remaining in their familiar surroundings, but this structure can place additional burden on caregivers, who need to be well-prepared and integrated in the provision of Hospital-at-Home programmes.

Doctor-led or nurse-led outreach teams are dispatched from a hospital to offer assessments and simple interventions and can avoid emergency admissions and subsequent hospitalisations. While still a new concept, first evaluations are yielding positive results. Findings from Australia, Canada, Denmark and Finland indicate a reduction in emergency admissions and suggest that they are perceived as less disruptive than hospital admissions. Australia found a significant reduction in emergency department presentations by around 10-20% (Kwa et al., 2021^[58]; Fan et al., 2015^[59]; Hutchinson et al., 2014^[60]). Similarly, investigations from Finland recorded a reduction in less acute emergency admissions from long-term care facilities by about 20-30% depending on the severity with savings of 14% per resident in a long-term care facility (Perttu et al., 2025^[61]; Mäki et al., 2023^[62]).

Intermediate care structures introduce a layer in between hospitals and primary care and can provide better and more cost-effective care to people that do not require a full hospitalisation, but more intense monitoring than provided in a long-term care facility. They are often used as a step-down unit to shorten hospital stays and to ensure a smooth transition from hospitals to a patient's home. Intermediate care structures can help freeing hospital capacities and contribute to reducing delayed discharges, where people stay in a hospital for longer than medically necessary because of shortages in long-term care. Intermediate care facilities have largely been identified as successful in improving health outcomes, for example reductions in hospital readmissions, and have been found to be cost-effective, and might be worth the investment (Tyler et al., 2023^[63]; Blum et al., 2020^[64]). Intermediate care structures require a good co-ordination with hospitals and outpatient providers to ensure that they contribute to a smooth care transition rather than additional fragmentation of the healthcare system.

1.3.3. Some integrated care programmes have shown promising effects on functional outcomes and cost, but setting up effective programmes remains challenging

Older people with complex needs often receive care from different healthcare providers, and from healthcare, social and long-term care sector concurrently. This requires a good co-ordination to ensure patient-centred, seamless care within and across different sectors. Policies that aim at improving care while reducing costs through better integration and co-ordination have long been hailed as a highly promising policy, but evidence from several decades of experimentation has shown heterogeneous effects

that take several years to materialise. Integrated Care Programmes formalise the co-ordination among workers, often changing the way providers are paid. For example, in a set of countries, such as France and Ireland, they replace traditional fee-for-service payments by risk-adjusted capitation payments to a group of providers that shall incentivise better continuity of care.

Across the OECD, 20 countries have already introduced Integrated Care programmes for an older population, with another three planning to do so. In Canada, several provinces have gained experience with integrated care for older people. For example, Quebec launched the Program of Research to Integrate the Services for the Maintenance of Autonomy, also known as *Réseau de Services Intégrés aux Personnes Âgées* (PRISMA, or RSIPA) in 1999, which was later integrated in standard care. The evaluation of the programme showed a 6.3%-reduction in functional decline in people who participated in the programme, with no difference in annual cost compared to the control group (MacAdam, 2015^[65]). In England, increases in emergency admissions were up to 70% lower in integrated care programmes compared to the control group (Morciano et al., 2021^[66]; Keeble et al., 2019^[67]). In these *Pioneer* and *Vanguard* schemes and their successor, *Integrated Care Systems*, improvements took three to six years to materialise (Morciano et al., 2021^[66]; Lloyd et al., 2021^[68]).

1.4. Promoting ageing close to people's homes

1.4.1. Adapting environments to older people reduce the risk of hospitalisation and institutionalisation, but such adaptations are not always sufficiently generous

As discussed in Section 1.2, there are significant health and economic benefit from having people age closer to their own home. At present, however, less than 20% of homes are adapted to the needs of older people, fewer than 30% of people with long-term care needs receive formal care and less than 1% are enrolled in day care. To maximise its potential, ageing close to people's home requires ensuring that houses are adapted to the needs of older people and environments are more age-friendly, and rethinking long-term care in community to ensure a more comprehensive, affordable and high-quality care (pillar 3 and 4 of the framework).

Simplifying the process for housing adaptation and ensuring that it is sufficiently generous to cover modifications would be needed to better promote ageing in place. Studies have found that home modifications that make housing more accessible are associated with lower likelihood of being admitted to nursing homes, lower need of help with activities of daily living such as bathing, lower levels of functional decline and better carer's outcomes (Petersen and Aplin, 2021^[69]). In France, to simplify access to such support older people who require housing adaptations will be able to apply to *MaPrimeAdapt'* to receive financial support up to a maximum amount of EUR 22 000 (French government, 2023^[70]). In several countries (Latvia, the Netherlands, Norway and Portugal), municipalities provide advice on housing adaptation. The need for the intervention must be assessed and verified by a health professional, most often an occupational therapist, and the housing adaptation application is subsequently submitted to the municipality.

Supporting independent living also requires access to services and activities located within a convenient distance or reachable through affordable, accessible public transportation. Countries need cities that are more pedestrian-friendly, with mixed activities in areas to encourage accessibility to goods and services while balancing access to green spaces within walking distance (OECD, 2020^[71]). Urban infrastructure, such as traffic lights, benches, and green spaces, should also be designed with an age-friendly perspective to further promote independence for older adults. In New Zealand, the Accessibility for New Zealanders Bill aims for the removal and prevention of accessibility barriers in public spaces and transport. Some countries have looked at flexible transport systems, which are based on demand or do not have a fixed route, or subsidised taxis as an alternative to expanding public transport: In Norway, the "Ruter age-friendly

transport (RAT)", the "AtB 67 plus" and the "Pick me up!", are services of shared door-to-door transport that older people can book online and access at the cost of a public transport, which is proven to contribute to improved quality of life (Nordbakke et al., 2020^[72]). An offer of activities to enhance social participation is also important: In Japan, almost 87% of Japanese municipalities have implemented salons for older people on educational programmes and social activities, which has halved the incidence in long-term care needs and led to about one-third reduction in the risk of dementia onset for participants (Saito et al., 2019^[73]).

1.4.2. Home care services that are comprehensive and affordable are available in a small number of countries

Complex regulations and lack of available places limit access to home care. Current coverage, that is the share of people with self-reported long-term care needs receiving formal care services (both home and institutional), is close to 30% across the OECD. While people with low needs might not need formal services, and might rely on an informal carer, which can also have a toll in terms of employment loss of informal carers, survey responses point to up to 50% having unmet needs. Lack of awareness about benefit or service entitlement might be one reason why people do not receive formal support. At the same time, eligibility requirements are one the main reason for low access. Needs assessments are complex and lengthy and individuals with needs might not reach the minimum thresholds for entitlements. Income and wealth testing will also deter individuals from applying as they might still need to pay out-of-pocket and provide documents to justify their situation. In four countries, a family or so-called informal caregiver is also considered in the decision and generosity for accessing services. Finally, even when individuals are entitled to services, they might need to wait to receive them. Waiting lists can be lengthy and 11 countries do not have regulations to target curbing waiting times, while five others do have them for some services but they are rarely enforced.

A number of policies would have an impact on improving access to long-term care at home, such as simplifying the application procedures and providing a timely response. In Greece, community centres in municipalities can advise older people about home care and help them with the application process for home care, particularly with the paperwork required. Similarly, in the Netherlands, Care offices (*Zorgkantoren*) in regions help people find care that is appropriate to them. Germany has a requirement to notify the applicant about the needs assessments within a maximum time of 25 working days. In Sweden, services should be provided within three months. Spain started in 2021 a process of monitoring waiting times for being assessed and receiving services with an additional inflow of funds to reinforce human resources and simplify the needs assessment. The current body of evidence suggests that well-structured and developed long-term care benefits and services reduce use of emergency care, and hospital admissions and utilisation (Costa-Font, Jimenez-Martin and Vilaplana, 2018^[74]).

Beyond availability, the depth and breadth of long-term care has room for improvement in many OECD countries. Enhancing the hours and services for home care, while seeking for innovative solutions is one principal element to address service shortcomings. Personal budgets as introduced in England and the Netherlands could provide flexibility to users in deciding the home care services that they need. Spain has changed the limit on the hours available for the highest grade of long-term care in 2023 to cater for more home care for those who have more severe needs (Ministerio de Sanidad, Servicios Sociales e Igualdad, 2023^[75]). Countries like France and Australia have also recently recognised the importance of providing financial support towards certain instrumental activities of daily living, such as assistance with outings or appointments. Digital technologies as implemented in Nordic countries and Japan can help contain the costs of monitoring and free workers time for providing other type of care to older people. In addition to that, where unit costs of home care services are lower than institutional care, countries could consider expanding the hours and piloting 24-hours care options. Such options could take the form of a cash benefit or with 24-hour helplines so that older people could be monitored and additional help might be sent on

demand. Finland's initiative to progressively reduce institutional care and expand the possibility of 24-hour care at home is coupled with minimum staffing requirements and benchmarking data to guarantee quality of care.

Gaps in the public provision of home care leave vulnerable people with severe needs and low income at the risk of unmet needs or high out-of-pocket costs in many OECD countries. The generosity of long-term care services varies across countries but out-of-pocket costs (the share of the total long-term care costs that is left for older people to pay, after receiving public financial support) can be high when compared to disposable incomes. More specifically, in 16 countries, out-of-pocket costs for individuals with severe needs at home represent more than half of the median income of an older person and in seven countries the costs are higher than an older person's median income itself. Older people with low incomes also face high out-of-pocket costs in seven countries.

Countries would need to find better ways to balance the affordability of home care for users and the sustainability of finances. Previous OECD work highlighted that fully eliminating out-of-pocket costs will require increasing expenditures by 6% annually until 2050 (OECD, 2024^[21]). Countries are likely to seek additional sources to fund long-term care but options to manoeuvre are tight. Similarly, countries should investigate policy options that promote efficiency and help contain the costs of long-term care. In addition to these two options, given current gaps for vulnerable people, countries could also aim for better effectiveness by targeting their existing long-term care funds towards those most in need, that is those with higher needs and lower income. Estonia has recently started a reform to reduce the out-of-pocket costs for users. Slovenia has launched a wider reform to introduce a long-term care insurance, promote a rehabilitation first approach and make the range of long-term care services more generous to users.

1.4.3. While adult day care is associated with positive health outcomes, there is a need for more widespread provision and a more systematic focus on quality

Countries could consider giving a stronger priority to day care for older adults. Adult day-care services appear to have substantial benefits on outcomes: it is associated with reduced social isolation, improved social functioning and improvement in health outcomes such as physical health and functional status (Benedetti, Sancho and Hernández, 2024^[216]). Day-care attendance is also linked to a reduction in emergency attendance, hospital admissions and days in hospital, resulting in lower health costs and can also delay nursing home admission (Lunt, Dorwick and Lloyd-Williams, 2018^[76]). Japan has promoted adult day care as part of the integrated community care approach and adult day care is a very popular service among the older population with needs (Naruse et al., 2023^[77]). Chile started developing the national network of day-care centres for older adults at the same time as the national system for home care, rolling it out throughout the country, being a key part of its strategy to promote healthy longevity and promote autonomy of older people and reaching in 2025 almost half of the municipalities. Ireland has set recently a target to prioritise and increase the availability of day-care places.

A renewed focussed on health could improve the potential benefits of adult day care. In many countries, adult day care centres have a strong element on providing essential long-term care services and a focus on social activities. On the other hand, health screening and medical care is available in 56% of countries, and mandatory in 22%. While rehabilitation services are offered in a slightly higher share, with 65% countries providing them but less so on a mandatory basis (13%). In Japan, it is mandatory to provide a health screening service as part of adult day care. In the United States, there exists diverse types of adult day care: there are social day care programmes which have social and recreational activities but also help to maintain mental health and maintenance day care programmes. The latter type of day care provides more skilled care which includes screening for and monitoring of chronic disorders and physical exercise and has a stronger focus on maintaining or improving the person's ability to function for as long as possible.

To ensure high-quality care for all those providers that offer adult day care services, countries could consider putting additional policy instruments in place. Quality assurance measures for adult day care are

relatively light compared with institutional care and the health sector in many OECD countries. Seven countries have a system of external audit in place and public reporting is available in only three countries. Requirements and evaluation most often involve the setting of minimum standards for inputs, which are mostly structure-oriented (e.g. workforce standards) and occasionally relate to processes or outcomes and six countries perform no regular evaluation. Mandatory quality reporting to help future residents and their relatives to make more informed choices and to foster quality competition between nursing homes can be used. In Japan, information on providers is publicly available on a website which provides information on staffing, complaints, respect of user's human rights and other items. Unannounced inspections of long-term care providers to monitor their compliance with rules and regulations that shall guarantee high-quality care. Colombia requires for the agency in place to set up a plan with the list of facilities which will be inspected the following year.

1.4.4. Affordable high-quality community housing options are only available in between one-quarter to two-fifths of countries

Staying at home might not be optimal for everyone due to social isolation and other health risks but communal options beside nursing homes are either costly or scarce. Shared living arrangements such as co-housing or co-operatives were reported in about one-third of OECD countries. Intergenerational housing arrangements can provide older adults with more social contacts, support and sense of community, reducing loneliness and isolation (Van Gasse and Wyninckx, 2023^[78]) and similar findings exist for co-housing options. Assisted living is widely available (in 24 of the 27 OECD countries), but only half of them reported that public funding at the national or local level are used to fund assisted living facilities. In 15 countries, out-of-pocket spending is required to receive services in assisted living facilities. An additional challenge for assisted living is the heterogeneity of quality measurements and monitoring: seven countries have quality standards, six have mechanisms of external or internal audit, public reporting (e.g. mandatory quality reports) is available in four countries, and quality indicators in three countries (OECD questionnaire, 2023).

Few countries systematically promote and fund innovative housing models for older people. France is considering options for co-operative housing and intergenerational housing whereby people could benefit from the allowance for LTC and there is also a special allowance for inclusive housing, the so-called "allowance for shared living" (*aide à la vie partagée*). This allowance available since 2021 is meant to fund social activities for people living together in inclusive housing. In Germany, there are 530 multigenerational housing projects receiving federal funding from the programme "Multigenerational House. Together – For Each Other". In the United States, Green House care facilities include Medicaid and Medicare residents and offer small home-like environment with higher quality of care, resulting in lower hospitalisation. Austria has recent initiatives have aimed at making assisted living facilities more accessible and safer for older people with the use of technological tools.

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Notes

¹ The growth in life expectancy from 2012 to 2023 is not linear due to the effect of COVID-19.

² Households are considered to have a housing overburden if they spend more than 40% of their disposable income in housing costs.

2 Are people ageing healthily?

This chapter explores the extent to which people live the additional life years gained over the past decades in good or poor health. While life expectancy has been improving over time, such gains have started to stagnate across OECD countries. Still, not all years in old age are spent in good health, and significant inequalities exist across socio-economic groups. Younger generations are experiencing smaller health gains compared to older generations. Unhealthy lifestyles, comorbid conditions, shifting disease patterns, and poor environments increase the risk that current and future generations of older people will not age healthily. Population ageing and health inequalities highlight the need for health and long-term care systems to step up in promoting healthy longevity.

Key findings

- **Gains in life expectancy are slowing down, with signs of widening socio-economic disparities.** Over the past decades, countries have realised impressive gains in life expectancy, but progress has slowed down since 2010. Life expectancy growth has plateaued on average across the OECD but with some differences across countries: life expectancy at age 60 was stable in 30 countries and increased in eight countries. Among the causes of mortality, dementia and infectious diseases contributed to this stalling of life expectancy. While life expectancy tends to be higher for women, their rate of growth has been slower than men's. People with lower socio-economic status have lower life expectancy, and in some countries, the gap has been widening between people with higher socio-economic status.
- **Not every additional year lived is a year lived in full health.** In 2021, the gap between life expectancy and health life expectancy at age 60 stood at 5.7 years, meaning that the last years of people's lives are characterised by poor health and limitations. This gap has increased by 0.5 years over the past two decades, from 5.2 years in 2000.
- **While overall trends in activity limitations show improvements over time, this hides different trends by age and level of severity.** The share of older people with any limitations in (instrumental) activities of daily living decreased from 25.5% to 22.3% across the OECD between 2011 and 2021. Trends show that the improvement in activity limitations is driven mostly by a decline in the share of older people having low levels of activity limitations. In addition, older birth cohorts exhibit a decline in activity limitations, whereas younger birth cohorts show stagnation.
- **Engaging more older people in preventive health measures and chronic condition management can support healthy ageing.** Only five out of 29 countries in the European Region exceeded participation rates in all three recommended cancer screening programmes for women. In contrast, around half of the population aged 75 and above took at least five medications at the same time, which can negatively impact safety and increase health risks, such as falls.
- **The home and community environment also matter for healthy ageing.** More than 30% of older people aged 65 or older were living alone across the OECD. Adapted housing and urban design remain important to enhance older people's independence, promote their social engagement, reduce the risk of social isolation, and delay long-term care needs.

2.1. Ageing is currently not as healthy as it could be

Life expectancy has risen steadily in most OECD countries by over ten years on average since 1970 (OECD, 2023^[1]). At the same time, population ageing will have an impact on healthcare and long-term costs. Health spending from public sources across the OECD is projected to grow at an average annual rate of 2.6% for 2019-2040 for the base scenario and projected to reach 8.6% of GDP, an increase of 1.8 percentage points (p.p.) from 2018 (OECD, 2024^[2]). Long-term care expenditures are projected to nearly double by 2050 (OECD, 2024^[3]). Healthy longevity could then attenuate future demand for health and long-term care expenditures, even with population ageing. However, a previous OECD report showed that the pace of mortality improvement has slowed in several EU countries and Australia and Canada since 2011 (Raleigh, 2019^[4]).

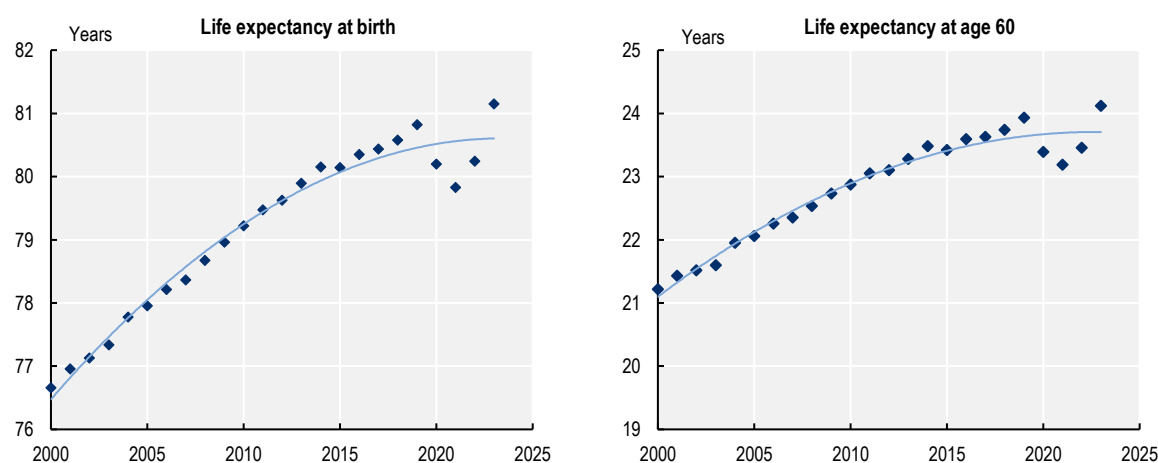
This chapter reviews the most recent trends in life expectancy, healthy life expectancy and activity limitations among older people. It highlights stark inequalities in the process of healthy ageing with certain groups experiencing lower (healthy) life expectancy. It also explores potential barriers to the full potential of healthy ageing and identifies areas for policy interventions to promote healthy ageing which will be discussed in more detail in the subsequent chapters.

2.1.1. Improvements in life expectancy show limited progress across the OECD

Lifespan has increased across OECD countries over the last 60 years, but progress has been limited in recent decades. Although average life expectancy at birth in OECD countries has increased by 13.3 years from 67.8 in 1960 to 81.1 in 2023 (United Nations, 2024^[5]), improvement in life expectancy has experienced a slowdown since the mid-2010s (Figure 2.1). Life expectancy growth had already started to stagnate before the significant decline during the COVID-19 pandemic and subsequent rebound. This stagnation occurred in 2015 for life expectancy at birth and in 2012 for life expectancy at age 60.

Figure 2.1. The growth in life expectancy has slowed in the mid-2010s, with a temporary drop during the pandemic

Average life expectancy at birth and at age 60 in OECD countries, 2000-2023



Source: United Nations, Department of Economic and Social Affairs, Population Division (2024^[5]), World Population Prospects 2024, Online Edition, <https://population.un.org/wpp/>.

The limited growth in life expectancy between 2000 and 2023 demonstrates varied trends across countries. Based on the 10-year averages, the growth rates of life expectancy at birth exhibited no clear trend in 26 countries, while consistently declining in five countries (Australia, Austria, Belgium, Iceland, Korea). Seven countries (Colombia, Czechia, Hungary, Latvia, Mexico, Poland, the Slovak Republic) saw a significant rebound in life expectancy after COVID-19, temporarily increasing their growth rates. Similarly, the growth rates of life expectancy at age 60 remained stagnant in 30 countries during 2000-2023, except for eight countries (Chile, Colombia, Czechia, Hungary, Latvia, Mexico, Poland, the Slovak Republic) that showed an increase after the pandemic. No country experienced a downward trend in life expectancy at age 60. Among the 38 member states, Colombia, Czechia, Hungary, Latvia, Mexico, Poland, and the Slovak Republic were the only countries to consistently improve life expectancy growth both at birth and at age 60. A slowdown in life expectancy growth in numerous OECD countries has been similarly reported by previous studies using various sources (INSEE, 2019^[6]; Mehta, Abrams and Myrskylä, 2020^[7]; Raleigh, 2019^[4]).

Diseases in older ages are becoming a major barrier to extending the lifespan. In the past, declines in childhood mortality and avoidable mortality with improved healthy behaviours have contributed to increases in the number of years people can be expected to live over time (Mathers et al., 2015^[8]; OECD, 2023^[1]; Mehta, Abrams and Myrskylä, 2020^[7]; Lopez and Adair, 2019^[9]). However, improvements in cardiovascular mortality have slowed in many countries. Respiratory diseases, including influenza and pneumonia, have claimed excess lives in some winters, while deaths from mental disorders or nervous system diseases in old age are rising. Fall-related deaths and injuries have plateaued or increased in the past decade after decreasing until 2010, particularly among older adults (Harada, Koyama and Yamada, 2024^[10]; Kim et al., 2025^[11]). In some countries, notably the United States and the United Kingdom, mortality improvements have also slowed or even reversed, particularly due to the rising numbers dying from drug use and Alzheimer's disease (Raleigh, 2019^[4]; Ho, 2022^[12]).

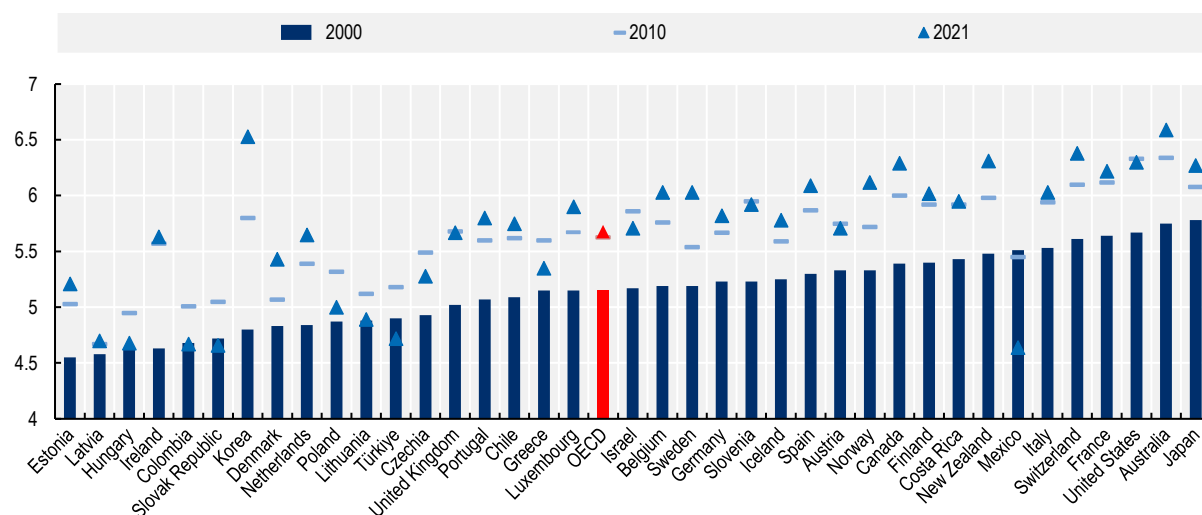
2.1.2. Healthy life expectancy has also failed to keep up

People in OECD countries live longer, but not necessarily healthier. Healthy ageing can be assessed in various ways, such as measuring healthy life expectancy and other ways to document whether people are ageing in good health (Box 2.1). Over the past two decades, the difference between life expectancy and healthy life expectancy at age 60 has continued to grow slightly in many OECD countries. In other words, the increased lifespan achieved did not entirely translate into a healthy life, increasing the share of years lived in less than full health due to disease or injury. This gap in life expectancy and healthy life expectancy increased from 5.2 years in 2000 to 5.7 years in 2021 on average for OECD countries (Figure 2.2).

The gap between life expectancy and healthy life expectancy varies across OECD countries. In 2021, the difference ranged from 4.6 years (Mexico) to 6.6 years (Australia). By region, Central and Eastern European countries report the lowest gap between life expectancy and healthy life expectancy, approximately 5 years, while non-European countries report the highest gap, over 6.3 years.

Figure 2.2. The gap between life expectancy and healthy life expectancy is growing

Difference in years between life expectancy and healthy life expectancy at age 60, 2000-2021



Source: WHO Global Health Observatory (2024^[13]), "Healthy life expectancy (HALE) at 60 (years)", <https://www.who.int/data/gho/data/indicators/indicator-details/GHO/gho-ghe-hale-healthy-life-expectancy-at-age-60>.

Box 2.1. Measuring healthy ageing: Diverging definitions and implications for international comparisons

Healthy ageing is defined as “the process of developing and maintaining the functional ability that enables well-being in older age” by WHO (WHO, 2020^[14]). Healthy ageing is a process characterised by great functional ability, either with or without chronic conditions that are well-managed, influenced by experiences and exposures throughout life. Key considerations for healthy ageing include diversity and equity. The OECD also defines healthy ageing as a multidimensional concept that goes beyond the absence of disease, such as “maintaining physical, mental, and social well-being in older age, enabling older people to remain active contributors to society (Oxley, 2009^[15])” With a focus on policy approaches, healthy ageing is seen as the state of maintaining good health and overall well-being with independence, which enables active participation in society, achieved through prevention and integrated policies.

Healthy life expectancy is one of the crucial measures for population health that counts not only years lived but also the quality of life. However, the method of measuring healthy life expectancy has not been agreed upon. For example, the WHO defines health-adjusted life expectancy (HALE) as “the average number of years that a person can expect to live in “full health” by taking into account years lived in less than full health due to disease and/or injury (WHO, 2023^[16]).” The Eurostat’s healthy life years (HLY) are calculated more straightforwardly, based on two questions from the EU-SILC survey: “Are you limited because of a health problem in activities people usually do?” and “Have you been limited for at least the past six months?”.

The variations in definitions, measurement, and estimation methodologies across institutions can lead to differences in healthy life expectancy and, therefore, the estimated trends and ranking across the countries. The 2000-2019 Global Burden of Disease indicates a comparable upward trend in the LE-HALE gap among OECD countries, consistent with WHO data, but starting from a significantly higher baseline. Focusing on Europe, the LE-HLY difference from the Eurostat data also gradually widened from 2004 to 2023, although it temporarily narrowed during the COVID-19 pandemic. However, its country rankings and estimate sizes differ significantly from those based on WHO data (OECD/European Commission, 2024^[17]). Such data discrepancy in health trends among European countries has also been indicated in other studies (e.g. (Rubio-Valverde, Mackenbach and Nusselder, 2021^[18])).

In addition, a frequently used indicator for health-related quality of life is activity limitations, measured by limitations in activities of daily living (ADL) and instrumental activities of daily living (IADL). ADL and IADL limitations help countries assess a person’s needs for additional support to manage their daily life and provide long-term care benefits based on their limitations. The indicators of activity limitations can be used individually or in aggregate (also combined with other relevant measures, as suggested by the Ageing Trajectories of Health: Longitudinal Opportunities and Synergies (ATHLOS) project). In this report, data on activity limitation are sourced from the Survey of Health, Ageing and Retirement in Europe (SHARE) for EU countries. For non-EU OECD countries, the data come from international sister studies of SHARE: Health and Retirement Study (United States), English Longitudinal Study of Ageing (United Kingdom), Korean Longitudinal Study of Aging (Korea), and Mexican Health and Aging Study (Mexico).

Note: Japanese data is sourced from the Japanese Aging and Health Dynamics, which is not part of the internationally comparative database.

Source: OECD/European Commission (2024^[17]), *Health at a Glance: Europe 2024*, <https://doi.org/10.1787/b3704e14-en>.

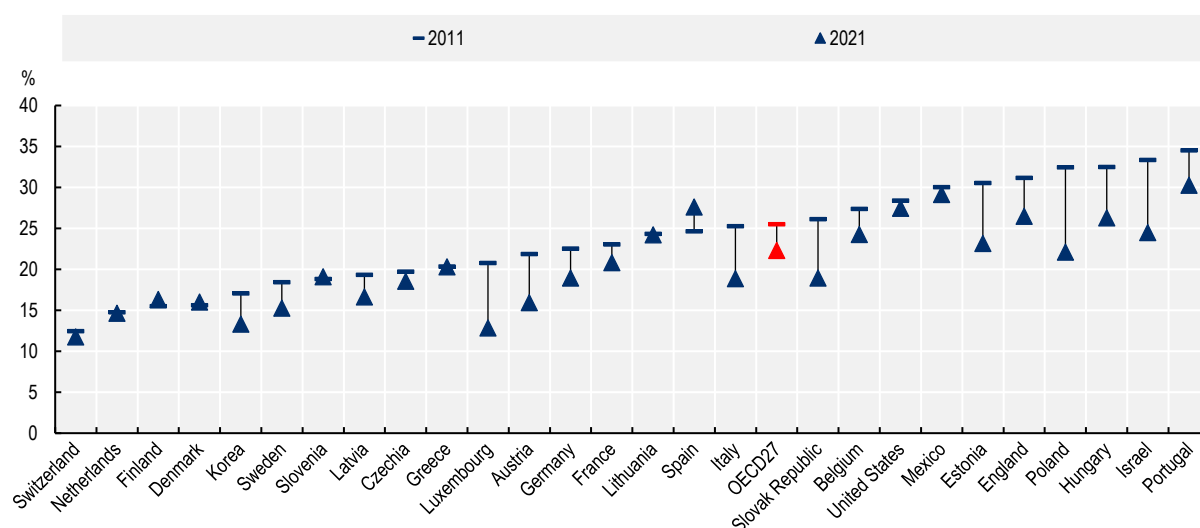
2.1.3. Nonetheless, trends in the share of people having activity limitations show signs of improvement

Dependency and disablement is a process where chronic and acute conditions impact bodily impairments, activity limitations, and social functioning (Verbrugge and Jette, 1994^[19]; Jette, 2009^[20]). This process often begins subtly after a stroke or cognitive decline and progresses to impair basic activities of daily living (ADLs), such as bathing and dressing, and instrumental activities of daily living (IADLs), like cooking and managing finances. Declines in physical performance in older ages are also associated with poor oral health (e.g. edentulism) and chronic pain (Kimble et al., 2022^[21]; Balicki et al., 2025^[22]). Older individuals experiencing disablement require some form of assistance to carry out everyday tasks on top of ongoing medical treatment over an extended period.

Between 2011 and 2021, the share of older people with any limitations in (instrumental) activities of daily living decreased from 25.5% to 22.3% across the OECD (Figure 2.3). Declines in IADL limitations (-4.6 p.p.) contributed more to the overall decrease than declines in ADL limitations (-2.8 p.p.). Seventeen out of the twenty-seven countries showed a decline, while nine countries exhibited a stagnant trend, and only one country, Spain, displayed an increasing trend. Poland showed the largest drop in any activity limitations (-10.4 p.p.), while Spain showed the biggest increase (3 p.p.). A similar finding emerged when looking at two or more activity limitations, with the share decreasing from 15.7% in 2011 to 13.6% in 2021. These findings are consistent with previous research reporting improved functioning and lower disability among older adults (Crimmins, 2004^[23]; Verropoulou and Tsimbos, 2017^[24]), although other sources indicated increased prevalence (Nguyen and Hong, 2023^[25]; Roma and Miglio, 2025^[26]).

Figure 2.3. Improvement in activity limitations in old age varies across countries

Percentage of people aged 65+ with any limitations in (instrument) activities of daily living, 2011 vs. 2021 (or nearest)



Note: First data points for England, Korea and the United States are from 2010, for Mexico from 2012, for Israel and Luxembourg from 2013, for Greece from 2015, and for Finland, Latvia, Lithuania, and the Slovak Republic from 2019. Last data points for England and Mexico are from 2018, and for Korea and the United States, from 2020. Japan has a single observation in 2017 and is not presented. All numbers are weighted estimates.

Source: Survey of Health, Ageing and Retirement in Europe (European Union and Israel), Health and Retirement Study (United States), English Longitudinal Study of Ageing (England), Korean Longitudinal Study of Aging (Korea), Mexican Health and Aging Study (Mexico).

Reduced activity limitations are associated with long-term care needs.¹ From 2011 to 2021, the OECD average of long-term care needs shows a less than two p.p. decline in all levels of severity – low, moderate, and severe –, showing only minimal variation. Some countries experienced more notable reductions: Austria experienced the most significant decrease in low-level needs (-5.2 p.p.), Poland in moderate needs (-5.2 p.p.), and Israel in severe needs (-4.8 p.p.). While most countries followed a moderate downward trend, a few countries reported an increase in LTC needs, such as Denmark (low level, 2.3 p.p.), Spain (moderate level, 2.9 p.p.), and Slovenia (severe level, 1.7 p.p.). Notably, the severity of needs also varied by age groups. Across the OECD, the decline in the low level of needs was more marked for people aged 75-84, whereas reductions in medium and severe needs were more significant among people aged 85 or over compared to younger groups.

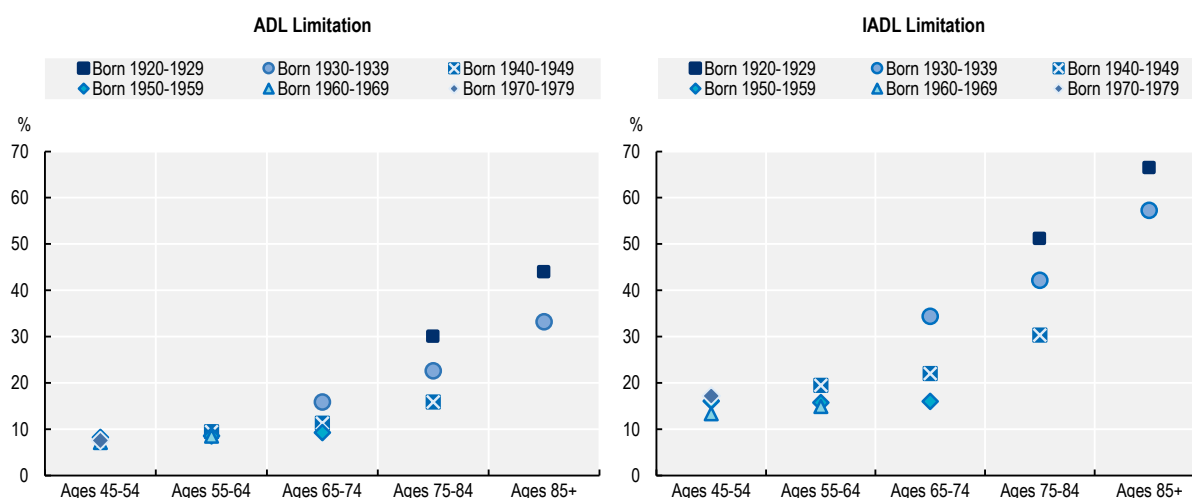
2.1.4. Younger generation lags behind older generation in health gains

Recent evidence suggests that the decline in activity limitations among older people in the past decade may not apply to their younger counterparts. Unlike older birth cohorts, which consistently reported health improvements, the trend for younger birth cohorts is less clear (Crimmins et al., 2019^[27]; Verropoulou and Tsimbos, 2017^[24]). Studies on activity limitation among people under 65 have yielded mixed findings, with some showing an increasing trend (Beller and Epping, 2021^[28]; Freedman et al., 2013^[29]), others a stagnating trend (Jehn and Zajacova, 2019^[30]; Choi et al., 2022^[31]), and still others an inconsistent trend (Lafortune and Balestat, 2007^[32]) up to the mid-2010s across Europe, England, Canada and the United States. These results are further nuanced by the severity of impairment, gender, income, and education, while the age and birth year thresholds varied slightly across the studies.

Nonetheless, data analysis suggests that in OECD countries, gains in old-age health over the last decade may not be equally distributed across generations (Figure 2.4). Particularly, midlife health has shown a sign of stagnation or even decline from 2011 to 2021, revealing an age divide before and after the age of 75. The prevalence of ADL limitations remained stable at around 8% under age 65 across three consecutive cohorts, whereas at age 65-74, the reduction rates of ADL prevalence became smaller across cohorts. Similarly, the prevalence of IADL limitations declined less for later cohorts under age 75. At ages 45-54, IADL limitations have in fact become more prevalent for people born in the 1970s (17%) compared to those born in the 1960s (13%). In contrast, an improvement in activity limitation among the later born becomes noticeable after they reach the age of 75. Despite healthcare advances and improved living conditions, young-old (ages 65-74) and midlife functional health lag behind older age groups.

Figure 2.4. Generational health gains have mainly benefited older people rather than midlife adults

Percentage of people aged 45 or over with any limitations in (instrument) activities of daily living, 2011-2021



Note: Activity limitation includes activities of daily living and instrumental activities of daily living. The estimates are weighted estimates pooled across available datasets between 2011 and 2021.

Source: Survey of Health, Ageing and Retirement in Europe (European Union and Israel), Health and Retirement Study (United States), English Longitudinal Study of Ageing (England), Korean Longitudinal Study of Aging (Korea), Mexican Health and Aging Study (Mexico), Japanese Aging and Health Dynamics (Japan).

2.2. Ageing unequally is driving the lower gains in life expectancy

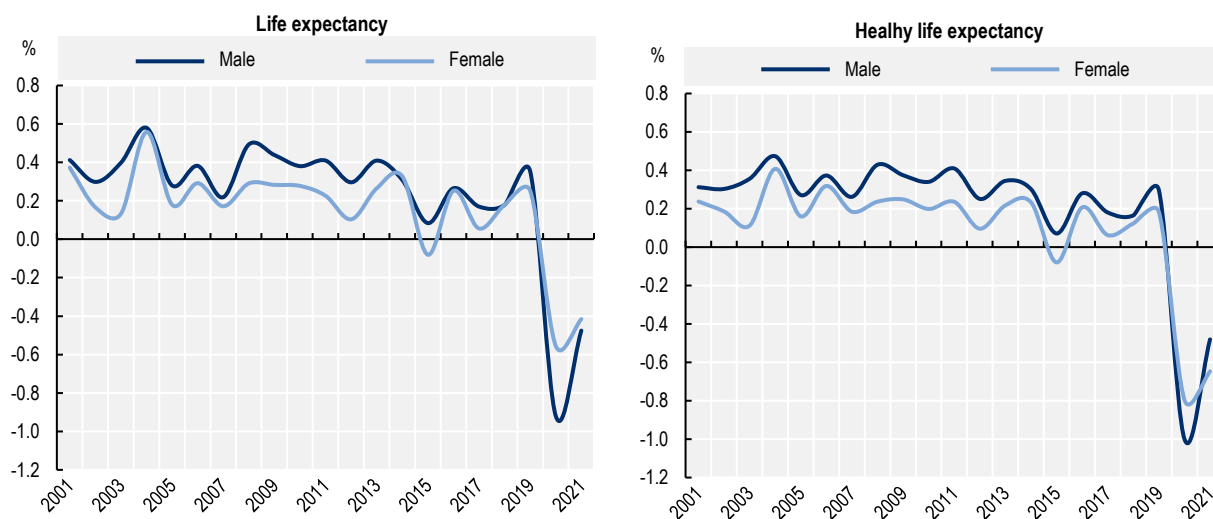
The limited improvement in life expectancy over recent decades highlights the need to examine the underlying social determinants of health – the non-medical factors that influence health outcomes. These factors are related to the conditions in which people are born, live and age, including social (like access to education and decent housing), economic (like income and social protection), and environmental (like living in safe neighbourhoods) aspects. A critical factor is the unequal distribution of health outcomes across different segments of the population. According to the WHO,² social determinants may influence health more than healthcare quality or lifestyle choices, accounting for 30-55% of health outcomes. In particular, health outcomes in older age vary by demographic characteristics, such as gender, and socio-economic status, such as education and income, with disadvantaged groups facing worse results (Hiam et al., 2018^[33]; Kabir and O'Brien, 2023^[34]).

2.2.1. Women are consistently experiencing smaller gains than men

Life expectancy and healthy life expectancy are generally higher for women than men, although the gap is closing due to smaller gains for women. In 2023, life expectancy at birth was 83.7 years for women and 78.6 years for men across OECD countries, with women also having a higher healthy life expectancy at birth. Likewise, healthy life expectancy at age 60 is also higher for women across the OECD than for men. Over the past decades, growth rates in healthy life expectancy and life expectancy have been lower for women than men, leading to reductions in gender differences (Figure 2.5). Over the period from 2010 to 2021, life expectancy increased at an annual rate of 0.24% for men, while it rose by only 0.16% for women. Similarly, men's healthy life expectancy has grown by 0.21% each year, whereas women's has risen by half that rate (0.10%).

Figure 2.5. The narrowing gender gap masks women's lesser gains in life expectancy

Annual growth rates in life expectancy at birth and healthy life expectancy at birth by male and female, 2000-2021



Note: Estimates for life expectancy at birth are based on the UN World Population Prospects, and those for healthy life expectancy at birth are based on the WHO Global Health Observatory.

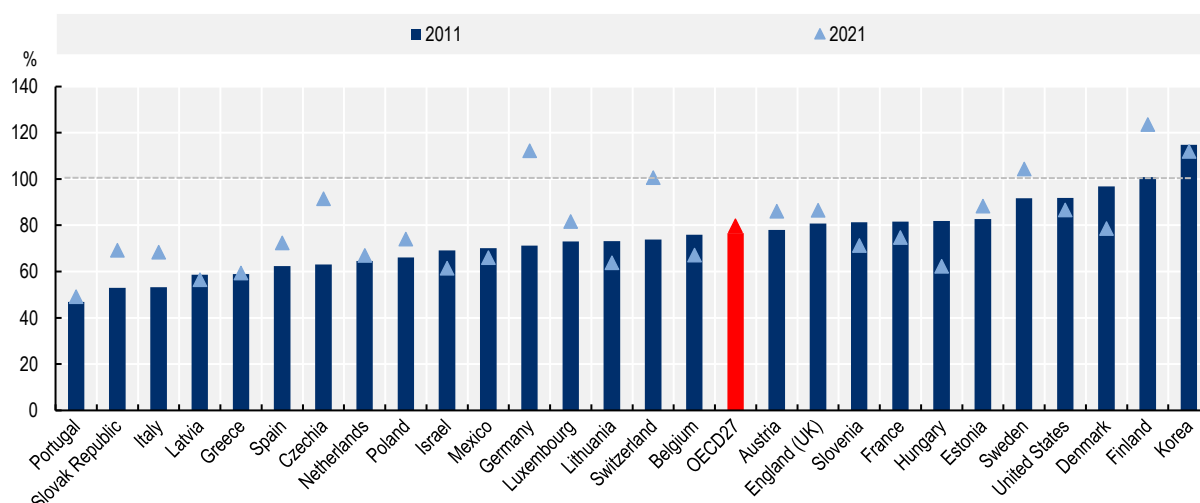
Source: UN Department of Economic and Social Affairs, Population Division (2024^[35]), <https://population.un.org/wpp/>; WHO Global Health Observatory (2024^[13]), "Healthy life expectancy (HALE) at 60 (years)", <https://www.who.int/data/gho/data/indicators/indicator-details/GHO/gho-ghe-hale-healthy-life-expectancy-at-age-60>.

Paradoxically, owing to their longer life expectancy, women spend more of their lives in debilitating health than men due to chronic diseases and activity limitations. Women generally experience higher prevalence and poorer outcomes in conditions like chronic kidney disease, rheumatic heart disease, depression, dementia, and multimorbidity, while men have higher premature death rates from cardiovascular diseases (Schmitz and Lazarevič, 2020^[36]). Moderate conditions with a high prevalence contribute to a greater prevalence of old-age disability in women compared to men (Nusselder et al., 2019^[37]; Portela et al., 2020^[38]). Women's more rapid cognitive decline compared to men is suspected to be a contributor to women's deteriorating functional activities in old age (Levine et al., 2021^[39]; Nader et al., 2023^[40]; Gure et al., 2013^[41]). The difference between men and women in activity limitation increases with age, partly due to the survival effect, whereby men who reach very old age tend to be the healthiest (Scheel-Hincke et al., 2020^[42]).

These health disparities between men and women in old age have persisted across OECD countries over the past decade. Data from 27 OECD countries suggest a decline in ADL or IADL limitations for both men and women between 2011 and 2021, yet limitations remained more common among women (Figure 2.6). Although the overall gaps in limitations narrowed from 6.6% to 5.0%, 11 countries reported increased limitation gaps, without a significant age difference between men and women. Notably, in Hungary (-19.7 p.p.), Denmark (-18.2 p.p.), and Slovenia (-10.1 p.p.), the relative prevalence of activity limitations among men dropped even further in 2021 compared to 2011, exacerbating the gap considerably. The differences in activity limitations were reduced in nine countries and remained unchanged in three countries (<5%). Simultaneously, Germany, Sweden, Korea and Finland exhibit reversed gaps due to a greater prevalence of limitations among men than women.

Figure 2.6. Despite the progress, women are still more likely to experience activity limitations

Proportion of men 65+ with any limitations in (instrumental) activities of daily living relative to women, 2011-2021



Note: First data points for England (United Kingdom), Korea and the United States are from 2010, for Mexico from 2012, for Israel and Luxembourg from 2013, for Greece from 2015, and for Finland, Latvia, Lithuania and the Slovak Republic from 2019. Last data points for England and Mexico are from 2018, and for Korea and the United States, from 2020. Japan has a single observation in 2017 and is not presented. All numbers are weighted estimates.

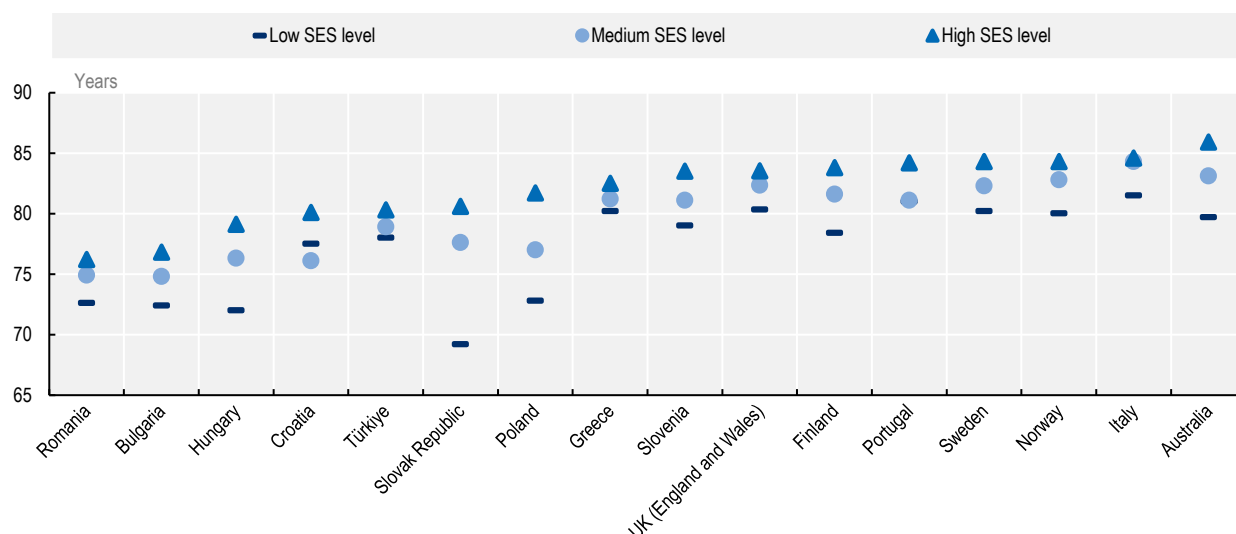
Source: Survey of Health, Ageing and Retirement in Europe (European Union and Israel), Health and Retirement Study (United States), English Longitudinal Study of Ageing (England, United Kingdom), Korean Longitudinal Study of Aging (Korea), Mexican Health and Aging Study (Mexico).

2.2.2. Health gaps tied to socio-economic status are widening

Health in older age is shaped by social determinants of health throughout their lifetime, influencing people's ability to live long and healthily. People from higher socio-economic backgrounds tend to have a longer life expectancy and enjoy more years of better health than those from lower backgrounds. The burden of disease is greater among people with less education, low income, and from deprived areas due to more chronic diseases, more activity limitations, and poorer working and living conditions (OECD, 2021^[43]; OECD, 2023^[44]; OECD, 2017^[45]). In 2017, the gap in life expectancy at birth based on socio-economic status in the EU ranged from approximately 2 years in Greece to nearly 11 years in the Slovak Republic (Figure 2.7). In the OECD, longevity advantages for the educationally and financially better-off are well-documented. The high-low educational differentials in life expectancy at age 65 were 3.5 years for men and 2.5 years for women across OECD countries around 2011 (Murtin et al., 2017^[46]). Such educational disparities in longevity account for around 10% of the overall differences in ages of death, on average.

Figure 2.7. People with a lower socio-economic status are expected to have lower life expectancy

Life expectancy at birth across different SES levels, 2017 (or nearest year)



Note: For the United Kingdom (England and Wales), low socio-economic status refers to occupations classified as class 1-3 according to the National Statistics Socio-Economic Classification, high socio-economic status corresponds to occupations classified as class 5-7 according to the National Statistics Socio-Economic Classification. For Australia, low SES level refers to the 1st decile of the Socio-Economic Indexes for Areas (SEIFA), medium refers to the 5th decile and high refers to the 10th decile. For all other countries, a low socio-economic status corresponds to people with level 0-2 of education according to the International Standard Classification of Education (ISCED 2011), while a high socio-economic status corresponds to level 5-8 of education according to the International Standard Classification of Education (ISCED 2011). Source: Eurostat (2023^[47]), "Eurostat data on LE by age, sex, education attainment level", ONS (2022^[48]), "Trend in life expectancy by National Statistics Socioeconomic Classification, England and Wales: 1982 to 1986 to 2012 to 2016" for the United Kingdom (England and Wales), Australian Government Centre for Population (2021^[49]), "Life tables by relative socio economic advantage and disadvantage", <https://population.gov.au/sites/population.gov.au/files/2021-12/sgm-paper3.pdf>, for Australia.

Socio-economic disparities in life expectancy have widened over time, mainly due to health advantages for the better-off. Over the past decades, socio-economically advantaged groups have seen steady gains in life expectancy, whereas disadvantaged groups have faced stagnation or decline. In the United States, mortality rates among bachelor's degree holders continued to decline, while those of people without the degree rose from 1992 to 2021, expanding the gap in life expectancy by 8.5 years in 2021 (Case and Deaton, 2023^[50]). Similarly, men in the top income percentiles live, on average, 14.6 years longer than those in the bottom percentile from 2001 to 2014; for women, the difference was 10.1 years (Chetty et al., 2016^[51]; Deaton, 2016^[52]). These patterns are also echoed in other OECD countries, including the EU (Rubio-Valverde, Mackenbach and Nusselder, 2021^[18]),³ Norway (Kinge et al., 2019^[53]), Sweden (Hederos et al., 2018^[54]) and Finland (Tarkiainen et al., 2012^[55]).

People from lower socio-economic backgrounds experience earlier onset of chronic diseases and activity limitations, leading to shorter healthy life expectancy and greater time spent in poorer health. From 2000 to 2014, people with less education experienced a higher proportion and a higher rate of increase in all measures of functional limitations, compared to those with more education, in the United States (Tsai, 2016^[56]). Consequently, declining health among disadvantaged groups has contributed to the slowdown in the improvements in life expectancy and healthy life expectancy. However, the magnitude and speed at which socio-economic disparities affect life expectancy may differ by country. In the United States, the high-low income gaps in life expectancy increased from 6.2 years to 8.4 years for men, and from 2.5 years to 6.2 years for women between 2005 and 2015 (Chetty et al., 2016^[51]). In Sweden, the gap increased by

approximately one year for men and two years for women between 1986 and 2007 (Hederos et al., 2018^[54]).

2.3. What is preventing healthy longevity?

The recent slowdown and disparities in healthy ageing, despite the increased healthcare spending, underscore the importance of various social determinants shaping life expectancy throughout the life course (Venkataramani, O'Brien and Tsai, 2021^[57]). Unhealthy lifestyles, insufficient physical activity, chronic diseases, dementia, and multimorbidity increase the risk of reporting poorer health and developing ADL and IADL limitations in old age (UK OHID, 2023^[58]; Nguyen and Hong, 2023^[25]). At the same time, while shifting disease patterns and causes of death contribute to the stall in life expectancy gains (Ramsay et al., 2020^[59]), health and long-term care systems, as well as the community environment, have not yet been fully adapted to these changing needs in old-age health. To remove the barriers to living longer and healthier in old age, health systems would need to adapt to these new patterns, which demand more prevention, integrated services, and long-term care management.

2.3.1. *Many people are not engaging in preventive health measures*

Across the OECD, a significant portion of the population makes unhealthy lifestyle choices, with a higher likelihood among older people than their younger counterparts. As illustrated in Chapter 1, only one in four people aged 65 and above meets the physical activity recommendations of at least 150 minutes of moderate-intensity physical activity per week. Unhealthy diets and sedentary lifestyles can significantly increase the risk of chronic diseases, including cardiovascular disease, diabetes, obesity, dementia, and cancer, as well as metabolic anomalies and increased mortality (Malhotra, Noakes and Phinney, 2015^[60]; Livingston et al., 2020^[61]). Poor oral health literacy among older people also leads to their reduced use of dental care services, resulting in an increased risk to nutritional intake and overall health (Gil-Montoya et al., 2015^[62]; Lowenstein, Singh and Papas, 2025^[63]). These factors not only lead to 2-6% of a country's overall healthcare spending worldwide (WHO, 2018^[64]), but also result in a loss of 6.3 healthy years in life expectancy and 2.9 years of chronic disease-free years after age 50 (Leskinen et al., 2018^[65]).

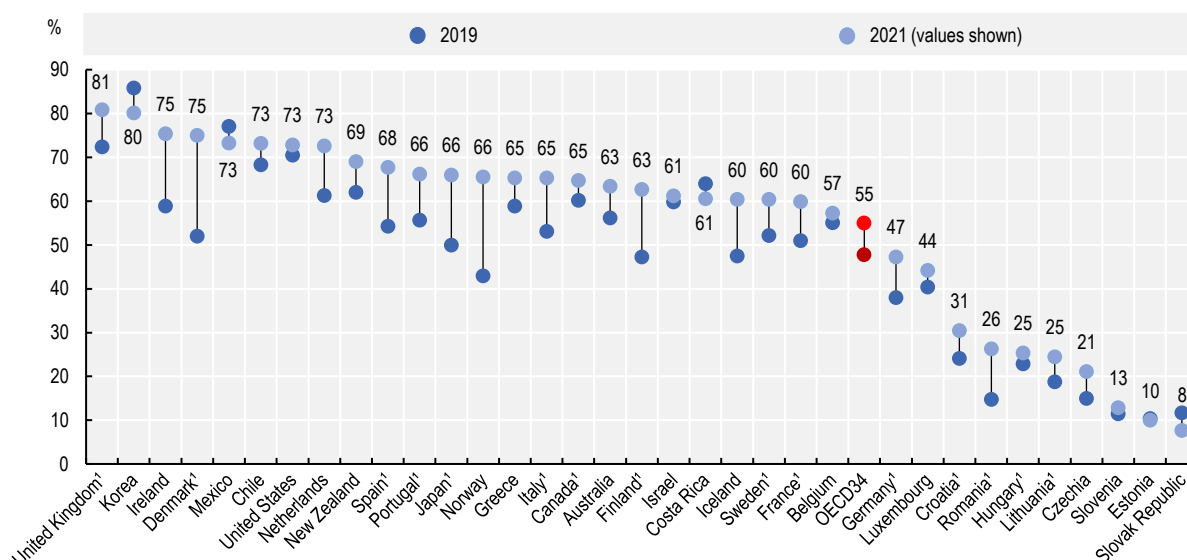
Encouraging healthy lifestyle choices can help people live longer in good health. For example, engaging in physical activity lowers the prevalence and severity of chronic diseases, improves mental health and bone density, and reduces muscle loss and osteoporosis, thereby helping to decrease falls and related injuries and activity limitations (Bull et al., 2020^[66]; OECD/WHO, 2023^[67]). Choosing healthy eating also reduces the mortality risks related to cardiovascular disease, one of the most significant contributors to the life expectancy stall, by helping to avoid putting on weight and taking in essential nutrients (Ramsay et al., 2020^[59]; Steel et al., 2025^[68]; Mehta, Abrams and Myrskylä, 2020^[71]). Improving oral health literacy among older adults can help encourage preventive dental visits and enable them to make informed choices (Lowenstein, Singh and Papas, 2025^[63]). Proactive measures to help make healthy lifestyle choices can support healthy ageing and improved quality of life in old age. Investments in prevention measures, such as routine health checkups, immunisations, and screenings, can help mitigate risks before they escalate (see Chapter 3).

At the same time, the share of older people having received routine vaccinations is heterogeneous across OECD Member countries and often ranks below international recommendations. In 2021, only the United Kingdom, Korea, Ireland and Denmark met the WHO and the 2009 EU Council Recommendation to have at least 75% of their population aged 65 and above vaccinated against influenza (European Council, 2009^[69]). The share varied widely across OECD countries, ranging from 80.9% in the United Kingdom to 7.7% in Latvia, with the average of 34 OECD countries amounting to 55% (Figure 2.8). Particularly, people of a lower socio-economic status, lower levels of education, and lower levels of income display lower vaccination rates than those of a higher socio-economic status, the more educated and more

affluent (Okoli et al., 2020^[70]; Gatwood et al., 2020^[71]). These gaps in vaccination make older people more vulnerable to communicable diseases which are vaccine-preventable, leading to higher death risks as shown in England (Raleigh, 2024^[72]).

Figure 2.8. Most OECD countries do not meet the recommended vaccination rates for older people

Percentage of population aged 65 and over vaccinated for influenza, 2019 and 2021



Note: 1. Data refer to the calendar year 2020 or the flu season 2020/21; otherwise, refer to the calendar year 2021 or the flu season 2021/22.

Source: OECD Health Statistics (2023^[73]), "Immunisations" (Indicator), <http://data-explorer.oecd.org/s/2g5>.

Participation is also largely insufficient in public screening programmes, such as cancer screening. The European Council recommends breast cancer screening for women aged 50-69, colorectal cancer screening for individuals aged 50-74, and cervical cancer screening for women aged 30-65. In 2021 (or the latest year available), only five out of 29 countries in the European Region exceeded participation rates in all three cancer screening programmes, them being Austria, Denmark, Finland, the Netherlands and Slovenia (OECD, 2024^[74]). This limits the potential of early diagnoses and early intervention, which are essential to reducing the impact of cancer on individuals.

Part of the reason for the low participation of older people might be related to health literacy. Older people are displaying lower levels of health literacy than younger ones. Across EU countries, the shares of people needing help to read medical instructions are larger for older age groups. At ages 65-74, 16% of people need help to read medical instructions and this share nearly doubles to 29% among people aged over 75 (OECD/European Commission, 2024^[17]). Promoting health literacy in communities, as discussed in Chapter 3, might help older people make informed choices that benefit health across their lifespan, while also increasing access to services for uptake.

2.3.2. Complex health needs in old age require people-centred and integrated approaches

Older people are vulnerable to age-related health conditions, such as falls, frailty, and cognitive decline. Falls are common among older adults, often caused by multiple risk factors at biological, individual, environmental, and social levels, necessitating multifactorial interventions for prevention. In the United States, each year, about 1 in 3 people aged 65 and older and 1 in 2 people aged 80 and older

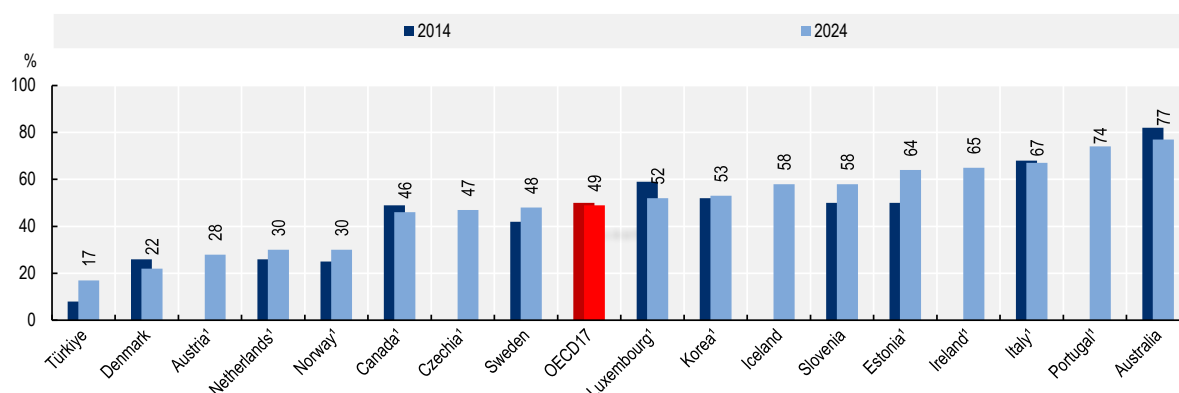
experience at least one fall (CDC, 2023^[75]). Falls can lead to bone-related injuries, accelerated frailty, and even deaths in older adults, resulting in emergency department visits and increased health expenditures (WHO, 2021^[76]; Florence et al., 2018^[77]; Dykes et al., 2023^[78]). Cognitive impairment and decline are also prevalent conditions in old age, affecting 20 to 50% of the population aged 65 or older (Manly et al., 2022^[79]; Yao et al., 2020^[80]). Cognitive decline is a well-known precursor to dementia, which is the second leading cause of disability among people aged 70 and older, costing over USD 1 trillion annually worldwide (OECD, 2018^[81]).

The risk of chronic conditions and disability also increases as people age (OECD, 2023^[44]). Across OECD countries, nearly two in three people aged 65 and over live with more than one chronic condition (OECD, 2019^[82]). Mental health issues are also significant in old age, with more than 35% of people aged 75 or over having multiple depressive symptoms in the EU in 2021-2022 (OECD/European Commission, 2024^[17]). Depression and anxiety are the most common mental health conditions for older people and increase their risk of developing certain chronic diseases, including heart disease, diabetes, stroke, pain, and Alzheimer's disease (National Institute of Mental Health, 2024^[83]). Chronic conditions and mental health significantly impact instrumental activities of daily living limitations in older adults. Multiple chronic conditions are associated with increased ADL and IADL limitations, with the effect varying by age and specific tasks (Mueller-Schotte et al., 2020^[84]; Nguyen and Hong, 2023^[25]). Likewise, mental health conditions account for 10.6% of the total disability in old age (WHO, 2023^[85]). The synergistic effect of concurrent mental and physical chronic conditions predicts persistent and future incidence of IADL limitations and self-reported poor health, dragging down the improvement in healthy life expectancy (Gontijo Guerra, Berbiche and Vasiliadis, 2021^[86]; UK OHID, 2023^[58]).

The presence of multiple chronic conditions among older people often results in polypharmacy, where they are prescribed an increased number of medications to manage their complex health needs (OECD, 2025^[87]). Across 15 OECD countries with available data, around half of the population aged 75 and above took at least five medications at the same time, ranging between 21% (Denmark) and 89% (Luxembourg) (Figure 2.9). Polypharmacy increases the risk of inappropriate medication usage, inappropriate prescription, insufficient monitoring, poor adherence, adverse drug interactions, and dosage errors (Gurwitz et al., 2003^[88]). It could also lead to a higher risk of falls, disability, memory problems, and death (Hung, Kim and Pavon, 2024^[89]; OECD, 2023^[11]), increasing emergency hospital admissions, healthcare costs and resource inefficiency (Budnitz et al., 2021^[90]; Clark et al., 2020^[91]; Schiavo et al., 2022^[92]; Chang et al., 2020^[93]).

Figure 2.9. One in two older people have experienced polypharmacy consistently over the past decade

Share of population aged 75+ taking more than five medications concurrently, 2014 and 2024



1. Latest data from 2022-2023.

Source: OECD Health Statistics 2023, <https://www.oecd.org/en/data/datasets/oecd-health-statistics.html>.

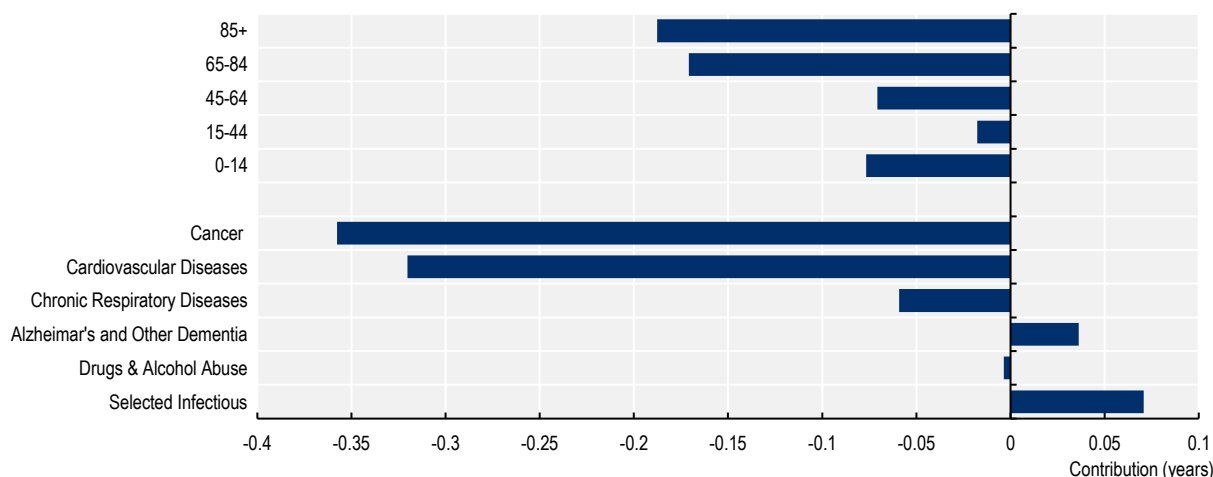
Health systems can enhance their awareness and responsiveness to the health conditions of older adults. The specific vulnerabilities and needs of older adults may be overlooked in community and primary care settings due to a lack of awareness and ageism among older individuals, their families, and healthcare professionals. New workforce models, with care pathways for older people and co-ordination across different professionals, can help detect and manage age-related health issues such as polypharmacy, chronic diseases, falls, and cognitive decline (see Chapter 4).

2.3.3. Shifting disease patterns require a new approach to long-term care

The changes in the dominant causes of illness and death over the past decades have significantly contributed to the stagnation in life expectancy gains, having chronic diseases and complex comorbidities in older populations – particularly Alzheimer’s disease and other dementias, as key contributors (Raleigh, 2019^[4]; Darlington-Pollock and Norman, 2019^[94]). Alzheimer’s and other dementias have become a leading cause of death across the OECD, particularly in the United States and the United Kingdom, where there has been a surge in deaths attributable to dementia by over 70% between 2000 and 2013, although this could be partly attributed to a change in the classification due to better diagnosis and awareness of dementia (Murphy and Grundy, 2022^[95]; OECD, 2023^[96]; OECD/European Commission, 2024^[17]). From 2010 to 2020, there have been marked slowdowns in mortality due to cancer and cardiovascular diseases, contrary to the growths in selected infectious diseases (including COVID-19) and Alzheimer’s and other dementias (Figure 2.10). Alzheimer’s and other dementias contributed to a 0.04-year increase in the life expectancy gap compared to the previous decade.

Figure 2.10. Dementia has had a considerable negative impact on life expectancy

Number of years each cause of death contributed to the life expectancy gap, 2000-2009 and 2010-2020



Note: The life expectancy differentials are decomposed into age and cause-specific components using the analysis based on Arriaga decomposition (2014^[97]).

Source: OECD analysis based on the WHO Mortality Database.

Moreover, Alzheimer’s and other dementias are closely linked to an increased risk of activity limitations and disability. Neurovascular dysfunction that causes dementia leads to both cognitive decline and functional impairment, while increasing frailty and the risk of falls, leading to higher morbidity and mortality over time (Nguyen and Hong, 2023^[25]; Xia, Ntim and Wang, 2025^[98]). These effects are further compounded when dementia co-occurs with other chronic conditions, such as depression, cardiovascular diseases, and musculoskeletal disorders, resulting in a higher prevalence of ADL and IADL limitations

(Marengoni, Angleman and Fratiglioni, 2011^[99]). The downstream effects of dementia on health, frailty, and survival are particularly significant in people aged 90 or over (Ramsay et al., 2020^[59]). However, having available support with everyday life, as well as good relationships with family members and relatives, can help reduce the likelihood of having functional limitations (Ćwirlej-Sozańska et al., 2019^[100]).

Long-term care systems can delay the disablement process by providing targeted interventions and support that address the care needs of older people and their families. Providing accessible, affordable, and quality care services enables countries to ensure that older people with health conditions receive the care they need at the right time. Offering a range of care options in various settings can enhance personal choices and support older people in living in less restrictive environments (Chapters 5 and 6). Furthermore, these services can reduce the emotional and financial burdens on informal carers, as well as the negative impacts of caregiving on their own health and well-being.

2.3.4. Community environment does not always support independence and quality of life for older people

Community environments influence older people's ability to remain active and engaged within their communities. Health and well-being at older ages are determined by multiple interacting factors, including individual physical and mental conditions, social connections, and the environment where people live and interact (Abdi et al., 2019^[101]; Ćwirlej-Sozańska et al., 2019^[100]). Older people's basic needs, such as housing, food security, and basic mobility, significantly affect their care needs at home and in the community and health-related quality of life (Dobarrio-Sanz et al., 2023^[102]; Baptista et al., 2018^[103]). Among others, a home is where older people spend most of their time (Hatcher et al., 2019^[104]), and therefore, housing quality is vital for their ability to age healthily in place. Good quality housing can reduce respiratory, cardiovascular, and infectious diseases in older people (Howden-Chapman et al., 2023^[105]), while promoting independence, reducing the risk of injury, and improving their quality of life (Oswald et al., 2007^[106]). However, many older people still have unmet housing needs that support their age-related lifestyle changes (see Chapter 5).

Community programmes that encourage older people to participate in social engagement opportunities and urban planning can positively impact their mental and physical health. Interpersonal factors, such as social engagement and cultural attitudes, also influence healthy ageing. Sufficient social support is linked to reduced disease and mortality, with psychological mechanisms involving stress buffering and brain networks affecting health and longevity (Vila, 2021^[107]). In the past decade, the number of older people living alone has risen. In 2022, more than 30% of older people aged 65 or older were living alone across the OECD (OECD, 2024^[108]). Changes in health and social connections, such as the loss of hearing, can heighten the risk of social isolation and loneliness (Reed et al., 2025^[109]). Social isolation and loneliness can pose higher risks for physical and mental health and increase the likelihood of developing dementia in older people, even with increased use of long-term care services and support (Pomeroy et al., 2023^[110]; Livingston et al., 2020^[61]).

The spatial design of public spaces, including walkable streets, street furniture, and green spaces, promotes later-life health outcomes and life satisfaction and reduces difficulties in physical activities for those already experiencing functional decline (Finlay et al., 2025^[111]; Laborde, Ankri and Cambois, 2022^[112]). Increased access to diverse food options and services, facilitated by public transportation, promotes older people's independence and mobility and reduces their need for assistance (Levasseur et al., 2015^[113]).

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Notes

¹ LTC needs are defined as low, moderate, and severe levels based on corresponding hours of care per week. See Box 1.1 in OECD (2024_[3]) for more details.

² See https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1.

³ This study uses the global activity limitation indicator (GALI), an instrument measuring longstanding activity limitation in performing usual activities due to health problems, with a survey item from the EU-SILC: “For at least the past six months, have you been hampered because of a health problem in activities people usually do? Yes, strongly limited / yes, limited / no, not limited” (OECD/European Commission, 2024_[17]).

3

Promoting healthy ageing from the outset

This chapter presents policy options countries have to outright prevent health complications for older people and to help them recover their functional ability after a sudden deterioration of their health. It discusses means to improve health literacy to empower people to make healthy lifestyle choices and to manage complex care needs as well as policies to support people in taking up healthier behaviours. It zooms in on strategies to identify people at risk to allow for targeted and timely interventions, such as fall interventions, and closes with an overview of policies to support the reablement of people to help them recover the capacity to perform (instrumental) activities of daily living.

Key messages

- **Large parts of the population display unhealthy lifestyles.** Sedentary behaviours and unhealthy diets limit the potential of healthy ageing and translate into higher healthcare costs at a later stage. Low levels of health literacy further limit the potential of older people to make healthy choices. Unhealthy behaviours come at a cost: Obesity and related diseases were estimated to reduce life expectancy by 2.7 years, and healthy life expectancy by 3.2 years on average across the OECD from 2020 to 2050.
- **Policies are insufficiently targeted.** Policies work most effectively when they target people at risk. For example, fall prevention only has a significant benefit when it targets people who are at risk of falling, such as frail older people. This requires a good identification of people at risk who benefit from such interventions to ensure effective and efficient delivery of care amid workforce shortages and financial constraints.
- **Investment in prevention remains low across the OECD.** In 2023, OECD countries spent about 0.3% of their GDP on prevention, equating around 3.3% of their total spending on health. This limits the scale and scope of programmes and the impact they have in leading to tangible effects.

Policy options

- **Building health literacy.** Health literacy builds the knowledge to make healthy lifestyle choices and manage complex care needs. Health workers are key in building health literacy but often operate under time constraints and only reach people who already interact with them. Hungary has introduced Health Promotion Officers across the country, and Austria and Switzerland have introduced a foundation that supports health literacy programmes across the country in communities.
- **Promoting a healthy lifestyle adapted to the needs of older people.** The benefits of healthy lifestyles, such as good diet and high levels of physical activity, are clear and well-established. For example, regular physical activity can reduce the rate of falls among older people by 38%. Group physical activity programmes might be more motivating for older people to follow, improve physical activity, and can also be beneficial to help fighting social isolation. For example, Japan facilitates a community-led sports course that helps older people increase their physical activity while also building social networks.
- **Identifying people at risk.** Public health measures that target broad populations offer few gains, but targeted measures, for example towards frail people, yield positive effects. This makes an effective and successful identification of people at risk a key building block for healthy ageing. Ideally, these screenings are not based on chronological age but on specific risk parameters. In Denmark, municipalities offer preventive home visits to people who have experienced an event that could lead to a deterioration in their health, such as a hospitalisation or the death of their partner. Preventive home visits were also positively evaluated in Norway and reduce the use of healthcare resources, such as emergency hospitalisations.
- **Integrating and expanding reablement across the healthcare system.** Reablement aims at supporting independence, relearn (instrumental) activities of daily living and reduce the need for long-term care. It is typically provided to people in their home-based setting after a health event, such as a fall and a hospitalisation, or upon the deterioration of their health. The concept is new, and evidence is scarce, but where available, points at promising results. Reablement remains in its infancy and access is heterogeneous within OECD countries.

3.1. Harnessing the potential of prevention and reablement at older age

Many older people do not live a lifestyle that puts them on a trajectory towards healthy ageing. Healthy behaviours, such as regular physical activity, a balanced diet, low alcohol consumption and non-smoking are key predictors of healthy ageing, slow down the process of ageing and can prevent health conditions and limitations or reduce their severity (Sowa et al., 2016^[1]). For example, physical activity has consistently been identified as a successful strategy to reduce cognitive decline and falls. It can lower the number of people aged 65 and above that experience at least one fall by 15%, and the incidence of falls by 38% (Sherrington et al., 2019^[2]). Once people have developed limitations and chronic diseases, interventions require substantial, concerted effort to prevent a worsening of their health. While the evidence on the benefits of prevention is clear, policies that target populations that have already developed certain conditions, such as frailty, yield more mixed results (Yao et al., 2020^[3]; Sherrington et al., 2019^[2]; El-Khoury et al., 2015^[4]).

Across the OECD, public health indicators, such as physical activity rates, alcohol consumption, smoking and vaccination coverage against vaccine-preventable diseases indicate further room for improvement (OECD, 2023^[5]; 2019^[6]). In most countries, the majority of people lives a lifestyle that does not meet the recommendations by the World Health Organization (WHO) and national institutes (OECD, 2023^[5]; OECD, 2019^[6]). This puts them at risk for adverse events, such as falls, which occur frequently among older people. For example, in Australia, Canada, France and the United States, around one fourth to one-third of those aged 65 and above, and about half of those aged 80 and above report at least one fall per year (AIWH, 2023^[7]; CDC, 2023^[8]; Santé Publique, 2020^[9]; Public Health Agency of Canada, 2022^[10]). Falls increase healthcare consumption, such as visits to emergency departments following fractures and hospital readmissions, increase health expenditures, reduce quality of life and are a major cause of mortality (Florence et al., 2018^[11]; Dykes et al., 2023^[12]; Hoffman et al., 2019^[13]). A share of these falls and costs associated with them could be reduced by healthier lifestyles.

Healthier lifestyles and prevention have a clear economic benefit. OECD calculations using the OECD's *Strategic Public Health Planning for NCDs (SPHeP-NCDs) model* show that meeting the WHO recommendations of 150 minutes of physical exercise could increase life expectancy by 7.5 months and healthy life expectancy by 7.9 months on average for those that are currently insufficiently active across the 27 countries of the European Union over the period between 2022 and 2050 (OECD/WHO, 2023^[14]). Obesity and related diseases were estimated to reduce life expectancy by 2.7 years, and healthy life expectancy by 3.2 years on average across the OECD over the time span from 2020 to 2050. While these calculations estimate gains that are accumulated across the lifespan, prevention and promoting healthy behaviours at an older age can still generate positive returns and improve healthy ageing.

3.1.1. Early intervention is desirable, but prevention can still be (cost-)effective in old age

Early prevention is desirable and can yield better returns than prevention at a later age. Firstly, behaviours are easier to influence when people are still in the process of forming them (Heckman, Pinto and Savelyev, 2013^[15]). Patterns are shaped by socio-economic and environmental characteristics and are difficult to break. They are handed over from parents and grandparents to children and are often exacerbated by time and money constraints. Earlier intervention at a point where behaviours are still in the process of being formed require less intense policies than those that target people who have already spent several decades with unhealthy lifestyles and who might already experience negative consequences of these behaviours, such as chronic diseases. Secondly, earlier interventions can extend the duration to which people live healthily. This increases the cost-effectiveness of programmes that target people at a younger age. Thirdly, younger people are often easier to target. In most OECD countries, compulsory education ranges from 6 years or below to 16 years, allowing for at least a decade of policy interventions, and contain a share of

instruction time dedicated to physical education (OECD, 2023^[16]). Working-aged people can be targeted through workplace interventions, such as incentivising cycling to work (OECD/WHO, 2023^[14]). Thirdly, the contribution to the gross domestic product (GDP) is greater from increased labour market supply and productivity through healthier lifestyles.

Nevertheless, prevention and promoting healthy behaviours at an older age can still generate positive returns and improve healthy ageing. Across the OECD, almost one in five people are aged 65 and above, thus representing a considerable share of the population, and countries might want to offer support to live healthier lives and participate in prevention measures to already existing populations. Secondly, not every public health measure has a long trajectory. For example, vaccinations against seasonal influenza are strongly recommended for everyone aged 65 and above, and for younger people only when certain risk factors, such as diabetes, are present, and influenza vaccinations are only valid for one year. Thirdly, support for healthier behaviours and prevention measures that target older people have shown to lead to improved health and lower expenditures even if only picked up at a later age. For example, people that increase their physical activity at the age of 60 or 65 can still significantly benefit and delay the onset of physical impairments (Hamer, Lavoie and Bacon, 2013^[17]). Physical activity in older age reduces falls, supports cognitive and emotional functioning and improves well-being and quality of life (Pinheiro et al., 2022^[18]).

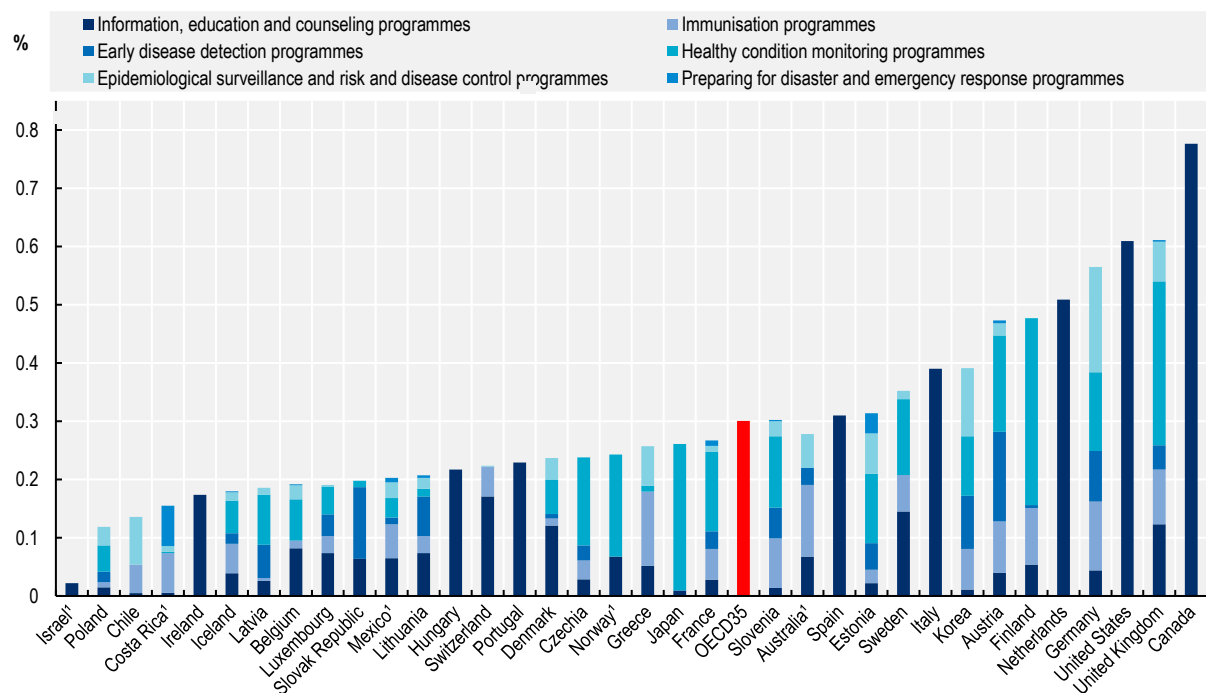
3.1.2. Spending on prevention is low and programmes are insufficiently targeted to older people

Despite the clear and manifold evidence of the positive effects of healthy lifestyles and prevention on healthy ageing, adherence to and compliance with recommendations is difficult to realise. Older people that make unhealthy lifestyle choices have usually already spent many years with these habits, making these patterns difficult to break, or experienced recent lifestyle changes that make it hard for them to keep up with healthy behaviours. Older people tend to be in a disadvantaged situation over their younger peers. Health literacy – especially using health information online – is lower in older and less educated people than in younger and better educated ones, limiting their potential to make healthy lifestyle choices and to manage complex health conditions, such as several chronic conditions concurrently (OECD, 2025^[19]; Kwon and Kwon, 2025^[20]). Older people can already face limitations that present additional barriers to healthy lifestyles. For example, they avoid physical activity because they lack of strength, discomfort and pain as some obstacles that prevent them from doing sports (Hida et al., 2023^[21]). In addition, financial barriers of access, and competing tasks, such as caregiving responsibilities, can further deter people from physical activity. A share of older people also experiences cognitive decline and dementia which can negatively affect the extent to which they can consume and apply health-related information (Rostamzadeh et al., 2020^[22]).

Countries currently invest limited resources into prevention, which restricts the scale and scope of measures to support healthy lifestyles and prevention. In 2023, OECD countries spent around 0.3% of their GDP on prevention, representing 3.3% of their total spending on health (See Figure 3.1). Only in 6 out of 22 countries where a more granular breakdown of spending on prevention was available, spending on information, education and counselling amounted to 1% or more out of total health expenditures.

Figure 3.1. Spending on prevention remains low across OECD countries

Spending on prevention by health function as part of total health spending, 2023 (or latest available year)



1. Data refers to 2022.

Source: OECD (2025^[23]), "Health expenditure and financing", <https://data-explorer.oecd.org/s/2wd>.

3.1.3. Countries can make better use of prevention and reablement through action in four policy areas

Figure 3.2. Four policy areas of prevention and reablement to improve Healthy Ageing



Four policy areas prevail for OECC countries to better harness the potential of prevention and reablement to advance on healthy ageing. Firstly, they can help people to make healthier lifestyle choices. For example, countries can improve health literacy through information, education and training that inform older people about the benefits of living a healthy lifestyle and use financial incentives to nudge them. Secondly, countries can promote the participation of older people in public health measures, such as regular screening to reduce the rate of preventable diseases. Thirdly, countries can work with different tools to identify people at risk, for example people that are frail and at the risk of falling and might require additional support to avoid falls to improve the effectiveness of healthcare interventions. Finally, countries can help citizens to regain their health after a health shock, such as trauma-related injury. This section first describes policies countries have in place before it synthesises and reflects on the evidence of each of these policy areas and formulates policy recommendations on which policies to advance further.

3.2. Helping people live healthy lives

OECD countries have well-recognised the importance of supporting their populations in leading healthy lifestyles. All 29 OECD countries that responded to the *OECD Questionnaire on Healthy Ageing and Community Care* have introduced some type of policy in this field. These aim at improving the health literacy of people to empower them to make healthy choices, and to further support them in adopting healthier behaviours by improving access and nudging them towards living more healthily.

3.2.1. Health literacy equips people with the skills needed to make healthy choices

High levels of health literacy are related to better health outcomes, as people more often live healthy lifestyles, follow screening and vaccination guidelines and adhere to the treatments they need (Chesser et al., 2016^[24]). Health literacy refers to the ability to access, understand, evaluate and act upon health information and are a key contributor to good health outcomes. Vice versa, insufficient levels of health literacy of older adults drive up healthcare utilisation and expenditures and hamper the effectiveness of education and training for people to self-manage their health, such as education to reduce falls, and increase mortality (Park et al., 2024^[25]; Bostock and Steptoe, 2012^[26]). Effective interventions to support health literacy can save significant resources by equipping people with the skills to make healthy lifestyle choices and to self-manage their health conditions, which can reduce healthcare needs, delay the worsening of health conditions, reduce their severity and help avoid adverse events, such as avoidable hospitalisations (MacLeod et al., 2017^[27]; Moreira, 2018^[28]).

While promoting health literacy ideally starts in school, specific interventions targeting older people can still be effective and are essential in supporting this population in confidently managing their own health. Older people display lower average levels of health literacy while having more complex needs (Lee and Oh, 2020^[29]). At the same time, they face additional challenges in maintaining and improving health literacy. Some of them already suffer from cognitive impairment and difficulties to read and to hear, which affects their ability to process information. This collides with their need to manage more complex conditions, such as several chronic diseases and the intake of multiple pharmaceuticals concurrently, raising the need for health literacy. Health literacy is strongly associated with socio-economic status and particularly educational attainment, and risks exacerbating differences in healthy ageing by socio-economic status and education (Stormacq, Van den Broucke and Wosinski, 2019^[30]; Cutilli et al., 2018^[31]).

3.2.2. Platforms are a great first step, but might reach only those that are already somewhat literate

The majority of OECD countries (23 out of 29 countries that responded to the *OECD Questionnaire on Healthy Ageing and Community Care* have advertisements and information campaigns in place to improve health literacy of their population and to help older people make informed choices. Countries have built information platforms that offer advice to their population on how to live and age healthily and where to find additional support. For example, in **Australia**, **Canada** and **Spain**, national and subnational levels offer information including free phone and online coaching, such as *Active and Healthy* by the Government of New South Wales, or *En buena edad* by the region of Andalucía. **France** has set up the webpage *Pourbienvieillir*, which offers information on preparing for the retirement, maintaining good physical and mental health, remaining socially active and ageing better at home. **Germany** offers the platform *Gesund und aktiv älter werden* as well a national health portal (*gesund.bund.de*) and the government works together with leading associations of the healthcare system in the alliance for health literacy, while **Japan** operates the *Online Kayoinoba App* alongside dedicated websites with good practices for older people. **New Zealand** offers the digital balance app *Nymbi* to people aged 50 and above in addition to the website *Live Stronger For Longer*. Dietary and physical activity guidelines (*Eating and Activity Guidelines for New Zealand Adults*) offer further directions to older people. **Luxembourg** offers a similar website that offers advice on nutrition and physical activity (*Gesond iessen, Méi beweegen*). In the **Slovak Republic**, the Public Health Authority offers information leaflets alongside health literacy and awareness-raising activities by regional public health authorities and in **Türkiye**, public institutions and organisations offer posters, brochures and electronic messages to inform and support older people in living healthily.

Evaluations of mass media and information campaigns suggest a positive effect on selected healthy behaviours, such as a reduction in sedentary behaviour (den Braver et al., 2022^[32]; Stead et al., 2019^[33]). Interventions to increase older people's health literacy can achieve a lot, but they cannot reach everyone

or eradicate socio-economic disparities, making it is crucial to ensure that healthcare is more accessible to those with low health literacy. This can include introducing less complex service structures, simplifying health-related documents, training doctors to give plain language explanations and sending out regular reminders for screenings and vaccinations to facilitate adherence (OECD, 2025^[19]). Adapting communication and intervention strategies to the health literacy level of the target population and to the specific needs of older people is key to ensure that messages are well received and clearly understood (Michel and Goldberg, 2021^[34]).

3.2.3. Health workers are key in improving health literacy, but require people to have good access

Health workers, particularly primary care physicians and nurses, play a key role in improving health literacy, as they are generally primary point of contact for patients and are well-equipped to assess their knowledge and provide targeted guidance. Health workers enjoy high levels of trust and are often already involved in the treatment pathway of older people. As digital health literacy is lower among older people than among younger people, older people have limited means to turn to alternative sources to health workers and to educate themselves, which reinforces the role of health workers in building health literacy among older people (OECD, 2025^[19]).

While measures delivered by health workers are essential, it is also crucial to note that since not everyone has a general practitioner or access to dental care or other healthcare professionals, they may fail to reach some of the people who would need it most (Batterham et al., 2016^[35]). Training non-health workers who frequently interact with older people, such as meals-on-wheels volunteers (Rubin et al., 2014^[36]) or religious and community leaders (Rivera-Hernandez, 2015^[37]; Cook, 2021^[38]) as health literacy coaches can thus be an important supplement to general practitioner-based interventions.

3.2.4. Partnering with other stakeholders can help diffuse health literacy across communities

OECD countries often partner with local stakeholders, such as civil societies, to reach individuals at the local level, and some countries have set up contact points across the country. For example, **Hungary** has introduced Health Promotion Offices that aim at helping individuals to develop health-related skills and promote healthy lifestyles, such as physical exercise and nutrition, help communicate guidelines, such as on nutrition, strengthen community action and support, and support the uptake of public health measures, such as screening. **Austria** and **Switzerland** have both launched funds, the *Fonds Gesundheit Österreich* and *Gesundheitsförderung Schweiz/Promotion Santé Suisse/Promozione Salute Svizzera*, which co-ordinate and financially support health promotion programmes. Both countries now offer a broad set of activities on the community-level to inform people of strategies to live healthier. For example, the Cantons Zurich and Bern (*Zwäg ins Alter*) offer advice on health and prevention for older people, and the programme *HEKS AltuM Zürich/Schaffhausen* in Zurich and Schaffhausen offers support for migrants aged 55 and above and refugees aged 50 and above and their families that offers information and counselling on ageing and living in Switzerland as well as sports courses, tandems and meetings with that are offered in a variety of languages. The project *Tavolata* brings together older people in a private or semi-private setting to cook and eat together and helps supporting a balanced diet while fighting social isolation. In addition, **Austria** is currently testing model regions (*Modellregion für Gesundheitskompetenz und -förderung*), for example in the region Liezen in the Steiermark. Regions offer approved and easily understandable information, health workers are trained in patient-centred communication, physical and activity programmes, information offers guidance on how to navigate the health system, and counselling on nutrition and health checkups aims at preventing health limitations. In **Canada**, the province of New Brunswick has launched the *Healthy Aging Champion* programme, where people aged 60 and above promote healthy ageing, work

with community organisations that support and promote healthy ageing and share their own experiences on healthy ageing.

Health literacy campaigns have to balance outreach, costs, effectiveness and targeting. Broad awareness campaigns, for example via posters, newspapers or television, yield smaller results but may reach more people. Educational interventions for health literacy among older adults are most effective when they include active and interactive learning components, e.g. if participants apply their learnings within the scope of the programme and collaboratively design plans for healthy lifestyle changes. For example, a 24-week active learning programme for community-dwelling older adults with low health literacy in **Japan** yielded significantly improved health literacy, lifestyle behaviours, physical function, and mental health compared to a didactic learning course (Uemura, Yamada and Okamoto, 2021^[39]).

Health literacy campaigns often reach those best that are already receptive to information. People who respond better to these campaigns are generally higher educated, which risks increasing differences in healthy ageing by socio-economic status (Moreira, 2018^[28]). Countries can counter this through an active outreach to people at risk. Places where older adults often gather, such as churches, community centres or adult day care facilities can also be pivotal in distributing health literacy messages and conducting campaigns (de Wit et al., 2018^[40]).

3.2.5. Benefits of healthy lifestyles are well-established, but need targeted interventions to reach individuals

The benefits of physical activity on healthy ageing are well-established and manifold. Physical activity reduces the risk of chronic diseases and cognitive decline, prevents falls, fights sarcopenia, has a positive effect on mental health and reduces loneliness if performed in a group. This translates into lower healthcare costs and a lower burden on healthcare systems. To date, there is a wide range of activity programmes across countries with demonstrated success in improving physical strength and stability, reducing the number of falls, delaying the onset of limitations of daily living and mild cognitive impairment (Table 3.1). Broadly speaking, most types of physical activity programmes improve people's health, reduce adverse events and are often cost-effective. Structured programmes of 12 to 24 weeks were found to be able to reduce the number of falls by around 30-40% (See Table 3.1).

Table 3.1. Several structured, evidence-based physical exercise programmes are now available

Programme name	Objective	Description	Findings
Activating Falls and Fracture Prevention in Ireland Together (AFFINITY)	Reducing risk of and harm from falls and bone fractures	Multi-stakeholder and multi-disciplinary approach: fall prevention activities (e.g. exercise programmes, physiotherapy, awareness raising), integrated clinical care pathway for falls treatment and rehabilitation	Only limited process and implementation data available so far
AlltagsTrainingsProgramm (ATP)	Increase physical activity and incorporate it into daily life	Tips and guidance on how to build exercise into daily routines for older people with low levels of physical activity, group exercise classes with trained coaches 12-week intensive prevention courses or ongoing programme	High satisfaction of participants, 95% would do the programme again and 100% would recommend it. 93-95% reported having integrated more physical activity into their daily lives and two-thirds built lasting social connections
Falls Management Exercise (FaME) programme	Improve balance, functional strengths, reduce falls	24-week intervention for older adults	Reduced number of falls, increased physical activity levels and well-being among older adults

Programme name	Objective	Description	Findings
FINGER	Prevent cognitive decline	2-year multidomain intervention including diet, exercise programme, cognitive training and vascular risk monitoring for people with high dementia and cardiovascular risk	Improvements or better maintenance of cognitive function compared to control group, potential for delaying the onset of dementia and Alzheimer's disease
Fujisawa +10 exercise program	Community-wide increase in physical activity, dementia prevention	Information, education, and awareness campaigns to highlight importance of physical activity, regular low-intensity exercise groups. Motto "+10" (10 more active minutes than now)	Balanced health improvements, including functional health, mental and social well-being, cognitive function
Good Life with osteoArthritis in Denmark (GLA: D)	Improve access to education and treatment and reduce the need for surgery for knee/hip osteoarthritis and ongoing/recurring back pain patients	Educating physical therapists to deliver patient education and neuromuscular exercise training, two education sessions and at least 6 weeks of neuromuscular exercise	Significantly less pain, sick leave and medication use, higher walking speed and quality of life. 8-9 out of 10 patients are very satisfied with the intervention
Healthy Activity & Physical Program Innovations in Elderly Residences (HAPPIER)	Reduce falls and physical decline	12-month weekly exercise and light gym programmes across retirement homes, adapted to the person's physical and mental capabilities	Prevents on average one fall every 18 months per person, improves balance and subjective health and well-being indicators, reduces aggression. Benefits largest for residents < 83 years-old, with BMI < 22, and with walking difficulties. Highly cost-effective
Lifestyle integrated Functional Exercise (LiFE) programme	Fall reduction	Lifestyle integrated approach to balance and strength in high-risk people living at home: teaching balance and strength training principles and integrating balance and lower limb strength exercises into daily routines	Reduced falls by around 30% compared to control group with gentle exercise programme. Improved balance, ankle strength, ADL function, and participation
Matter of Balance (MoB0)	Reduce falls and increase activity among community-dwelling older adults	Virtual or in-person educational and exercise programme of 8 two-hour classes in groups of 8-12 led by two trained coaches	Reduced fall rates, increased confidence and activity levels
Otago Exercise Program	Fall reduction	17 strength and balance exercises provided by a Physical Therapist	Reduced falls by 35%-40% for frail older adults, more effective as group programme than when performed individually (Chiu et al., 2021 ^[41] ; Mgbeojedo et al., 2023 ^[42]).
Stay Active and Independent for Life (SAIL)	Improve strength, balance and fitness, reduce falls	One-hour group fitness classes led by community volunteers, fitness trainers and healthcare professionals, 2-3 times per week	Reduction in falls and fall risk factors, improvements in ADLs, strength, balance and mobility, especially for people below normal levels at baseline
Stopping Elderly Accidents, Deaths, and Injuries (STEADI)	Fall and injury reduction	3 elements: screen patients for fall risk, assess modifiable risk factors, intervene to reduce risk through various evidence-based techniques, incl. educational materials for patients and caregivers, medication, home adjustments, nutrient supplements, exercise programmes, etc.	Fewer falls and sustained injuries from falls, fewer and shorter fall-related hospitalisations, improved fall-risk scores

Programme name	Objective	Description	Findings
Stepping On	Fall reduction	7-weeks fall reduction programme, 2h per week. Group classes and individual follow-up on fall risks, strength and balance exercises, home hazards and adaptations, safe footwear, mobility, medication, vision and falls, etc.	31% fall reduction in the community, less fall-related healthcare use, increased confidence. Ineffective with Parkinson's Disease patients and certain other neurological disorders. Cost-effective
Tai Ji Quan Moving for better Balance	Fall reduction, improving stability, co-ordination and motion range	Functional balance training and movement therapy based on Tai Chi with an 8-form core and variations adapted to the person's capabilities	55%-58% fall reduction, improved lower limb strength, sensory integration, stability, and cognitive function. Highly cost-effective

Source: AFFINTY: (HSE, 2024^[43]); ATP: (BIÖG, n.d.^[44]; BIÖG, n.d.^[45]); FINGER: (Ngandu et al., 2015^[46]); Fujisawa +10: (Komatsu et al., 2017^[47]); GLA: D: (Thalund Grønne et al., 2021^[48]); HAPPIER: (Senik, Milcent and Gerves, 2015^[49]); LiFE: (Clemson et al., 2012^[50]); MoB: (aging, 2023^[51]); SAIL: (Stay Active and Independent for Life (SAIL), 2025^[52]; York et al., 2011^[53]); STEADI: (CDC, 2024^[54]; Nesper, 2020^[55]); Stepping On: (Carande-Kulis et al., 2015^[56]; Clemson, Swann and Webb, 2025^[57]); Tai Ji: (Tai Ji Quan: Moving for Better Balance, 2024^[58]; Fuzhong, 2022^[59])

All OECD countries recommend some form of physical activity and have some policies in place that improve access to physical activity programmes by informing people of these programmes, offering them free of charge or at low cost and increasing their offer across communities. In addition, several countries have helped develop programmes, and finance or directly offer sports courses. For example, in **Germany**, the Federal Institute of Public Health (formerly *Bundeszentrale für gesundheitliche Aufklärung*) has developed a 12-weeks prevention course and a continuous sports prevention programme with sports associations and the German Sport University of Cologne and courses are now offered across the country. In **Switzerland**, a number of Cantons offer programmes to improve physical activity, moving physical activity closer to people's homes, and improving social interaction, for example through joint group walks (e.g. *Café Bâle*, *DomiGym*, *Hopp-la*, *Pas de retraite pour ma santé*, *Zämegolaufe*). **Greece** has set up community centres that offer a variety of activities including physical and cultural services (*Κέντρα Ανοικτής Προστασίας Ηλικιωμένων*, KAPI) to people aged 60 and above for free, and **Mexico** offers four cultural centres run by the National Institute for Older Adults (*Instituto Nacional de las Personas Adultas Mayores*, INAPAM) that offer free educational, physical and cultural services to people of the same age group and in **Korea**, senior welfare centres offer a variety of physical exercise classes, such as dancing and gymnastics, to older people. In **England**, Public Health England recommends the Falls Exercise Management (FaME) programme and the Otago Exercise Program, both offered free of charge or against a small user fee of GBP 3-8 per session and in the **United States**, Medicare, Medicare Advantage and private insurers also cover the Otago Exercise Program under certain conditions.

3.2.6. Promoting group exercises has benefits beyond physical activity alone

While the benefits of healthy lifestyles are well-established, participation and adherence of older people is challenging to achieve. The individual benefits of healthy lifestyles, such as physical activity, are not clear to all individuals, who might also lack of motivation, and there is a gap between the stated intention to live healthily, for example to engage in physical activity, and to actually realise it (Mandigout et al., 2025^[60]). In addition, adherence to physical activity programmes is often higher by people who enjoy better physical and mental health to begin with and that have a higher socio-economic status (Picorelli et al., 2014^[61]).

Generally, team-based or combined (group and individual components) incentives seem to be most effective, and ambitious but realistic goals and regular feedback are also key (Patel et al., 2016^[62]; Kullgren et al., 2014^[63]). Programmes that offer social interaction offer short-term gains through building social ties and increase the perceived value of being physically active. These short-term effects are more effective

than informing of the long-term benefit of physical activity, and can offset concerns about one's capability about the need to engage in physical activities (Devereux-Fitzgerald et al., 2016^[64]). Participants of the programme *Fujisawa 10+* (+10: Be active for 10 more minutes than now) in **Japan**, for example, strongly value the social interaction with people of their same age, and reported to feel as an integral part of the community (Komatsu et al., 2017^[47]). This programme combines the promotion of physical activity through information, such as the media, leaflets and T-shirts with the logo, and supports older people to voluntarily gather in their community and to perform simple exercises in the community. Since 2014, it also includes activities to prevent dementia. An evaluation over a period of five years showed that physical activity increased from 108 min per day to 134 min per day, increased for groups of a high and low socio-economic status, and improved more steeply for those of a low socio-economic status than for those of a high one (Saito et al., 2021^[65]).

Supervised programmes that are available to older people tend to show better outcomes. Unsupervised programmes offer greater flexibility and can be performed at home at a time that is most convenient to the individual, but they lack the social element of performing physical activity in a group. Supervised programmes are led by an instructor in a group. They require some form of transportation to the place where the exercise is performed and have to be integrated into a person's schedule but offer social interaction in a group and having an instructor can offer additional security to people who are afraid of falling or that fear negative side-effects of sports. The participation in both supervised and unsupervised programmes largely yields positive results (Gómez-Redondo et al., 2024^[66]), as physical exercise generally has a positive effect on an older person's health. Comparisons of health outcomes of and adherence to supervised versus unsupervised programmes suggests a slight advantage of supervised over unsupervised programmes (Gómez-Redondo et al., 2024^[66]).

3.2.7. Financial incentives can further nudge healthy behaviours, but success is mixed

Around a third of countries operates with financial incentives and financial support for certain physical activities to reduce barriers of access and to incentivise the uptake and maintenance of healthy lifestyles. For example, in **Austria**, **Germany** and **Switzerland**, health insurance funds co-pay the participation in physical exercise programmes. In **New Zealand**, the *SuperGold programme* offers discounts of in most cases around 10% to a set of health-related services, such as dentists, pharmacies, and healthy food and supplements.

While financial support for certain activities, such as physical activity, can reduce barriers of access, which are prominent among certain population groups of old age, the empirical evidence of dedicated financial incentives on the behaviour of individuals is mixed and points at some short-term gains while their sustainability is unclear (Salmani et al., 2025^[67]). While financial incentives targeting occasional behaviours like screenings or vaccinations quickly become cost-effective, evidence on the cost-effectiveness of measures to promote regular behaviours like walking and better nutrition remains mixed, especially because effects often do not last beyond the intervention period (Barte and Wendel-Vos, 2017^[68]; Finkelstein et al., 2008^[69]; Luong et al., 2021^[70]; Mitchell et al., 2020^[71]). For smoking cessation, financial incentives to providers are effective in improving the recording of patients' smoking status, smoking cessation advice, and referrals to further cessation services, but it is unclear whether this actually lowered smoking rates (Hamilton et al., 2013^[72]). Incentives for smoking cessation might need to be higher to show results and a significant share of participants relapses post-intervention, but due to the very large healthcare costs associated with smoking, they are still often cost-effective, though probably more so at a younger age (Halpern et al., 2015^[73]). For larger and most persistent effects, incentives should always be paired with information campaigns to build intrinsic motivation that can last beyond the initial intervention. Consistent monitoring and evaluation of any intervention is also essential to adjust policies and strengthen the existing evidence base.

Some design choices could improve the effect of financial incentives. Financially incentivising healthy behaviours such as physical activity, improved nutrition, or weight loss and smoking cessation aims at further supporting people in overcoming motivational barriers to build better habits that prevent or delay age-related health issues. Firstly, incentives should be specifically tied to certain outcomes rather than unconditional or attendance-based to maximise their motivating effects (Barte and Wendel-Vos, 2017^[68]). Secondly, older people may be more motivated by donations to charity, possibly because they mitigate skepticisms about the morality of financial incentives (Harkins et al., 2017^[74]). Other incentive designs that target older people's emotional and social needs, such as vouchers for family entertainment nights, may also increase engagement (Klein and Karlawish, 2010^[75]). Although not specifically about older people, Patel et al. (2016^[76]) suggest that loss-based incentives (for example, allocating a certain sum at the start and deducting money for days that a goal is not met) may be more effective than rewards as they utilise people's loss aversion. However, deposits are the least popular incentives while non-cash rewards like vouchers are most accepted, despite opposite trends regarding effectiveness. This highlights potential disparities between the methods that people may feel most comfortable with and those that are the strongest motivators in practice (McGill et al., 2018^[77]; Halpern et al., 2015^[73]). Thirdly, for the largest and most persistent effects, incentives should best be paired with other policies, such as information campaigns, to build intrinsic motivation that can last beyond the initial intervention, and efforts to strengthen social interaction (Yamashita et al., 2021^[78]).

Other type of incentives can also be beneficial. In many experiments on financial incentives, the control group also received regular feedback on their performance and showed significant improvements compared to baseline levels, often larger than those between the control and incentive group. This suggests that just consistently measuring results (such as step count or calorie intake) and discussing them may already induce behaviour changes, especially when paired with social effects (Kullgren et al., 2014^[63]). Gamification and nudges can also be powerful and cost-effective motivators that can be combined with financial incentives or used on their own. For example, just giving sedentary older adults in the United Kingdom a booklet with tips around forming activity habits and a tick-sheet for self-monitoring decreased mean sitting time and led to more light and moderate activity (Matei et al., 2015^[79]).

Inadequately designed incentives are not only inefficient but also risk unintended consequences such as crowding-out intrinsic motivation, where people may start expecting incentives and be even less willing to continue a habit once they are withdrawn (Vlaev et al., 2019^[80]). Paying for behaviours that someone would have done either way can exacerbate this, and too small or too large incentives or poor framing may also be counterproductive, so it is essential to carefully consider these aspects and build policies based on a combination of theory and existing empirical findings (Kamenica, 2012^[81]).

These findings are limited by the fact that most of the research on the effectiveness of financial incentives is not specifically about older people or even largely excludes them by being workplace-based. Although prevention ideally starts early and studies on young and middle-aged people are therefore important, the lack of research on older people creates issues as they often show distinct decision making patterns from younger age groups, and the same interventions may therefore not always be effective on them (Klein and Karlawish, 2010^[75]). Additionally, it can be harder to reach older people who are retired but not in institutional care settings, and they are often wary of explicit financial incentives and of technologies used for tracking, such as smartphone apps (Tambor et al., 2016^[82]; McGill et al., 2018^[77]).

3.2.8. Social prescribing is gaining attention, but evidence is still missing

Several OECD countries, including Austria, Canada, Germany, Ireland, Portugal, Spain and the United Kingdom (OECD, 2024^[83]), have been introducing “social prescribing” into their healthcare systems. Social prescribing refers to health workers prescribing initiatives that aim at prevention, helping to reduce loneliness and social isolation, delaying the development of care needs, reducing the care needs of those who require assistance and enabling people to live as independently as possible. Furthermore, the concept

of social prescribing has emerged as a person-centred approach to link people to non-clinical and community-based support to improve their health and well-being (The King's Fund, 2020^[84]).

Social prescribing initiatives might vary in terms of activities and services prescribed, target populations, as well as professionals involved in the referrals. The activities and services prescribed span from services that address basic material and legal needs (e.g. food, shelter, transportation), to lifestyle interventions to improve health behaviours (e.g. exercise, diet, smoking), to programmes to develop vocational skills (e.g. education, vocational training) or social activities (e.g. volunteering, arts and crafts, nature activities, community engagement). Recipients of social prescriptions might be people with chronic conditions, people who are socially isolated, those at high risk of mental illness, people with a vulnerable housing situation, as well as older people.

Social prescribing is currently gaining momentum across the OECD. In a first pilot phase, **Austria** supported 24 institutions and has just launched a new funding period for the period from 2026-2028 (Gesundheit Österreich GmbH, 2025^[85]). In **Ireland**, social prescription is now available in 30 sites across the country. Older people are one target group that is thought to benefit particularly from social prescribing, and countries have launched several programmes that specifically target older individuals. For instance, in **Canada** (Ontario), almost half the participants of social prescribing initiatives were between 61 and 80, mostly female and with low income. The professionals authorised to prescribe services as part of social prescribing practises may vary across countries, spanning from primary care physicians in **Spain** and **Portugal**, to non-clinical “link workers” in **Canada** (Alberta) and in the **United Kingdom** (England and Wales) (OECD, 2024^[83]).

Social prescribing is intuitive and intriguing, but evidence is scarce, although pointing to positive results (Husk et al., 2018^[86]; Bickerdike et al., 2017^[87]). Evidence on the impact of social prescribing practices is scarce due to the heterogeneity of such practices and their local nature. Trials often include a low number of people and suffer from high drop-out rates. A review of seven evaluations of social prescription programmes to older people reported an average completion rate of 66% (Percival et al., 2022^[88]). Where available, evidence points at some improvements in quality of life, physical and mental health (Aggar et al., 2020^[89]), while some evidence also suggests that social prescribing contributes to improved well-being and the ability to self-manage of people receiving socially prescribed services. Social prescribing has also been found to be useful to improve individuals' well-being and reducing repeat visits, as well as improving care integration (Hamilton-West, Milne and Hotham, 2020^[90]; Drinkwater, Wildman and Moffatt, 2019^[91]).

3.3. Promoting public health measures and preventive care

3.3.1. Improving access to public health services can increase their take-up

OECD countries can improve the uptake of public health services, such as vaccination rates and screenings, by informing people about their benefits, by reminding people of participating in, and providers of performing public health measures, and by lowering access barriers, for example by improving their financial coverage and by moving the provision of certain measures to communities and people's homes.

According to the *OECD Questionnaire on Healthy Ageing and Community Care*, 22 OECD countries recommend certain vaccinations for everyone beyond the age of 60 or 65, and earlier for people at risk, for example those with chronic diseases. These vaccinations aim at protecting them from vaccine-preventable diseases, such as the seasonal influenza and pneumococci. Vaccinations against seasonal influenza have proven to be effective in reducing hospitalisations and mortality among older people. However, success rates are lagging behind. The take-up of vaccinations against seasonal influenza among people aged 65 and above is below target across all but six out of 36 OECD countries, them being Mexico, the United Kingdom, Korea, Denmark, Portugal and Ireland.

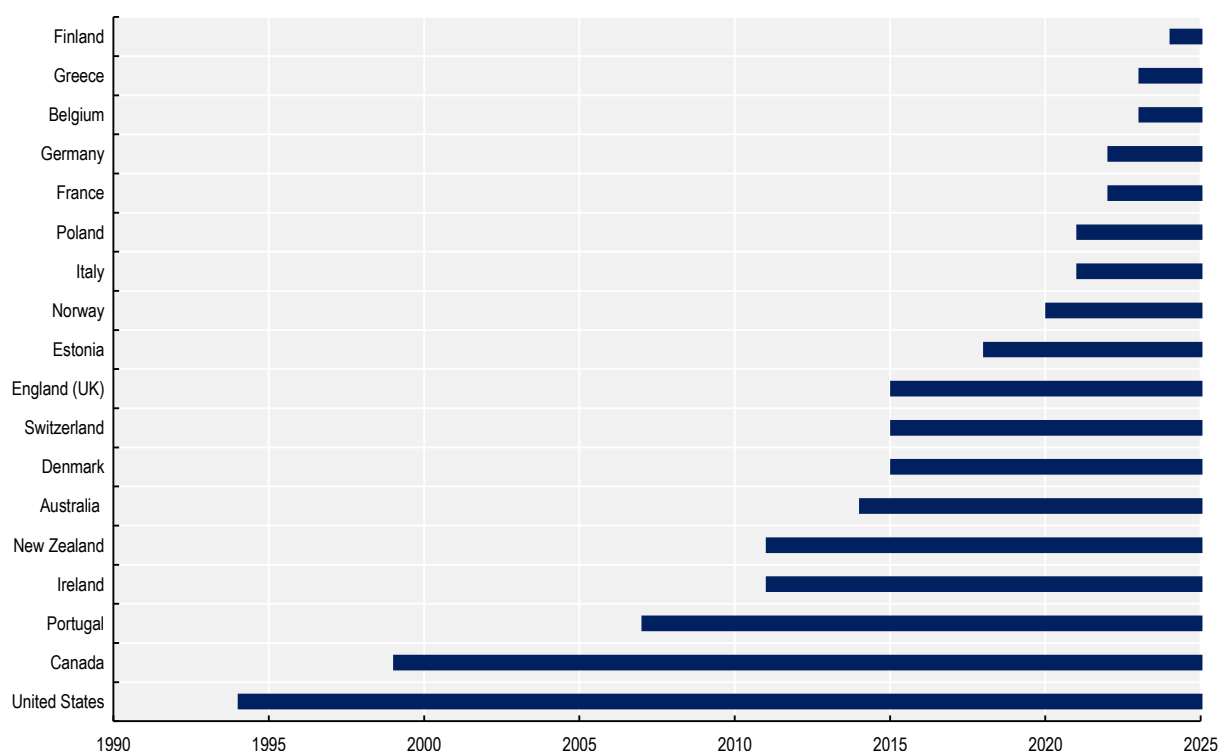
Countries use a set of strategies to improve vaccination rates that target both health workers that perform vaccinations and individuals for whom the vaccinations have been recommended. Education about the benefits of vaccinations, reminders to get vaccinated, and interventions to improve access, such as vaccinations at home and free vaccines, were largely found to be effective (Jacobson Vann et al., 2018^[92])

Reminders have been successful in reminding older people to get vaccinated (Jacobson Vann et al., 2018^[93]; Buttenheim et al., 2022^[94]). For example, **England** sent out invitations to people aged 65 and above and other people at risk (National Call and Recall Service) for the first time in 2020 in addition to already existing efforts already undertaken by general practitioners and in **Latvia**, text messages were sent to older people about COVID-19 and flu vaccinations during the pandemic emergency. The effect might be modest, but the intervention is also largely low-cost, for example if executed via SMS. While interactive and targeted interventions that include healthcare providers are generally more impactful than education-only policies or generic measures like posters and reminder or recall letters, those interventions reach a greater audience at a smaller cost (Eiden, Barratt and Nyaku, 2023^[95]). Hurley et al. (2018^[96]) showed that generic reminders for influenza, tetanus, diphtheria, acellular pertussis, and pneumococcal vaccines for adults aged 65 and above in the United States led to one additional vaccination per 29.4 contacts, but at a cost of USD 0.86 per person, this may still be a cost-effective policy.

National vaccination programmes that are free of charge to older people can help streamline the delivery of vaccinations. In 2014, for example, **Japan** introduced the pneumococcal vaccination for people aged 65 and above into their five-year routine vaccination programme. An evaluation found a pronounced increase in the annual vaccination rate from 2-5% prior to the integration to 10-11% afterwards, which helped increase the cumulative vaccination rate (Naito, Yokokawa and Watanabe, 2018^[97]). The use of digital records can help identify individuals who have an incomplete vaccination status and to tailor strategies to people who are particularly at risk. Japan introduced a checkbox in the electronic medical records that indicate whether a patient is vaccinated or not as part of the introduction of pneumococcal vaccinations into the regular vaccination schedule and contributed to better vaccination rates (Fukushima et al., 2019^[98]).

Figure 3.3. Pharmacists can now perform seasonal flu vaccinations in 18 countries (by year of introduction)

Year of authorisation of pharmacists to perform seasonal flu vaccinations



Note: In several OECD countries, the authorisation of pharmacists to perform vaccinations is decided on a subnational level. For these countries, the year of the subnational region that first introduced it was chosen (Australia: Western Australia; Canada: Yukon; Switzerland: Canton Zurich, the United States: Washington State). In Norway, France and Germany, vaccination performed in pharmacies was first piloted (Norway: 2017, France: 2019, Germany: 2020). The dates displayed refer to the national roll-out.

Several countries have broadened access to vaccinations by allowing other professional groups, such as pharmacists and nurses, to perform vaccinations, as well. In 18 OECD countries, pharmacists have been performing seasonal influenza vaccinations since several years. For example, in **Portugal**, pharmacists have been allowed to perform vaccinations since 2007, in **New Zealand** since 2011, and several **Canadian provinces** expanded their pharmacists' competencies over the past decade. **Germany** introduced seasonal flu vaccinations in pharmacies in 2022 following pilots in several states in the two previous years and **Italy** had rolled out the mandate one year earlier to pharmacists with respective training (Buchan et al., 2016^[99]). Pharmacists are allowed to perform vaccinations after additional training. Similarly, **Belgium** and **France** authorised pharmacists to perform vaccinations against seasonal flu after additional training from 2023 onwards. In **Switzerland**, all cantons are now allowing pharmacists to perform vaccinations that have performed the respective training, and training on vaccinations has been added as an integral part of the education of pharmacists. Some countries have also expanded influenza vaccinations beyond medical doctors and pharmacists. For example, in 2021, **Poland** has expanded the mandate to perform seasonal influenza vaccinations to dentists, physiotherapists and laboratory diagnosticians alongside medical doctors and pharmacists. Since 2025, community pharmacies contracted with the National Health Fund (*Narodowy Fundusz Zdrowia*, NFZ) can provide seasonal influenza vaccinations and a broad range of other vaccinations, such as against pneumococcal disease, human papillomavirus, herpes zoster, COVID-19. Vaccinations are partially or fully reimbursed by the National Health Fund, with particular exemptions for priority groups such as adults aged 65 and above and pregnant women.

Expanding the mandate of performing vaccinations to professions beyond medical doctors can help improve access to vaccinations. Patients might pass by a pharmacy more frequently than a doctor's office, and the roll-out to other professions can maintain access in areas where access to general practitioners is hampered, for example in rural areas and in countries with long waiting times for medical practitioners. In addition, it can reduce the workload of medical doctors. While vaccinations in pharmacies are also of particular interest to the working-age population at risk, such as people aged 55-65 with chronic diseases and health workers for convenience and longer opening hours, they are also taken up by people and help reducing the workload to general practitioners.

However, it can take some time to familiarise patients with this additional means to get vaccinated. In Canada, the roll-out of vaccinations in pharmacies for seasonal influenza was associated with a limited increase in coverage by 2.2% (Buchan et al., 2016^[99]). In 2023-2024, pharmacies have become the most frequently reported place of vaccinations in Canada, with 57% of individuals that were vaccinated against seasonal influenza reporting to have received it in a pharmacy against, e.g. 28% in 2016-2017 (Public Health Agency of Canada, 2025^[100]). Those that decide to get vaccinated in a pharmacy report high satisfaction rates, which stood at 99% among surveyed individuals in Australia, New Zealand and Switzerland (Stämpfli et al., 2020^[101]; Burt, Hattingh and Czarniak, 2018^[102]; Dalgado et al., 2023^[103]) and report easy access as their main reason (Stämpfli et al., 2020^[101]).

3.3.2. Financial incentives for prevention to providers cannot overcome broader staff shortages and time constraints

A number of OECD countries have introduced financial incentives to improve the performance of providers to meet public health objectives for older people. A total of 16 countries reported in the OECD's 2023 Health System Characteristics Survey that part of the income of general practitioners is subject to pay-for-performance criteria. The pay-for-performance part can be considerable and reach up to a quarter of a physician's total income. For example, in Estonia, it represents a bit more than 3% of a physician's total income, around 10% in the Netherlands and can reach up to 30% in Portugal (Levévre, Levy and Van de Voorde, 2023^[104]). This is a contrast to hospital pay-for-performance programmes, where only a minor fraction of a few percentage points (p.p.) is conditional on quality, which is deemed insufficient to really alter provider behaviour (Milstein and Schreyoegg, 2016^[105]).

A few countries operate a pay-for-performance programme with indicators that directly relate to older people. They either directly apply to an older population, for example a share of people aged 65 and above that are vaccinated against seasonal influenza or have been screened for cancer, or to a population with chronic conditions that are generally more prevalent among older people, such as congestive heart failure and diabetes. **England** offers the probably most comprehensive pay-for-performance programme in the OECD. The *Quality and Outcomes Framework* (QOF) was introduced in 2004. In this scheme, physicians can collect points for meeting predefined objectives and can obtain up to 127 points for public health-related items that cover four categories, them being blood pressure, smoking, vaccination and immunisation as well as cervical screening. Twelve clinical domains, which are very present among older people, such as cholesterol control and lipid management, heart failure, diabetes mellitus, and dementia complement the public health domain and represents a total of 437 points. **France** joined in 2012 with the *Remuneration sur Objectifs de Santé Publique* (ROSP), which built upon the *Contrat d'Amélioration des Pratiques Individuelles* (CAPI) and covers 12 prevention-related indicators alongside 8 indicators on managing chronic diseases (diabetes, hypertension, and cardiovascular risks) and 9 efficiency-related indicators (CNAM, 2023^[106]). Medical practitioners can obtain a total of 940 points, with one point equating EUR 7. It is being replaced by the *Forfait Médecin Traitant* (FMT) from 1 January 2026 onwards. **Portugal** offers pay-for-performance to Family Health Units to the team and individual practitioners for access, care performance, user satisfaction and efficiency.

Evidence from pay-for-performance programmes points at modest improvements that are likely not sustainable and cost-effective. Pay-for-performance pays physicians more for meeting certain health objectives, and sufficiently higher payments generally translate into higher service provision. For example, the French scheme *ROSP* was found to increase screening for chronic kidney disease among people with diabetes and hypertension, albeit remaining low, and diabetic retinopathy screening and HbA1c measurement improved steadily, as well (Atramont et al., 2019^[107]), but the link to improvements in health outcomes is modest and patients do not necessarily perceive any changes (Saint-Lary et al., 2015^[108]). Its predecessor, *CAP*, did not lead to any significant changes in cancer screening rates (Sicsic and Franc, 2016^[109]). Also in the English *QOF* and the Estonian *Quality Bonus System*, where physicians quickly adhered to meeting targets, the effect on mortality was modestly significant to insignificant (Ryan et al., 2016^[110]). In addition, gains were short-lived and not sustainable after the withdrawal of financial incentives (Ho et al., 2025^[111]).

Pay-for-performance can help direct the focus of general practitioners to the provision of care that aligns with public health goals and generally comes with the benefit of better data collection. Pay-for-performance can lead to an increase in the number of people with chronic diseases (Merilind et al., 2016^[112]), but it is unclear to which extent this closes diagnostic gaps, as suggested for dementia, and to which extent this leads to upcoding. However, pay-for-performance does not fix broader health system constraints, such as an overall shortage in health workers (Merilind et al., 2016^[112]), and after several decades of experience, it still remains difficult to design programmes that set a sufficiently high incentive to alter provider behaviour while remaining cost-effective, that do not increase health disparities by rewarding physicians while penalising providers that provide care to disadvantaged populations, and choosing indicators that translate into better health outcomes.

3.4. Identifying people at risk

3.4.1. Early detection allows for early intervention

OECD countries work with two sets of programmes that either offer comprehensive screening of all people beyond a certain age, or specific screening for certain diseases or conditions, such as cancer, frailty, and polypharmacy. In addition, they employ means to identify unmet and suboptimal care that requires interventions, such as polypharmacy and dehydration. Besides general preventive screenings, countries employ screening campaigns for specific disease groups, such as dementia and mental health, oncological and musculoskeletal screenings, as well as setting-specific screenings, for example screenings of the health status of residents in long-term care facilities. A total of 23 out of 29 OECD countries offers either home visits (17 countries), preventive consultations (15 countries), or a combination thereof. The schemes vary in how systematic and structured they are. Eligibility for screenings can be conditional on reaching a certain minimum age or having certain risk factors.

Some OECD countries have integrated preventive screening procedures into their healthcare system to detect diseases as early as possible and to identify unmet needs. These take place at a doctor's office or at home. Several countries offer preventive check-ups beyond a certain age, mostly from 65 or 75 years onwards. In **Australia**, people are entitled to an annual health check-up free of charge from the age of 75 onwards (*75+ Assessment*). Besides clinical questions, it covers items related to the individual's social history, such as their housing situation and participation in social events, their risk of falling, nutrition, cognitive status, personal well-being and safety and suggests a list of referrals to health, social and long-term care services. **Chile** offers annual exams to people aged 65 and above (*Examen de Medicina Preventiva en el Adulto Mayor*), which assesses the person's ability to live independently, potential abuse in the home, and their mental health besides a list of health-related and other items. **France** offers preventive screening (*Mon bilan prévention*) free of charge to everyone aged 60 to 65 and 70 to 75 (Ministère du Travail, 2023^[113]). In **Spain**, the region of Andalucía has launched the medical exam for

people aged 65 and above in 2006 (*Examen de Salud para mayores de 65 años*) (Consejería de Salud, 2017^[114]).

Evidence on general screening programmes is mixed. A Cochrane review of 17 randomised control trials found little to no effect on overall mortality or heart disease, which was linked to already existing awareness of physicians of their patients' conditions and a lack of follow-up to findings in general health checks (Krogsbøll, Jørgensen and Gøtzsche, 2019^[115]). However, while preventive screenings might not reduce overall mortality and diseases, they can lead to the better identification and management of chronic diseases, increase participation in preventive services, and were associated with better patient-reported outcomes (Liss et al., 2021^[116]). Some screenings have succeeded in achieving an improvement in both processes and outcomes. For example, the NHS Health Check was found to reduce cardiovascular diseases and help prevent other conditions thanks to earlier detection and timely intervention (McCracken et al., 2024^[117]). In addition, they offer an opportunity to refer individuals to services that offer support in adopting healthier lifestyles, but are met by funding constraints and compete with other tasks of providers (Duddy et al., 2022^[118]).

3.4.2. Better targeting of screenings to people at risk can improve their efficiency and effectiveness

While the effect of general screenings on health outcomes might be very limited and could consume already limited time resources of health workers, countries have several means to improve the effectiveness of screenings by moving towards more targeted approaches, such as preventive home visits, that allow for a comprehensive assessment of the health and living conditions of older people in their home setting.

Preventive home visits are widely available and have been found to be cost-effective. A total of 16 OECD countries report offering preventive visits at home. Some countries, such as Australia, Denmark, Germany (Berlin), Finland, Norway and Switzerland have introduced dedicated home visits schemes for individuals aged 75 and above, and **Norway** for people aged 75 or 80 and above. **Australia** and **Denmark** introduced them in 1998. Some municipalities in Norway experimented with preventive home visits in the early 1990s already, before it took off on a large scale in the early to mid-2000s (Bannenberg et al., 2021^[119]). **Mexico** offers periodic visits to people aged 65 and above and people with disabilities irrespective of their insurance status to assess the person's health, well-being and living conditions in their home and to refer them to refer them to other services if necessary (*Salud casa por casa*). In **Switzerland**, at least eight Cantons (E.g., Bern, Jura, Wallis and Zürich) offer preventive home visits to people 65 and above, which are sometimes part of a broader preventive programme. For example, the health promotion and prevention programme *Zwäg ins Alter* includes preventive home visits to older people and an assessment of their home setting for fall-inducing risks. In **Germany**, Hamburg introduced preventive home visits (*Hamburger Hausbesuche*) in 2018, and Berlin launched a pilot of preventive home visits to people aged 70 and above in 2021. In the Netherlands, municipalities also offer preventive home visits. For example, Hof van Trente introduced them in 2012 for everyone aged 78 and above and they are performed by volunteers. Home visits in Denmark, Finland, Norway and Sweden were found to be cost-effective (Kronborg et al., 2006^[120]; Liimatta et al., 2019^[121]; Sahlen et al., 2008^[122]). The introduction of preventive home visits in Norway was led to a 7%-reduction in hospital admissions among those aged 80 and above and in admissions to long-term care facilities, 11% in the average number of hospital days, and 4% lower mortality of those aged 80 and above (Bannenberg et al., 2021^[119]).

Preventive home visit programmes require good co-operation of practitioners and collaboration between health workers and other stakeholders. Evaluations of the first phase of *Zwäg ins Alter* highlighted low support by general practitioners who were sceptical of the programme, felt that their time commitment was too demanding and that the additional work was not sufficiently reimbursed (Egger, Künzi and Oesch, 2010^[123]). The outright integration of general practitioners in the design and implementation of preventive

care programmes can support the acceptance of such programmes, but questions around the reimbursement of their activities might likely require a more fundamental rethinking of the way providers are paid.

Box 3.1. From an age-based to a risk-based approach: The Danish home visit scheme

Denmark uses its generous data infrastructure and additional information to identify people at risk

Denmark has been offering preventive home visits to older people (*forebyggende hjemmebesøg til ældre*) since 1996 (LBK no. 868 of 10 September 2009, see also law no. 1 117 of 20 December 1995 and law no. 469 of 14 May 2025). Municipalities can offer their citizens preventive home visits unless they already receive services from the municipality. Home visits are offered to people aged 70 and above if they live alone, to anyone aged 75 to 80, and annually to everyone aged 82 and above as well as everyone aged 65 to 81 based on their needs and particular risk of reduced social, mental or physical functional capacity. People at particular risk include those that have, for example, lost a spouse, been discharged from a hospital, or display an overconsumption of alcohol.

Denmark uses its comprehensive data environment and co-operates with partners to identify people at risk. It uses a range of data sources, such as the register of residents, death statistics, medical data and pension data to changes in places of living, the loss of a spouse, discharge from hospital, and a change in benefits, which could indicate a deterioration in health. The co-operation with a range of actors, such as general practitioners, hospitals, social, community and long-term care workers, care co-ordinators, funeral homes, librarians, self-help groups and NGOs as well as family members, neighbours can suggest a preventive home visit to the community. People can also refer themselves for a visit.

During the visit, a prevention consultant of the municipality assesses the physical, mental and social status and well-being of the individual. This includes, for example, the nutrition status, physical ability but also loneliness, cognitive impairment, grief reaction after loss, depression and suicide risk. The person's housing condition and financial situation are also assessed as well as their IT literacy and need to use additional technologies. Following the visit, the person is informed about and referred to services in the municipality, such as health and long-term care services, dementia co-ordinators, as well as offers by the civil society, among them networks of older people, visiting services, and cultural events. The visit is documented and a follow-up visit can be arranged.

Municipalities have adopted their own approaches, with some, such as the Odense Municipality and the City of Copenhagen, having adopted a more structured approach, and Copenhagen and Høje Taastrup Municipality have developed their own conversation guide as a scoring tool.

Source: Højgaard et al. (2019^[124]), "Forebyggende hjemmebesøg til ældre – tidlig opsporing. Litteraturgennemgang og ti kommuners erfaringer. Vive."; Sundhedsstyrelsen (2020^[125]), "Forebyggende hjemmebesøg til ældre. Vejledning".

3.4.3. Screening for specific age-related conditions allows for early detection and intervention

Countries use targeted strategies to identify people at risk of a certain condition or people who have already developed it and are particularly prevalent among older people, such as dehydration and weight loss, a risk of falling, and inappropriate prescriptions. Unintended, sudden weight loss is associated with an increase in mortality (Hussain et al., 2023^[126]; McMinn, Steel and Bowman, 2011^[127])

A total of 17 countries reported to have measures in place to allow for an early prevention of people at risk of falling in the *OECD Questionnaire on Healthy Ageing and Community Care*, and all countries employ some strategies to identify inappropriate medication or polypharmacy. Several countries offer tools to healthcare professionals to equip them with the necessary information to improve prescribing patterns, either through digital prescription tools (mandatory in Hungary, Iceland, Latvia, New Zealand, Portugal, Sweden, the United States, voluntary in Japan offering health workers to identify and potentially deprescribe fall-inducing drugs. In **Portugal**, for example, the single computer system, (Prescrição Eletrónica Médica, PEM) allows different health professions to access a person's medication plan and pharmacists are involved in monitoring person's medication including those in long-term care facilities. Similarly, in **Hungary**, the use of a digital prescription tool is mandatory, and pharmacists are involved in reviewing the patient's medication and assess potential medication problems.

Several lists are now available to health professionals that help detect inappropriate medication (Anrys et al., 2021^[128]). For example, the Swedish National Board of Welfare has developed a list of Fall-Inducing Drugs (FRIDs), the American Geriatrics Society Beers Criteria include a list of potentially inappropriate medication that should be avoided for older adults, and the European Geriatric Medicine Society (EuGMS) Task and the Finnish Group on Fall-Risk-Increasing Drugs have developed the "Screening Tool of Older Persons Prescriptions in older adults with high fall risk" (STOPPFall) (Seppala et al., 2020^[129]) and Norway has the nursing-home specific list "NORGE-P-NH" (Nyborg et al., 2015^[130]).

Guidelines on reducing inappropriate prescriptions, that are used in 12 OECD countries, further help health workers in detecting inappropriate medication and take necessary steps to reduce it, and are supplemented by training of the health workforce on polypharmacy, which is mandatory in Iceland and voluntary in another nine countries (Austria, Chile, Czechia, Denmark, the Netherlands, New Zealand, Portugal, Sweden and the United States). Guidelines also support health workers in detecting other risks and health concerns among older people. At least 16 OECD countries now have guidelines on diagnosing dementia in place, and have a treatment plan in place to reduce the worsening of cognitive impairment, to delay the onset of dementia, to ensure high quality of care and well-being to people with dementia and to direct them to dementia-related activities (OECD, 2018^[131]). These cover, for example, cognitive training in group activities (12 countries), individual activities for cognitive stimulation (11 countries), talks (11 countries), cognitive rehabilitation (9 countries) or other means. For example, in **Luxembourg**, the *Programme Démence Prévention* has been introduced for people with mild cognitive impairment and offer personalised activities.

OECD countries also use a set of policies to identify people at a risk of falling, with at least 17 countries having such means in place. An early identification allows them to launch mechanisms to reduce or avoid the risk of falling, to then provide people at risk with a safety checklist to identify potential hazards for falls (in 14 countries), to have primary care teams discuss fall prevention (in 13 countries), and to refer them to specialists if needed (8 countries).

3.4.4. Single interventions likely have a limited effect, but comprehensive interventions fare better

The evidence of individual interventions on adverse events, such as the rate of falls, often shows a limited effect. While the negative effects of polypharmacy and fall-inducing drugs on falls is well-established, the effect of deprescribing certain drugs alone is modest at best (Lee et al., 2021^[132]; Colón-Emeric et al., 2024^[133]). The effect of certain nutritious supplements alone on falls is mixed, as well. A total of 15 OECD countries reported to offer dietary advice and follow-up, 10 OECD countries also prescribe supplements, such as Vitamin D and Calcium, and another 9 countries offer prescriptions of proteins to prevent muscle loss. First evaluations of checklists to identify potential fall hazards suggest a positive effect on reducing falls at a low cost, but the evidence remains unclear (Ziebart et al., 2020^[134]; Clemson et al., 2019^[135]).

This suggests that individuals require more comprehensive interventions to reduce the rate of falls than individual interventions, such as deprescribing, alone, but rather a combination of a set of interventions, such as physical activity, deprescribing of certain drugs and the removal of fall-inducing hazards (the Task Force on Global Guidelines for Falls in Older Adults, 2022^[136]; Colón-Emeric et al., 2024^[133]). Several countries offer such comprehensive packages. For example, the **Netherlands** have just integrated fall prevention measures in their basic insurance package in 2024. It consists of the identification of people who are at risk of falling, and assessment to identify modifiable risk factors, and a referral to tailored interventions and treatments that reduce the individual's risk of falling. In **Austria**, a medication review is part of the 12-week-long programme *Trittsicher & Aktiv*, which covers a self-assessment of the risk of falling, recommendations to build strength, a checklist of potential fall-inducing risks, suggestions for housing adaptation. Such interventions include a strong component of physical activity, which is instrumental in reducing the rate of falls and is a key ingredient for these more complex interventions to be successful.

3.5. Supporting rehabilitation and reablement after health shocks

Reablement and rehabilitation services aim at supporting older people to maintain their functional capacities, or to regain them after injuries and illness to allow them to live independently, to participate in social and physical and social activities and to enjoy high quality of life. It generally includes a set of targeted interventions for individuals to maintain and/or regain these functions. From an economic perspective, reablement and rehabilitation can also translate into a lower consumption of high-cost care, such as frequent hospital admissions, and home-based care instead of long-term care facilities.

Most OECD countries that responded to the *OECD Questionnaire on Healthy Ageing and Community Care* reported that they have measures for rehabilitation and reablement in place, with 24 OECD countries having responded positively to this question, one country (Latvia) considering it, and one country (Slovenia) having just introduced it. Reablement and rehabilitation follow different objectives and use different interventions to achieve their objectives. Reablement refers to care that aims at helping people relearn (instrumental) activities of daily living, such as cooking meals and doing the laundry, is time-limited, for example to up to 12 weeks, and occurs after a hospital stay or other health event, such as a fall, or upon any other deterioration of health (Cochrane et al., 2016^[137]; Metzelthin et al., 2022^[138]). In contrast to that, rehabilitation often takes place after an acute event, such as a heart attack, stroke, trauma, hip or knee replacement, tends to have a medical orientation and often takes place in a hospital or in outpatient care amid moves to strengthen community-based rehabilitation.

OECD countries offer a diverse set of services. Physical activity is the most commonly offered type, with 23 countries offering some type of physical activity during rehabilitation and recovery. The next three most prevalent types of services are occupational therapy, speech and language therapy, and skills training for daily living, such as cooking and shopping to allow people to live as independently as possible, with a total of 19 countries each having these services included. Cognitive therapy and mental health therapy were slightly less common, with 16 countries offering these services. Only 7 countries also accompany patients in their home setting, for example in public transport.

Table 3.2. Duration, referral pathways and services offered in rehabilitation and reablement programmes across selected OECD countries

Country	Duration (in weeks)	Referral					Services offered							
		Self-referral	Outpatient	Inpatient	LTC	Other	Physical therapy	Occupational	Speech and language	Cognitive	Mental health	Skills training	Accompanying	Other
Australia	8-12	•	•	•	•	Friends, relatives	•	•	•	•	•	•		
Canada (NB)	13	•	•	•	•		•	•	•					
Chile	12					•	•			•		•		
Colombia	-						•	•	•	•	•	•		•
Denmark	12		•	•	•		•	•	•	•	•	•	•	
France	-	•	•	•			•					•	•	
Germany	3		•	•			•	•	•	•	•	•		•
Greece	-		•	•			•	•						
Iceland	10		•	•	•		•	•	•	•		•	•	
Ireland	-	•	•	•			•	•	•	•	•	•	•	•
Japan	-	•	•	•			•	•	•	•	•	•		
Latvia	-				•	Municipalities	•	•	•		•	•		•
Luxembourg	3			•			•	•	•	•	•			
Netherlands	-						•	•	•	•	•	•		
New Zealand	-	•	•	•			•	•	•	•	•	•	•	
Norway	-	•	•				•	•	•	•	•	•		
Poland	6-16		•	•	•		•	•	•					
Portugal	6-16		•	•	•	Social services	•	•	•	•	•	•	•	
Slovak Republic	-	•	•	•	•		•	•	•	•	•	•		
Slovenia	-				•									
Sweden	-		•	•			•	•	•	•	•	•		
Switzerland	2		•	•										
Türkiye	-	•	•	•			•	•		•	•	•		
United States	-	•	•	•		Self-referral but certified	•	•	•			•		•

Note: – = depends. No clear limit. NB: New Brunswick.

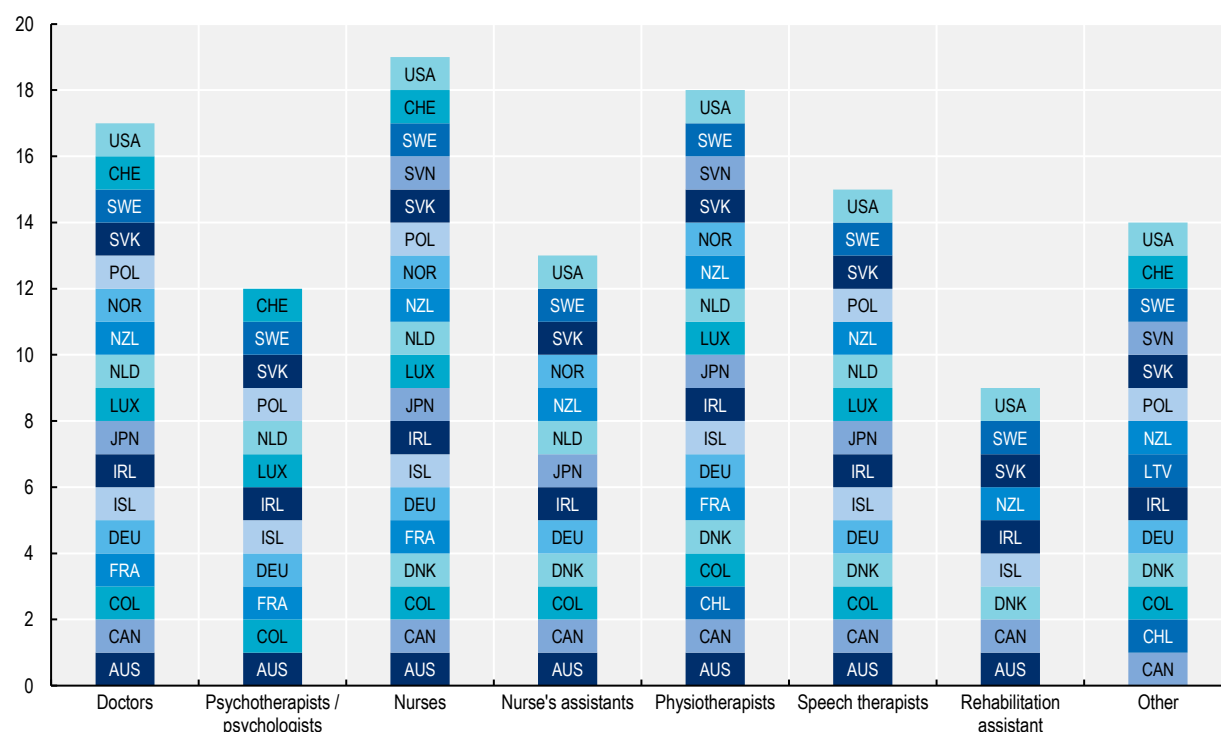
Source: OECD Questionnaire on Healthy Ageing.

The duration of reablement and rehabilitation differs across countries. Fourteen countries do not set clear time limits but make the duration conditional on the patient's need. In the remainder of countries, the maximum duration individuals have access to ranges from 2 weeks in Switzerland to 16 weeks in Poland and Portugal.

Rehabilitation and reablement services are offered by a broad set of professions (See Figure 3.4). Nurses, physiotherapists and doctors are the most common profession and are involved in providing services in 20, 19 and 18 countries, respectively. Speech therapists are another prominent profession and provide services in 16 countries, followed by nurse assistants (14 countries) and psychotherapists and psychologists (13 countries). 15 countries also reported the involvement of other professions, such as occupational therapists (e.g. Canada, Chile, Denmark, Germany and Sweden) as well as care workers (e.g. Slovenia, Türkiye), social workers (e.g. New Zealand) and home health aides (the United States).

Figure 3.4. Rehabilitation and reablement involves a multitude of different professions

Type of professions involved in rehabilitation and reablement across 29 OECD countries



Note: The data for Canada refer to New Brunswick.

Source: 2023-2024 OECD Questionnaire on Healthy Ageing.

While all countries offer physical therapy, and the majority of countries offers, occupational therapy, speech and language therapy as well as skills training, only few countries offer all types of rehabilitation and reablement. **New Zealand** and **Portugal** also offer comprehensive rehabilitation services across all types listed in Table 3.2. In New Zealand, the *Non-Acute Rehabilitation Pathway* service includes rehabilitation in four different settings (inpatient, community, transitional care rehabilitation as well as rehabilitation admission avoidance) depending on a person's need. Following the assessment of a health professional and the development of a rehabilitation plan, care is provided in the most appropriate setting by a multidisciplinary team. Services are funded by a case-mix model depending on the person's complexity and the services needed. In Portugal, integrated continued care programme includes dedicated units for intensive rehabilitation for short-term and medium-term rehabilitation (short and medium-term units). In 2022, Portugal had 4 397 of such places.

3.5.1. Evaluations suggest that rehabilitation is cost-effective, but access is limited

Rehabilitation can help people regain part of their functions after an adverse health event, such as a stroke, a heart attack, chronic obstructive pulmonary disease, or a surgery. Cardiac rehabilitation and rehabilitation after stroke can reduce mortality in the longer term, improve functioning and reduce hospitalisations (Yagi et al., 2017^[139]; Taylor, Dalal and McDonagh, 2021^[140]; Song et al., 2023^[141]; Long et al., 2019^[142]; Shields et al., 2018^[143]). It can support a faster discharge from hospitals to a dedicated rehabilitation centre or home and through that reduce hospital expenditures (Anderson et al., 2002^[144]; Peiris et al., 2018^[145]). In addition, tailored interventions that help older people to regain their abilities after a health shock can reduce expenditures in the longer term (Shields et al., 2023^[146]). A number of rehabilitations were also

found to be cost-effective, among them pulmonary rehabilitation for chronic obstructive pulmonary disease (Mosher et al., 2022^[147]), Rehabilitation displayed a cost-effectiveness ratio of USD 1 065 to USD 71 755 per quality-adjusted life-year gained (Shields et al., 2018^[143]).

While rehabilitation has been found to have positive effects on health outcomes and to be cost-effective, their effect depends on the overall constitution of the patient. The effect of physical activity on activities of daily living among people in long-term care facilities, for example, and enhanced medical rehabilitation performed by physical and occupational therapists in long-term care facilities is modest (Crocker et al., 2013^[148]; Lenze et al., 2019^[149]).

Rehabilitation and reablement have been successful in helping people regain their functional ability, but the offer remains limited across OECD countries. Internationally comparable data on the number of people who used rehabilitation and reablement services is lacking. Where available, it shows high heterogeneity across OECD countries. For example, reablement and rehabilitation services are very limited in Latvia, where 20 people per 100 000 received reablement and rehabilitation services in 2022 compared to New Zealand, where 157 people per 100 000 received rehabilitation services provided by the Non-Acute Rehabilitation services, whereas in Germany and France, 646 and 789 people per 100 000 inhabitants received rehabilitation and reablement services in 2022. Some countries are responding in increasing the availability and access to rehabilitation. For example, the **Netherlands** have increased access to geriatric rehabilitation from 2025, which can also now be initiated directly at home following the assessment of a geriatric specialist who determines the optimal geriatric rehabilitation. **Slovenia** has been starting to introduce rehabilitation services in 2025.

In 18 countries, reablement and rehabilitation is generally covered by the health insurance or the national health service, except for two countries, Japan and Slovenia, where it is covered by the long-term care insurance. In 11 countries, people co-pay to rehabilitation and reablement services.

3.5.2. Rehabilitation at home can reduce costs while offering similar quality to hospital rehabilitation

Rehabilitation services are offered at the place of residence of a person or a dedicated facility. In 18 countries, rehabilitation and reablement is offered at home, and in 17 countries in a nursing home. Another 18 countries reported offering long-term care in a dedicated rehabilitation facility, in 15 countries it takes place in a hospital and a total of 14 countries reported offering rehabilitation and reablement in day-care facilities.

Rehabilitation services in outpatient and home-based care often constitute the minority out of all rehabilitation services. For example, in Germany, rehabilitation in outpatient care represented 12% of all cases, and 9.5% of all days provided, with the remainder being provided in an inpatient setting. In Japan, 15% of rehabilitation was provided through home visits whereas the remainder took place in an outpatient setting, and in New Zealand, close to 60% of people who received Non-Acute Rehabilitation Services did so in an inpatient facility while the remainder received non-acute rehabilitation in a community-setting. In the Slovak Republic, in 2022, around a fifth of social rehabilitation was provided at home and the remainder of in other settings, like facilities for older people, like social service homes, and specialised facilities.

While the provision of some more complex services might be more cost-effective, home-based rehabilitation often performs well against rehabilitation in other settings (Dalal et al., 2010^[150]). It can either entirely replace inpatient rehabilitation or shorten and complement inpatient rehabilitation and offer continued support after inpatient rehabilitation and support the transition to living at home.

For cardiac rehabilitation, home-based rehabilitation was found to be cost-effective compared to centre-based options (Shields et al., 2022^[151]) and studies also suggest cost-effectiveness of home-based over centre-based rehabilitation for stroke (Candio et al., 2022^[152]). Studies evaluating inpatient rehabilitation versus home-based rehabilitation did not find a significantly better improvement of outcomes

in inpatient rehabilitation over home-based rehabilitation (Buhagiar et al., 2017^[153]; Buhagiar et al., 2019^[154]; Lee and Lee, 2022^[155]).

3.5.3. Reablement is a relatively new concept with limited but promising evidence

Reablement aims to delay and ideally reverse the more gradual decline that comes with ageing and can thus be applied in a preventive manner in contrast to rehabilitation, which is usually offered as part of the recovery process after an acute event (Metzelthin et al., 2022^[138]) and is a new and intriguing concept, but in very early stages, the concept is not clearly defined yet and evidence is scarce.

Some OECD countries are in process of introducing and expanding reablement in their health systems. **Australia**, for example, has introduced the *Short-Term Restorative Care* (STRC) Programme, which provided support for up to eight weeks to help maintain functional capacities and delay or avoid the need for long-term care services. Services include, among others, occupational and physiotherapy, nursing support and personal care, as well as minor home modifications and technologies that help with daily activities. Patients undergo an assessment by an *Aged Care Assessment Team* and can be referred to the assessment by an outpatient provider, hospital, long-term care provider, or can refer themselves. Services are provided at home or in residential care, or a combination of both. In **England**, for example, people can receive reablement services (intermediate/aftercare) for up to six weeks that can be provided by a set of different professions, such as doctors, nurse, occupational, speech and language therapist, physiotherapist, social workers and carers. Several countries have launched pilots to test reablement models in their country. For example, the **Netherlands** have introduced several pilots, such as the training programme “*I-MANAGE*” in the region of Limburg (Mouchaers et al., 2023^[156]), which covers five phases totaling eight weeks on average. During this time, the patient receives a comprehensive assessment of their needs in collaboration with their informal caregiver if applicable, a tailored care plan that is enacted with the support of a reablement team and continuously evaluated during the programme and adjusted if necessary. The programme also offers additional support to informal caregivers if necessary. After the end of the programme, the patient can be referred to usual care or receive a two-week extension (Mouchaers et al., 2023^[157]).

Reablement is a new and promising intervention. Countries have just started to integrate it into their health systems. As a result, reablement programmes so far also often lack a strong evidence base regarding their efficacy and cost-effectiveness, and systematic research on the topic is still in its infancy, but where available, evidence suggests a promising approach. Some countries have already gained positive experience with reablement services with programmes generating positive results (Aspinal et al., 2016^[158]). For example, in Australia, people who underwent a home-based reablement programme were less likely to have an unplanned emergency admission or unplanned hospital admission, required 40% fewer hours of home-based care and had 35% lower total home-based costs and 20% lower total health and home-care-related costs than those receiving standard care in a follow-up period of two years (Lewin, Alfonso and Alan, 2013^[159]; Lewin et al., 2014^[160]). In Norway, reablement was also found to lead better performance of and satisfaction with daily activities while requiring 25% fewer home visits, and costs being 17% lower than standard care (Kjerstad and Tuntland, 2016^[161]).

First evidence from pilots indicate that the interdisciplinary development and collaboration and organisational support are important enablers for the successful implementation of reablement programmes (Mouchaers et al., 2023^[157]). In contrast to that, the success of reablement programmes was hampered by a lack of motivation and engagement among participants, financial and time constraints among providers (Mouchaers et al., 2023^[157]). This stresses the need to introduce clear goal-setting and a clear and well-communicated care plan.

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4

Adapting health systems to an ageing population

This chapter presents options countries have to adapt their health systems to an ageing population. It covers policies to better prepare the workforce for an increase in the number of older people with complex needs, discusses redirections of the delivery of care to primary health and outpatient care, and avenues to foster the integration of providers within healthcare system and with other sectors, such as social and long-term care. This chapter puts particular focus on measures to avoid, shorten or replace hospital stays for older people.

Key findings

- **Older people have more, more complex, and different needs than younger people.** In 2019, more than every second person aged 65 and above had at least two chronic conditions, and more than every fifth person had at least one limitation in (instrumental) activities in daily living, requiring care from different providers from the health, social and long-term care sector. This makes them vulnerable to health system deficiencies, such as a lack of primary care and care fragmentation.
- **Care provision to older people displays inefficiencies.** More than 10% of long-term care spending is directed to hospitals, suggesting cost-efficiency gains by redirecting these flows to long-term care facilities and long-term care at home. Older people frequently experience avoidable hospital admissions. Expanding on high quality patient-centred care can help curb the rate of avoidable admissions and improve health outcomes of older people to support healthy ageing.

Policy options

- **Preparing the health workforce for a change in patient structures.** New roles that are particularly designed to support older people, the expansion of already existing roles, and additional education and training help equipping the health workforce with the skills they need to take care for the needs of an ageing population. In 19 countries, geriatrics is now an independent specialisation, and Latvia, Lithuania, France and Germany have just expanded the roles of nurses to offer more care to older people.
- **Providing care in a person's home.** Outreach teams offer non-life-threatening emergency care at a patient's home or in a long-term care facility. Nurses and medical doctors are dispatched to offer assessments and simple interventions where the patient resides. First results from Australia, Canada, Denmark and Finland indicate a reduction in emergency admissions and suggest that they are perceived as less disruptive than hospital admissions. Hospitals at home offer hospital-type care in a patient's home or long-term care facility to outright replace or shorten inpatient stays and are dominant in at least 22 OECD countries, such as Chile, France, Spain and the United Kingdom. First evidence shows 20-30% lower costs than an inpatient stay and patients value remaining in their familiar surroundings, but it can be an additional burden on caregivers, who need to be well-prepared and integrated in the programme.
- **Setting up new provider structures.** New physical structures offer better people-centred care by teaming up different health professionals within primary care, for example in Canada, Greece and Poland. Intermediate care structures function as a bridge between primary care and hospitals to help shorten hospital stays or to avoid them altogether, and a number of countries have introduced them, such as France, Hungary and Italy. These new structures offer better access to primary care, and can shift some care away from hospitals, but still operate on a small scale.
- **Formalising integrated care structures.** Health workers regularly interact with other professions. Integrated care programmes aim to seamlessly co-ordinate care from different professionals by teaming up different professions. New provider payments aim at incentivising co-ordination and reform the way providers are paid to incentivise better continuity of care, as in France and Ireland. Some integrated care programmes like PRISMA/RSIPA in Canada (Québec) have been successful in achieving better health outcomes and cost-effectiveness, but integrated care programmes are conditional on having built a trustful and collaborative team climate, which takes time to implement.

4.1. Making health systems meet older people's needs

4.1.1. Health systems are insufficiently tailored to the needs of older people

Older people often have more complex needs than the younger parts of the population, which pose challenges to healthcare systems and expose older people to greater risks of unmet need, care fragmentation and insufficient quality of care. They often have several co-morbidities, require support in their (instrumental) activities of daily living (see Chapter 2) and use a set of providers from the health, social and long-term care sector concurrently to meet their health and long-term care needs. Some symptoms and diseases, such as cognitive impairment and dementia, are particularly prevalent among older people: cognitive impairment and decline affect 20 to 50% of the older population and can progress into different forms of dementia, such as Alzheimer's (Manly et al., 2022^[1]; Yao et al., 2020^[2]). A lack of access, short consultation times, insufficient training of health workers for their needs, fears of and experiences with *ageism* in the healthcare system, which encompasses prejudices against and discrimination of a person on the basis of their age, are only some of the barriers that older people are facing when seeking care (Federal/Provincial/Territorial Ministers Responsible for Seniors Forum, 2023^[3]; Cabañero-Garcia et al., 2025^[4]; Iyengar and Mitchell, 2023^[5]).

Because health systems are not yet well adapted to ageing, older people receive insufficient, inappropriate or uncoordinated levels of care to meet their needs, and in a setting that is more costly, but poorly equipped to respond to the needs of older people, and to facilitate healthy ageing.

Firstly, some people **do not sufficiently use primary care resources** that allow for continuous monitoring of people's health and prevent deterioration in health and increase in limitations where possible (OECD, 2020^[6]). This results in emergency admissions, avoidable hospitalisations and an increase in the number and severity of limitations and diseases, which are costly to countries and consume financial and human resources that could better be directed elsewhere (OECD, 2020^[6]; OECD, 2017^[7]; OECD, 2024^[8]).

Secondly, the **provision of health and long-term care does not always take place in the appropriate setting**. Older people represent the majority of hospital stays. A share of these hospitalisations is not necessary and care provision in hospitals is generally more expensive, resulting in an inefficient use of financial and human resources that are designed to treat urgent and acute rather than chronic and long-term care conditions. Separate funding channels and budgets hamper efficient spending. Budgets have historically evolved over time, and greater spending on primary and long-term care can reduce spending on hospital care, but gains are not transferred from the sector where cost savings materialised to the sector where higher costs occurred.

Thirdly, **care is often poorly co-ordinated** among different providers within healthcare, and between health and long-term care providers (Barrenho et al., 2022^[9]; OECD, 2023^[10]). This problem becomes even more prevalent for an ageing population with multiple, chronic conditions that use services from a set of different providers. Poor co-ordination and integration within health, and with long-term care, leads to disruptions in care, worse health outcomes, system inefficiencies and wasteful spending. Responses from the OECD's *Patient-Reported Indicator Surveys* (PaRIS) show that only 47% of patients aged 65 and above perceive their primary care practice as well-prepared to co-ordinate with long-term care providers (see Chapter 1).

4.1.2. Countries have recognised the need to better align their health systems with the needs of older people

Figure 4.1. Four areas of health system adaptation for an ageing population



Four policy areas prevail to accompany people in their ageing trajectory and to improve healthy ageing across OECD countries (Figure 4.1). Firstly, countries are taking measures to ensure that they have the right workforce in place to offer care to an ageing population. This includes the right roles, either by expanding the roles of already existing professions or by introducing new roles, and the right skills to ensure that health workers have the appropriate education and training to support their patients in their ageing process. Secondly, countries are exploring measures to ensure that older people receive the right, and sufficient services they need. Thirdly, countries are active in introducing policies to ensure that people are provided care in the setting that is best for their needs, which largely consists of measures to shift the delivery of care from the in- to the outpatient sector. Finally, countries are experimenting with new ways to link and team up health and long-term care providers to offer patient-centred, seamless care.

This chapter offers an overview of how these different system adaptations look like in closer detail, synthesises findings on the effect of these policies where available, highlights good practices across OECD countries and points to avenues to further adapt health systems to accommodate demographic change. It presents a summary of the experience with these policies, synthesises the evidence to date and formulates policy recommendations to support countries in further tailoring their healthcare systems to the needs of an ageing population.

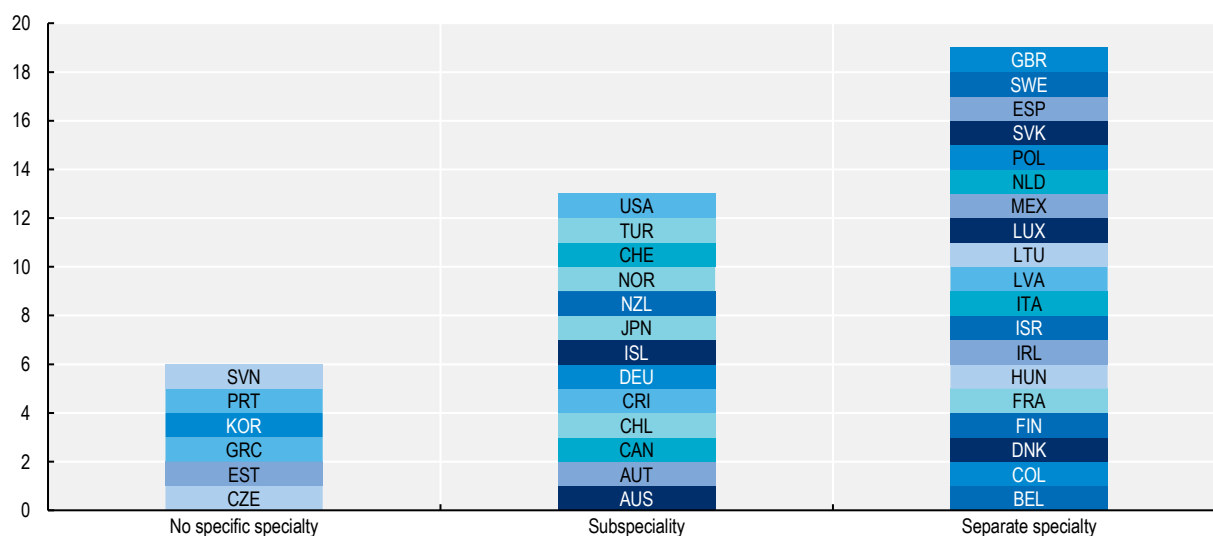
4.2. Preparing the health workforce for an ageing population

A changing demographic and more complex and different needs of older people pose challenges for the health workforce. Countries respond to it by introducing new roles, by expanding the roles of health professionals, and by offering additional education and training to equip the health workforce with the necessary skills. More than a third of countries that responded to the OECD Questionnaire on Healthy Ageing and Community Care have expanded the roles of health professionals, for example by increasing the roles and competencies of already existing health workers (11 out of 29 countries), and/or introduced new professional roles (12 out of 29 countries).

4.2.1. The introduction of geriatricians is still in early stages

In half of all OECD countries (19/38), geriatrics now form an independent specialty, followed by 13 countries in which geriatrics is available as a subspecialty with one to three years of training required (Pitkala et al., 2018^[11]) (Figure 4.2). Several countries discuss introducing geriatrics as a (sub-)specialty. **Norway** is currently investigating the introduction of a separate specialisation in gerontology and home care, which would augment its role from a subspecialty status to its own specialty (Norwegian Government, 2024^[12]).

Figure 4.2. Status of geriatrics as specialty across OECD countries



Note: Japan does not have a dedicated specialty scheme, but medical students can receive training in geriatrics and work as geriatricians afterwards.

Source: Based on Pitkala et al. (2018^[11]), "Status of Geriatrics in 22 Countries", <https://doi.org/10.1007/s12603-018-1023-7> and additional compilation by the authors.

Geriatricians can play an important role in assessing and managing the role of older people and several OECD countries are promoting a geriatrician-led frailty assessment in the delivery of care to older people (Cesari et al., 2024^[13]). Comprehensive geriatric assessments for frailty have been associated with improved health outcomes and have been piloted in different settings at different points of the patient's care trajectory and for different conditions, for example in emergency departments, trauma centres and for oncology treatments. Geriatric assessments in oncology can be beneficial for better-tailored treatment and communication as well as a higher likelihood of treatment completion, better physical functioning and quality of life (Hamaker et al., 2022^[14]). England has piloted a geriatrician assessment within 72 hours after

admission to a trauma centre, which is associated with reduced risk of death (Braude et al., 2022^[15]). This echoes findings from Ireland, where a frailty screening with a comprehensive geriatrician-led multidisciplinary assessment in an emergency department was associated with shorter length of stay in an emergency department, lower rates of admissions to long-term care facilities, better quality of life and a lower decrease in functional decline (Leahy et al., 2024^[16]). Norway has also piloted the assessment and joint medication reviews by a geriatrician and general practitioner and found an increase in deprescribing of certain medicines, a reduce in dosages, an increase in new medication plans, and improvements in quality of life, but also an increase in hospital admissions which might have resulted from new medication plans (Romskaug et al., 2020^[17]).

Geriatrics as a specialisation has been growing in relevance, but suffers from shortages and a lack of attractiveness (Rowe, 2021^[18]; Cesari et al., 2024^[13]). Geriatrics is insufficiently integrated in medical education and training, earnings are generally much lower than in other specialties, prestige is low, the workload is demanding and caring for older people is often deemed unattractive (Meiboom et al., 2015^[19]).

4.2.2. More OECD countries are closing in on expanding the roles of nurses

Community health nurses and advanced practice nurses are already common in at least half of all OECD countries (Brownwood and Lafortune, 2024^[20]). They play an integral part in improving access to primary care and continuity and quality of care, and in delivering care to older people. They have consistently shown that they can reduce the workload of medical doctors by taking over some of their tasks, such as prescribing medicine, and can have a more comprehensive overview of the care trajectory of people, which is particularly beneficial for older people with complex needs (Htay and Whitehead, 2021^[21]; Lukewich et al., 2022^[22]; Jakimowicz, Williams and Stankiewicz, 2017^[23]; Maier, Aiken and Busse, 2017^[24]). Additionally, nurse practitioners tend to spend more time than general practitioners on each patient, enabling them to address more concerns per visit and spend extra time on examinations, patient education and comprehensive, multidimensional care (Roots and MacDonald, 2014^[25]). Several systematic reviews found higher patient satisfaction in nurse-led compared to physician-led care, equal or better quality of care, and similar or lower resource use across age groups as well as for older people specifically (Maier, Aiken and Busse, 2017^[24]; Brownwood and Lafortune, 2024^[20]; Morilla-Herrera et al., 2016^[26]; Woo, Lee and Tam, 2017^[27]). Older people, for whom visiting a medical doctor may be difficult due to mobility restrictions, have been found to particularly benefit from home visits and care by advanced practice and community health nurses (Kasa et al., 2023^[28]). Although the precise channels are unknown, research also suggests lower mortality rates among chronically-ill older adults under community-based nurse-led care (Coburn et al., 2012^[29]) and fewer hospital admissions for all older adults, especially with high-intensity team-based services and self-help education (Dunn, Bliss and Ryrrie, 2021^[30]). Rising demand for medical services due to population ageing and heightened medical complexity increases the need to expand the roles of community health nurses and advanced practice nurses. By monitoring patients long-term, they can identify risks, such as poor nutrition and dehydration, loneliness and isolation, detect changes in health, such as sudden weight loss, signs of depression and cognitive impairment, and perform medication reviews, for example for patients receiving several prescriptions concurrently and at risk of inappropriate prescriptions, as is the case for older people. Nurses also engage with informal carers and can help detect deficiencies in care provision at home.

OECD countries have continuously expanded the roles of nurses in the delivery of care (Maier, Aiken and Busse, 2017^[24]; Maier, 2019^[31]). For example, OECD countries have started allowing nurses to prescribe medicines, order diagnostic tests, and provide teleconsultations, either independently or under the supervision of a physician (Brownwood and Lafortune, 2024^[20]). In 2022, **Austria** and **Switzerland** joined other OECD countries in introducing community health nurses. Austria introduced 116 pilot projects for people aged 75 and above who live at home and are care-dependent and their caregivers. Programmes aim at enabling people to stay at home for as long as possible, at improving their health literacy and quality of life, and at connecting them with other regional offers of care. Community health nurses perform

preventive home visits, inform and advise the care dependent and their carers on suitable offers and support, and connect them with other providers as needed. **Latvia** is also planning to introduce advanced nurse practitioners (*paplašinātās kompetences māsa*) in 2026 to offer better care to people with chronic diseases, which complements the introduction of general nurses with bachelor's degrees in 2022 (Republic Latvia, 2024^[32]). **Luxembourg** followed two years later with the introduction of a bachelor's degree in general nursing (*Bachelor en Sciences infirmières – Infirmier responsable de soins généraux*). In 2023, **France** expanded the roles of advanced nurse practitioners (*infirmières en pratique avancée*) to also prescribe specific drugs, some of which patients can also access directly without referral now, as part of a set of efforts to improve care in underserved areas. In 2022, **Germany** expanded the roles of nurses by allowing them to recommend a prescription of care aids and make more important decisions independently (Brownwood and Lafortune, 2024^[20]). Moreover, there is a legislative proposal to further expand the role of nurses and Germany is considering introducing advanced practice nurses, too. **Lithuania** also expanded the competencies of nurses by allowing them to perform vaccinations and renew prescriptions issued by a medical doctor (Ministry of Health of Lithuania, 2023^[33]).

Despite the perceived benefits and expansion in some countries, the scale of community health nurses and advanced practice nurses remain limited in many OECD countries. The introduction of these roles and their increase can help improve the quality and effectiveness of care, but staff shortages and the time needed to integrate community health nurses and advanced practice nurses into the care pathway and to be accepted by the public limit their scale and scope. The nursing workforce is already facing challenges with overall shortages. Low salary levels, poor levels of recognition and difficult working conditions affect the nursing profession in general, leading to a low stock of people who could potentially become advanced practice nurses and community health nurses. Within healthcare systems, the community sector faces competition from the hospital sector, where nurses can enjoy much higher salaries than in other sectors (OECD, 2023^[34]). The introduction and increase of advanced practice nurses can help improving the professional standing of nurses and offer a career path, which can positively affect the recruitment and retention of nurses. Community healthcare, however, faces low to moderate levels of attractiveness among nurses in education and training. Efforts to increase interest in community healthcare by increasing the exposure to community-related tasks have not yet led to significant improvements in interest (van Iersel et al., 2019^[35]). Additionally, the successful integration of community health nurses depends on their acceptance by people in need of care, who might not recognise their needs or feel uncomfortable with a stranger entering their private sphere. While this is not unique to community health nurses, this is a particularly limiting factor for a profession that was introduced to offer people at home. Countries are invited to consider that the adaptation of community health nurses might require several years to familiarise older people with the concept and to experience the benefits. In addition, advanced practice nurses and community health nurses can be a great addition to the health workforce but require appropriate training in geriatric care and in the additional services that they are intended to provide to be able to perform them. The introduction of advanced practice nurses or community health nurses offers an opportunity for OECD countries to identify which skills are needed for these professions to perform additional tasks for an older population, to ensure that education and training allows them to perform these tasks, and incorporate additional training in, e.g. geriatrics, dementia care, and mental health support if needed.

Other professions, such as general practitioners, pharmacists, dental hygienists and dental therapists, have seen increases in their roles, as well, to improve access and reduce the workload of other professions. For example, **Belgium** increased the roles of so-called “reference pharmacists” of patients with chronic diseases in 2023, who can now review medication schemes of patients with polypharmacy and check for inappropriate medication, deprescribing and dangerous interactions with subsequent notification of the patient's general practitioner (RIZIV-INAMI, 2022^[36]). **Czechia** increased prescription rights of general practitioners in 2024, that are now also allowed to prescribe medicines that are often consumed by older people, such as diabetes-related medication and blood thinners, and were previously limited to specialists. The **United States**, several states expanded the roles of dental hygienists and dental therapists over the past years, for example by allowing direct access to prophylaxes performed by dental

hygienists and by allowing them to administer local anaesthesia and to prescribe, administer and dispense fluoride, topical medications and chlorohexidine (Teekshana, Shirey and Surdu, 2025^[37]). An increase in the autonomy of dental hygienists was associated with better outcomes in population oral health and found to be particularly helpful in areas with shortages of dentists and other dental health professional (Chen, Meyerhoefer and Timmons, 2024^[38]; Langelier et al., 2016^[39]).

4.2.3. *Equipping the health workforce with the right skills and tools*

Countries offer additional education, training and technical support to the already practicing workforce to help them detect suboptimal care. For example, one common risk factor of older people is the prescription of several medications concurrently (polypharmacy), which increases the risk of adverse drug-related events. A total of 12 countries offers guidelines to reduce inappropriate polypharmacy to offer guidance to health workers and 10 countries provide additional training to health workers on reducing polypharmacy (voluntary in all countries except Iceland, where it is mandatory). Training aims at increasing awareness and improving appropriate prescribing patterns. Secondly, they offer tools to healthcare professionals to equip them with the necessary information to improve prescribing patterns, either through digital prescription tools (mandatory in Hungary, Iceland, Latvia, New Zealand, Portugal, Sweden and the United States, voluntary in Japan). For example, several countries, such as England, Finland and Sweden offer a screening tool for health workers to identify and potentially deprescribe fall-inducing drugs. The *Screening Tool of Older Persons Prescriptions in older adults with high fall risk* (STOPPFall) was developed by the European Geriatric Medicine Society (EuGMS) Task and the Finish Group on Fall-Risk-Increasing Drugs (Seppala et al., 2020^[40]). This list currently covers 14 drug groups.

4.3. Increasing the supply of and access to healthcare services

OECD countries have introduced a set of policies that aim at expanding access to and the supply of services for older people. Good levels of access to primary care services and to the *right* services aim at improving the management of their health conditions to reduce a worsening of care that results in adverse events, such as avoidable hospitalisations, which drive up healthcare expenditures and bind human resources. Policies that aim at increasing supply cover, for example, **reducing co-payments** for certain population groups to increase demand for certain services, **increasing the payment** of already existing services to incentivise the health workforce to reallocate their time towards these services by **adding new services** to the list of services provided, for example for the case management of older people. In most instances, these services are provided in a doctor's practice. For example, **Australia** tripled financial incentive payments to doctors for treating, among others, older people above the pension age and below a certain income threshold without charging additional costs to the patient (triple bulk-billing), translating into an increase from AUD 6.85 to AUD 20.65 in metropolitan areas, or from AUD 13.15 in very remote areas to AUD 39.65 (Australian Department of Health and Aged Care, 2024^[41]). In 2022, **Czechia** introduced payments for geriatric doctors for frailty assessment and the case management of geriatric patients on a pilot basis. In 2024, these payments were integrated as additional services in the fee schedule and are now reimbursed by health insurance funds. **Latvia** increased capitation payments for older people to doctors and reduced co-payments of people aged 65 and above for visits with general practitioners. **Germany** pays quarterly flat rates to physicians which differ by patient age and are higher for older patients to compensate for higher costs and more intensive care provision due to higher patient complexity. The quarterly flat rate for patients aged 76 and above for general practitioners was 75% higher than for patients aged 19 to 54. In 2025, Germany decided to replace quarterly flat rates to general practitioners by longer terms in case of one chronic disease, which has no need for an extensive treatment, to avoid unnecessary practitioner visits. **Norway** and **Slovenia** have just modified the adjustment of payment to physicians. In Norway, payments for general practitioners are now weighted by gender, age, service use, density of doctors and a socio-economic factor, with age being a major factor in cost differences (Helfo, 2023^[42]).

Slovenia reduces the fee-for-service part in favour of an increase in capitation, and introduces billing for people with multiple chronic diseases, but has been criticised for reducing the capitation payment for older people (Zdravniška zbornica Slovenije, 2024^[43]).

Payment systems that incentivise physicians for providing volume and higher prices can increase the number of services provided (Quinn et al., 2020^[44]). Policymakers can make use of these dynamics in a threefold way to improve the delivery of care to older people. Firstly, they can adjust the payment to physicians by complexity to ensure a fair compensation that accounts for the medical complexity of older people and that reduces the risk of physicians giving preference to younger, healthier patients over older, sicker ones. Secondly, they can operate with price changes to increase the delivery of care for certain services and to steer the time and attention of health workers towards certain activities, such as an increase in the number and length of consultations for people above a certain age. Patients value sufficient time during consultations, which becomes even more important for people when they suffer from several chronic diseases (OECD, 2025^[45]). Vice versa, shorter visits in primary care have been associated with some increases in inappropriate prescribing (Neprash et al., 2023^[46]). For example, a change in the price structure due to a rearrangement of Medicare structures in 1997 led to an increase in services in the United States, with a 2%-price increase translating into a 3% increase in service provision on average (Clemens and Gottlieb, 2014^[47]). Similarly, changes in the Affordable Care Act led to price increases in some states in the United States, which in turn resulted in increased services (Devlin and McCormack, 2023^[48]). Increases in prices were also found to improve access for underserved patient groups. Financial incentives in France led to an increase in workload among specialist physicians and improved access for low-income patients (Kingsada, 2024^[49]).

Increases in prices can come with negative consequences unless well-designed. In Norway, physicians are allowed to charge higher prices once they have obtained their specialisation in general practice, which was found to lead to an increase in visits but at the expense of a reduction in consultation time (Brekke et al., 2017^[50]). Countries can counteract reductions in consultation time by introducing a minimum length of consultation time to bill such an item, but an increase in one set of services will come at the expense of the service provision in other areas. Evidence on the effect of payment increases on integration is mixed. Lower prices have been found to incentivise integration between providers because it can increase the need for providers to explore efficiency gains through integration, while price increases have also led to more integration because it gave providers the means to build better co-ordination and interaction with providers.

4.4. Providing care where it is best

An increase in the share of older people is projected to lead to an increase in healthcare use, such as an increase in hospital stays, which already meets tight financial resources and can pose risks to older people. In many countries, the average costs of a hospital stay are equal to or considerably exceed average annual health expenditures per person. For older patients, hospital stays can often be stressful and expose them to risks. They can lead to an increase in limitations of (instrumental) activities of daily living (*hospital-associated disability*) (Lloyd et al., 2020^[51]), cause delirium after operations, which can exacerbate cognitive decline (Kunicki et al., 2023^[52]; Saczynski et al., 2012^[53]) and expose them to hospital-acquired infections (OECD, 2023^[54]; Bates et al., 2023^[55]). As a result, the benefits of hospitalisation do not always outweigh the risks.

A range of OECD countries aim at reducing and shortening hospital stays by improving the amount and quality of care provided outside of hospital settings. These initiatives aim at outright avoiding admissions, substituting inpatient stays with intensified home care, reducing readmissions after hospital discharge, and shortening length of stay in hospitals, either through an increase in **services provided at a person's residence**, or the introduction of **new, physical provider structures** that regroup medical specialties and

can offer better patient-centred primary care, or offer an intermediate layer in between a physician's office and a hospital.

4.4.1. Avoiding hospitalisations through outreach teams

Several OECD countries have set up primary care teams that visit patients in their homes to provide care support to avoid health deteriorations and hospital (emergency) admissions. For example, in **Australia**, the *Community Older Persons Intervention and Liaison Outreach Team* (COPILOT) in New South Wales offers care to people in their own homes and long-term care facilities for ten conditions and services, such as pneumonia, cognitive decline, fall prevention, malnutrition and polypharmacy. The outreach team is composed of geriatricians, nurses, social workers, physiotherapists, pharmacists, dietitians and occupational therapists (NSW Government Agency for Clinical Innovation, 2024^[56]). The *Residential In-Reach* programmes in Victoria and the *Residential Aged Care Facility Support Service* in Queensland particularly target people in long-term care facilities, where hospitals dispatch medical doctors and nurses to facilities in urgent, non-life-threatening situations to reduce the need for emergency admissions (Victoria Department of Health, 2024^[57]; Queensland Government, 2022^[58]). Similarly, several provinces in **Canada** have such outreach teams, such as the *Primary Care Outreach to Seniors* programme in Ontario or the *Older Adult Outreach Program* in Vancouver (Vancouver Coastal Health, 2024^[59]; Provincial Geriatrics Leadership Ontario, 2025^[60]). A team of a registered nurse and a community health worker, which collaborates with other health and community care providers, help with medication review, help manage chronic illnesses, and may also offer clinical assessments and follow-ups and advanced nursing care in a person's home. In **Ireland**, community intervention teams offer patients in need of acute care support in their homes to avoid hospitalisations, facilitate early discharge and support people with chronic diseases in their homes, and can offer a set of services such as the administration of intravenous antibiotics, enhanced nurse monitoring, wound care and dressings. Several parts of the **United Kingdom** have introduced these teams for general and disease-specific purposes, such as the *Older Persons Mental Health Liaison and Care Home Outreach Team* in Wales.

Denmark established a new model in Odense (Southern Denmark) where emergency consultants are dispatched to long-term care facilities to provide emergency care in non-life-threatening conditions and perform diagnoses and treatment, such as intravenous fluids and antibiotics, on-site and help set up a treatment plan. In **Finland**, mobile hospitals (*Liikkuva sairaal*, LiiSaa) offer diagnostics and treatment in non-life-threatening emergency situations to people who receive long-term care at home or in a long-term care facility to avoid emergency admissions. A nurse visits patients in their living arrangement to assess their health and can perform diagnostics and offer simple interventions, such as treating wounds and urinary problems and giving intravenous hydration and antibiotic drips.

Evidence on the effect of outreach programmes on health outcomes and costs is very limited, but the little evidence available points at promising results in curbing emergency admissions. Findings from Australia found a significant reduction in emergency department visits and hospital admissions from long-term care facilities (Hutchinson et al., 2014^[61]; Fan et al., 2015^[62]; Kwa et al., 2021^[63]). Similarly, an investigation from Finland recorded a reduction in less acute emergency admissions from long-term care facilities by around 20-30% depending on the severity with savings of 14% per resident in a long-term care facility (Mäki et al., 2023^[64]; Perttu et al., 2025^[65]). First impressions by patients and caregivers also suggest positive experiences. In Denmark, patients valued remaining in their familiar surroundings, reducing confusion and stress, and caregivers reported that it was less disruptive and more effective than a hospitalisation, which would have been more difficult to integrate in their daily lives than a visit at home, for example through accompanying their relative to the hospital, which would require some to take time off work and to arrange childcare (Udesen et al., 2021^[66]).

4.4.2. Replacing and shortening hospital stays through more intensified care at home

A set of countries have been introducing programmes that aim at outright replacing a hospital stay, or at allowing for an earlier discharge from hospitals to home, through intensified monitoring in a patient's home. These “**hospital-at-home**”-programmes have been introduced in the 1970s and recently gained momentum to help address long waiting lists and capacity constraints, to navigate increasing demand amid financial constraints, and to offer safe care at home during the COVID-19 pandemic (Pandit et al., 2024^[67]). Today, at least 22 OECD countries offer hospital-at-home programmes, among them Australia, Canada, Chile, France, Israel, Japan, Mexico, the Netherlands, Norway, Switzerland (e.g. Geneva, and additional pilots in Basel-Land and Zurich), Spain, the United Kingdom and the United States (Table 4.1). In addition, selected countries, among them Denmark, Estonia, Germany (Berlin), Latvia and Ireland, are currently piloting them and Luxembourg has announced the development of Hospitals at Home in its 2023 coalition agreement.

Table 4.1. Overview of key characteristics of hospital-at-home programmes across OECD countries

Country	Name	Referral	Conditions	Eligibility	Staff type	Type of services provided	Additional information
Australia	Hospital in the Home	GP, long-term care facility, private and public hospitals, no self-referrals	No restriction, examples include DVT, COPD, UTI, infections, septic arthritis, endocarditis	Clinically stable, support at home, suitable environment with access to telephone	E.g. hospital doctor, nurse, pharmacist, physiotherapist, social worker	E.g., post-surgical care, IV, chemotherapy, anticoagulant therapy	
Austria	Medizinische Hauskrankenpflege	GP	No specific restriction	Long-term care needs, specific diagnosis which would otherwise be treated in the hospital	Nurses	E.g. tube feeding, infusions, injections, wound care, stoma/ catheter/ fistula care	Up to 4 weeks for the same condition, can be extended if medically necessary
Belgium	Thuishospitalisatie / Hospitalisation à domicile	Hospital specialist doctor	Mostly oncology or antibiotic, antifungal or antiviral therapy	Eligible for inpatient or day hospital stay but condition stable and manageable from home	Hospital infectiologist GP, nurse, pharmacist	E.g. chemotherapy, IV and oral medication, pediatric care	
Canada (British Columbia)	Hospital at Home	Hospital treatment team	No specific restriction	17+ years, admitted to hospital, stable condition but still requiring close care and monitoring for few days	E.g. hospital doctor, nurse, pharmacist, occupational therapist, physiotherapist, social worker, care manager	E.g. taking lab/blood samples, IV medication, monitoring, wound care, supplying healthcare equipment	Exact eligibility criteria (especially age) differ by region even within British Columbia
Chile	Hospitalización domiciliaria	Treating physician	E.g. heart conditions, infections, pneumonia, vascular and neurological diseases, AIDS, liver diseases	Definite diagnosis, stable but requiring hospital-level care, caregiver at home, within coverage area	Doctors, nurses, other professional as needed	E.g. chemotherapy, monitoring, palliative care, wound care, post-operative care, tube feeding, IV medication	

Country	Name	Referral	Conditions	Eligibility	Staff type	Type of services provided	Additional information
Colombia	Hospitalización en casa / atención médica domiciliaria	Hospital doctors	No specific restrictions, chronic or acute conditions	Hemodynamically and ventilatory stable condition, caregiver at home, within coverage area	Doctor, nurse, social worker, nursing assistant, psychologist, therapist, pharmacist, coordinator	E.g. wound care, tube feeding, IV medication, respiratory/enterotomal/rehabilitation therapy, palliative care	Maximum 14 days
Denmark	Hospital hjemme	Hospital doctors	Mostly pulmonary or infectious respiratory diseases	18+, stable condition after at least 24h hospital stay, Danish language skills and ability to use the App	Doctors, nurses	E.g. check-ins via app, monitoring, oxygen supplement, invasive interventions by a mobile health team	
Estonia	Koduhaigla	GP or hospital doctor	E.g. cardiac / pulmonary conditions, infections, diabetes, anemia, cancer	Time-limited, stable but requiring hospital-level care, can manage basic tasks, 20km radius from hospital	Home nurse, doctor (remotely), coordinator, non-medical professional (e.g. social worker) as needed	E.g. monitoring, palliative care, IV medication, wound care, diagnostics	
France	Hospitalisation à domicile (HAD)	Regular physician (médecin traitant) or hospital physician	No specific restriction	All ages and populations, depending on medical eligibility and feasibility. Care could not be provided by liberal professional	Home hospitalisation physician, nurses	E.g. chemotherapy, rehabilitation care, palliative care, perinatal care, blood transfusions	Fixed duration (usually 3-7 days) but can be extended if needed. Possibility of a nurse staying at the home overnight
Finland	Mobile Hospitals/ Kotisairaala	Medical doctor	No specific restriction	Age 16+, sufficient functional capacity to manage mostly independently	Physician, nurses	E.g. IV medication, monitoring palliative care, blood tests and transfusions, infusions	
Germany	Stay@Home-Treat@Home	GP	No specific restriction but needs to be in need of long-term care	Age 60+, caregiver who also participates, internet access, condition sufficiently stable	GP and hospital doctors, nurses	Virtual medical check-ups, home visits, monitoring	
Greece	Νοσοκομειακή Κατ' Οίκον Νοσηλεία και Φροντίδα Υγείας	Hospital doctor	E.g. chronic respiratory or cardiac diseases, neurological diseases, cancer	All ages, medical eligibility (depends on complexity/ chronicity of the disease rather than specific diagnosis)	Doctors, nurses, other health professional as needed	E.g. chemotherapy, immunotherapy, IV medication, respiratory support, tube feeding	

Country	Name	Referral	Conditions	Eligibility	Staff type	Type of services provided	Additional information
Ireland	Virtual Wards	Hospital doctor or GP	Mostly cardiac and respiratory conditions and post-operative care	Aged 16+, coming from hospital with stable and manageable condition but still requiring care	Hospital doctors and nurses	Monitoring, IV medicine, stoma and catheter management, wound care, anti-coagulation	Average stay of 6.6 days, often longer. Most check-ins with doctors are virtual
Israel	בית חולים בבית (Hospital at Home)	Hospital doctor or GP	No specific restriction, e.g. heart/lung failures, psychiatric conditions, dementia, infections, diabetes, etc.	All ages, requiring hospital-level care but stable enough for home care	Doctors, nurses, social workers, various types of therapists, dieticians, pharmacists	E.g. wound care, testing, hospice and palliative care, neuro-logical rehabilitation, speech therapy, de-conditioning	Services differ by provider but often very extensive, incl. largest physician-based home hospital in the world
Latvia	Slimnīca mājās	Hospital doctors	Chronic lung/heart/neurological conditions, infections	All ages, internet access, chronic diseases with medium to high risk of rehospitalisation and stable acute patients	Specialist doctors, nurses (mostly remote)	E.g. monitoring, medication	
New Zealand	Hospital in the Home	Medical team at the hospital	Respiratory conditions, manageable heart failure, infections	Post-hospital discharge, still requiring hospital-level care but stable enough for home care	Nurses, doctors, coordinators	E.g. IV medication, monitoring, wound care, stoma or catheter management	
Norway	Hjemmesykehus	Hospital doctor	Acute or chronic condition, post-stem cell transplantation	Post-hospital discharge, some more advanced projects only for children	Nurses, response team, doctor (remotely)	Long-term IV antibiotics	
Spain	Hospitalización a Domicilio	GP or hospital doctor	E.g. blood/heart/lung diseases, psychiatric conditions, cancer, post-operative recovery, infections, multiple sclerosis	All ages, time-limited, definite diagnosis, stable but still requiring hospital-level care, caregiver at home	Nurses, doctors, therapists	E.g. tube feeding, palliative care, IV medication, physical therapy, counseling	
Sweden	Avancerad sjukvård i hemmet (ASIH) / Hemsjukhuset	GP or hospital doctor	Especially chronic or complex conditions	All ages, serious condition but no need for 24/7 care or monitoring	Specialist doctor and nurse + e.g. physiotherapist, dietitian, occupational therapist, counselor	E.g. palliative care, post-operative care	

Country	Name	Referral	Conditions	Eligibility	Staff type	Type of services provided	Additional information
Switzerland	Hospitalisation à domicile (HAD) (Geneva)	GP or hospital doctor	No specific restriction, e.g. cancer, diabetes, osteoporosis, anemia, infections	All ages, stable but still requiring hospital-level care, within coverage areas	GP, hospital doctors, nurses, pharmacists, home care teams	E.g. blood transfusions, tube feeding, chemotherapy, IV medication, palliative care, respiratory support	
United Kingdom	Hospital at Home (formerly known as Virtual Ward)	Any health professional, either for hospital avoidance or early supported discharge	No specific requirement	Anyone aged 18+ who has been assessed as suitable for the service	Multidisciplinary teams of specialist physicians (hospital doctors, nurses, therapists)	E.g. ECG testing, palliative care, COPD treatment, IV/oral antibiotics, diagnostics	Limited to 14 days maximum
United States	Acute Hospital Care at Home (AHCAH)	Hospital and primary care doctors, usually after surgery or emergency hospital visit	No specific restriction (differs by hospital), respiratory and cardiac conditions most common	Requiring hospital-level care but stable enough for home care, no need for 24/7 monitoring	Physicians, nurses, and other advanced practice providers	E.g. imaging and laboratory services	Option for in-home provision of ancillary services like meals and pharmacy

Note: COPD=Chronic obstructive pulmonary disease, DVT=Deep Vein Thrombosis, GP=General Practitioner, UTI=Urinary Tract Infection. Source: Austria: (Österreichische Gesundheitskasse, n.d.^[68]); Belgium: (Farfan-Portet et al., 2015^[69]; INAMI, n.d.^[70]) (RIZIV-INAMI, 2023^[71]); Canada (British Columbia): (Vancouver Coastal Health, 2025^[72]); Chile: (Campos Alarcón and Leiva Parisi, 2021^[73]); Colombia: (Mi Salud me Mueve, 2024^[74]; Secretaría Distrital de Salud, 2023^[75]); Denmark: (Nordsjællands Hospital, 2023^[76]; Nordsjællands Hospital, n.d.^[77]); Estonia: (Ülikool, 2023^[78]); Finland: (Pohjanmaan hyvinvointialue, n.d.^[79]); France: (République Française, 2025^[80]); Germany: (Charité, 2024^[81]); Greece: (Skylakakis, Plevris and Gaga, 2023^[82]) ΦΕΚ 3 396/19-05-2023 τ.Β' Νοσοκομειακή Κατ' Οίκον Νοσηλεία και Φροντίδα Υγείας; Ireland: (HSE, 2024^[83]; Vhi, 2025^[84]); Israel: (Sabar Health Hospital at Home, 2025^[85]); Latvia: (Ministry of Health, 2025^[86]; Ozolina, 2025^[87]); New Zealand: (Wrigley, 2024^[88]; New Zealand Government, 2024^[89]); Norway: (Helseinnvasjonssenteret, n.d.^[90]; Inger et al., n.d.^[91]); Spain: (IFSES, 2024^[92]; Gómez Rodriguez de Mendarozqueta et al., 2020^[93]); Sweden: (Region Stockholm, 2025^[94]); Switzerland: (imad, 2024^[95]; imad, 2023^[96]; Hospital@Home, n.d.^[97]); England: (Hospital at Home, 2022^[98]); United States: (MedPac, 2024^[99])

In hospital-at-home programmes, patients generally have access to a 24-7-hotline, receive visits at home by doctors and nurses in their home and can also receive additional digital assistance depending on the programme. The exact type, frequency of services and content differs across countries and programmes (Table 4.1). The number of providers of Hospital-at-Home services and the share of patients in these structures is small but growing across various OECD countries. For example, France counted 293 providers of hospital-at-home services in 2023 that treated a total of 278 600 inpatient stays and accounted for 6.8 million patient days (DREES, 2025^[100]). Similarly, the United States recorded a total of 366 Help-at-Home providers under the *Acute Hospital Care at Home Initiative* (AHCAH) in 2024 (Adams et al., 2024^[101]).

Hospitals at home are mostly hospital-led and paid through the country's respective hospital payment system. The hospital has a co-ordinating role and provides at least part of the workforce, such as nurses that visit the patient in their home to provide care. Hospital-at-home programmes are generally financed via the regular hospital payment system, based on diagnosis-related groups, global budgets, or a combination of diagnosis-related groups and per-diem payments. In the **United States**, under AHCAH, hospitals can bill the diagnosis-related group of the inpatient stay, but provide care in a less costly setting, which offers a strong financial incentive to hospitals. For payers, this approach does not offer financial

gains from the hospital stay itself but can offer indirect efficiency gains from fewer hospital re-admissions. In **Australia** and **France**, hospital-at-home stays are paid through diagnosis-related groups. In France, patients are allocated into one of the 31 diagnosis-related groups for hospital-at-home stays based on their main and co-diagnoses, their dependency determined based on the so-called Karnofsky index, and the length of stay (Système National des Données de Santé, 2024^[102]; ATIH, 2024^[103]). Medication is charged separately. In **England**, the payment for hospital-at-home programmes (virtual wards) is determined by regional authorities (Integrated Care Systems). NHS England has made GBP 450 million available in 2022-2024 for the expansion of hospitals at home, which is allocated to these authorities to expand services in their regions. Most of this funding is expected to contribute to workforce costs (NHS England and NHS Improvement, 2022^[104]). Other countries that use global budget schemes, such as **Scotland** and parts of **Spain** (e.g. Valencia, Madrid), finance hospital-at-home programmes through the general hospital budget, or use additional activity-related payments (e.g. Catalonia, Basque Country) (SEHAD, 2020^[105]). In **Israel**, hospitals at home are also part of the global budget payment, but hospitals face a 1%-penalty if they do not expand on this service. In **Belgium**, hospitals at home are paid via a combination of lump-sum, flat-rate, and fee-for-service payments for hospitals, specialists, GPs and home nurses.

Overall, findings indicate that hospital-at-home programmes yielded the same, or better outcomes, and are cost-effective (Shepperd et al., 2021^[106]; Arsenaault-Lapierre et al., 2021^[107]). Mean hospital costs of hospitals at home were generally around 20% to 30% below their comparable inpatient stays (Cryer et al., 2012^[108]; Singh et al., 2021^[109]; Yehoshua et al., 2024^[110]). Lengths of stay in hospitals are often shorter and patients have fewer referrals to emergency departments. Similar results were found in the United States for providing post-acute care for people with dementia at home, which resulted in similar outcomes at lower costs than skilled nursing facilities (Burke et al., 2021^[111]; Ruiz et al., 2017^[112]).

Patients are reporting high levels of patient satisfaction with hospital-at-home stays, which generally exceed satisfaction with inpatient stays (Leff et al., 2006^[113]; Pandit et al., 2024^[67]; Shepperd et al., 2021^[106]; Wang, Stewart and Lee, 2023^[114]). They feel more relaxed, less anxious and less depressed in their home settings, which might have helped their recovery. Caregivers have also reported positive experiences and reported feeling more comfortable and less stressed, but also show room for improvement in preparing them for their roles and in integrating them in the care pathway (Rossinot, Marquestaut and de Stampa, 2019^[115]). Caregivers in the AHCAH programme noted the initial orientation they received as key to preparing for the start of Hospital-at-Home (CMS, 2024^[116]).

To date, the number of hospitals at home is still limited. While they are increasing steeply in rate, some barriers hamper their growth. The expansion of hospital-at-home structures are subject to similar workforce shortage constraints of other healthcare sectors. While hospitals at home are less workforce-intensive than regular inpatient admissions, they require an active restructuring of staff that is otherwise allocated to inpatient care. The efficiency and cost-effectiveness of the structure depends on the price-setting. If hospitals receive the same tariff for a hospital-at-home stay as for an inpatient stay, the tariff will largely exceed costs and make hospitals at home lucrative to them but offer no direct gains for payers. Such a structure might be used to set an incentive to providers in the first years of the programme, but lower cost structures of hospitals at home should be accounted for in price-setting in the longer run.

Hospitals-at-home are also at risk of exceeding the time period they are intended for. Experience from Canada shows that hospitals-at-home programmes can last longer than the intended acute care phase, becoming a cost and resource-intense discharge programme that might not be medically necessary. In this case, the economic gains from an earlier discharge are overtaken by the costs of the hospital-at-home programme which might not have been medically necessary and just duplicate existing programmes at a higher price (Crisci, 2023^[117]). This makes a clear definition of the role and scope of hospital-at-home programmes necessary to ensure that it does not exceed the medically necessary period and does not duplicate existing structures.

Finally, patients and caregivers are often unaware of the option of hospitals at home (Rossinot, Marquestaut and de Stampa, 2019^[115]). In addition, some programmes might need to expand on the nursing care provided to ensure that informal caregivers do not have to take additional time off or hire additional support out of pocket (CMS, 2024^[116]).

4.4.3. New provider types can improve access and efficiency of care delivery

Several OECD countries have introduced new provider types to offer an intermediate layer in their healthcare systems, and rearranged the way they provide care to avoid or shorten hospital stays for older people. These incentives aim at providing care that is better tailored to the needs of older people, and at shifting the delivery of care from hospitals to other providers to reduce costs and bed blocking, where patients stay longer in a hospital bed than medically necessary, thus “blocking” a hospital bed.

Two dominant forms prevail across OECD countries. Firstly, countries are building health centres for older people in **primary care**, which group various specialties and can include experts from other policy sectors, such as social care workers, and can collaborate with other health, social and long-term care structures (OECD, 2020^[6]). Secondly, countries are setting up **intermediate care** structures that are located between the in- and the outpatient sector and generally offer beds for overnight stays for a limited number of days, and can be physically integrated in a hospital, or a separate, free-standing facility. They aim to either prevent a hospital admission altogether by offering an alternative place of care provision that does not require complex structures, or to allow for a quicker hospital discharge to reduce bed blocking for people that require some monitoring or post-acute care and are not ready to be discharged to a home setting, but also do not require the level of hospital care, anymore.

Teams are a promising structure to improve access to primary care and to facilitate the teaming up of different professions through multidisciplinary teams that operate within one network (primary care teams), or under one roof (primary care centres). Primary care centres are generally not exclusive to older people, but as the complex health status of older people requires patient-centred care from a set of different specialties, they are a core target group of these centres. For example, **Greece** launched primary care centres (*Τοπικές Μονάδες Υγείας*, ToMYs) in 2017, which are part of a general restructuring of the health system. In these around 120 structures, a team of general practitioners, internists, pediatricians, nurses and social workers offers health prevention and promotion, diagnosis, treatment, monitoring and care. **Austria**, **Germany** (Baden-Württemberg) and several cantons in **Switzerland** are also in the process of reorganising primary care structures in light of an ageing population. These primary care centres (*Primärversorgungszentren*) regroup a set of primary care specialties, such as general practitioners, nurses, dieticians and extend services beyond existing group practices and care centres (Baden-Württemberg, 2022^[118]). **Poland** is currently introducing one health centre per 100 000 inhabitants for people aged 75 and above (*Centra Zdrowia 75+*) over the next five years, totaling about 300 centres for the whole country. Similarly, the **Slovak Republic** is running additional pilots of that link health and long-term care.

Primary health centres and teams can increase access to care. *Family Health Teams* in **Canada** (Ontario) helped expand service volumes to people enrolled in their networks, had fewer referral rates and treated slightly sicker patients than regular primary care teams (Somé et al., 2020^[119]; Kantarevic, Kralj and Weinkauff, 2011^[120]; Strumpf et al., 2017^[121]). Findings from France echo Canada’s experiences, which reported increases in the number of patients seen, and the targeted allocation of Primary Care teams in rural areas also helped improving the recruitment and retention of doctors, thus improving access to primary care for people in poorly served areas (Chevillard and Mousquès, 2021^[122]; Cassou, Mousquès and Franc, 2020^[123]). The integration to foster the integration of general practitioners and advanced practice nurses and to delegate tasks to nurses was found to further increase access through an increase in the number of patients registered and seen (Loussouarn et al., 2020^[124]).

At the same time, primary care teams have experienced difficulties in engaging older patients in decision making, reported shortages in healthcare resources particularly in rural areas, and insufficient interaction with other providers, such as specialised dementia care, partly resulting from a lack of knowledge (Elliott et al., 2018^[125]). The introduction of primary care centres can be cumbersome. The roll-out of primary care centres in Greece was slow and heterogeneous, faced criticism by health professionals, low enrollment and its effects on improving access to primary care has been limited, so far (Emmanouilidou, 2021^[126]; Myloneros and Sakellariou, 2021^[127]). In addition, while some primary care teams increased their list sizes, the service volume did not always increase. Instead, primary care teams did not change their service volume or reduced it compared to other, “regular” general practitioners (Cassou, Mousquès and Franc, 2023^[128]). It is not clear whether this results from quality improvements, that make fewer visits necessary, is due to task shifting, or could point at under provision of care.

In **Canada**, various provinces are operating transitional care units to offer a transition from a hospital to home for people that do not need full hospital care, but require monitoring and receive care from nurses, personal support workers, and rehabilitation providers if needed (Barber et al., 2024^[129]). **Ireland** has been setting up geriatric day hospitals, allowing for a faster discharge (Romero-Ortuño, 2025^[130]). People above the age of 65 receive care from a multidisciplinary team for a number of conditions, such as chronic illnesses, cognitive impairment, poor nutrition and incontinence, and return to their own homes overnight. They are integrated in hospital structures and engage with other departments, for example for diagnostics. Similarly, **France** has launched several system interventions to better accompany people that have recovered enough to be discharged from hospital but still require some monitoring and do not receive sufficient care at home. The *hébergement temporaire en sortie d’hospitalisation* (HTSH) after a hospital stay takes place in long-term care facilities and is available for up to 30 days for people aged 60 and above. This compliments two already existing programmes, them being the *programme d’accompagnement au retour à domicile après hospitalisation* (PRADO) and the *Aide au retour à domicile après hospitalisation* (ARDH). In addition to that, France offers *hôpitaux de proximité*, which collaborate with primary care providers and long-term care facilities and offer preventive services, diagnostics, and short-term hospitalisations close to people’s homes. Italy offers community hospitals (*ospedali di comunità*), which consist of around 15 to 20 beds and offer care to people that were discharged from acute care hospitals, acute care or rehabilitation facilities, or are admitted from home and have chronic conditions or frailty. Their condition is too severe to allow them to be at home, but they also do not require high complexity care and spend up to six weeks in a community hospital but also do not require intense monitoring. **Hungary** is in the process of introducing “specialist nursing” departments in hospitals for people that do not require full hospital care but still need some monitoring. These units are placed under the competencies of the social care sector. In 2023, this plan covered six centres with a total of 318 beds (Directorate-General for Social Affairs and Child Protection, 2023^[131]). In the **United States**, skilled nursing facilities also offer an in-between layer between hospitals and home-based care or long-term care facilities, offer around-the clock care, provide help in activities of daily living and are staffed by doctors, physical therapists, and other medical professionals.

Intermediate care facilities have largely been identified as successful in improving health outcomes, for example reductions in hospital readmissions, and have been found to be cost-effective, and might be worth the investment (Weeks et al., 2018^[132]; Verhaegh et al., 2014^[133]). In the United States, discharges to home care had lower costs, but higher 30-day readmissions than discharges to skilled nursing facilities, suggesting that lower expenditures could come at the expense of quality of care (Werner et al., 2019^[134]).

So far, intermediate care facilities are limited in scale and scope and are often in a pilot stage. Shortages present a barrier in increasing the availability of intermediate care facilities (Leland et al., 2024^[135]). Intermediate care facilities are also prone to care fragmentation, which can negatively impact quality of care. Outcomes of intermediate care facilities (skilled nursing facilities) in the United States that have good levels of integration with hospitals enjoyed significantly better health outcomes than those with poor levels

of integration (Rahman et al., 2018^[136]), but low levels of data sharing (Adler-Milstein et al., 2021^[137]) hinder co-ordinated and patient-centred care.

While transition care facilities can be a viable policy option to shorten inpatient stays, patients can also spend excessive lengths in such units because of a lack of supply and long waiting times for long-term care at home or in facilities. Canada has been experiencing both waiting times for transitional care facilities, and delayed discharges to long-term care settings. In addition, some countries display further room to improve efficiency along the pathway from hospitals to long-term care. Large spending increases on skilled nursing facilities and other post-acute care settings in the United States have raised questions about additional efficiency gains and financial incentives might lead to longer hospital stays than medically necessary (Chandra, Dalton and Holmes, 2013^[138]; McGarry et al., 2021^[139]). In addition, just setting up any new physical structure for older people does not automatically lead to cost-effective care. Long-term care hospitals in the United States, which provide care similar to Skilled Nursing Facilities, but receive much more generous payments, have generated wasteful spending that are estimated to equate to USD 4.6 billion per year (Einav, Finkelstein and Mahoney, 2023^[140]).

Intermediate care facilities can represent a successful strategy in shortening hospital lengths of stay by offering a step-down structure for people that still require some form of monitoring and supervision. Intermediate care structures can improve the efficiency of healthcare systems by directing patients, that do not require high-intensity hospital structures anymore to a less resource-intensive setting. This frees up human and financial resources for patients that require such intensity. At the same time, patients can get stuck in intermediate structures, for example though a shortage in long-term care facilities that patients could be discharged to from an intermediate care structure. To further improve the efficiency of healthcare systems, countries have to make sure to offer sufficient structures post-intermediate care. Clear pathways, data sharing arrangements, and co-ordination and integration with other providers can help address fragmentation or adding another layer these challenges, for example through a formalised agreement with other providers.

4.5. Ensuring patient-centred care

Care provided to older people is often fragmented. They receive care from a set of different providers from different sectors, which is challenging to co-ordinate and align. Older people often face several limitations and multiple chronic diseases concurrently, requiring a set of interventions to help them maintain and improve their health status. Interventions that focus on individual mechanisms alone tend to work below potential and care provided to older people often displays high variability (Jarman et al., 2022^[141]). They often do not sufficiently address the risk, and if they do, might not materialise in better health outcomes. For example, programmes that support deprescribing are very limited and their success in reducing polypharmacy are mixed. Even if they are successful in reducing polypharmacy, lower rates do not always lead to improvements in health outcomes, such as reductions in hospitalisation rates (Cole et al., 2023^[142]). Similarly, evidence on deprescribing fall-risk inducing drugs indicates that deprescribing alone might not be sufficient to reduce falls if not combined with other fall-reducing policies (Lee et al., 2021^[143]). Countries are working with care pathways to better structure the care provision along a patient's care pathway and are setting up integrated care programmes to further support and formalise the integration of care from a set of different providers.

4.5.1. Care pathways aim at streamlining care along the patient pathway

A total of nine countries (Colombia, France, Iceland, Ireland, Luxembourg, the Netherlands, Norway, the Slovak Republic and Slovenia) reported that they have introduced care pathways for older people to harmonise and streamline the provision of care. They are often broadly structured along the steps outlined by the World Health Organization (2024^[144]) in the handbook for integrated primary care for older people,

which consist of a basic assessment, in-depth assessment, developing a personalised care plan, and implementation and monitoring. Each of these steps may contain a range of actions depending on the patient and condition and should integrate various healthcare providers as well as the community. For example, **Norway** offers several disease-specific guidelines for older people. In 2009, it introduced the *Patient Trajectory for Home-dwelling elders* (PaTH) to improve the discharge from inpatient care and primary care follow-up, and while the programme has potential to improve care co-ordination and follow-up, low adherence has been limiting its impact. Specifically, training home care staff to use the care pathway and integrate it into daily practice required substantial work, but when municipalities achieved this, it could function as a management tool to drive change and enhance knowledge and skills (Røstad et al., 2015^[145]). The **United States** introduced the *Financial Alignment Initiative* (FAI) in 2001 to better align services for people with dual eligibility (Medicare and Medicaid).

Table 4.2. Overview of care pathways for older people across several OECD countries

Country	Pathway	Target Group	Setting	Description	Evaluation (if available)
Australia	Clinical Pathway for older people in aged care homes	Residents in long-term care facilities	Long-term care facilities	32 pathways for long-term care facilities	
Australia (New South Wales)	Older People's Suicide Prevention Pathway Project	Older people at risk of suicide, especially men 85+	Community care (implemented by local health districts)	Adjustments to existing referral system to refer people at risk directly to mental health services and slow down wait time. Adjustments to roles within mental health teams, additional training and increased focus on risk factor identification.	Wait times for support reduced from 1-2 weeks to 1-2 days
Australia (Queensland)	Clinical Practice Guidelines and Care Pathways for People with Dementia Living in the Community	Home-dwelling adults with dementia	Community care	Various care pathways for different types and stages of dementia and guidelines for various stakeholders, including health and social professionals and informal carers. Focus on enabling and improving access to diagnosis and community-based follow-up care	People, esp. patients and informal carers, often do not know or understand care pathway, not all communities have or follow pathways aligned with guidelines
France	Parcours de santé des aînés (PAERPA)	People aged 75 and above	Community care	Identify and target main factors for avoidable hospitalisation: depression, falls, malnutrition, medication-related problems. Optimising co-ordination of health and social professionals, securing hospital discharges	Qualitative evaluation shows need for larger project teams and project managers, insufficient investments in auxiliary digital tools. Home returns after temporary inpatient care and telemedicine use in nursing homes improved
Ireland	Geriatric Emergency Medicine Service (GEMS)	Patients aged 75+ who present at acute services	Acute hospital care	All patients are screened for frailty at the hospital, if positive they receive a Comprehensive Geriatric Assessment within 72 hours by a specialty team. Another specialised team later supports the transition from hospital to home	

Country	Pathway	Target Group	Setting	Description	Evaluation (if available)
Ireland	Integrated Care Programme for Older Persons (ICPOP)	People aged 65+ with complex care needs	Acute hospital care and community care	Mapping and redesigning existing care pathways with a focus on patient experience and quality of care. Creation of multidisciplinary Community Specialist Teams for Older Persons (CST-OP) that aim to provide a one-stop shop for care co-ordination and patient point of contact. Includes specialised pathways for frailty, falls and dementia	Faster hospital discharges but often uncertainty about duration of care. Need to treat patients and carers as service delivery partners and strengthen transparency and consistency. Positive feedback from patients, carers and staff, but concern about administrative burden and loss of specialist skills
Ireland	Pathfinder: Alternative Care Pathways for Older Adults who Dial 999/112	People aged 65+ who call 999/112 with non-urgent needs	Case-specific but primarily community care	People who dial 999/112 with low-acuity concerns (e.g. falls non-traumatic back pain, generally unwell, blocked/dislodged urinary catheter) are visited by a Rapid Response Team (advanced paramedic and occupational or physiotherapist) and assessed at home rather than brought directly to the emergency room. Whenever appropriate, the patient stays at home and is referred to an alternative care pathway to avoid hospitalisation	485 patients visited by Rapid Response Team in first year, 68% could remain at home, of which 89% got follow-up treatment through another pathway. Positive feedback from patients and carers. Has been expanded since
Italy	Guidance on Integrated Care pathway for People with Dementia (GICPD)	Anyone with dementia	Community care	Objective of providing a standardised framework for the definition, development and implementation of integrated care pathways (ICP) for people with dementia. Precise steps of the ICP can still vary slightly	Only 5 out of 21 regions had an ICP and compliance was moderate
Netherlands	Care pathway for older adults presenting at the emergency department (ED) with nonspecific complaints	Older adults visiting Eds with nonspecific complaints	Hospital care (emergency departments) and follow-up community care	Testing, diagnostics and follow-up guidelines for older people who come to EDs with nonspecific complaints. Focus on integrated care for more accurate and quicker diagnosis and access to treatment, ideally community-based	Positive patient feedback on quality of care, non-significant improvements in readmission rates and diagnostic completeness. No change in length of stay
Netherlands	Regional Integrated Cardiovascular Risk Management Care Pathway	Patients of all ages at risk of or with cardiovascular diseases, primarily older people (mean age 64)	Hospital and community care	Integrated care guidelines across levels and settings of care for managing cardiovascular patients and those at risk and improving access to diagnosis and treatment	Better quality of care and interprofessional collaboration according to patients and professionals through 4 working mechanisms. Promising blood pressure and cholesterol outcomes. Some tests and data entries were redundant, showing potential for cost savings

Country	Pathway	Target Group	Setting	Description	Evaluation (if available)
Norway	Patient Trajectory for Home-dwelling elders (PaTH)	Older people using home care services	Community care (post-hospital discharge)	Checklists for hospital discharge and follow-up primary and home care, with aim of more structured and co-ordinated care across health and social professionals and better exchange of information	Only 36% of patients were assessed by at least 3 of 4 main PaTH checklists, but adherence improved over time. No effect on hospital readmissions or other outcomes except more GP consultations for PaTH patients
United Kingdom (England)	Frailty Pathway	People aged 65+, frail and receiving care	Community care (delivered by neighbourhood health services)	Pathways for various scenarios involving frailty, e.g. post-discharge follow-up care, home hospital referral, same-day discharge after emergency department admissions, etc. 5 key principles: Focus on acute problem, refer, assess, identify needs, leave	Inconsistent adherence, e.g. variations in frailty assessment and strategy, lack of training. Reduced emergency room and hospital admissions and cost savings in some districts
United Kingdom (England)	Getting It Right the First Time	Health services	Over 40 medical and surgical specialties across different healthcare levels	In-depth reviews of health services, performance benchmarking, and building a data-driven evidence base to improve healthcare delivery, consistency and efficiency, including for geriatric medicine	Follow-up Orthopedic report detailed GBP 696 million savings to the NHS. Objective to save GBP 1.4bn across all services and improve patient outcomes
United States (Indiana)	Indiana Pathways for Aging	People aged 60+, enrolled in Medicare and eligible for Medicaid	Community care	Provides various health plans that support people in ageing at home or in the community, each plan includes a care and services co-ordinator to help them get the benefits for which they qualify	
Belgium, Czechia, France, Germany, Greece, Ireland, Italy, Luxembourg, the Netherlands, Norway, Poland, Slovenia, Spain, Sweden (some still in analysis or development phase)	Streamlined Geriatric and Oncological evaluation based on IC Technology for holistic patient-oriented healthcare management for older multimorbid patients (GERONTE)	Patients aged 75+ with multimorbidity and cancer	Community care	Guidelines for baseline evaluation, decision making, treatment, monitoring, and follow-up. First evaluation by advanced practice nurse and then inclusion of other professionals and services as needed	RCTs being carried out in Belgium, the Netherlands and France

Source: Australia: (NSW Health, 2023^[146]; Palk et al., 2008^[147]; Fitzgerald et al., 2019^[148]); France: (Ministère de la Santé, 2025^[149]; Gand et al., 2017^[150]); Ireland: (Health Management Institute of Ireland, 2022^[151]; Kennelly, Fitzgerald and O'Shea, 2017^[152]; OECD, 2025^[153]; Ward et al., 2022^[154]); Italy: (Gervasi et al., 2020^[155]); Netherlands: (van der Velde et al., 2025^[156]; de Koeijer et al., 2025^[157]); Norway: (Røstad et al., 2017^[158]); United Kingdom: (NHS England, 2024^[159]; NHS England, n.d.^[160]; Duncan and Sayers, 2023^[161]; Hopper, 2021^[162]; NHS Confederation, 2022^[163]; McGrath, Almeida and Law, 2019^[164]); United States: (State of Indiana, 2025^[165]); GERONTE: (GERONTE, 2021^[166]; Seghers et al., 2024^[167]).

Care pathways can help health workers streamline the provision of care and are often associated with improvements in health outcomes (Seys et al., 2017^[168]), but can be challenging to implement. The diffusion of clinical guidelines and care pathways takes time, and time constraints, staff shortages and turnover are only some of the limiting factors that hinder the adherence to care pathways (Gladman et al., 2016^[169]; Evans-Lacko et al., 2010^[170]). Context-specific challenges to implementation, such as insufficient knowledge about palliative drugs or taboos around dying for palliative care pathways, may further complicate adherence, while other barriers like a lack of multidisciplinary teams or resistance to change are more general (Watson, Hockley and Dewar, 2006^[171]).

Although the need for care pathways for older people has been identified long ago (Katsaliaki et al., 2005^[172]), systematic research is still scarce. Evaluations of many pathways are complicated by poor adherence and if available, point at mixed results, indicating a need to more thoroughly consider prerequisites for effective implementation (Røstad et al., 2017^[173]). However, there are some promising studies on care pathways for specific outcomes after acute issues, such as reducing frailty in trauma patients among older people (Bryant et al., 2019^[174]) or in acute care, where the implementation of geriatric care pathways reduced costs and shortened hospital stays while health outcomes remain similar (Ijadi Maghsoodi et al., 2022^[175]). Similarly, Suhm et al. (2014^[176]) found that co-managed care pathways for older hip fracture patients reduced the length of hospital stays and complications while in the hospital compared to usual care.

4.5.2. Integrated care programmes increasingly link health with social and long-term care

In the *OECD Policy Questionnaire on Healthy Ageing and Community Care*, a total of 20 OECD countries responded that they have already introduced integrated care programmes for an older population, with another 3 planning to do so. Countries can build on the experience with more “traditional” programmes that aimed at integrating providers within one sector and are widespread cross the OECD, for example to improve care co-ordination for people with chronic diseases (OECD, 2023^[10]). Integrated care programmes that particularly target older people are either exclusive to people beyond a certain age threshold, such as 60 or 65 years, or are open to everyone, but focus on certain conditions that tend to be more prevalent among older people. While integrated care pathways are usually designed systematically based on existing experience and relevant research (Dubuc et al., 2013^[177]), follow-up research to determine their real-world effectiveness is often lacking.

Table 4.3. Integration of different health sectors in integrated care programmes

Country	Outpatient care	Inpatient care	Long-term care	Social care	Other
Australia			•		
Canada (New Brunswick)	•	•	•	•	•
Chile			•	•	
Costa Rica				•	
Czechia	•	•	•	•	
France	•	•	•	•	
Germany	•	•	•	•	•
Hungary			•	•	
Iceland			•	•	
Ireland	•	•	•	•	
Japan	•	•	•	•	•
Latvia	•	•	•	•	•
Luxembourg	•	•	•	•	
Netherlands	•	•	•	•	
New Zealand	•	•	•	•	•
Norway	•	•	•	•	•
Portugal	•	•	•	•	•
Slovak Republic	•	•	•	•	
Slovenia			•		
Türkiye	•	•	•	•	
United Kingdom	•	•	•	•	
United States	•	•	•		
Sum	16	15	21	19	7

Source: 2023 OECD Policy Questionnaire on Healthy Ageing and Community Care.

More recently, countries have been active in reaching beyond the healthcare system alone. This reflects a move towards a more comprehensive understanding of care beyond the healthcare system and interacts with social and long-term care (See Table 4.3). Integrated care programmes generally combine at least two different sectors. The long-term care sector is the most frequently involved sector, with 21 countries integrating long-term care in their integrated care programmes, followed by social care (19 countries), outpatient care (16 countries) and inpatient care (15 countries). Seven countries also co-operate with other providers and sectors, such as short-term and rehabilitation and palliative care in Portugal, and private sector companies, volunteers, and non-profit organisations in Japan (OECD, 2023^[178]).

Integrated care programmes for older people combine a variety of different health professions, reflecting a move towards more patient-centred care through multi-disciplinary teams. Long-term care facilities were involved in all 21 countries that responded to having implemented an integrated care programme. Nurses (18 countries), general practitioners, home care providers and social care workers (17 countries each) were also prominently involved, followed by outpatient specialists (16 countries). Inpatient providers were slightly less involved (14 countries), and 12 countries also interacted with other professions, such as occupational therapists in Iceland, physiotherapist in the Netherlands, volunteers and informal carers in New Zealand, and professionals from the voluntary, community, and social enterprise sector in the United Kingdom.

Integrated care programmes differ in scale and scope. **Belgium** and **Luxembourg** are both in the process of introducing integrated care programmes. Belgium has launched a pilot of 12 programmes for chronic diseases in 2018, and of another 19 programmes for alternative forms of care for older people in 2019 and is currently integrating its findings into a new plan on integrated care (RIZIV-INAMI, 2023^[179]), while Luxembourg is teaming up providers for a selection of pathologies (*réseaux de compétences*), them being neuro-degenerative diseases, immuno-rheumatology in adults and children, diabetes and morbid obesity for children and chronic pain (Ministry of Health and Social Security of Luxembourg, 2024^[180]). These link patients and caregivers with hospitals, care co-ordinators, home care providers, outpatient physicians, and other professionals to one joint network. In **Canada**, several provinces have gained experience with integrated care for older people. For example, Quebec launched the Program of Research to Integrate the Services for the Maintenance of Autonomy, also known as *Réseau de Services Intégrés aux Personnes Âgées* (PRISMA, or RSIPA) in 1999, which was later integrated in standard care. **Costa Rica** has set up the Progressive Care Network for the Comprehensive Care of Older Adults (*Red de Atención Progresiva para Cuido Integral de las Personas Adultas Mayores en Costa Rica*). **France** has experimented with different iterations of Integrated Care Programmes for older people. In 2014, it launched the programme *parcours santé des aînés* (Paerpa) for people aged 75 and above and their caregivers in nine French regions. The programme aims at supporting older people to stay at home for as long as possible, improving care co-ordination and quality of life. The new pilot programme, the *expérimentation d'un paiement forfaitaire en équipe de professionnels de santé en ville 2* (PEPS2) builds on this experience. A group of at least five medical professionals, covering at least three general practitioners, and at least one nurse, receive a global budget to provide care for a certain population group, such as people aged 65 and above, or people aged 50 to 64 with cognitive impairment. **Ireland** has introduced *Enhanced Community Care* (ECC). In **New Zealand**, several regional programmes focus on providing integrated care to frail people, or those at risk of becoming frail, such as the *community health of older people initiative* (CHOPi) in Wellington, and the Kare Project in Auckland. **Portugal** has launched a pilot project of *local health units* (*Unidade Local de Saúde*) that team up Primary Care, outpatient specialist services and inpatient care and shall improve vertical integration (Goiana-da-Silva et al., 2024^[181]). This structure resembles *Integrated Care Systems* in the **England**, which were introduced in 2022. The country's 42 ICSs are responsible for commissioning health, social and long-term care, serving 0.5 to 3 million people each. In the **United States**, several states have set up new structures under the Program of All-Inclusive Care for the Elderly (PACE).

Several additional OECD countries are in the process of setting up Integrated Care Programmes in their countries. For example, **Czechia** has launched a Regional Health and Social Plan (*Krajské zdravotně sociální plány*, KARPL). The Ministry of Health co-operates with the Ministry of Labour and Social Affairs on mapping already existing health and social services to assess unmet need, and to identify rooms of improvement for co-operation and co-ordination, and on developing and piloting a strategy on how to address both (Czech Ministry of Health, 2024^[182]).

4.5.3. Integrated care programmes reform the way providers are paid to foster integration

Integrated care programmes are either paid through a combination of different payment schemes, or through a capitation-based approach. A group of countries uses existing payment schemes, such as payments based on diagnosis-related groups for inpatient providers, and fee-for-service for outpatient providers, and monthly contributions for long-term care facilities. Some countries have decided to reform the way providers are paid and use payment schemes to support provider integration. In these programmes, a group of providers is either entirely paid based on a global budget, or through a combination of a global budget and their traditional payment scheme. In **France**, provider groups of the pilot programme *PEPS 2* receive a capitation-based global budget to provide care to a group of patients, replacing the existing fee-for-service scheme. Capitation payments per patient are adjusted by age, sex, the number of chronic conditions, the presence of one or more out of five selected chronic conditions, the socio-economic background of the patient. In addition, a regional factor is applied based on average expenditures, density of General practitioners, and socio-economic status of the region based on poverty rates of the areas the patients and provider are located in. Additional payments can be issued for nursing-related costs (Ministère du Travail, de la Santé, des Solidarités et des Familles, 2024^[183]; Ministère du Travail, de la Santé, des Solidarités et des Familles, 2024^[184]). Similarly, **Luxembourg** and **Portugal** are currently in the process of moving Integrated Care Programmes towards global budget schemes. In the **United States**, in *PACE*, providers are paid monthly on a capitation-basis, replacing the traditional fee-for-service method. Capitation payments consist of four components, them being health provider-related costs (Medicare Part A and B), which are adjusted by morbidity and frailty, drug-related costs (Medicare Part D), which are adjusted based on a patient risk score, Medicaid payments that are determined based on a state-level, which in most states consists of a flat-rate for Medicaid eligibility, and private payments, that generally represent about 1% of total costs (CMS, 2011^[185]).

Several countries are adjusting payments or offer add-on incentives for quality of care to financially incentivise quality improvements. At least 10 OECD countries link integrated care payments to quality indicators. In some instances, these are part of a regular pay-for-performance programme and focus on a specific sector. **Latvia** and **England** target general practitioners, **Poland** rewards for cardiovascular prevention and Iceland targets home-care providers. Four countries, them being **France**, **Japan**, **Portugal** and the **United States**, have set more comprehensive pay-for-performance programmes that address integrated care more specifically. These programmes are very heterogeneous in their design. France ties part of the payment to quality indicators in *PEPS2*. Provider networks are paid on a capitation basis, where providers can receive an additional up to 10% for continuity of care, prevention and health education as well as patient experience (Ministère des Solidarités et de la Santé, 2019^[186]).

4.5.4. Integrated care programmes are intuitive, but gains are difficult to materialise

While the introduction of integrated care programmes seems intuitive to fight fragmentation through integrated, patient-centred care, tangible improvements in quality of care and reductions in expenditures are difficult to achieve and are insufficient to offset major deficiencies of health systems, such as health workforce shortages and insufficient capacities of providers. Overall, evaluations of Integrated Care Programmes show mixed, heterogeneous results and gains take time to materialise. For example, the

French programme *PAERPA* was successful in reducing avoidable hospital admissions, and reducing polymedication, inappropriate prescriptions and visits to emergency rooms, but not on hospitalisations and suffered from low engagement of health professionals (Or, Bricard and Penneau, 2019^[187]). Three integrated care programmes for older frail people in the Netherlands largely failed to offer significant improvements in quality of care and largely failed on measures of cost-effectiveness (Hoogendijk, 2016^[188]). Some programmes in **England** were successful in mitigating avoidable admissions, but results are heterogeneous across different integrated care programmes (Morciano et al., 2021^[189]).

Integrated care programmes seem to work better when professionals already have some level of team integration and trust, but these take time to build, especially when programmes aim at integrating providers from different sectors with different modes of operation. Knowledge of integrated care, communication, teamwork and shared decision making are key skills to delivery integrated care (OECD, 2025^[190]; OECD, 2025^[191]). In **Canada** (Ontario), trust was identified as a key enabler to integrating care, but this process takes time to build and has a gradual phase-in (Embuldeniya et al., 2018^[192]). Similarly, in the **Netherlands**, building integrated care took several iterations and financial and expert support (Nies et al., 2021^[193]).

Changes in provider payments can support continuity of care, foster the identification as a team, and offer financial security to providers. For example, a move from existing, separate payment schemes, such as fee-for-service for outpatient providers, diagnosis-related groups for hospitals and per-diem payments to long-term care providers towards a quality-adjusted capitation payment to a group of professionals holds a group of different providers accountable for delivering care. At the same time, a move towards payment schemes that support continuity of care, offer financial security to providers and facilitates longer-term planning can come at a risk of longer waiting times and efficiency reductions. Providers that operate in Integrated care programmes often report that measures to foster trust, integration and team building, such as multidisciplinary team meetings, are insufficiently covered in the financing of integrated care programmes (Grol et al., 2021^[194]). Policymakers can add these dimensions to the way providers are paid, but it increases the costs of integrated care programmes and counteracts efforts to reduce spending.

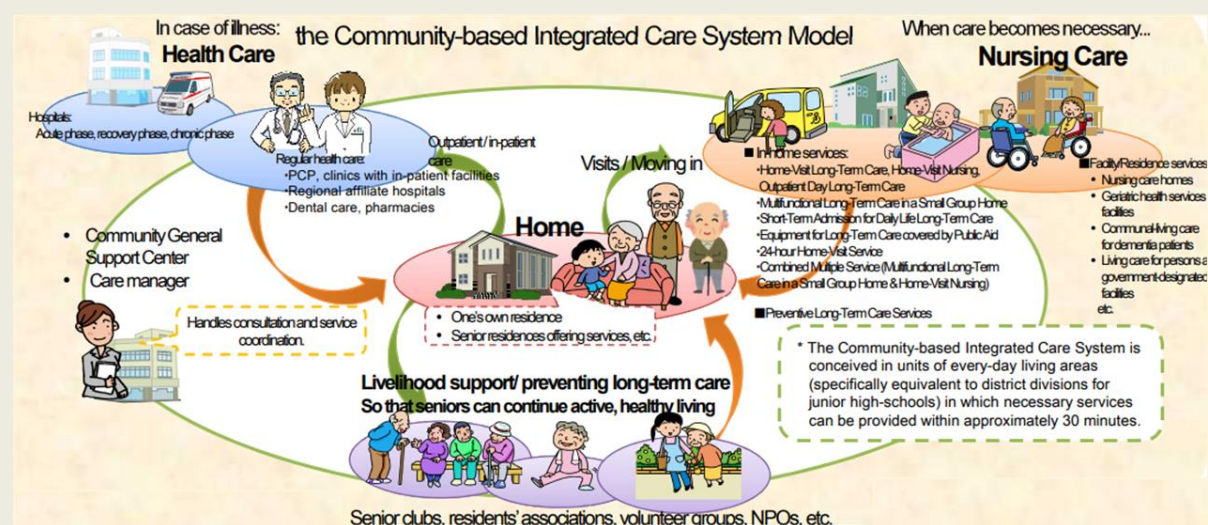
Flexibility for local authorities to adapt programmes to people's needs are difficult to balance with limitations in skills and capacity constraints. Providers that participated in integrated care programmes in Canada (Ontario) highlighted the wish for greater accountability and flexibility (Embuldeniya, Gutberg and Wodchis, 2021^[195]). At the same time, experience from **England** and the **Netherlands** has shown that regional entities and provider groups might require some additional expert support in making use of their increased autonomy and also need some financial support in setting up new governance structures (Morciano et al., 2021^[189]).

Box 4.1. The Japanese Community-Based Integrated Care System

A community-based Integrated Care Programme improves outcomes and reduces expenditures

Japan offers Community-Based Integrated Care systems that group providers from a variety of sector from the health, social and long-term care centre and are centred around the patient. It offers healthcare, nursing care, prevention, housing and livelihood support to ensure that people can age actively and independently in place. Services are co-ordinated by a care manager and are offered within a catchment area of 30 minutes and older people are referred to it based on their need.

Figure 4.3. The Japanese Community-based Integrated Care System Model



Source: MHLW (2025^[196]), 地域包括ケアシステム [Community Integrated Care System], https://www.mhlw.go.jp/stf/seisakunitsuite/bunya/hukushi_kaigo/kaigo_koureisha/chiiki-houkatsu/.

This structure originated in Mitsugi in 1974, resulting in half a century of experience in designing and implementing integrated care for older people. Japan is currently revising its Community-Based Integrated Care System and moving towards a new system by 2025. Municipalities and prefectural governments are tasked with creating such community-based integrated care systems as insurers of long-term care and are responsible for tailoring it to the needs of their municipality. Since 2025, municipalities have to formulate a long-term care plan every three years and implement community-based comprehensive care system in their respective entity. As part of it, municipalities have established community comprehensive support centres, in which public health nurses, social workers and other specialists offer mental and physical health support. In 2024, there were 7 362 such centres available across the country.

The comprehensive system has been successful in preventing the rate of hospitalisations and institutionalisations (Tomita, Yoshimura and Ikegami, 2010^[197]). Integration and a shared vision were reported as key enablers in building successful integrated care systems (JICA, 2022^[198]), but staff shortages and difficulties of informal caregivers, such as relatives, to reconcile caregiving roles and labour supply, remain constraining factors of community-based integrated care (Costantini, 2021^[199]).

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5 How to ensure better ageing in place?

This chapter provides insights into different policy dimensions necessary to promote ageing at home. It first describes how countries are ensuring that housing remains affordable for older people and whether there is sufficient help for adapting housing when people develop mobility limitations. It also focusses on the broader environment where people live, highlighting necessary changes to enable more age-friendly communities that provide access to services and promote participation. Finally, the chapter looks at the comprehensiveness and affordability of home care services.

Key findings

- **Current living environments do not always promote ageing at home.** The current housing stock is not always affordable or well-adapted for older people to remain at home as they age, and public funding for housing adaptation is often insufficient. In the United States and Europe, home modifications that make housing more accessible are in place in less than 20% of homes. Essential services and green spaces are not always readily accessible to older people. In cities, on average, a person has access to only 0.2 green areas and only 0.5 hospitals within 15 minutes' walking time. Public transport does not yet fully meet the needs of older people in accessing services. Among 27 OECD countries with available information, only 16 countries reported that public transportation is easy to access for people with mobility limitations and affordable for older people.
- **Home and community care provision remains limited, presenting challenges in ensuring access and meeting current needs.** Currently, 40% of countries impose a limit on the hours of care, while care for instrumental activities of daily living is not always covered in 20% of those cases. Continuous LTC support at home is available in only 30% of countries across the OECD. Gaps in the public provision of home care leave vulnerable people with severe needs and low income at the risk of unmet needs or high out-of-pocket costs, incentivising the use of institutional care.

Policy options

- **Support people in making their houses age-friendly.** Home modifications are associated with a lower likelihood of being admitted to nursing homes and a lower need for help with activities of daily living. Simplifying the process for housing adaptation and ensuring that it is generous enough to cover modifications would be needed to better promote ageing in place. Currently, out-of-pocket payments are required in one-third of countries to cover the cost of housing adaptations. Countries like France have simplified access to such support for older people who need housing adaptations by creating a financial aid programme, *MaPrimeAdapt'*. In several countries like the Netherlands, Sweden and Norway, municipalities provide consultation on housing adaptation with an occupational therapist who assesses needs and subsidise providers upon request once the adaptation is in place.
- **Adapt communities to an ageing population.** Environments which encourage accessibility help to promote independence for older adults, especially for people with dementia. Health services in rural areas where there are more older people could also be enhanced by innovative solutions to strengthen health professionals, as in France and Norway. Public transportation that is accessible and affordable to older people fights social isolation and maintains functional capacities. Countries like Australia and Japan have looked at flexible transport models for older people while Austria has promoted concessionary fares. An offer of activities to enhance social participation is also important: In Japan, municipalities have implemented salons for older people on educational programmes and social activities, which have halved the incidence of long-term care (LTC) needs.
- **Make home care services more comprehensive.** Enhancing the hours and services for home care, while seeking innovative solutions, can incentivise people to stay at home longer. Personal budgets, as in England and the Netherlands, could provide flexibility to users in deciding the home care services that they need. Spain in 2022 changed the limit on the hours available for the highest grade of LTC to cater for more home care for those who have more severe needs. Digital technologies, as implemented in Nordic countries and Japan, can help contain the costs

of monitoring and free workers' time for providing other types of care to older people. In addition, where unit costs of home care services are lower than those of institutional care, countries could consider expanding the hours and piloting 24-hour care options.

5.1. Introduction

Older people across OECD countries prefer to age at home and in their community. According to evidence from the United States, 77% of adults aged 50 and above wish to age at home (Binette and Farago, 2021^[1]). With an ageing population and a growing burden of chronic conditions leading to an increasing demand for long-term care, allowing people to age in place is gaining importance. Many OECD countries have developed services to support home-based care for older adults. Between 2011 and 2021, the proportion of long-term care recipients who received care at home increased slightly, from 67% to 69%. However, having more older people living at home is not without its own challenges.

5.2. Being able to afford a home is the first step towards ageing in place

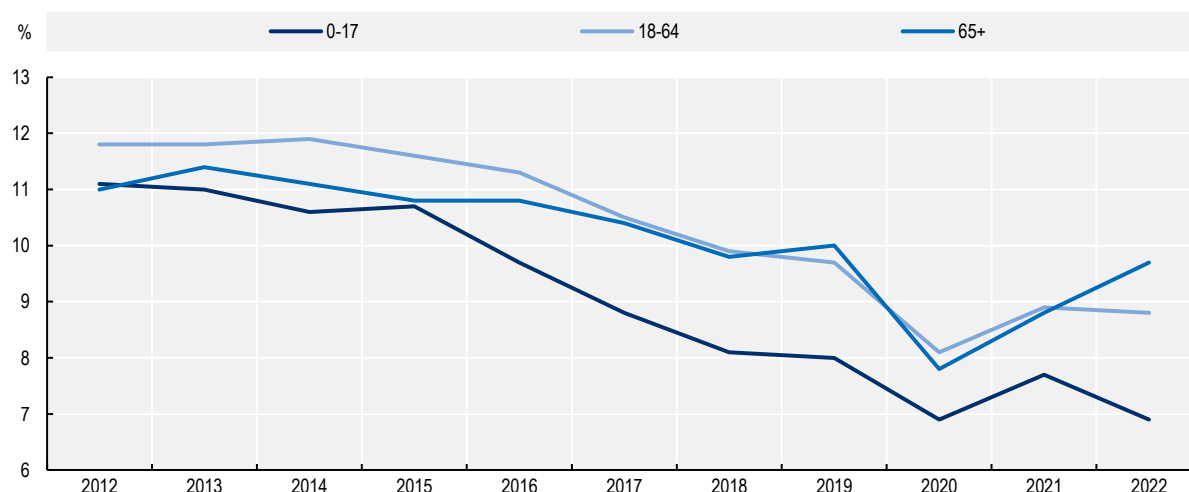
Although a majority of older adults in OECD countries are homeowners, housing affordability is declining, and the proportion of older people owning homes is expected to shrink as younger generations grow older. Additionally, many older adults experience reduced incomes, making it increasingly difficult to afford rent and cover essential living expenses. Policies aimed at enabling individuals to age in place and remain in their own homes for as long as possible should address the challenge of ensuring suitable housing that supports independent living in later years.

5.2.1. Decreasing homeownership is likely to pose a challenge to older people in the coming decades

Among OECD countries, the majority of people in older ages own their homes, but housing affordability is decreasing. Homeownership is an important asset for older people for several reasons. In most countries, a home is the biggest financial asset that people own, representing more than 70% of total wealth in European households (Vignoli, Tanturri and Acciai, 2016^[2]) and acquiring a house is associated with better mental health in old age (Courtin, Dowd and Avendano, 2017^[3]). The share of homeowners, as well as housing tenure, has been declining for the overall population across OECD countries. This is driven by several factors. Housing affordability (i.e. housing price to income ratio) has decreased since 2017 in OECD countries (OECD, 2023^[4]). Today, families pay considerably more to buy a flat than previous generations. The years of annual income needed to buy a 60 square-metre flat in the country's capital city or financial centre, for a median income couple with two children, grew from 6.8 years in 1985 to 10.2 years in 2015, based on data from 16 OECD countries (OECD, 2019^[5]). Moreover, between 2020 and 2022, the housing cost overburden rate has been growing considerably for people aged 65 or older, moving from 7.8 in 2020 to 9.7 in 2022 on average in the EU (Figure 5.1).

Figure 5.1. Housing cost overburden rates have been rising for older people in latest years in EU countries

Percentage of the population living in a household where the total housing costs (net of housing allowances) represent more than 40% of the total disposable household income (net of housing allowances), by age groups



Note: Data includes 27 EU countries.

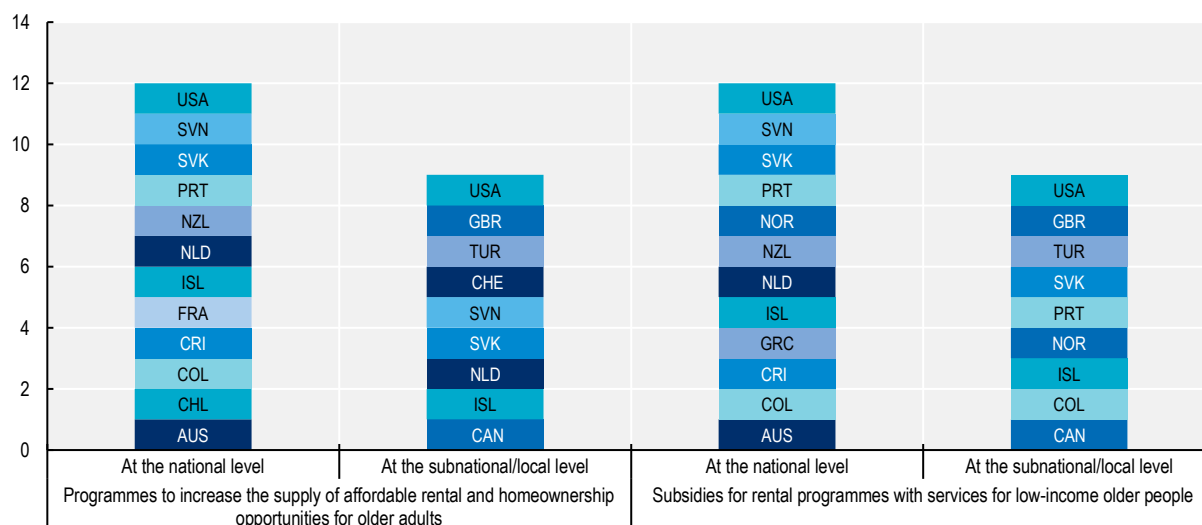
Source: Eurostat (2024^[6]), "Housing cost overburden rate by age group – EU SILC survey", https://ec.europa.eu/eurostat/databrowser/view/tessi161_custom_10348800/default/table?lang=en.

As home ownership becomes increasingly unaffordable, a growing share of older people are expected to become renters in the coming years and need additional support to ensure affordable housing. Older renters are often faced with the challenge of rent overburden and difficulty making ends meet due to decreasing incomes at older ages.¹ Poverty rates for older people are higher than for the total population in two-thirds of OECD countries and increase with age, limiting the capacity of older people to pay rent in tight housing markets (OECD, 2023^[7]). Research has highlighted growing housing insecurity and rent unaffordability, together with lower quality of housing among older people, particularly affecting women and minorities, partly contributing to a growing number of people becoming homeless at the age of 50 or older (Bates et al., 2019^[8]; Bates et al., 2019^[9]; Cram and Munro, 2020^[10]; Waldron, 2021^[11]; Petersen and Aplin, 2021^[12]; Airgood-Obrycki, Hermann and Wedeen, 2022^[13]). The precarity caused by renting at older ages poses additional challenges and can compromise older people's well-being (Bates et al., 2019^[9]; Bates et al., 2019^[8]; Mawhorter, Crimmins and Ailshire, 2021^[14]).

Several countries are supporting people in securing stable housing through policies that aim to either improve the supply of affordable rental and homeownership opportunities or support housing-related costs, such as rental costs. Across OECD countries that replied to the *OECD Questionnaire on Healthy Ageing and Community Care*, 73% (16 out of 22) of countries reported the existence of programmes to increase the supply of affordable rental and homeownership opportunities among older adults, and 68% (15 out of 22) of countries reported the existence of subsidies for rental programmes with services for low-income older people (Figure 5.2). In most cases, the programmes and subsidies are not exclusively dedicated to older people. However, in some cases, access is subject to age requirements. Furthermore, two-thirds of the countries reported that when programmes to promote ageing in place existed, they offered care services at home, in addition to affordable housing options (OECD questionnaire, 2023).

Figure 5.2. Most responding countries have programmes to make housing more affordable for older people

Number of programmes by type and availability at the national or subnational level



Note: N=19. Measures for affordable housing that do not specifically target older adults are not considered.

Source: OECD questionnaire (2023).

However, more demand and enhanced public support for housing on the supply side are necessary. Government investment in housing development has been declining in recent years (OECD, 2021^[15]), leading to a decline in social rental dwellings available in the past decade, as a share of the total housing stock, in several OECD countries (Cournède and Plouin, 2023^[16]). The type of housing affordability support needs to be carefully designed, taking into consideration its possible negative spillovers and balancing costs and benefits to support people in ageing in place.

5.2.2. Incentivising supply is important to have sufficient affordable housing for older people in the face of demand changes

Some countries have public-private partnerships aiming at supporting private companies to increase the supply of affordable housing. In **Canada**, the previous *Investment in Affordable Housing* (IAH) programme established partnerships with the private sector and community organisations to increase the availability of affordable housing while a new programme has affordable loans (*Affordable Housing Fund*). The programme offers forgivable loans to for-profit, not-for-profit and co-operative organisations to build housing opportunities that are rented at affordable prices for a minimum period of time. Access to such housing is available for people who are eligible for social housing, while some projects can also target specific subgroups, such as low-income seniors (Leviten-Reid and Lake, 2016^[17]). In **Switzerland**, the federal government supports private entities developing new housing that is barrier-free, particularly those that follow the LEA (Living Every Age) label. Even though this programme does not exclusively target older people, the latter are likely to benefit from a growing number of affordable and accessible – barrier-free – housing options (OECD questionnaire, 2023).

In other countries, there is public support in the form of subsidies to build affordable housing opportunities. In the **Netherlands**, any legal entity involved in creating social housing can apply for public subsidies. This is part of the incentive scheme for building meeting spaces in housing for older people (called *Stimuleringsregeling Ontmoetingsruimte voor Ouderenhuisvesting*, SOO). This incentive scheme aims at

increasing the availability of spaces where older people can meet and support each other. At least 50% of the residents who can benefit from the meeting spaces must be over the age of 55 (Dutch Government, 2023^[18]). Furthermore, to ensure the affordability of social housing in the Netherlands, the “Passend Toewijzen” (“appropriate allocation”) programme ensures that people living in social housing pay a rent that is adequate to their income level (Dutch Government, 2023^[19]). In **Spain**, the Spanish Government has approved the State Plan for access to housing 2022-2025, which provides government contributions for the promotion of newly built or rehabilitated residential buildings that are accessible and affordable for people with limitations and older people. The design of the buildings must guarantee accessibility and adequacy for people with disabilities and older people to live as independently as possible. Furthermore, the accommodations financed through this subsidy must be rented or transferred for use to people aged 65 or older or to people with disabilities, subject to means testing of the beneficiaries. The persons or entities promoting the accommodation or homes, even from their rehabilitation, may obtain direct aid, proportional to the useful surface of each accommodation or home, of up to a maximum of EUR 700 per square metre of said useful surface (Agencia Estatal Boletín Oficial del Estado, 2022^[20]). In **England**, private housing providers can receive subsidies through the Affordable Homes Programme (AHP) and the Care and Support Specialised Housing Fund (CASSH). The programmes aim at incentivising the availability of affordable housing for older people. In 2021, the Secretary of State for Health and Social Care presented to Parliament the white paper on Adult Social Care Reform, highlighting the commitment to continued investment in the CASSH fund, forecasting a GBP 70 million investment per year until 2026 (Department of Health and Social Care, 2021^[21]).

In **New Zealand**, the Ministry of Housing and Urban Development (HUD) has started a number of programmes to improve the availability of affordable housing for both buyers and renters. The *Affordable Rental Pathway* (ARP) offers grant funding to not-for-profit organisations to build new affordable housing to rent. The first round of the programme received USD 50 million; the second round, USD 100 million. Housing targets people with low income, but also households (whānau) who cannot access public housing but cannot afford market rent either. Such a programme does not specifically target older people (OECD questionnaire, 2023).

In other countries, affordable housing is funded and supplied by public authorities. For instance, in **Slovenia**, the Pension Real Estate Fund and the Housing Fund of the Republic of Slovenia provide affordable rental housing targeting older people (OECD questionnaire, 2023). In the **United States**, the Housing Opportunities for People Everywhere (HOPE), which was replaced by the Choice Neighbourhoods Initiative, programme has provided funding to Public Housing Authorities that have severely distressed public housing since 1993. The programme supports the construction and rehabilitation of social housing, as well as the demolition of severely distressed public housing (US Department of Housing and Urban Development, 2023^[22]). Studies have found that residents of housing within the previous programme (HOPE IV) reported higher scores on mental health, social functioning and vitality, but results are mixed when looking at physical health outcomes (Spillman, Biess and MacDonald, 2012^[23]). In **Australia**, the state of Victoria funded the Big Housing Initiative, while New South Wales announced in 2020 an increase of AUD 900 million investment for the construction of 1 300 new social dwellings (OECD, 2021^[15]).

5.2.3. Providing financial support and social housing would help to make housing more affordable for older people

Some countries have social housing options with services to support older people with low income to live at home as independently as possible. In the **Netherlands**, there are examples of multigenerational social housing, where older people and young students live in the same social housing buildings, to support each other and allow each other to be independent (International Observatory on Social Housing, 2023^[24]). In **Switzerland**, similar programmes for older people exist at the local level. For instance, in the City of Zurich,

the SAW Foundation (*Stiftung Alterswohnungen*) offers apartments for older people at affordable rents. The apartments also include a wide range of services, such as move-in assistance, laundry, emergency telephone, house maintenance, courses, and social events and common areas (OECD questionnaire, 2023).

Other countries have subsidies to support older people to pay rent or buy a house. Some recent evidence also shows that older renters living in subsidised housing are less likely to develop activity limitations compared to unsubsidised older renters (Jenkins Morales and Robert, 2023^[25]). Some studies on the effectiveness of subsidised housing have shown positive results of such programmes on the mental health of beneficiaries, with mixed results on physical health (Spillman, Biess and MacDonald, 2012^[23]). In **France**, older people can receive financial support to pay for their rent (i.e. the *Aide Personnalisée au Logement* or the *Allocation de Logement Social*) (French government, 2023^[26]). In **New Zealand**, Superannuation and Veterans' Pension recipients are entitled to the weekly Accommodation Supplement to help with rent or the cost of owning a home. Furthermore, the *Progressive Home Ownership Fund* (PHO Fund) supports people in buying a house by offering options such as the rent-to-buy arrangements, shared ownership or leasehold schemes (OECD questionnaire, 2023). For older people who are planning to become homeowners, the **United Kingdom** has the *Older Persons Shared Ownership* (OPSO) initiative, a form of shared ownership for people aged 55 or older, who do not own a home, with a gross annual household income equal to or less than GBP 80 000 (or 90 000 in London). The OPSO initiative allows people to buy a share of a home – between 10% and 75% of its market value – and to pay rent on the remaining share (Own Your Home - UK government, 2024^[27]). Furthermore, older people can be eligible for a housing benefit to support renters who have reached the state pension age (or older) have a low income and less than GBP 16 000 of savings. The amount of the support depends on the income and savings of the renter, as well as the amount of rent to be paid, the size of the home and whether the person already receives other benefits (e.g. the carer's allowance, or disability allowances) (Age UK, 2024^[28]).

In a number of countries, subsidies are usually not targeted at older people, but older people with low income can benefit from them. For instance, in **Canada**, a one-year programme was in place and those who paid rent in 2022 corresponding to at least 30% of their net family income received a one-time top-up of CAD 500 to the *Canada Housing Benefit*. The benefit is application-based, non-taxable and can be received by pensioners (OECD, 2023^[7]). Colombia has a subsidy for households from vulnerable populations to support them to buy or rent a house, while **Costa Rica** has subsidies to support housing improvements, repairs and maintenance for people with lower socio-economic status (Government of Colombia, 2023^[29]) (IMAS, 2023^[30]). **Latvia** passed a law in 2004 to support people with different types of housing assistance, including renting out social housing, financial support to cover rent, and allowances to renovate residential space. The support does not target older people specifically, but is rather referred to people with low incomes, without age restrictions (*Law 22 December 2004 on Assistance in Solving Apartment Matters*). In **Luxembourg**, the Affordable Housing Act (2023) promotes equitable access to housing through financial participation from the state, tailored rent calculations, and a dedicated allocation process for people aged 60 and over, ensuring their affordability and social inclusion (Gouvernement du Grand-Duché de Luxembourg, 2023^[31]; Gouvernement du Grand-Duché de Luxembourg, 2023^[32]). In the **Netherlands**, the “Passend Toewijzen” (“appropriate allocation”) programme ensures that people living in social housing pay a rent that is adequate to their income level (Dutch Government, 2023^[19]). The **United Kingdom** has a number of initiatives to support people to pay their rent or become homeowners. People can receive support for the payment of mortgage interest (the SMI – Support for Mortgage Interest). The initiative provides people with a loan to support them in paying for mortgage interests or for some home improvements. In the **United States**, people who are unable to pay the rent can apply for rent relief resources (US Department of Housing and Urban Development, 2023^[33]).

In addition, previous OECD work has highlighted the importance of broader governmental investments in social housing to improve the quality of existing housing and the development of new social housing that is environmentally sustainable (OECD, 2021^[15]). Studies have found that when social housing is available,

it is often tailored for younger families and poses accessibility challenges for older people (Bogataj, Bogataj and Drobne, 2023^[34]). Housing that is accessible and facilitates the independence of people with physical and/or mental limitations, as well as being environmentally sustainable and adapted to changes in temperature and weather, is vital for populations with more precarious health status, including older populations with care needs.

5.3. Adequate housing is crucial for age-friendly communities

Living in a housing environment tailored to individuals' needs and conducive to their independence and well-being is another crucial factor for policymakers to consider when crafting policies to promote ageing in place. As people age, moving around the house, taking the stairs and living in a place that is not adapted to people with physical limitations can lead to fear of falling and to increased risk of falls and injuries (Chen et al., 2023^[35]; Braubach, 2011^[36]). Facilitating independent living at home involves enabling people to make necessary housing modifications and promoting the building of new accessible housing environments. While for new residential construction, accessibility requirements can be implemented, the current housing stock also needs adaptations and residential renovations to ensure a minimum level of accessibility.

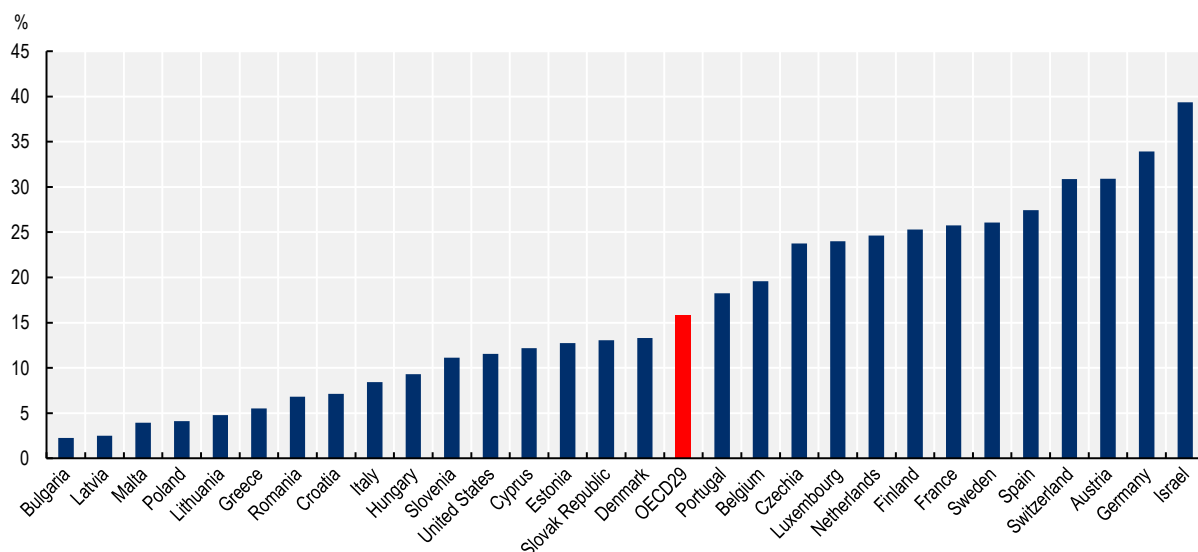
5.3.1. Housing affects older people's ability to live independently and is not always accessible

The current housing stock across many countries does not adequately meet the needs of older people, leaving many of them in unsuitable housing conditions. Data from the American Housing Survey shows that only 40% of homes had the most basic features to be considered ageing-ready, such as a step-free entryway into the home with a bedroom and a full bathroom on the entry level floor (Davis, Clark and Vespa, 2023^[37]). In the United Kingdom, only 12% of older people had level access to the entrance of their building, while less than half had a bathroom on the entry level (Older People's Housing Taskforce, 2024^[38]). In France, only 6% of housing was considered adapted to older people's needs in 2013 (CNAV, 2013^[39]). In Spain, a recent survey highlighted that eight out of ten dwellings were not adapted to older people's needs (CGATE, 2023^[40]).

Housing adaptations friendly for ageing are still uncommon, and they vary significantly across the OECD. Only 15.8% of households in the European Union (EU) and the United States had special features for increased accessibility and independence as of 2022 (Figure 5.3). The share of households living in housing with any accessibility features was highest in Israel (39.4%) and lowest in Bulgaria (2.2%). Bathroom and toilet modifications, such as grab bars or shower seats, were most common (9.8%) in the United States. In EU countries, rails were also common (8.0%), as well as bathroom and toilet modifications. Housing equipped with ramps or alerting devices was relatively uncommon, with fewer than 3.5% of properties featuring these features across the countries. The overall low prevalence of housing adaptations and the limited modifications to the most basic features are likely due to the tendency for people to postpone introducing these special features until they reach the age of 80, which is often linked to cost constraints (Wu, Fu and Yang, 2022^[41]).

Figure 5.3. Over 80% of older people live in housing lacking mobility and independence support

Share of households living at home with any special features for older people or people with physical impairments, 2022



Note: Data for Europe and the United States are based on SHARE Wave 9 (2021-2022) and HRS 2022, respectively. The OECD average includes only the values of OECD Member countries.

Source: Survey of Health, Ageing and Retirement in Europe (European Union and Israel) and Health and Retirement Study (United States).

In addition to housing adaptations, several items can support people's autonomy at home. Among OECD countries for which data is available, the most common items that people use to move and perform basic activities of daily living in autonomy are canes and walkers (20% of respondents on average in 13 OECD countries), incontinence pads (7%) and personal alarms such as alarms used to make emergency calls after falls (5%). Other items like wheelchairs, buggies and special eating utensils are much less common among older people living at home (less than 5%).

There has recently been a lot of discussion about the potential of new technologies to improve the conditions of care recipients and prevent additional interventions by caregivers. Technological solutions can facilitate active ageing and social participation of older people, reducing loneliness and facilitating social inclusion via participation in virtual activities. For example, in **Denmark**, a digital training tool for physical activities at home (called "DigiRehab") contributed not only to efficiently monitoring care recipients' physical ability but also to reducing their need for home care (Healthcare Denmark, 2019^[42]). In Canada, the **Canada's Aging in Place Challenge programme** focusses on improving the quality of life of older adults and their personal caregivers through technology and innovation for safe and healthy ageing. A few studies have emphasised effects on improved communication, family interactions, a better sense of safety and participation in health decisions (Moreno et al., 2024^[43]). Wearable devices or smart home and monitoring technology increase older people's independence and mobility. At the same time, current evidence on the effectiveness of technological devices remains scarce. A review identified that a number of wearable devices, such as a pedometer, a biofeedback device and an online video platform, can indeed facilitate ageing in place (Ollevier et al., 2020^[44]). Challenges in using technology and privacy concerns are also preventing the wider use of such devices.

Housing adaptations can support people's autonomy at home

According to several studies, accessible housing design has a positive impact on the ability of older people to live independently, resulting in lower health-related outcomes, such as fewer falls, and delayed nursing home admissions. Studies have found that home modifications that make housing more accessible are associated with a lower likelihood of being admitted to nursing homes, lower needs for help with activities of daily living such as bathing, lower levels of functional decline and carers' better outcomes (Spillman, Biess and MacDonald, 2012^[23]; WHO Europe and European Commission, 2017^[45]; Petersen and Aplin, 2021^[12]). Some studies in the past decade found that the impact of accessible housing on specific outcomes such as preventing falls is less clear, with studies finding contrasting results when analysing the effect of installing supportive features such as grab bars and railings, together with healthcare workers' visits at home (Chase et al., 2012^[46]; Spillman, Biess and MacDonald, 2012^[23]; Leviten-Reid and Lake, 2016^[17]). Nevertheless, a recent Cochrane review including 22 studies in 10 countries found that home fall-hazard interventions reduce the rate of falls by 26% overall, with greater reductions for people with a high risk of falls (38%) (Clemson et al., 2023^[47]). Previous analysis based on **England** has also found that unhealthy housing impacts health outcomes of older people, producing GBP 1.4 billion of health expenditure per year, while home adaptations could bring potential savings of GBP 1.5 billion a year due to lower health costs as a result of falls or reduced residential care costs (Garrett and Burris, 2015^[48]; Centre for Ageing Better, 2024^[49]).

The housing space can also impact the ability of older people to build and maintain social ties, while the housing location can influence older people's choice to remain in their homes or to relocate to different areas. For instance, in **Canada**, balconies and common areas such as lobbies and common rooms have been found to boost relationships among neighbours. Studies have also shown that housing located in rural communities can hamper older people's ability to live in their homes, particularly if adequate public transportation is missing (Leviten-Reid and Lake, 2016^[17]).

The impact of housing adaptation is still rarely measured. Only six OECD countries perform evaluations of the effects of housing adaptations on the outcomes, and three conduct evaluations of the economic impact. **France**, **Japan** and **Portugal** report evaluations focussing only on the effects on the outcomes, while the **Slovak Republic**, **Sweden**, and the **United States** perform evaluations of both the impact on outcomes and the economic impact of housing adaptations. **Latvia** reported that the measurement of effects depends on the municipal level and may vary across the country (OECD questionnaire, 2023).

5.3.2. Financial support for housing adaptations focusses on more basic equipment, while the application process and out-of-pocket costs limit user access

Given that for a substantial number of older people, their current living environment is unsuitable and that they might not have the means to finance the adaptation of their dwellings to their functional possibilities, governments would need to consider subsidising housing adaptation in addition to stimulating accessible design for new homes.

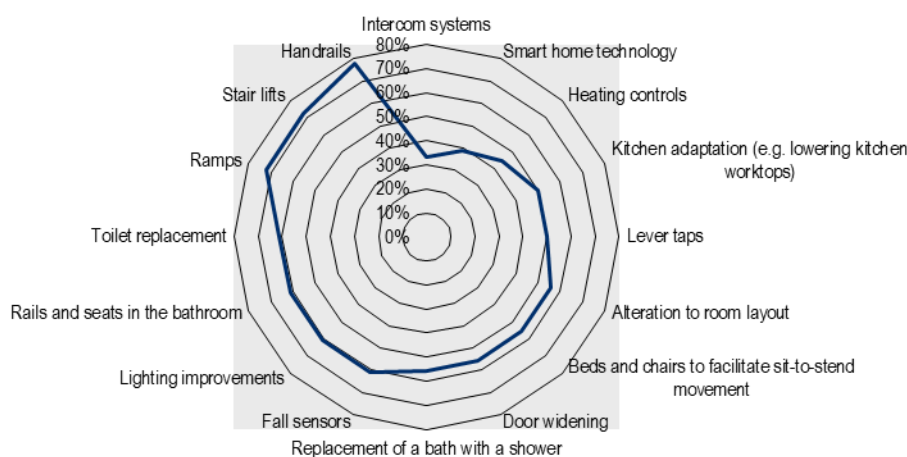
Public funding for home adaptations is available across the OECD. Among 22 OECD countries that responded to the *OECD Questionnaire on Healthy Ageing and Community Care*, more than 60% of countries reported funding handrails (78%), stair lifts and ramps (72%), toilet replacement, fall sensors, lighting improvements and rails and seats in bathrooms (61%). On the other end, assistive technology is the least publicly funded. Only around one-third of countries reported that intercom systems and smart home technology can be covered through public funds (Figure 5.4).

Limited financial support for assistive technology may result in a lower availability of technologically advanced housing adaptations, such as smart home technology. In fact, only 10 out of 28 responding countries have reported that public funding is available to cover digital tools that can support ageing in place, a result that shows that the availability of digital technologies might vary across countries. Seven

responding countries have reported that remote rehabilitation or exercise and medication dispensers for people living at home can be covered by public funding. **Norway**, the **Slovak Republic** and **Sweden** also cover location trackers with public funding. Other examples of digital tools for people living at home that can be publicly funded are home security alerts and remote monitoring, which are available in **Canada** (New Brunswick), **Luxembourg** and **New Zealand** (OECD questionnaire, 2023).

Figure 5.4. The type of housing adaptations whose cost can be covered by public funds varies across countries

Percentage of countries that reported that public funding can be used to cover specific housing adaptations, by type of housing adaptation



Note: N=22.

Source: OECD questionnaire (2023).

In half of the countries for which information is available, people who need to perform housing adaptations to allow them to live independently at home will need to contract out the adaptation work before receiving partial or total reimbursement of expenses (OECD questionnaire, 2023). It is therefore important to have clear information available to support people in navigating the housing adaptation process. Among the 28 countries that responded to the questionnaire, only 10 reported the existence of an entity providing advice on housing adaptation.

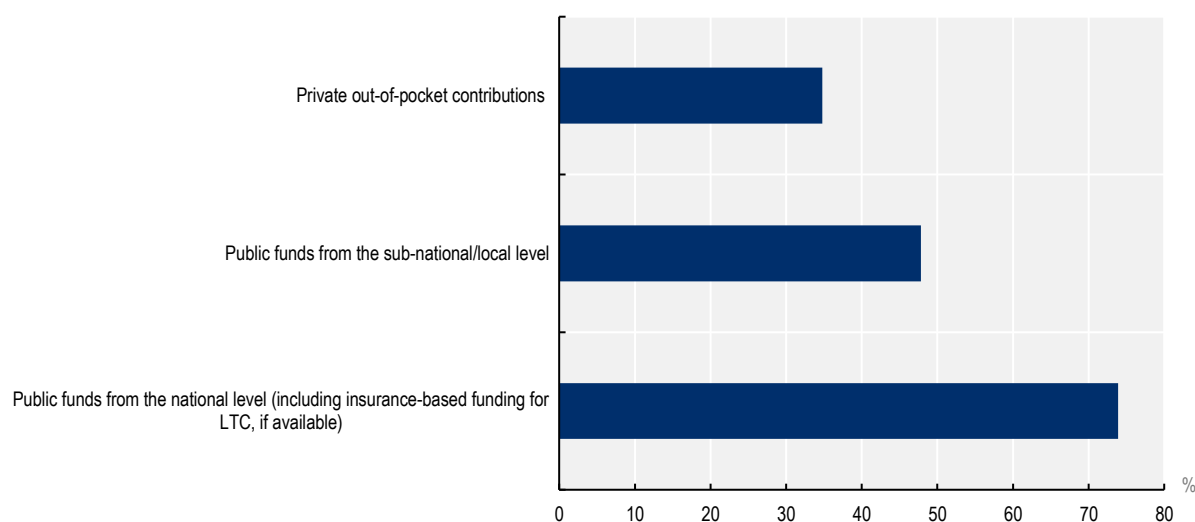
In some countries, there are specific agencies that people can refer to when looking for information on housing adaptation, while in other countries, this role is held by local authorities. For instance, France has designated information centres, the *centres d'information et de conseil sur les aides techniques* (CICAT), which provide information to professionals, older people or other people with limitations in need of housing adaptation, as well as their families and informal caregivers. The centres can provide information and allow people to test the available housing adaptation options to choose the most suitable solution for their needs. In **Luxembourg**, ADAPTH is a consultancy office that provides support to both building companies and individuals with limitations who need housing adaptation. *ProSenectute* in **Switzerland** also has a similar role. **Ireland** operates the *Healthy Age Friendly Homes Programme* by appointing a local co-ordinator in all local authorities, who performs home-based assessment, identifies and designs supports for independent living. Meanwhile, the municipality is responsible for providing information on housing adaptation in **Latvia**, the **Netherlands**, **Norway** and **Portugal**. In most cases, occupational therapists are responsible for providing information on housing adaptation options (in 8 countries out of 10 that reported

this information), followed by social workers (5 countries) (OECD questionnaire, 2023). In Sweden, a health professional can also initiate the process of housing adaptation, and, in most cases, an occupational therapist inspects the home to assess environmental barriers and the extent of people's limitations and identify needs.

Most OECD countries that answered the questionnaire reported supporting housing adaptation with public funding, but public support is usually means-tested. The national level funds such measures in 74% of countries that replied to the *OECD Questionnaire on Healthy Ageing and Community Care* and by the local level in 48% of countries. Private out-of-pocket contributions also seem to play a significant role, with one-third of countries reporting that private out-of-pocket contributions are required to fund housing adaptations (Figure 5.5, OECD questionnaire, 2023). Data from Europe shows that people delay the introduction of housing adaptation often until they are at least 80 years old and such modifications tend to be limited, focussing on the most necessary modifications because of affordability constraints (Wu, Fu and Yang, 2022^[41]). In **Sweden**, on the contrary, the grants for housing adaptation do not depend on the financial situation and, after the application is accepted, the invoice is sent to the local authority so that older people do not need to advance the funds.

Figure 5.5. National funds are the most common source of funding for housing adaptations, but out-of-pocket contributions seem significant

Share of countries by the source of funding for housing adaptations



Note: N=23.

Source: OECD questionnaire (2023).

5.3.3. Public subsidies and tax credits for older people to adapt their housing remain limited

Public subsidies are the most common form of support, available in 12 countries (Austria, Canada, Colombia, France, Iceland, Ireland, New Zealand, Portugal, the Slovak Republic, Spain, Sweden, the United States), followed by grants and long-term care insurance funds, tax credits and loans (OECD questionnaire, 2023). The generosity of these types of support varies across countries. For instance, in **Austria**, the city of Vienna covers up to 35% of the cost of housing adaptation for up to EUR 4 200. **Sweden** allocates a total of SEK 1 billion annually for housing adaptations, with 70% spent on older people and approximately 74 000 projects undertaken each year (Slaug, Granbom and Iwarsson, 2020^[50]).

Starting from January 2024, **France** merged three forms of financial support available to cover housing adaptations into one financial aid: people with physical limitations who require housing adaptations² will be able to apply to *MaPrimeAdapt*⁷ to receive financial support equal to 50% or 70% of the adaptations up to a maximum amount of EUR 22 000 (French government, 2023^[51]).

Public subsidies might fall short to help people with limited means and major needs. Studies on the costs of housing adaptations suggest that such costs are sizeable. A study from the United Kingdom suggests that the costs of major adaptations represent on average more than GBP 16 000, ranging from GBP 2 500 to GBP 36 681 (Curtis and Beecham, 2018^[52]). In **Ireland**, older people (65 or older) living in poor housing conditions can receive the *housing aid for older people grant* to make improvements or repairs such as replacing windows and doors, heating, and sanitary facilities. The grant can cover up to 95% of the cost for a maximum amount of EUR 8 000 and is means-tested. The grant is financed by the Department of Housing, Local Government and Heritage (80%) and the local authorities (20%) (OECD questionnaire, 2023). A review of the grant advised nonetheless to increase the size of the grants and the threshold limits to obtain them (Department of Housing, Local Government and Heritage of Ireland, 2024^[53]).

Grants for providers are available in a number of countries. In **Australia**, 232 service providers receive grants to deliver home modifications, with a total public funding of USD 70.8 million in 2023-2024. Furthermore, people living in social housing receive support for home modifications through the local government (OECD questionnaire, 2023). In **Poland**, under the *Za życiem* (For Life) programme, communities, social care organisations, and NGOs can apply for non-repayable financial support of up to 80% of investment costs for the development of protected housing for persons with disabilities, including assisted and training units, as well as for upgrading the existing housing. Furthermore, the *TERMO programme* allows owners and managers of multi-family buildings to apply for funding to cover the cost of the thermal modernisation of buildings, up to a maximum of 90% of the total cost (OECD questionnaire, 2023). In the **United Kingdom**, the Department of Health and Social Care and the Department for Levelling Up, Housing and Communities deliver annual grants to local authorities to support home adaptations for people with disabilities and limitations. Since 2010, almost half a million housing adaptations have been covered by public funding, for a total of GBP 573 million. In September 2023, an additional GBP 50 million has been granted to local authorities. Further grants are foreseen, for a total of GBP 102 million over two years (UK government, 2023^[54]).

Tax credits are much less common as a measure to support housing adaptations. Across the OECD, tax credits for such scope are available in **France**, the **Netherlands**, **Switzerland** and the **United States** and are sometimes set at the local level. For instance, Switzerland foresees tax credits to cover the cost of housing adaptations for people with low income or above the retirement age. The amount of the credits is set by the cantonal law (OECD questionnaire, 2023).

5.3.4. Developing guidance on public housing design is important for future housing

Developing guidance for the design of housing represents another way for governments to support better accessibility and climate resilience of housing, adapted to the needs of older people. Guidance for housing design adapted to older people can include: housing adaptation to facilitate moving around with or without a wheelchair and performing daily activities; balconies and common areas to facilitate social relationships; green areas with benches available around the housing space to support people to take a walk around the housing space; energy efficiency and sustainability of housing design to support resilience to climate change. Examples of guidelines for housing design adapted to older people's needs are available in Canada, Poland, New Zealand, and the United Kingdom, among others.

In **New Zealand**, the government has developed a public housing design guidance which includes a specific chapter focussed on the needs of older people. It provides guidance on the basic requirements to make housing accessible, to allow for sufficient car parking spaces for family, friends, whanau or other informal carers to visit older people, as well as to facilitate older people's participation in social life by

including shared outdoor and indoor common spaces with seating available and balconies overlooking common spaces (Ministry of Housing and Urban Development, 2022^[55]).

In the United Kingdom, the Homes and Communities Agency set up the *Housing our Ageing Population Panel for Innovation* (HAPPI), an initiative established in 2009 to address the challenges posed by an ageing population in relation to housing. HAPPI promotes innovative housing solutions that are adapted to older people's needs to allow them to live independently in their homes and to foster community engagement, social interaction, and accessibility (The Housing our Ageing Population Panel for Innovation, 2009^[56]). The Ministry of Housing, Communities and Local Government in the **United Kingdom** has also published national design guidelines for public spaces, which take into consideration the needs of older people and people with disabilities (The Ministry of Housing, Communities and Local Government, 2021^[57]). Furthermore, the City of Cambridge developed a design guide for sustainable housing, including explicit mentions of the needs of older people and people with limitations. The guidelines include social inclusiveness among the requirements for sustainable housing, as well as adequacy to the HAPPI principles (Cambridge city council, 2021^[58]).

In **Canada**, the Affordable Housing Office of the City of Toronto has developed design guidelines for affordable housing design to make sure that housing with affordable rental is physically accessible for people with all needs, including people with disabilities and older people. The guidelines explicitly mention the need for housing and external areas to be accessible to older people with limitations (City of Toronto, 2017^[59]).

In **Poland**, as part of the National Housing Programme, the integrated programme of social support for rental housing co-finance the construction of apartments accessible to older people and people with limitations, along with additional features such as recreation rooms in common areas and/or day care centres. Furthermore, newly constructed residential buildings are required to have an elevator in the case of a project consisting of the construction of a residential building with three or more above-ground floors, together with barrier-free spaces and colourful arrangements to facilitate orientation when moving within the building (OECD questionnaire, 2023).

5.4. Building age-friendly communities calls for rethinking urban and rural planning

Shaping communities in an accessible way for older people has obtained growing priority on the policy agenda, from the international to the local level, leading to the shaping of the concept of age-friendly communities (WHO, 2024^[60]). Supporting independent living requires access to services and activities located within a convenient distance or reachable through affordable, accessible public transport. Urban infrastructure, such as traffic lights, benches, and green spaces, should also be designed with an age-friendly perspective to further promote independence for older adults. Age-friendly environments should incorporate an ageing lens with barrier-free physical features into urban planning, making services and activities available at an easily accessible distance or accessible via public transportation.

At the national and local level, examples of age-friendly communities are arising across OECD countries with the scope of rethinking urban planning and community life in view of ageing populations. In some cases, the national government actively promotes the creation of age-friendly communities. For instance, in **Canada**, since 2008 the Public Health Agency of Canada has convened the Pan-Canadian age-friendly communities Reference Group, which meets monthly to discuss important issues related to age-friendly communities across the country and exchange knowledge, resources, and best practices. This group includes provincial/territorial/municipal representatives, non-profit organisations, older adults, and academics. As of 2024, ten provinces and one territory are promoting age-friendly community initiatives in Canada, although the uptake of the age-friendly communities model varies within the country (OECD

questionnaire, 2023). **Chile** has 209 of its 346 municipalities enrolled as part of the Age-friendly World network and its public service entity in charge of older people (*Servicio Nacional del Adulto Mayor*, SENAMA) has a specific programme aiming to reduce environmental barriers for older people. Municipalities commit to performing a participatory assessment and designing an action plan. However, as this is a recent initiative, only 11 municipalities have performed the diagnostic, and 21 have an action plan (<https://www.ciudadesamigables.cl/sobre-el-proyecto/programa-adulto-mejor/>). **New Zealand** has a national Age-friendly programme by the Office for Seniors, and funding is available for projects (based in the Ministry of Social Development) supported by the Better Later Life strategy and action plan. Furthermore, New Zealand has established a Network of Age friendly cities and communities, which counted 29 members as of 31 July 2023. In other countries, subnational organisations promote the creation and spreading of age-friendly communities. In **Norway**, the Norwegian Association of Local and Regional Authorities (*kommunesektorens organisasjon*, KS), the organisation representing all local governments in Norway, published a handbook on age-friendly communities, which includes guidelines on how to design age-friendly communities, including through public transport, housing and social participation (OECD questionnaire, 2023). In the **United States**, there are organisations (e.g. USAging) and local agencies (e.g. Area Agencies on Aging) planning liveable communities for people of all ages (OECD questionnaire, 2023).

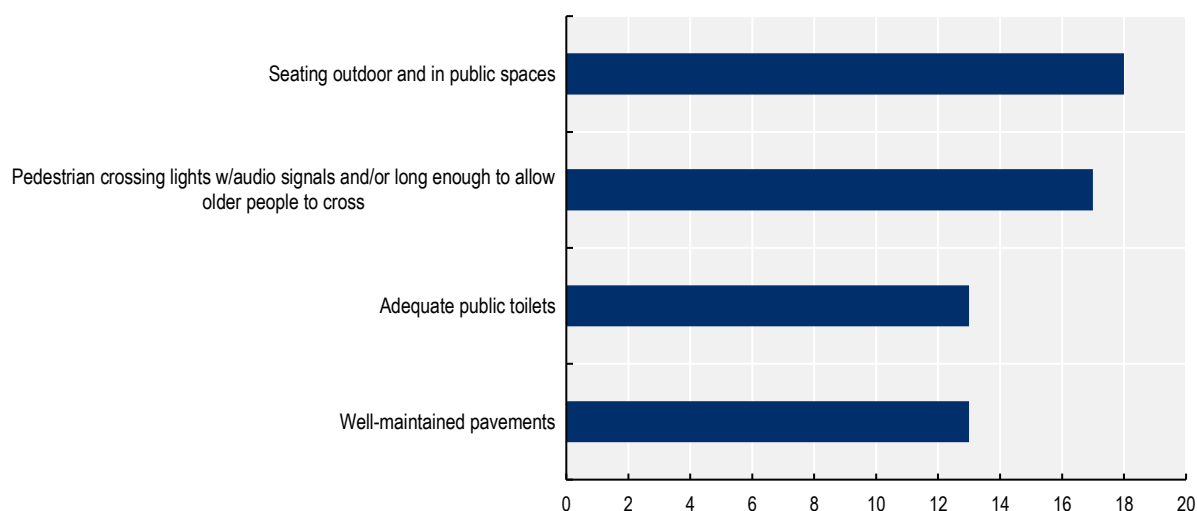
5.4.1. Urban planning can have an impact on the safety of older people

Previous studies have highlighted the importance of urban planning features for older people to feel safe walking independently in their community. Being able to walk regularly in a safe way contributes to older people's health. Existing literature indicates that 60 minutes of walking time during the day is desirable for older adults to maintain and improve their health (Ihara et al., 2022^[61]). Walkable paths and public facilities improve the cognitive function of older people (Gan et al., 2021^[62]). Environmental barriers near the person's home can influence the ability of older adults to walk outdoors and to reach services and activities within walking distance. Furthermore, environmental barriers and facilitators also influence the development of physical limitations. A study from Germany highlighted that study participants who were asked about urban features necessary to feel safe while moving around reported surface quality (71% of participants), good lighting (71% of participants), and crossings (68% of participants) as the most essential features. Barrier-free paths and space to walk were rated as important by around 60% of all older adults in the study (Brüchert, Baumgart and Bolte, 2022^[63]). Similar results have also been found in a previous study from Belgium (Van Cauwenberg et al., 2012^[64]). The physical space and social connections are important elements of age-friendly environment, while well-maintained and safe footpaths are critical to mobility and walkability. In **Spain** (the Basque Country), the *Ttapi-ttapa programme* was launched to revitalise walking routes and a strategy to promote community health initially targeting older and vulnerable people (OECD, forthcoming^[65]).

A majority of countries have age-friendly pedestrian crossings, but adequate pavement is less widespread. Across 27 OECD countries with available information, 18 reported the availability of seating outdoors and in public spaces, and 17 reported the availability of pedestrian crossing lights with audio signals and/or long enough to allow older people to traverse (Figure 5.6). A lower number of OECD countries (13 out of 27) reported well-maintained pavements and adequate public toilets. The availability of seating areas and shelters at bus, tram and metro stops, and the availability of information on public transportation times in analogic form (e.g. through timetables at bus and metro stops) can all support older people to move around in a safe and independent way.

Figure 5.6. Age-friendly features are available in the majority of countries

Number of countries that reported the following age-friendly features



Note: N=27.

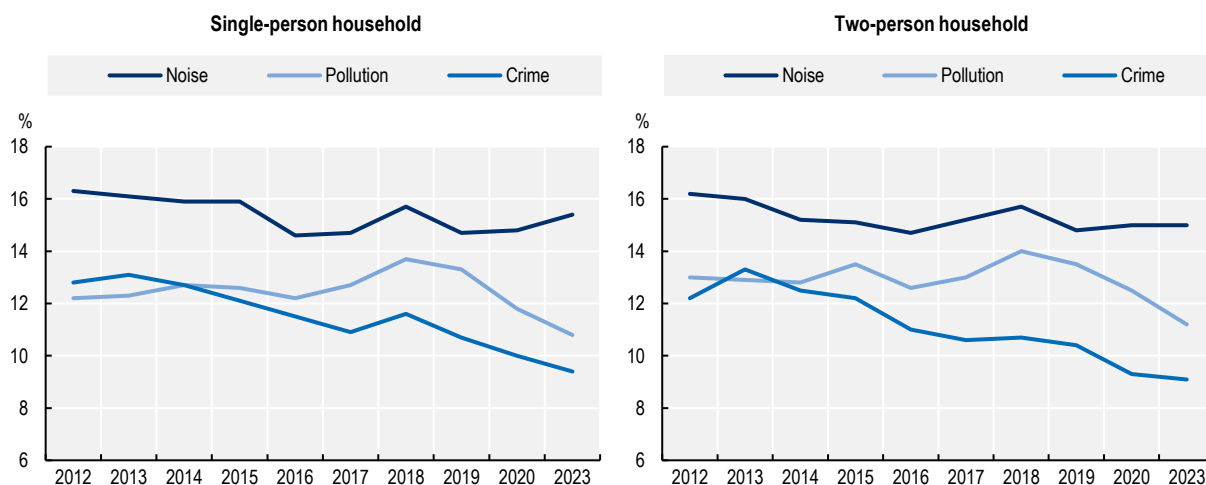
Source: OECD questionnaire (2023).

Safety for older adults, as well as exposure to noise and pollution, could be improved. Despite government efforts to improve community environments, a significant number of older people lose their lives while walking down the street. In Korea, the fatality rate of pedestrian accidents is 7.7 per 100 000 older people, the highest among OECD countries (Kim, Choi and Kim, 2025^[66]). In Europe, approximately 10-16% of older households consistently live in poor-quality neighbourhoods, exposed to noise, pollution, and crime (Figure 5.7).

Policies to implement age-friendly features in urban planning are in place in a number of countries, making cities more accessible for older people or people with physical or mental limitations. For instance, in **Colombia**, architectural standards have been introduced in urban planning. Such standards include: i) universal accessibility for all people, favouring those with difficulties in their displacements and in their bodily mobility that require support of technological elements, such as wheelchairs, elevators, special visual or sound signalling, among others, and ii) local, regional and national standards that affect the way in which infrastructures such as pedestrian bridges should be designed, built and maintained (OECD questionnaire, 2023). Furthermore, in **New Zealand**, work is underway on the Accessibility for New Zealanders Bill, aiming to accelerate progress toward a fully accessible New Zealand through the identification, removal and prevention of accessibility barriers. Key areas of focus include public spaces and transport, information and communication, and housing. The *National Policy Statement on Urban Development* (NPS-UD) aims to make sure New Zealand's towns and cities are well-functioning urban environments that meet the changing needs of diverse communities (OECD questionnaire, 2023). In the **United States**, the *Americans with Disabilities Act* requires cities to have pedestrian crossing lights with audio signals and/or with longer times to accommodate older people or those with physical limitations in crossing. The act is overseen by the United States Access Board (OECD questionnaire, 2023).

Figure 5.7. One in ten older people reside in a neighbourhood of low quality in Europe

Percentage of problems in the neighbourhood of the usual dwellings of households with people aged 65+, 2012-2023



Note: Single-person households consist of one adult aged 65 or older, and two-person households include two people, with at least one adult aged 65 or older. *Noise* refers to whether the neighbourhood of the older household has noise problems from neighbours or from the street; *pollution* refers to whether the neighbourhood has problems with pollution, grime, or other environmental issues; *crime* refers to whether the neighbourhood has problems with crime, violence, or vandalism in the area. Data in 2012-2019 is based on EU 28 while data in 2020 and 2023 is based on EU 27.

Source: Eurostat (2025^[67]), "Environment of the dwelling (ilc_mddw)", https://ec.europa.eu/eurostat/databrowser/explore/all/popul?lang=en&subtheme=livcon.ilc.ilc_md.ilc_mddw&display=list&sort=category&extractionId=ilc_mddw01.

5.4.2. Accessibility of services is important for the autonomy of older people

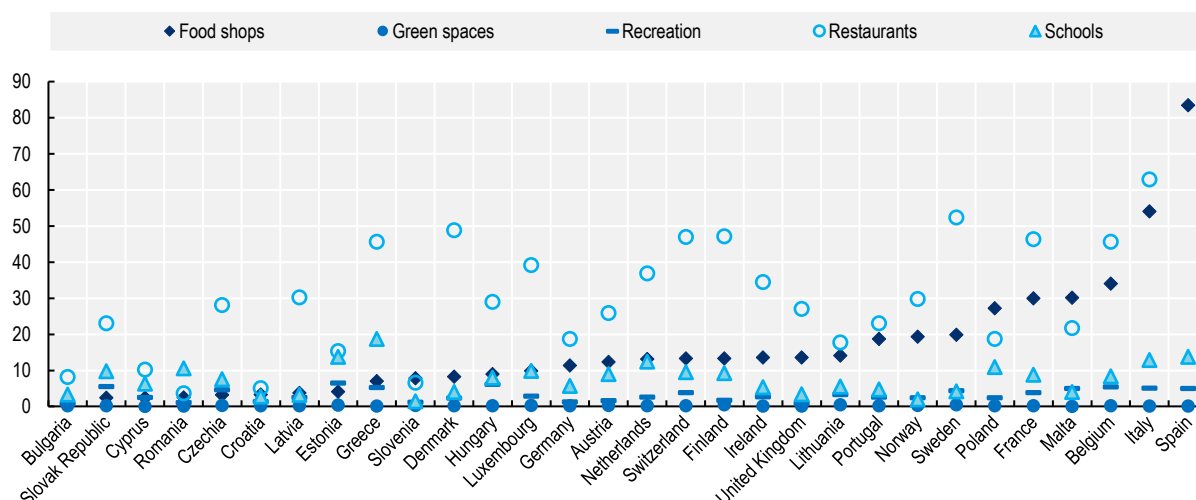
The distribution of services and green spaces can have an important influence on many factors affecting older people's health and well-being. The distribution of residential spaces and services across the cities, for instance, influences the time a person spends commuting to go to work, visit a loved one to provide care and support, and reach services and social activities. Furthermore, the availability of urban green spaces can improve the health and well-being of older people (Ali, Rahaman and Hossain, 2022^[68]). Existing literature has indicated that parks and green areas in cities are the most common environmental facilitators reported by older people as enabling them to go out independently and walk to access main activities and services (Eronen et al., 2014^[69]; Rantakokko et al., 2015^[70]). Having key destinations such as shops and amenities within a 20-minute walking distance can encourage older people to walk to reach such places (Hasselder et al., 2022^[71]).

Enhancing the accessibility to food and recreational services for older people requires careful urban planning (OECD, 2020^[72]). Available evidence suggests a great variation in accessibility to amenities within a short walking distance. Across OECD countries, the number of places that are reachable within a 15-minute walk varies widely depending on the type of services and the size and structure of the city. Data from a selection of 121 cities in 30 OECD and EU countries show that food shops and restaurants are the most available services in cities, followed by schools and recreational activities. Green spaces are much more sparse and hardly reachable within a 15-minute walk. In fact, on average, a person can reach 16 food shops and 34 restaurants by walking 15 minutes in some of the major cities across 30 OECD and EU countries, yet only 0.2 green areas are available within the same distance (Figure 5.8). The distribution and accessibility of such services and amenities vary across Europe, with restaurants and food shops most

widely reachable within a 15-minute walk in southern European countries, particularly in Spain, and green spaces more concentrated and accessible in Northern European countries. Countries need to balance ensuring a sufficient level of density to make the most of the agglomeration benefits, while building pedestrian-friendly areas to improve connectivity and increasing green spaces within walking distance (OECD, 2020^[72]).

Figure 5.8. Green spaces and hospitals are scarcely available within walking distance

Average number of services available within a 15-minute walk in selected major cities across 30 OECD and EU countries



Note: The data are collected from 121 cities across 30 OECD and EU countries. Spain has 176 restaurants.

Source: OECD (2024^[73]), "Urban access framework", <https://data-explorer.oecd.org/s/2vt>.

Healthcare services are harder to reach compared to other public services and amenities, calling for innovative solutions. As the health status is likely to decline while chronic conditions increase in older age, having healthcare services easily reachable and accessible may influence the choice of where to live in older age. Across a selection of 121 cities in 30 OECD and EU countries, hospitals are among the services that are scarcer within a 15-minute walking distance. On average, only 0.5 hospitals are reachable within that walking time, ranging from 0.1 in Northern European countries to almost one among Central and Eastern European countries and reaching 2.7 in Greece (Figure 5.9).

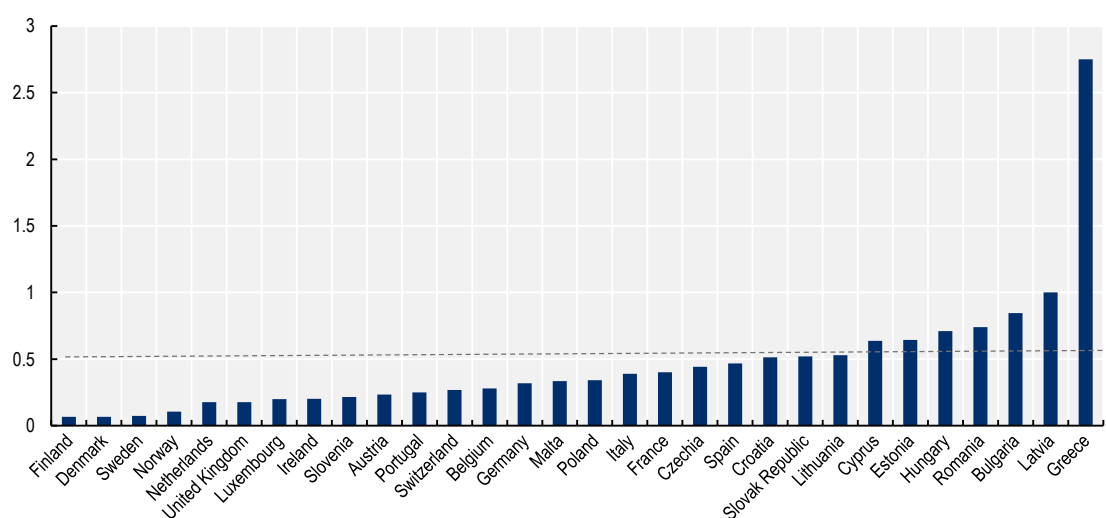
Rural areas face additional challenges in accessibility due to population ageing. First, rural areas tend to have more older people: remote regions have the highest dependency ratios and have experienced the highest increase in such ratios (OECD, 2020^[74]). Second, accessibility to some essential services is lower in rural areas. While schools, banks and pharmacies are relatively common in settlements of all types, including villages, as they need to be used often, this is less the case for health services (OECD, 2024^[75]). In 11 out of 19 countries with available data, hospital bed rates are lower in rural regions compared to metropolitan areas. The number of active physicians per 1 000 inhabitants was lower in rural areas than metropolitan areas in 12 out of 14 OECD countries (OECD, 2021^[76]).

Countries are designing integrated services and promoting financial incentives to attract health workers to rural areas as well as finding other innovative solutions. **France** has introduced the *communautés professionnelles territoriales de santé* in rural areas, which bring health professionals (general practitioners and specialists, pharmacists, nurses, physiotherapists, etc.) to work together in response to identified health needs in the same area. At the same time, *maisons de santé* group different doctors and have a

guaranteed income in the first two years after practice opening, with add-on payments for practising in rural hospitals, the training of trainees, and lump-sum payments upon opening a practice. In **Norway**, municipalities are required to set up municipal emergency beds or other supplemented primary healthcare units in order to strengthen healthcare in primary care settings and to promote the efficient utilisation of health resources (OECD, 2014^[77]). In **Australia**, people living in rural and remote areas need to travel hundreds of kilometres for healthcare service: the *Royal Flying Doctor Service* connects people to primary and specialised care (Gardiner et al., 2019^[78]). Expanding the use of teleconsultations could also be considered. This is an area which has expanded since the COVID-19 pandemic, where the use of teleconsultations per patient per year almost doubled from 0.6 in 2019 to 1.4 in 2021, but where previous research has highlighted that older people face greater challenges in its usage (Keelara, Sutherland and Almyranti, 2024^[79]).

Figure 5.9. 0.5 hospitals are accessible within a 15-minute walk across 30 OECD and EU countries

Average number of hospitals available within a 15-minute walk in selected major cities across 30 OECD and EU countries



Note: The data are collected from 119 cities across 29 OECD and EU countries.

Source: OECD (2024^[73]) "Urban access framework", <https://data-explorer.oecd.org/s/2vt>.

5.4.3. Public transport and safe public spaces are needed for older people to age in place

There are inequalities in access to public transport across countries. Across 27 OECD countries with available information, 16 countries reported that public transportation is easy to access for people with mobility limitations and affordable for older people, 15 countries reported that public transportation is widely available, and it connects key destinations, while in 14 countries it is widely available and connects urban and rural areas (OECD questionnaire, 2023). On average, 83% of the urban population across the OECD's cities can access a bus stop and 31% a metro or tram stop within a 10-minute walk. Although buses provide better coverage across a city transport network, their frequency tends to be more variable, and their speed is lower than that of metros. Promoting mobility and accessibility for peri-urban and non-urban populations requires alternatives to individual cars and going beyond incentives to cycle and walk with a sizeable investment in public peri-urban and inter-urban transportation (OECD, 2024^[80]).

A number of OECD countries have implemented policies to make public transportation more accessible and affordable for older people. For instance, in **Austria**, action has been taken throughout the Austrian

Länder, by implementing measures such as concessionary fares for older persons. Vienna has also taken a number of measures to enhance and maintain the accessibility of local public transport facilities. At present, all of Vienna's 109 underground stations and more than 95% of tram and bus stops are built to barrier-free standards (OECD questionnaire, 2023). In **Colombia**, the Ministry of Transportation has advanced preferential rates for older people to access public transportation, in order to promote access, accessibility and safety for older people and people with reduced mobility (OECD questionnaire, 2023). Furthermore, the Colombian Ministry of Transport, through the Sustainable Urban Mobility Unit, seeks to guarantee accessibility to all users, promoting the public transport infrastructure as a tool allowing for the circulation of users with the greatest autonomy and ease of movement (OECD questionnaire, 2023). In the **United Kingdom**, in England and in Wales, older people can ask for a pass for public transportation once they reach retirement age (UK Government, 2024^[81]).

While a number of measures and policies are in place to improve accessibility and affordability of public transportation, more can be done. Some countries, such as **Australia**, **Japan** and the **United Kingdom**, have looked at flexible transport systems, which are based on demand or do not have a fixed route, or subsidised taxis as an alternative to expanding public transport by bus (Lin and Cui, 2021^[82]). In **Norway**, the Norwegian National Transport Plan (NTP) has an overall objective of developing an efficient, environmentally friendly and safe transport system by 2050. Local programmes are also available in Norway, such as the "Ruter age-friendly transport (RAT)", the "AtB 67 plus" and the "Pick me up!", which are services of shared door-to-door transport that older people can book online and access at the cost of a public transport (OECD questionnaire, 2023).

5.4.4. A true participation of older people in the communities requires adequate cultural features

Making ageing in place possible also entails allowing older people to contribute to society and be active members of the community, supporting them to perform activities in the community outside of their home, offering older people opportunities for social participation, entertainment, volunteering, or employment, to reduce isolation and facilitate active ageing. Recent studies show that loneliness is common among older people, with 30-55% of older people in Central and Eastern Europe and 10-20% in Northwestern Europe feeling lonely (Vozikaki et al., 2018^[83]). In the United States, 37% of older adults (aged 50-80 years) experienced loneliness and 34% reported feeling socially isolated (Gerlach, Solway and PN, 2024^[84]). In Canada, Data from the Canadian Community Health Survey shows that almost one in five Canadians aged 65 and over reported experiencing loneliness in 2019 and 2020.³ Social participation contributes by three percentage points (p.p.) to the increase in the share of individuals reporting good or very good health on average (Sirven and Debrand, 2008^[85]). Existing evidence has shown that older adults who actively participate in social activities are more likely to maintain or increase physical activity than those without social participation (Kikuchi et al., 2017^[86]; Nemoto et al., 2021^[87]; Ihara et al., 2022^[61]). Evidence from Japan has also shown that social participation of older people through participation in clubs for hobbies, sports or volunteering is associated with lower cost of long-term care services (Saito et al., 2019^[88]). Furthermore, studies analysing the effects of dementia friendly initiatives on people living with dementia and informal carers have highlighted that dementia friendly initiatives can improve social contacts and enjoyment and can decrease stress (Thijssen et al., 2021^[89]). At the same time, social participation is also influenced by close proximity to resources, recreational facilities, neighbourhood security and transport options (Levasseur, G  n  reux and al., 2015^[90]). Finally, older people who participate in social activities regularly are more likely to maintain or increase physical activity than those without social participation, further highlighting the importance of the accessibility of social activities and services near where people live (Ihara et al., 2022^[61]; Nemoto et al., 2021^[87]).

Some initiatives have promoted raising awareness of the importance of involving older people in the community, in some cases by offering intergenerational activities. In **Poland**, initiatives by *Klub Seniora*

(Seniors Club), such as the “Seniors forward! – education for the body, health and spirit” and “The computer is a friend of the senior” in Wrocław, represent campaigns to highlight the importance of older people’s participation in activities to promote intergenerational integration (Wrocław Senior Center, 2024^[91]). In **Norway**, the “buddy intergenerational meeting – Samnager” are held in schools every Wednesday, offering meals, extracurricular activities and games that involve students, adults and older adults. Furthermore, both in Norway and **Ireland**, there are intergenerational choirs. Such choirs represent an occasion for different generations to meet and share activities. In most cases, in fact, the choir also organises trips, excursions and different activities involving people of all ages (Norwegian Association of Local and Regional Authorities, 2020^[92]).

A number of initiatives to involve older people in the community have also been put in place across the OECD. Most initiatives are developed and implemented at the local level to involve older people in volunteering or other activities. For instance, **Poland** developed a number of initiatives with this scope. The FIO project “Professional Senior – Volunteer in Non-Governmental Organizations” in the municipality of Wrocław consists of an initiative to encourage older people to participate in activities such as volunteering in non-governmental organisations. The project aims to improve the process through which organisations find volunteers with unique competencies that can increase the effectiveness of NGOs. Furthermore, the Academy of Active Senior Volunteers aims to keep older people active and combat social exclusion. To reach this goal, the “Active Senior” Foundation offers educational and sports activities for older people (Wrocław Senior Center, 2024^[91]). **Japan** has implemented local initiatives to involve older people in social interactions through the organisation of gathering salons called *ikoino saron*. The salons are managed by local volunteers and are open to all older adults aged 65 or older. The salons are occasions for participants to meet and interact through relaxing and/or educational programmes. In 2017, almost 87% of Japanese municipalities had implemented the salons, which have positive results. Participating in the salons has in fact resulted in a halved incidence of long-term care needs and about a one-third reduction in the risk of dementia onset (Saito et al., 2019^[93]). **Norway** also has several activities organised for older people, with the aim of offering activities that are accessible and enjoyable for older people. For instance, the “Grannehjelpa” walking club offers walking tours of different types, which are accessible for older people with various levels of physical conditions. Furthermore, some Norwegian municipalities have home library services for older people who have difficulty accessing a library. The library employee communicates with borrowers over the phone and delivers books and audiobooks directly to the person’s home (Norwegian Association of Local and Regional Authorities, 2020^[92]).

5.5. Enhancing access and affordability of home care services can facilitate ageing in place

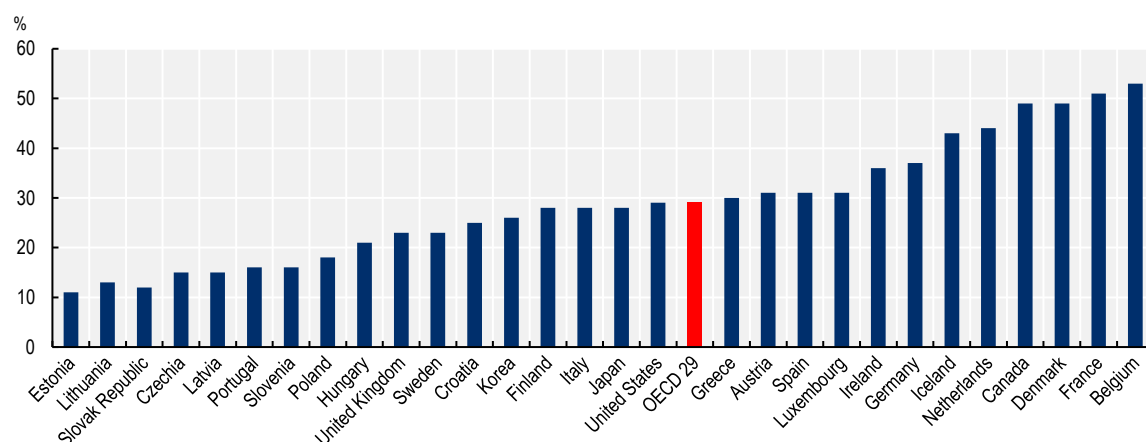
5.5.1. Coverage of home care services is not always sufficient

The availability of benefits and services for long-term care currently falls short of demand. On average, public formal care systems provide benefits and services to 29% of those with long-term care needs (Figure 5.10). While previous OECD work highlighted that approximately half of individuals with needs require care for less than 6.5 hours per week (OECD, 2024^[94]) and such individuals might rely on informal care, which can lead to higher social costs in terms of informal carers reducing their employment, hours worked or worse health. If public long-term care is insufficient, there is also a risk that people face high out-of-pocket costs, that needs go unmet, or that the pressure on the general health system increases in terms of higher hospital admission rates or longer stays in hospital beds for those who cannot afford to pay for LTC (Costa-Font, Jimenez-Martin and Vilaplana, 2018^[95]; ESRI et al., 2019^[96]). Across European countries, it was estimated that one-quarter receive neither formal nor family care (OECD, 2023^[97]). The OECD estimates suggest that if countries aim to expand the availability of LTC by increasing the coverage to meet the growing demand due to ageing, to the extent that 60% of people with care needs receive

benefits and services, the OECD would result in a 45% increase from the level of LTC expenditures in 2022 (OECD, 2024^[94]).

Figure 5.10. Formal care systems meet less than 30% of long-term care needs across the OECD

Public coverage of long-term care benefits as a share of individuals reporting low, moderate and severe needs



Note: Low, moderate, and severe needs correspond to 6.5, 22.5 and 41.25 hours of care per week, respectively. An older person with severe needs receiving LTC at home is assumed to live with a spouse who can provide 24-hour supervision, help with taking medicines, and manage the finances, but cannot provide any other ADL/IADL care.

Source: OECD analyses based on the Long-Term Care Social Protection questionnaire and the *OECD Health Database*.

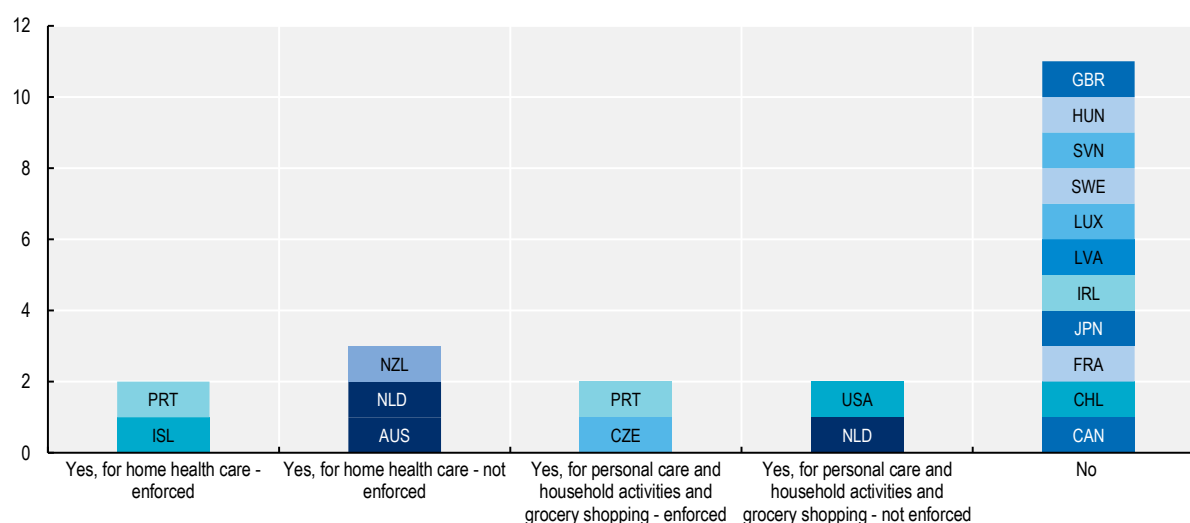
Low access is related to a variety of factors. First, individuals are not always aware of their rights and do not apply. They might be discouraged by a variety of barriers, such as the administrative requirements and the needs assessments. One-stop shops at the local level can help users to overcome such barriers. In Greece, community centres in municipalities can advise older people about home care and help them with the application process for home care, particularly with the paperwork required. Similarly, in the **Netherlands**, Care offices (*Zorgkantoren*) in regions help people find care that is appropriate to them. Second, tight eligibility criteria also limit the number of people who can access the system and the rate of rejections for applications varies widely across countries. Means-testing systems also limit the amount that individuals receive and how much they need to pay out-of-pocket and certain individuals who have a median or high income might be discouraged from applying. In six countries (Croatia, Greece, Japan, Latvia, New Zealand, the Slovak Republic) access to long-term care depends on whether people have an informal carer, while in **Canada** and Portugal, the provision of formal care is complementary to the care provided by an informal carer. In **New Zealand**, all district healthcare boards were required to adopt a new *interRAI assessment* that includes checks for the presence of an informal caregiver to determine eligibility. This change is attributed to the decrease in the share of LTC recipients (OECD, 2021^[98]). In Croatia, the home assistance programme and publicly financed nursing homes are not provided if there is an informal caregiver, although Croatia is introducing recent changes into its long-term care system. Finally, in several countries, even if individuals are eligible for benefits and services, there are waiting lists for assessment and then, once assessed, to access long-term care support.

Currently, just over half of the countries do not have any guidelines on waiting lists, while five additional countries do have guidelines to limit waiting times, but they do not appear to be enforced (Figure 5.11). In **Australia**, for instance, while individuals with high priority may be expected to receive their home care package within a month, those with medium priority may have to wait between 3 and 15 months (Australian Government, n.d.^[99]). In **Spain**, with waiting lists for benefits or services being monitored, the percentage

of people on waiting lists improved from 17% in 2020 to 9% (IMSERO, 2024^[100]). In the **United Kingdom**, there were more than 400 000 people waiting for an assessment, care or direct payments to begin or a review of their care plan (Associations of Directors of Adult Social Services, 2023^[101]). **Germany** has a requirement to notify the applicant about the result of the needs assessment and the decision on the granting of aid within a maximum of 25 working days. In **Sweden**, services should be provided within three months.

Figure 5.11. Most countries do not actively enforce policies to reduce or monitor a waiting list for services

Number of countries by type of policy on waiting lists for long-term care



Note: Canada is based on the data from New Brunswick.

Source: OECD questionnaire (2023).

5.5.2. Insufficient home care hours and funding for services hamper ageing in place

More than 40% of countries have limits on the number of hours provided for home care. In **Slovenia**, there is currently a weekly limit of 20 hours of care, although this is likely to change with the progressive introduction of the new system following the Adoption of the *Long-term Care Act* in 2023. **Luxembourg** offers 3.5 to 36 hours (210 to 2 171 minutes) per week, depending on the assessed level of care needed, along with an additional three hours of housework assistance. Japan has a maximum monthly service which differs by category of need (Gouvernement du Grand-Duché de Luxembourg, 2005^[102]). Similarly, in **Israel**, the limit on hours of care which individuals are entitled to varies according to the degree of dependency, but ranges from a maximum of 5.5 hours per week for the lowest level to 30 hours per week for the highest level. In **France**, the financial assistance for hiring a personal care worker at home cannot be more than 30 hours per week for a single person or 48 hours if a couple is entitled to such assistance. Iceland also has a limit of 60 hours per month for social home care services.

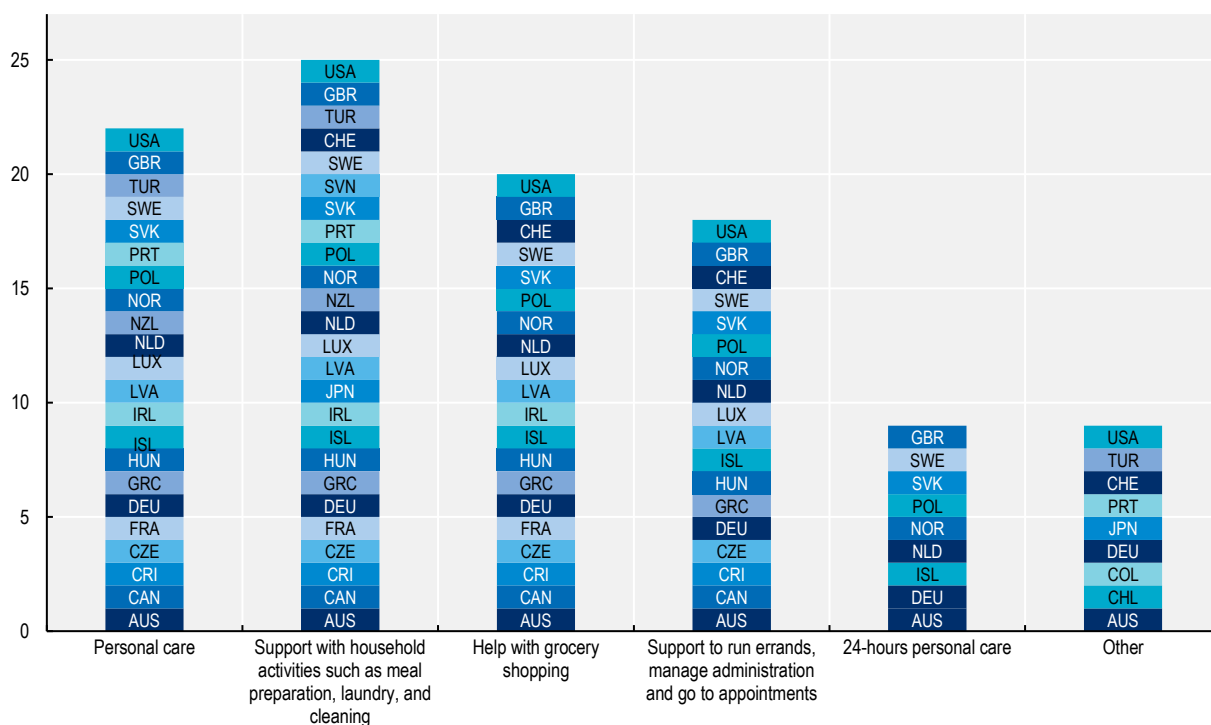
Several countries have taken steps to enhance the hours and services for home care, while seeking innovative solutions. In 2023, **Spain** changed the limit on the hours available for all levels of need, moving from 20 hours per month for grade I to between 20 and 37 hours, from 21-45 hours to 38-64 hours for grade II and from 46-74 hours to 65-94 hours for grade III (Ministerio de Sanidad, Servicios Sociales e Igualdad, 2023^[103]). Personal budgets, as introduced in **England** and the **Netherlands**, could provide flexibility to users in deciding the home care services that they need.

In particular, provision of 24-hour long-term care services at home is limited to one-third of the countries and is not always well covered in countries where such services are available. According to OECD calculations, the share of older people requiring care is expected to rise across all analysed countries by 30% by 2050 and it is expected that higher life expectancy may extend the period of living with severe needs (OECD, 2024^[94]). In England, for instance, a study estimated that the number of people aged 85 and over needing 24-hour care is set to double (Kingston, Comas-Herrera and Jagger, 2018^[104]). In a number of countries, 24-hour care is available but still sometimes falls short of public financing or availability. **Austria**, for instance, has offered the possibility since 2007 of financial support for 24-hour care at home. The benefit is means-tested and granted to people with a monthly income lower than EUR 2 500 and requires a minimum level of dependence (care level 3). This can be used to employ caregivers who are either family members, self-employed or from non-profit agencies. While the benefit is meant for 24-hour care and is more generous than the regular benefit, it falls short of covering all costs, as it constitutes a maximum of EUR 800 per month. In the **United States**, Medicaid can offer 24-hour care under exceptional circumstances through home and community-based services (HCBS) waivers in some states 52% of waivers serving include round-the-clock services as a benefit for the population with intellectual development disabilities (Watts, Musumec and , 2022^[105]). In the **Netherlands**, individuals are eligible for 24-hour care at home under *the 2015 Long Term Care Act* (Wet langdurige zorg – WLZ). A report from the inspection service highlighted that such services are not always appropriate and depend on the provider. For certain providers, a district nurse monitors the care quality and provides care available 24 hours a day if needed, including through alarms and digital aids, while for many small providers, those services are unavailable for 24 hours or not at the level of expertise needed.⁴ **Finland** has embarked on an ambitious reform since 2023 of abolishing institutional care by 2027 and increasing home care and is planning to address worker shortages, house calls and self-management in order to ensure the provision of around the clock home care, if needed. For this, it also includes provisions of data privacy for the use of technology at home and care alarms.⁵

Some countries do not adequately provide financial support for instrumental activities of daily living and social needs. The public social protection system does not fully cover the costs of help with all or certain instrumental activities and requires either partial or complete out-of-pocket payment by the care recipient. While most countries provided support with household activities such as meal preparation, laundry and cleaning, support with grocery shopping or support to go to appointments and administration were available to a limited extent, as this was available in 20 and 18 countries, respectively (Figure 5.12). In **Ireland**, the costs of help with laundry and shopping are not covered by the public social protection system. In an effort to reduce social isolation, since 2024, **France** has included the option to add a maximum of nine hours per month, covered by the public purse, for those receiving the home care allowance. Such hours can be used for cultural activities, outdoor activities, leisure and well-being. In Australia, home care packages include providing a companion to assist with making in-home or telephone-based social calls or arranging social activities and providing or co-ordinating transport to social events.

Figure 5.12. Personal care and support with household activities are the most commonly funded services

Countries by type of funded home care services



Source: OECD questionnaire (2023).

A number of countries would need to find efficiency gains in providing care at home for people with severe needs, as population ageing and people's preferences press for more people to age at home. Currently, in the majority of OECD countries, the cost of home care is higher than the cost of staying in a nursing home for an older person with severe needs: this is the case for 17 countries, while in 10 countries, the reverse is true (OECD, 2024^[94]). Formal home care can thus be very expensive when needs are severe and involve many hours of care each week. Professional carers must travel between care recipients' homes, which in some countries can take significant amounts of time during which they are not providing care. This limits the number of older people they can care for at any given time.

Technology has the potential to improve worker productivity, promote efficiency and potentially reduce the costs of long-term care at home. Digital technologies such as sensors and tablets can streamline administrative tasks, co-ordination, monitoring, and transportation, thereby maximising the time workers can spend on direct caregiving. Moreover, new technologies could improve the conditions of care recipients and prevent additional interventions by caregivers. In Denmark, a digital training tool for physical activities at home (called "DigiRehab") contributed to not only efficiently monitoring care recipients' physical ability but also reducing their need for home care (Healthcare Denmark, 2019^[42]). Similarly, in **Finland**, the telecare scheme called "Remote Care" helped long-term care workers reduce travel time (OECD, 2023^[97]). Furthermore, Artificial Intelligence (AI)-enhanced tools can facilitate independent living for older people, reducing the need for constant supervision, such as by managing medication regimens and systematically monitoring and recording the health status of care recipients (Eurocarers, 2024^[106]). In Japan, AI software is increasingly accepted to help long-term care workers smoothly optimise travel and avoid preventable harms in long-term care settings. There is a case like Japan where the AI detection of falls helped reduce

the burden on monitoring by long-term care workers (OECD, 2023^[97]). However, the overall evidence surrounding the effectiveness of AI (e.g. wearables) on avoiding falls is inconclusive at present and further development is to be expected (O'Connor et al., 2022^[107]).

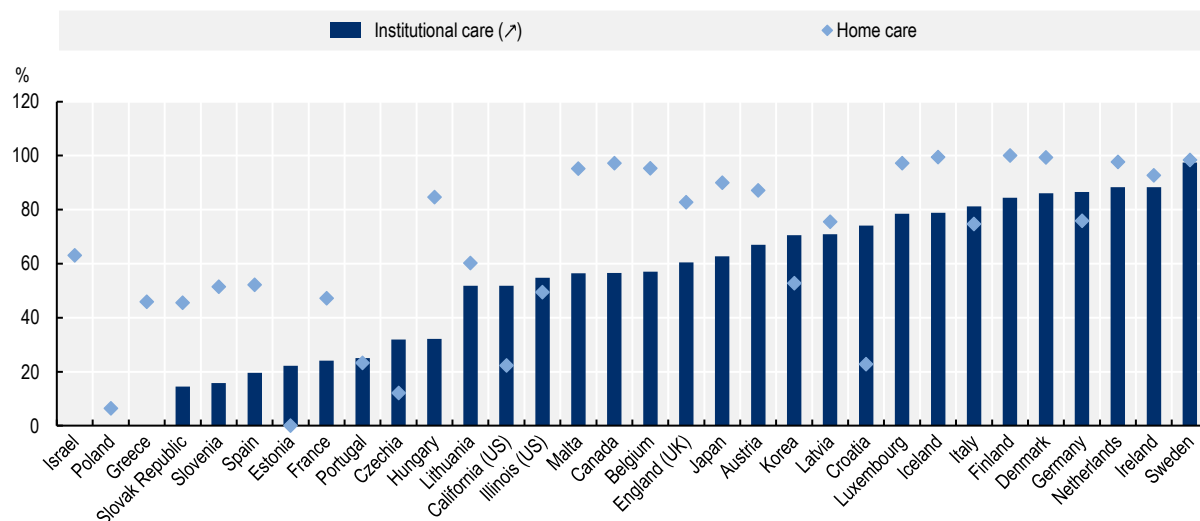
5.5.3. Improving the affordability of home care services would strengthen ageing in place

In several countries, limited public financial support and tight eligibility criteria pose challenges to the affordability of long-term care (Oliveira Hashiguchi and Llana-Nozal, 2020^[108]). This section discusses current gaps in the affordability of users, which can prevent them from ageing in place. It draws on the analysis of public social protection systems, which highlight how much of the costs are covered by the public purse and the degree of out-of-pocket costs (OECD, 2024^[94]). Out-of-pocket expenses are high in a majority of countries for individuals with severe needs at home and for moderate needs in some countries. In 16 countries and subnational regions, out-of-pocket costs exceed 50% of median income, while they are above median income itself in seven countries and subnational regions. For individuals with moderate needs, in 11 countries, out-of-pocket costs would be at least 50% of the median income (i.e. relative poverty line). Given that the median income of older people is generally lower than that of working-age individuals, it is unlikely that they can afford these basic living costs after spending a significant part of their income on long-term care. The median income is taken as a benchmark because, if costs are higher, this would mean that the remaining disposable income left might not be enough to cover basic living costs such as rent or utilities, food, or clothing. Despite higher incomes having less public protection, out-of-pocket costs remain high for those with low income in a number of countries: out-of-pocket costs for low-income earners exceed 50% in seven out of 32 OECD and EU countries and subnational areas.

While, on average, the generosity of public benefits is greater for care provided at home, certain countries are more generous for institutional care, which could discourage ageing in place (Figure 5.13). Around 65% of home care costs are covered in the OECD, while the average covered cost of institutional care is 10 p.p. lower. By contrast, the share of costs covered by public long-term care systems is higher for institutional care in Estonia, Portugal, Czechia, the United States (California and Illinois), Korea, Croatia, Italy, Germany and France. The public social protection for institutional care is the highest in Sweden, France and Ireland. At the other end of the scale, there is no public social protection for institutional care for a person with a median income in Poland and Greece. The support is also very limited (below 20%) for older people in the Slovak Republic, Slovenia and Spain. This significant difference is partly due to the design of the long-term care systems, some of which aim at covering all costs, while others are designed to provide partial support with the expectation that older people will organise most of their support themselves.

Figure 5.13. The public share of costs covered tends to be higher at home

Percentage of total costs covered by public funding by country, 2022



Note: Severe needs correspond to 41.25 hours of care per week. An older person with severe needs receiving LTC at home is assumed to live with a spouse who can provide 24-hour supervision, help with taking medicines, and manage the finances, but cannot provide any other ADL/IADL care. Data for Poland in institutional care corresponds to the social care sector.

Source: OECD analyses based on the Long-Term Care Social Protection questionnaire, the *OECD Income Distribution Database*, and the *OECD Wealth Distribution Database*.

Designing effective public support needs to take into account the generosity of the system. Across the OECD, countries are likely to seek additional sources to fund long-term care, but options to manoeuvre are tight. Countries should investigate policy options that promote efficiency and help contain the costs of long-term care. Slovenia has launched a wider reform to introduce long-term care insurance and make the range of long-term care services more generous to users but also promote a rehabilitation-first approach to bring costs down. In addition to these two options, given the current gaps for vulnerable people, countries could better target their existing long-term care funds towards those most in need, that is, those with higher needs and lower income. Estonia has recently started a reform to reduce the out-of-pocket costs for users. Countries might consider introducing progressive income-testing, such as in Lithuania, as the degree of cost-sharing increases progressively along the income distribution. They could also have wealth-testing to better target the most vulnerable older people with needs and to discourage strategic behaviour around wealth thresholds. For example, Spain has implemented a system where 5% of the value of wealth (excluding the primary residence) is added to the income to determine the level of public support for long-term care.

5.5.4. Public financial support for the provision of informal care can be further expanded

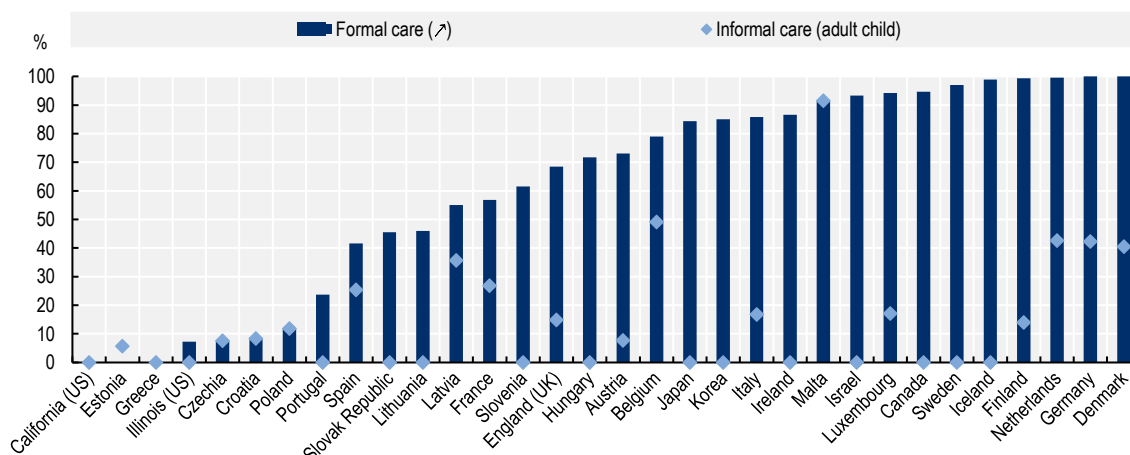
While many people prefer to be cared for by their family members or have to rely on them because of insufficient formal care, this can create poverty risk for such households. Informal care is widespread in many countries: among OECD countries for which data is available, about 60% of older people reported receiving only informal care (Rocard and Llena-Nozal, 2022^[109]). Public social protection for the provision of informal care is limited, especially compared with formal care and tends to be low (Figure 5.14). In nearly half of the countries, an adult child providing 22.5 hours of care to an older parent would receive no allowance, even though the adult child would have to reduce working hours or even resign from work to provide care. Even some countries with generous social protection for formal care, like Iceland and

Sweden, do not provide benefits for informal carers. On average, only 14% of the costs of care are covered in case of informal care compared with just over 60% for formal care.

As discussed in previous OECD work (OECD, 2024^[94]), countries need to balance the level of financial support for informal carers with financial constraints and the risk of informal caregivers becoming long-term caregivers. The level of compensation for informal carers is often a recognition that providing care involves costs for carers and for the opportunity costs of providing care – that is, for lower incomes caused by reduced working hours. At the same time, low allowance levels for informal carers are often driven by the risk that high compensation could trap carers in a role that is comparatively low paid. At the same time, countries should consider the potential risk of future shortages of informal carers and their concerns regarding livelihoods, and therefore, explore ways to support and address these issues. Broader public policies for these informal carers, such as psychological support, adequate training and work-life, are also important (Rocard and Llena-Nozal, 2022^[109]). This can provide win-win options for countries as people prefer being cared for by their relatives and a reasonable allowance for informal carers can be beneficial for families while limiting the costs to the system in terms of avoiding hospitalisations or using formal care which is likely to be of a higher cost.

Figure 5.14. Public financial support for informal home care is limited

Public support for formal and informal home care as a share of total formal home care costs for older people with moderate needs, median income and zero wealth



Note: Moderate needs correspond to 22.5 hours of care per week. Median income refers to the country's disposable median income of older people. The care is provided by an adult child who earns the country's median income for the entire population. Detailed descriptions of care recipients' needs and the informal carer's characteristics are available in Annex A (OECD, 2024^[94]).

Source: OECD analyses based on the OECD Long-Term Care Social Protection questionnaire, the OECD Income Distribution Database and the OECD Wealth Distribution Database.

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Notes

¹ Average incomes usually decline after retirement. The income of people aged 65 or older in 2020 amounted to 88% of the overall average population incomes on average across OECD countries. Older people are often more likely to live alone, which exacerbates declines in disposable income. This phenomenon impacts women to a larger extent, due to longer life expectancy (OECD, 2023^[7]).

² The support is accessible for: i) older people aged 70 years or older, ii) older people between the age of 60 and 69 with physical limitations, iii) people with disabilities of any age. An assessment of means is also performed to declare accessibility to this form of financial support. Means assessment is performed by the National Housing Agency (ANAH).

³ <https://www.statcan.gc.ca/o1/en/plus/4881-look-loneliness-among-seniors>.

⁴ <https://www.igj.nl/actueel/nieuws/2024/07/02/langdurige-zorg-aan-ouderen-thuis-vaak-nog-onder-de-maat>.

⁵ <https://valtioneuvosto.fi/en/-/1271139/legislative-reform-develops-services-provided-at-home-and-housing-services-for-older-people>.

6 Promoting the continuum of care in the community

The chapter examines how countries are promoting a continuum of long-term care options between home and institutional care. There is a strong focus on understanding how day care for older people contributes to healthy ageing and what the landscape of adult day care is in terms of access, services, and funding. The chapter looks at the different communal solutions that are available to ensure people-centred care and services as people age. It describes the advantages of co-housing and intergenerational solutions, and challenges to promoting such living arrangements. The chapter finally discusses assisted living, which is a residential option for people who start needing care services, to understand how countries fund it and ensure quality standards.

Key findings

- **Adult day care appears to have many benefits for older people and to be cost-effective but is often underused.** In many countries, options for community care are limited: the number of day-care users is below 1% of the population aged 65 or above. The use of adult day care is limited by a shortage of supply and transportation options, lack of awareness, and high costs, with 17 countries highlighting that out-of-pocket payments were required. Maintenance of personal hygiene, provision of meals and group activities are often the mandatory services provided. More than 40% of countries have no specific requirements or only require registration to operate. Quality monitoring relies mostly on quality standards while only nine countries have quality indicators and only seven countries have external audits
- **Innovative shared living arrangements have benefits for older people but remain limited.** Collaborative housing, such as co-housing or co-operatives, was reported in about one-third of OECD countries, similarly to intergenerational housing models. Both have been found to have potential in reducing loneliness and social isolation. Developing such options is sometimes constrained by legal challenges as well as conflict and privacy concerns. Retirement villages have grown in the United States, Australia and some European countries but are mostly privately financed from membership fees.
- **Assisted living facilities are common across OECD countries** (24 out of 26 countries), with varying degrees of funding and quality regulations. While often private, half of OECD countries reported that public funding at the national or local level is used to finance assisted living facilities. Quality monitoring is less developed with requirements on what and how to monitor being less strict than for nursing homes. For instance, auditing is available in only six countries, and quality indicators are used in three countries.

Policy options

- **Improve access to adult day care, the health services offered and quality regulation.** Adult day care services appear to have substantial benefits with reduced social isolation, improvement in health outcomes such as physical health and functional status and a reduction in emergency attendance and hospital admissions and can also delay nursing home admission. To better reap the benefits of adult day care, incentivising access and improving the offer of health services is paramount. Improving referral and addressing transportation challenges are important points to address barriers: The Netherlands has introduced a specific transport budget for day care for that purpose. In Japan, health screening is a mandatory service in adult day care.
- **Promote innovative housing models for older people.** France is considering options for co-operative housing and intergenerational housing whereby people could benefit from the allowance for LTC and there is also a special allowance for inclusive housing, the so-called “allowance for shared living” (*aide à la vie partagée*). Tax credits, such as in Canada (Québec), providing a legal status to such housing options to benefit from subsidies, as in France, as well as offering co-operative or intergenerational housing through rental options appear to have an impact on the development of innovative housing models.
- **Ensure that funding options and sufficient quality monitoring are available for housing options with care services.** Regulation on staffing competences might be needed to ensure the needs of a more dependent population, as well as recording adverse events. In New Zealand, audits are conducted regularly, similarly to the Netherlands, where public reporting of results is available. In the United States, Green House care facilities include Medicaid and Medicare residents and offer small home-like environment with higher quality of

care, resulting in lower hospitalisation rates. Considering how to provide public funding for emerging living arrangements and assisted living facilities could be beneficial in reducing overall health expenditures.

6.1. Adult day care can promote healthy ageing and ageing in place, but it is far from fulfilling its potential

Day care for older people provides a series of activities and services in a supervised community setting which can consist in a variety of medical, functional and social types of support. It differs from clubs or centres which are more focussed on recreational and leisure activities but largely lack support measures in terms of care. It is also different from outpatient health services which are more focussed on rehabilitation and other forms of health treatment and less on functional and social support, and where staff is more likely to consist of health workers. As such, day-care centres across OECD countries target individuals who need some form of care because of their health and dependency status. Depending on the country, they focus on older adults (e.g. 65+) or are open to a wider range of age groups. Adult day-care attendance is associated with several positive outcomes for both family carers and their care recipients. Although it is often difficult to quantify and price these positive outcomes, most research indicates that public investments in day care are generally cost-effective, as it can prevent and reduce other health system burdens (Caiels et al., 2010^[1]; Knapp, Lemmi and Romeo, 2013^[2]).

Most evidence on the benefits of adult day care is focussed on its impact in providing respite to family carers. A review of studies highlights that by providing respite to family carers, day care reduces caregiver burden, at least when the day care programme includes a caregiver-support dimension (Vandepitte et al., 2016^[3]). When the care recipient attends day care, the family caregiver's mental well-being improves and anxiety diminishes, their caregiving competencies develop, and the relationship between the family carer and the relative receiving care improves (Lunt, Dorwick and Lloyd-Williams, 2018^[4]; Tretteteig, Vatne and Rokstad, 2017^[5]; Klein et al., 2016^[6]). For people with dementia, day-care attendance contributes to limiting family caregiver stress and increasing the motivation to continue living together and providing care at home, thus delaying admission to a nursing home (Maffioletti et al., 2019^[7]).

In addition, adult day care can serve a social purpose and improve the quality of life and well-being of people receiving care, especially for those living alone or more isolated. By engaging people in social and recreational activities as well as exercise, adult day care can reduce the risk of social isolation and contribute to mental well-being (Iecovich and Biderman, 2012^[8]; Orellana and Samsi, 2024^[9]). Older people often experience network shrinkage as peers their age begin dying or becoming increasingly disabled, and many day care attendants report new friendships with people their age as a main benefit (Hagan and Manktelow, 2021^[10]). Activities organised at adult day-care centres can also contribute to improved social outcomes and give older people a sense of purpose and belonging. This not only improves quality of life but also has important public health benefits: A randomised controlled trial on psychosocial group rehabilitation services in day care centres found significantly reduced mortality among participants as well as improved subjective health and less need of health services, with almost EUR 1 000 lower healthcare costs per person in the year after the programme (Pitkala et al., 2009^[11]). A Finnish randomised controlled trial also found benefits of socially stimulating group interventions in day care centres on the cognition and mental function of lonely older people (Pitkala et al., 2011^[12]).

Social functioning and well-being are improved by attendance at adult day care centres. Based on 24 papers, a scoping review focussing on people with dementia finds that adult day care improves various aspects of social functioning, including connecting with others, increased interaction and participation (Tuohy et al., 2023^[13]; Rokstad et al., 2019^[14]; Österholm et al., 2023^[15]). Particularly activities based on bodily senses, such as music, art, multisensory, robotics and animal therapy, would facilitate the ability of

people with dementia to connect to others. According to a review, more than 80% of studies show positive effects on quality of life and well-being for adult day care users (Benedetti, Sancho and Hernández, 2024^[16]). Some of the strongest evidence on the benefits of day care emerged when centres were closed due to COVID-19, with several studies finding decreased independence, worsened physical and mental health outcomes and dementia symptoms where applicable, and increased caregiver stress due to day care facility closures during lockdown (Borges-Machado et al., 2020^[17]; Wong et al., 2022^[18]; Teramura et al., 2021^[19]).

Adult day care also generates beneficial health outcomes, fosters autonomy, and facilitates older people staying in their own environment. Day care can have a medical focus, providing physiotherapy and other healthcare, and the provision of meals can ensure sufficient nutritional intake for those who might find it challenging to cook or eat their meals in isolation. This can result in improved physical health and functional status (Benedetti, Sancho and Hernández, 2024^[16]; Orellana, Manthorpe and Tinker, 2020^[20]). For older people with long-term conditions, research indicates improved psychological, physical, and general health and better functioning and quality of life among day care attendants, though the strength of the evidence is mixed (Lunt, Dowrick and Lloyd-Williams, 2021^[21]). Marquet et al. (2020^[22]) find that day care attendance increases physical activity for relatively younger and older female participants, but not for other groups. Some countries or facilities offer targeted interventions to tackle specific health outcomes, often with meaningful results. For example, a fall-prevention programme held twice a month over three years in a Japanese day care centre significantly improved mobility and reduced falls among participants, compared to the control group (Yamada and Demura, 2014^[23]). Day-care attendance is also associated with a reduction in emergency attendance, hospital admissions and days in hospital (Kelly, 2015^[24]), as well as reductions in pain and fatigue and improvements in gait speed (Lunt, Dorwick and Lloyd-Williams, 2018^[4]). There is some more limited evidence from randomised studies of day care being associated with improved psychological health, lower depression and better cognition (Ellen et al., 2017^[25]; Femia et al., 2007^[26]). Honjo, Ide and Takechi (2020^[27]) conclude that day care use significantly improves cognitive function of Alzheimer's patients, and person-centred care strategies used in day care can also help manage other behavioural and psychological symptoms of persons with Alzheimer's and Alzheimer's Disease Related Dementias (Boafo et al., 2023^[28]).

The potential for adult day care to promote healthy ageing appears to be wide but it is unclear whether it is currently fulfilling its potential. Previous research has highlighted heterogeneity in the organisation of adult day care across countries, with a different target groups and different types of providers, coming from public, private for profit and not for profit and operating in different types of building, either independent or attached to a nursing home. At the same time, information remains limited in terms of services offered, funding and regulation, especially with services being provided at the local level in many countries. This section attempts to fill this gap by surveying these topics based on a questionnaire and providing evidence from the literature.

A number of barriers limit adult day care use

In most OECD countries, adult day care services cover a minor percentage of people in need of care, generally well below the coverage of home and institutional care which amounts on average to 7.6%. Currently, less than 1% of older people aged 65 or above have access to and use day care services, compared to over 20% who have low (13%) and moderate (8.5%) needs (OECD, 2024^[29]). The rates of unmet need for day care vary across the country. In Chile, it is estimated that adult day care covers only 3.5% of the target population (Pontificia Universidad Catolica Chile, 2022^[30]). In Israel, adult day care was used by 2.2% of older people in 2012, compared with 16.5% who would be in need; however, this represents more than a doubling of attendants since 1994 (Iecovich and Carmel, 2011^[31]; Resnizky et al., 2012^[32]). Respite day care use among carers was also rare, with 89% of primary carers of people with dementia never using respite care (Du Preez et al., 2018^[33]). The utilisation is particularly low in the early stages of dementia.

One reason for the limited coverage of adult day care is the low supply of services. People are often waitlisted due to a limited number of days or hours of entitlement, or there may be no facility in the area. According to responses to the OECD questionnaire, the total availability of places in adult day care remains limited in many countries. In France, adult day care falls short of meeting the high demand although several strategies have been implemented to promote their development, resulting in a 93%-increase in availability between 2008 and 2016. In Ireland, the amount of time a person can spend in adult day care may be reduced if local demand exceeds the number of available places, even after initially waiting up to five months for a place (Donnelly et al., 2016^[34]). In a British survey of day care users, most respondents only attended adult day care once or twice a week but 26% said that they would like to go more frequently than they did (Caiels et al., 2010^[1]). Some rehabilitation- and reablement-focussed day care programmes in Northern Ireland are time-limited, usually running for a period of 6-12 weeks, and have left some participants who wished to continue attending day care after the programme without sufficient long-term options and guidance (Hagan and Manktelow, 2021^[10]).

Cumbersome application processes may constitute a second barrier to day-care use for older adults. Most countries require a needs assessment to be eligible for adult day care services, except for four countries that accept a referral from the general practitioner (or a public nurse). While the needs assessment should help ensure fairness and targeting based on a comprehensive measure of needs, such assessments can take a long time to perform, and their administrative procedure might deter some eligible users. In England, there are almost 250 000 people waiting for an assessment, of which 33% wait for longer than six months (Schlepper and Dodsworth, 2023^[35]). In some countries, available places in day care remain unfilled: In Israel, daily occupancy rates were 73% while in France it varied between 47% and 50% (EHESP, 2019^[36]; Iecovich and Carmel, 2011^[31]).

Third, a lack of awareness of available services is also limiting overall demand and use. In addition to families, general practitioners or specialists from whom a referral is needed to access adult day care might not always be aware of day care as an option. A study in Spain carried out by providers highlighted that 65% of people believe that the main reason older people did not use day care was because they did not know about the existence of such services and 14% did not receive any information from a health or social professional about them, while most of them received a recommendation either from social services or from relatives or friends (STIMA, 2023^[37]). Information about providers is fragmented, and it is not always clear what services are available to potential users nearby. In Israel, about 60% of older people who did not attend day care indicated that they were unaware of its existence, and 78% said that they would not know how to go about joining a day care centre (Resnizky et al., 2012^[32]). Negative perceptions about attending day care or its use for respite care are possible obstacles to increasing the use of available services. In addition, there is a certain stigma or poor image associated with it, especially if day care is offered within a nursing home. In France, 86% of day care is offered within a nursing home, and older people are concerned that this means the first step into institutionalisation (EHESP, 2019^[36]). In England, research indicates that while day care is not stigmatised, awareness about it is low (Orellana, 2018^[38]).

Fourth, physical barriers might prevent access to adult day care. Travel time has been found to be a deterrent to attending an adult day care centre. Geospatial analysis from Ireland shows that this affects 18% of people with dementia who do not live within 15 km of their nearest day care centre. There is high variability in the availability of adult day care centres throughout the country and low population density areas tend to have less availability (Pierse et al., 2020^[39]). Across several countries, there appear to be geographical disparities in the availability of day care, with rural and peripheral areas experiencing greater access challenges (Vitman-Schorr and Khalaila, 2022^[40]). In the United States, another study using geospatial analysis found that many rural counties had a higher percentage of older adult populations but did not have adult day care services within one hour's drive distance (Li et al., 2023^[41]). In France, while transport solutions are offered in 90% of the cases, only 36% offer sufficient reimbursement of such transport costs (EHESP, 2019^[36]). The centre can arrange transportation in three ways: through its own vehicles, by contracting an external provider, or by compensating families for the cost of transporting their

family members, but the state caps the publicly subsidised amount that centres receive for transportation services. In the Netherlands, partly to incentivise its use and address barriers, transport costs have been largely reimbursed since 2021, and many providers offer specialised and integrated transport services for patients (HollandZorg, 2025^[42]). As adult day care attendants commonly have mobility impairments, using public transport to travel to the facility is often complicated and time-consuming (Du Preez et al., 2018^[33]).

Finally, the supply of services is not always aligned with people's needs in terms of flexibility of hours. Hours might also not suit family members. For instance, in Israel, most adult day care centres operate 5 to 6 hours per day, 5 days a week. While all centres offer organised transportation services, these usually only run once a day in each direction, meaning that attendants have to be there on time. This inflexibility seriously inhibits participation, with around 40% of respondents in a survey of non-users stating that they would be interested in attending day care, but would like to go at a later hour or attend afternoon services instead (Resnizky et al., 2012^[32]). A study from Montreal, Canada, showed that regular adult day care attendance is much more likely if users stay the full day rather than just half a day. This is probably because caregivers associate a burden with getting the recipient ready for day care and potentially transporting them there, which only pays off if they then stay for longer (Savard et al., 2009^[43]). Other countries also highlight that adult day care remains closed on weekends and holidays, and opening hours exclude early mornings or late afternoons and open for a maximum of 8 hours per day, which can be challenging for informal/family carers who work (Tretteteig, Vatne and Rokstad, 2017^[5]). In Greece, adult day care centres (KIFI) often operate from 08:00 to 15:00, excluding weekends when they are closed.

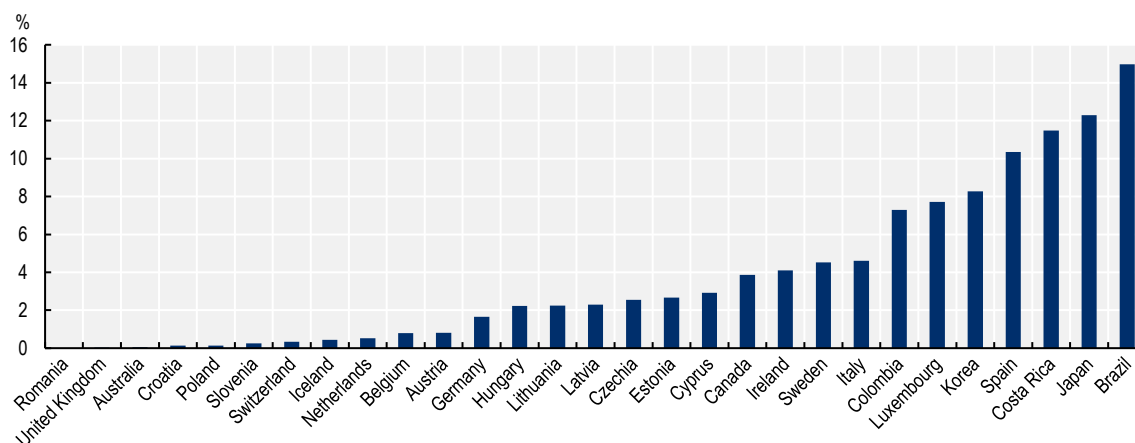
There is room for improvement in securing adequate financial and human resources for adult day care

Expenditures on adult day care constitute a small fraction of overall long-term care spending. Expenditures range between less than 1% to 5% of total long-term care spending in most countries. In Spain, Costa Rica, Japan and Brazil, day care is an important element as part of the overall LTC policy as it makes up more than 10% of all long-term care expenditures. In Japan, this could be explained by having a high number of recipients compared with other OECD countries while in Costa Rica, the relative importance of day care in total expenditures is driven by a strong focus on home and community care, which were, previously to the creation of a new care network, the only parts where public funding was available as residential care was primarily in the private sector (Medellín, 2020^[44]). Since 2015, the share of day care in total long-term care spending has only increased significantly in Germany, Korea and Lithuania, with most countries showing a decline or stagnation (OECD, 2023^[45]).

In many countries, day care is a very small component of total long-term care spending, with less than 1% of expenditures: this is the case in Romania, the United Kingdom, Australia, Croatia, Poland, Slovenia, Switzerland, Iceland, the Netherlands, Belgium and Austria. In a number of countries, low unit or hourly costs for day care partially explain low expenditures. For instance, in the Netherlands, hourly costs for day care are lower than for both home and institutional care. In England, some reports suggest that when there are reductions in local authority funding, day care can be particularly affected and that between 2009 and 2014 the number of day care or day services clients 65+ declined per week (Bennett et al., 2023^[46]). Data suggests that its share as a fraction of total long-term care has been declining since 2015 in the United Kingdom (Orellana et al., 2024^[47]). Low funding may affect staffing and its composition. In Chile, adult day care relies on centres having temporary funding for short periods and signing an agreement (often yearly). A study has found that this led to instability for the staff in the centres as some had to temporarily close until resources were renewed or people were asked to work without income (Rubio and Miranda, 2018^[48]).

Figure 6.1. Day care represents a small fraction of overall long-term care expenditures

Day long-term care (health) expenditure as a share of long-term care expenditure, 2022



Note: The information in this document with reference to “Cyprus” relates to the southern part of the Island. There is no single authority representing both Turkish and Greek Cypriot people on the Island. Türkiye recognises the Turkish Republic of Northern Cyprus (TRNC). Until a lasting and equitable solution is found within the context of the United Nations, Türkiye shall preserve its position concerning the “Cyprus” issue. The Republic of Cyprus is recognised by all members of the United Nations with the exception of Türkiye. The information in this document relates to the area under the effective control of the government of the Republic of Cyprus.

Data from 2017 for Colombia, 2019 for Brazil, 2021 for Australia, Lithuania, Romania and Sweden.

Source: OECD Health Statistics (2023^[45]), “Health Expenditure and Financing”, <https://data-explorer.oecd.org/s/2vw>.

As a result of limited expenditures, costs or eligibility requirements limit access to adult day care. Out of 28 OECD countries which provided information in the *OECD Survey on Healthy Ageing and Community Care*, 17 highlighted that out-of-pocket payments were required, although they most often constitute the second source of funding, after public funding. In Spain, 57% of adult day care centres were private in 2022, but 64% of available spots received public financing, with 22% of the price paid by users, amounting to over EUR 2 200 per year on average across the country in terms of user copayment (IMSERSO, 2022^[49]). In the **United States**, 57.4% of adult day care centres are for-profit, according to the Centre for Disease (2024^[50]). Costs of adult day care may vary between USD 25 and 100 per day, and Medicare does not pay for day care, leading to such centres being unaffordable for many who would attend regularly. The most common way for Medicaid to cover adult day care is through a *Home and Community Based Services (HCBS) Waiver*. HCBS Waivers have a limited number of enrolment spots, and once those spots are full, additional applicants may be placed on a waitlist¹ that can last months. In Poland, the fee for participation in adult day care is established by the government, but, depending on the participant’s individual (or family) annual income, the fee can be partially or fully covered by the social welfare services (Mazurek et al., 2020^[51]).

While all countries for which data is available do provide at least some support for day-care use among older adults, financing arrangements differ across countries (Table 6.1). In Luxembourg, while costs of medical and care services are covered by insurance, a fee for meals and other costs of EUR 25.60 per day needs to be paid. Fees for meals are also expected in other countries, such as **Iceland** and **Latvia**, while the **Netherlands** also requires a fee to access the services. In other countries, out-of-pocket costs depend on eligibility criteria and individuals with higher income will bear a higher fraction of the costs. For instance, in Ireland, 10% of the costs are paid by users but those with higher income contribute 20 to 30% of the costs. In the **United States**, only people eligible for Medicaid receive a reimbursement for day care and it depends on their assets and income. Means-testing is used in four countries and might reduce the

number of eligible participants. For instance, in **Chile**, people entitled to day care must belong to one of the first four sections of the socio-economic qualification of the Social Registry of Households.

Table 6.1. Adult day care is fully or partially financed from public resources

Countries by the level of out-of-pocket payment for adult day care

Paid fully out of pocket	Out-of-pocket costs depend on eligibility	No out-of-pocket costs except for meals	No out-of-pocket costs		Other
			Access depending on eligibility criteria	Access limited to number of hours or days	
0	10	4	7		0
	AUS	DEU	CHL	DNK	
	CAN – N.B.	ISL	COL		
	CZE	LVA*	CRI		
	FRA	LUX	IRL		
	HUN		NZL*		
	JPN		TUR		
	NLD				
	SVN				
	SWE				
	USA*				

Note: The data for Canada refer to New Brunswick. * In Latvia, municipalities determine the pricing of day-care services, although typically services are free or with minimal co-payment, with the exception of the meal. In New Zealand, in addition to public services, which provide day care free of charge, some support is available to people purchasing private day-care services depending on eligibility. In the United States, adult day care is a responsibility of the states, but Medicaid programmes typically include some targeted support for day-care services.

Source: OECD Questionnaire on Healthy Ageing and Community Care (2023^[52]).

A number of countries have given impetus to day care over time. In **Norway**, day care for people with dementia was highlighted as an essential part of the country's care strategy in the 2015 and 2020 National Dementia Plans, which also provided additional funding for day care services to the local authorities offering them. However, the focus is strongly on dementia patients, and despite increased availability, day care utilisation remains low (Rokstad et al., 2019^[14]). In **Japan**, the *1983 Health and Medical Services Act for the Aged* first established a consistent healthcare framework for older people, ranging from prevention to rehabilitation, including at day care facilities (Nakamura, 2018^[53]). The implementation of the *Community-Based Integrated Care System* and the 2015 reform of the *Long-term Care Insurance Act* then led to a broader approach targeting the whole community of older people and their caregivers rather than just high-risk individuals (Saito et al., 2019^[54]). These reforms place greater emphasis on home care and adult day-care and strengthen their seamless integration with healthcare services, and have been shown to decrease the proportion of bedridden people and long-term medical care costs in regions where they were first implemented (Hatano et al., 2017^[55]). In **Germany**, adult day care is part of the mandatory care insurance, meaning that it covers costs, including transportation to the centre, up to certain maximum amounts for people with at least moderate care needs. However, the maximum insurance coverage is often insufficient, meaning that in practice, most recipients also have to make out-of-pocket payments (Siegl, 2025^[56]). There is social assistance for people who do not have care insurance or who cannot afford the out-of-pocket expenses (Rosenberg, 2025^[57]).

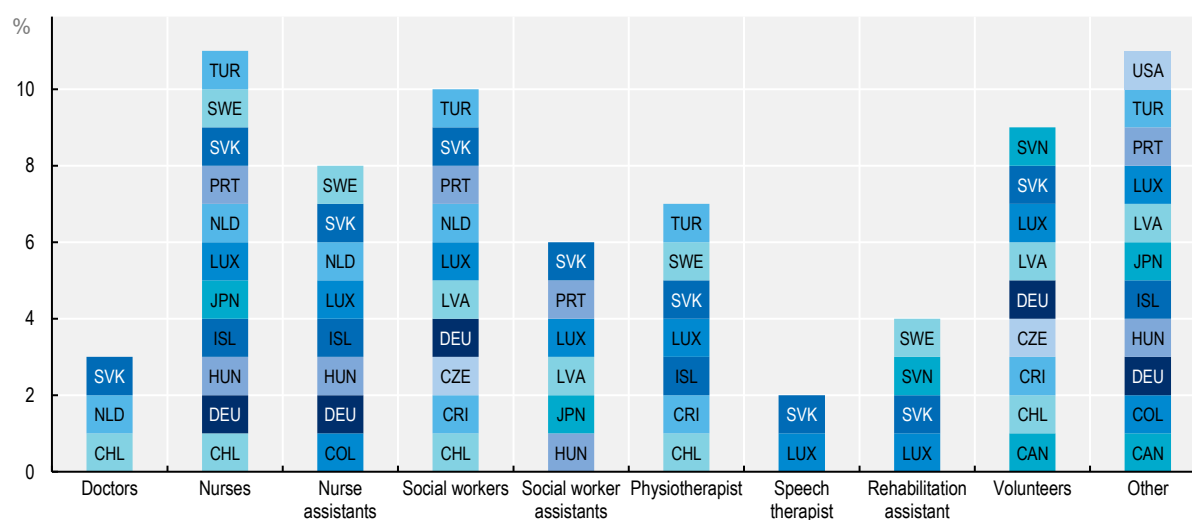
Funding for adult day care was recently improved in **Ireland**, and **Chile** has continued to expand beneficiaries. To improve funding for adult day care and *Meals on Wheels* community care services, Ireland just announced EUR 10 million in additional funding in 2024. Approximately 400 service providers, around 300 of which also offer adult day care, across the country are eligible to apply for up to EUR 25 000 each

in increased funding for improving their service provision. For example, they may use the money to purchase new equipment or upgrade their kitchens and other facilities, thus expanding and enhancing their care capacities. In total, the government invested around EUR 730 million in home support services in the last year, which includes day care and other measures to reduce and delay hospital and residential care admission (Grants and Funding, 2024^[58]). In general, older people in Ireland are referred to day care services by their doctor or nurse and need to pay a small fee for transport (for centres which offer transport solutions) and meals (Citizens Information, 2024^[59]). **Chile** launched the adult day care services in 2013 with 1 200 people attending only in the capital, while in 2023, this number reached 12 500 people, with 2024 seeing an increase by 14.5% of the budget in order to create 20 new centres and reach 52% of municipalities in the country (Ministerio de Desarrollo Social y Familia de Chile, 2024^[60]).

Nurses and social workers, together with volunteers, are the most often reported professionals in adult day care. Doctors are not often employed in adult day care: only four countries report having doctors (Chile, France, the Netherlands and the Slovak Republic). In France, only 30% of adult day care establishments had a doctor on site and for a limited time (0.4 full-time equivalent) (EHESP, 2019^[36]). Nurses, social workers and nurse assistants are the most common staff, together with physiotherapists. In Chile, initial evaluations of the adult day care centres suggested a need for better training about gerontology and teaching self-care. Many countries rely heavily on volunteers: 10 OECD countries cite them as part of the workforce in the questionnaire. Adult day care facilities face similar workforce shortages as the rest of long-term care due to poor salaries and working conditions such as temporary contracts (OECD, 2023^[61]), although day centre staff and volunteers seem to have higher job satisfaction and lower employee turnover than most other parts of the health and care sectors (Orellana, Manthorpe and Tinker, 2021^[62]).

Figure 6.2. Many countries have few healthcare staff in adult day care centres

Which of the following professionals are available in adult day care centres?



Note: The data for Canada refer to New Brunswick.

Source: OECD Questionnaire on Healthy Ageing and Community Care (2023^[52]).

6.2. Services and quality requirements for adult day care remain very heterogenous across the OECD

Services offered in adult day care often lack a health component

Across countries, adult day care services tend to focus on the provision of essential services for older adults (Table 6.2). Maintenance of personal hygiene, provision of meals and group activities are provided across all countries which responded to the survey and cited as mandatory in 60% of the countries. For instance, a study from Poland highlighted that adult day care services which are mostly offered in the social sector tend to focus on social isolation and sense of loneliness prevention, and maintenance of social activity (Mazurek et al., 2020^[51]). On the other hand, health and rehabilitation services are important yet not always offered, and if they are, they are not often mandatory. Health screening and medical care are available in 56% of countries, and mandatory in 22%. Rehabilitation services are offered in a slightly higher share, with 65% countries providing them, but less so on a mandatory basis (13%). Similarly, mental health services are available in 60% of countries, while only in 22% of countries are such services mandatory. Legal help is less likely to be mandatory, with only 20% of countries having it mandatory, but they are also offered in half of the countries.

Lack of national legislation or guidelines underpins this variability in the provision of services. Voluntary services will be included depending on the region, local authority, or type of provider in different countries. For instance, in the **United States**, Alabama requires only two services for adult day care, which are health monitoring and social services, while in Washington D.C., assistance for activities of daily living, health education and counselling, medication administration, nursing services, social services and transportation are required. D.C. also stands out positively through its *Adult Day Health Program* (ADHP), which provides a range of medically supervised adult day services to residents with chronic health problems (American Council on Aging, 2025^[63]). Services are determined based on individual needs, and the day care team consists of licensed professionals, including registered nurses and nutritionists. Additionally, the programme is covered by Medicaid and several private insurance schemes, limiting out-of-pocket costs for recipients (MBI Health Services, 2024^[64]). In **Poland**, there are no unified guidelines or coherent standards for day care (Mazurek, et al., 2020). In **Spain**, while there is a national legislation that includes adult day care as a service for older adults, regions are responsible for the provision and agreements on minimum standards nationwide have focussed on the ratio of professionals and the obligation to design a personalised plan for attendees, but not on the detailed services provided (Ministerio de Derechos Sociales y Agenda 2030, 2022^[65]). Some regions, like Castilla y Leon have enacted legislation to ensure that certain services are included across the region, while others leave it to the responsibility of local authorities to decide (Comunidad de Castilla y Leon, 2024^[66]).

Evidence highlights the strong health needs of attendees for adult day care centres. Older people attending day care centres tend to have significant health limitations and be at risk of social isolation. In the United States, for instance, over three-quarters needed assistance with at least one activity of daily living and 64% needed assistance with three to six ADLs, with bathing, dressing, walking, toileting and eating being among the most common. Participants also often had chronic conditions, especially high blood pressure (51%), diabetes (30%) and dementias (28%) (Lendon and Singh, 2021^[67]). In the United Kingdom, all attendees reported health conditions or disabilities impacting their life, while half reported at least two and two-thirds were at risk of isolation or depression (Orellana, Manthorpe and Tinker, 2020^[68]). In France, 80% of users had Alzheimer's and had moderate levels of dependency, indicating their need for assistance for bodily functions and meals (EHESP, 2019^[36]). Similarly, a study of informal caregivers in Bavaria, Germany, found that it is mostly informal carers who wish to use day care as a form of respite care and, as a result, use tends to be more likely for recipients having dementia and high care needs (Bösl et al., 2024^[69]). Data from Israel pinpoints that those more likely to be socially isolated tend to use day care. At the same time, compared with non-users, attendees are often younger, more likely to be

unmarried, live alone and have fewer functional limitations; it is thus likely that those with more severe limitations receive care at home (Iekovich and Carmel, 2011^[70]). Resnizky et al. (2012^[32]) confirm that adult day care users in Israel are more likely to be socially isolated, but according to them, 77% of users do suffer from problems of daily functioning, with 43% having serious disabilities. In Japan, although the need for social participation was the most important factor for people attending adult day care, 64% also listed hygiene and health needs as a key factor (Naruse and Yamamoto-Mitani, 2021^[71]).

Adult day care is often seen as mostly relevant to people with moderate care needs. However, **Germany's** pilot programme “Dying where you live and are at home”, which ran from 2020 to 2023, aimed to develop the availability of day care services in hospice and palliative care to support people in staying at home until the end of their life. As these people generally have severe care needs, the initiative required comprehensive integration of day care and other healthcare services, and the centres are often located in healthcare facilities such as hospitals or residential care homes (Ponz and Schoenmaeckers, 2021^[72]). The German long-term care system also offers specific day care facilities for people with dementia and other cognitive impairments, with trained specialists and other targeted healthcare services on-site (Siegl, 2025^[56]). Generally, the medical costs of day care are covered by health insurance, while recipients have to pay an out-of-pocket fee for meals, transportation, and specific investment costs (Federal Ministry of Health, 2025^[73]). Day care centres offer health screening services and there is stringent quality monitoring for inpatient long-term care facilities. The regularly published care quality reports of the Federal Medical Service (*Medizinischer Dienst Bund*) contain a separate chapter on quality inspections in day care facilities.

A limited offer of health services in adult day care might result in limited impact on outcomes. In Israel, day care use did not result in lower health utilisation in terms of visits to specialists, hospitals, etc. This was possibly related to the lack of health and rehabilitation services, as only around half the day care centres offer physiotherapy and occupational therapy services and their supply is very limited, and although 83% of centres had a nurse on hand, they were on average only present for 11 hours a week (Iekovich and Biderman, 2013^[74]; Resnizky et al., 2012^[32]). On the other hand, responses from the users of day care in Chile showed that it led to significantly lower healthcare expenditures (60%) due to lower consultations and medicine use (SENAMA, 2020^[75]). In Poland, a study of adult day centres highlights unmet needs with respect to health monitoring, such as blood pressure and sugar levels, due to a lack of nurses (Mazurek et al., 2020^[51]).

Adult day care in **Japan** now consists of four interconnected pillars, namely social participation, hygiene and health, exercise and eating habits, and family support. Studies investigating the relative importance of these four pillars for day care attendants found social participation to be most important, with 75% of respondents having needs in that domain, followed by health and hygiene with 64% (Naruse and Yamamoto-Mitani, 2021^[76]). Clients spend a significant share of their time at the day care facility on rehabilitation and health-related activities, and there must always be trained staff with professional qualifications in nursing and rehabilitation, among other areas, present to ensure that their high healthcare needs can be met. Adult day care services offer medical screenings and are co-ordinated with other health institutions, including hospitals, outpatient care, and home-visits by healthcare professionals (Naruse and Kobayashi, 2022^[77]). Japan also pioneers the use of technological innovations in care for older people, integrating telemedicine and remote monitoring with in-person day care services (TechSci Research, 2024^[78]) and employing assistive robotics to aid with meeting clients' healthcare needs (Takanokura et al., 2023^[79]).

Innovative solutions need to make adult day care more attractive and adapted to future needs. Studies have cited flexibility, personalisation and choice as important areas of improvement. Having more personalised attention and targeted health services, especially with respect to activities targeting cognitive and physical functioning, are perceived by professionals and users as particularly attractive. Working with a variety of other community organisations might facilitate having a diverse set of cultural, physical and artistic activities (Orellana et al., 2024^[47]; Bennett et al., 2023^[46]). Better co-ordination with healthcare is

important to help people manage their chronic conditions and to deliver preventive programmes. Providing adequate care and support for users with dementia would be of particular importance as previous OECD work (OECD, 2018^[80]) highlighted shortcomings in the availability of specialised day care for such older adults. For this, partnerships with specialised dementia associations might be helpful. More involvement of users and even co-design for the activities and organisation are also discussed as options for the future of day care to become more targeted, especially as some users describe day care services as paternalistic, with activities and offers decided by a top-down approach (Hagan and Manktelow, 2021^[10]; Wang et al., 2022^[81]). In addition, another needed enhancement is finding solutions for transport or addressing proximity to users, particularly to ensure access in underserved areas. For instance, in the **United States** (Georgia), mobile day care enables rural communities to have their own day care programme while “sharing” staff, which will travel between locations and sites that are open one to three days per week (Georgia Department of Community Health, n.d.^[82]).

Table 6.2. Services offered in adult day care are heterogeneous but tend to focus on basic needs

	Health screening and medical care	Rehabilitation, occupational and speech	Mental health support	Maintenance of personal hygiene	Physical activity	Help with legal	Group activities	Meals	Respite	Other
Canada (New Brunswick)	√ (v)	√ (v)			√ (v)		√ (m)	√ (m)	√ (v)	√
Chile	√ (v)			√ (v)						
Colombia			√ (m)	√ (m)			√ (m)	√ (m)		√
Costa Rica		√ (v)	√ (v)	√ (v)	√ (v)	√ (v)	√ (v)	√ (v)	√ (v)	
Czechia				√ (m)	√ (m)	√ (v)	√ (m)	√ (v)	√ (v)	
Denmark		√ (v)		√ (v)	√ (v)	√ (v)	√ (m)	√ (m)	√ (v)	√
France	√ (v)	√ (v)	√ (v)	√ (v)	√ (v)		√ (v)	√ (v)	√ (v)	
Germany	√ (m)	√ (v)	√ (v)	√ (m)	√ (v)		√ (m)	√ (m)	√ (v)	√
Hungary	√ (m)	√ (v)	√ (m)	√ (m)	√ (m)	√ (m)	√ (m)	√ (m)		
Iceland	√ (v)	√ (v)		√ (m)	√ (m)		√ (m)	√ (m)		
Ireland				√ (v)	√ (v)		√ (m)	√ (v)		
Japan	√ (m)	√ (m)	√ (v)	√ (m)	√ (m)			√ (v)	√ (m)	
Latvia				√ (v)	√ (v)	√ (v)	√ (m)	√ (m)	√ (v)	
Luxembourg	√ (v)	√ (m)	√ (m)	√ (m)	√ (m)	√ (m)	√ (m)	√ (m)	√ (m)	√
Netherlands			√ (m)							√
New Zealand	√ (m)		√ (v)	√ (m)	√ (v)		√ (v)	√ (m)	√ (v)	√
Poland										√
Portugal	√ (v)	√ (v)	√ (v)	√ (m)	√ (m)	√ (v)	√ (m)	√ (m)	√ (v)	√
Slovak Republic	√ (m)	√ (m)	√ (m)	√ (m)	√ (m)	√ (v)	√ (v)		√ (v)	
Slovenia				√ (m)	√ (m)		√ (m)			
Sweden	√ (v)	√ (v)	√ (v)	√ (m)	√ (v)	√ (v)	√ (v)	√ (v)	√ (v)	
Türkiye		√ (v)	√ (v)	√ (v)	√ (v)		√ (v)	√ (v)		
United States	√ (v)	√ (v)	√ (v)		√ (v)	√ (v)	√ (v)	√ (v)	√ (v)	√

Note: m=mandatory, v=voluntary. Data for Poland includes the social sector only, not health.

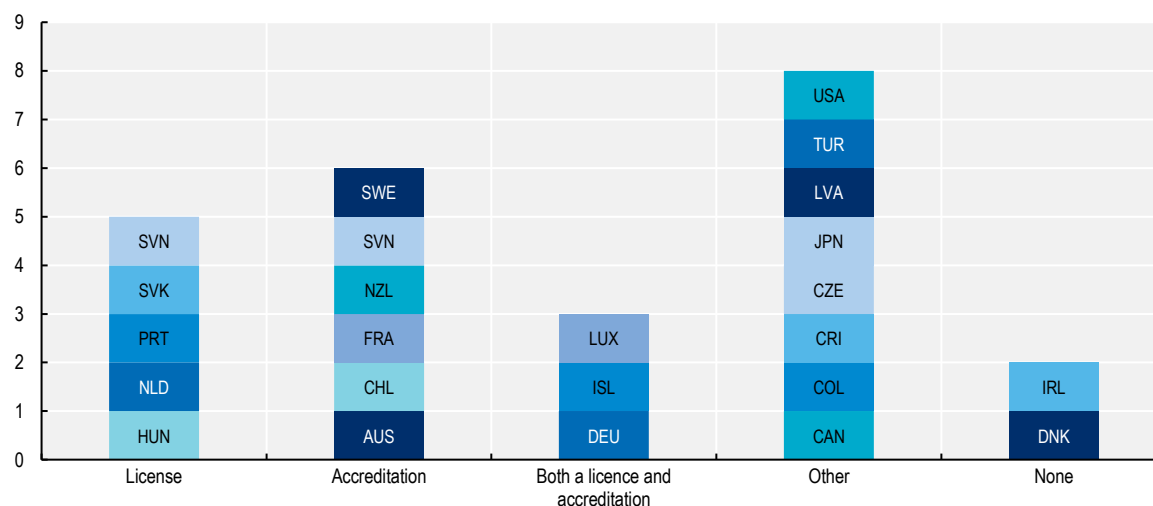
Source: OECD Questionnaire on Healthy Ageing and Community Care (2023^[52]).

Quality regulation is lagging behind in adult day care

Most countries have put in place regulatory practices to avoid abuse of older people in adult day care, although this tends to be more incipient than for institutional care. Two countries require no formal process of accreditation, licensing, registration or authorisation for the operation of day care providers (France, Ireland). The most widely used mechanism is a simple authorisation from the Ministry of Health or Social Services (Canada (New Brunswick), Colombia, Costa Rica, Japan, Türkiye) or registration (Czechia, Latvia). In **Luxembourg**, the Ministry for Family, Solidarity, Living Together and Reception of Refugees is in charge of the accreditation of the day care provider (agrément) while the National Health Fund (*Caisse Nationale de Santé*) concludes a contract with the providers allowing them to be reimbursed. Licensing is required in five countries while accreditation is in place in six and three countries require both. In the United States, requirements vary by state: 26 states require licensing only, 10 states require certification only, 4 states require both and 11 states do not require any. Both licensing and accreditation are usually more stringent regulatory practices in terms of quality than authorisation. Licensing requires that providers meet certain standards and that a public body authorises the provision of services for that provider. Accreditation involves an evaluation process that assesses the quality of care and services provided in LTC and gives recognition that providers are competent, comply with the regulations and meet certain quality standards in their services. The purpose of accreditation is to encourage quality and safety through a mix of compliance and quality elements, which can extend to continuous quality improvement. National accreditation bodies are often independent authorities (O’Keeffe and Siebenaler, 2006^[83]).

Figure 6.3. More than 40% of countries have no requirements or only registration for adult day care

Regulatory practices for adult daycare centres across OECD countries, by type



Note: The data for Canada refer to New Brunswick.

Source: OECD Questionnaire on Healthy Ageing and Community Care (2023^[52]).

The most common policy approach to safeguard and control quality in OECD countries focusses on having minimum acceptable standards with respect to the environment and minimum qualifications. This is the case for safety and the environment in 14 countries while minimum qualifications are required in 13 countries. **Colombia** has quite detailed guidelines in a resolution (*Resolución 00 024 – 2017 Ministerio de Salud y Protección Social*). Day care centres, in addition to complying with the sanitation, environmental and fire guidelines of the *Law 9 of 1979*, have minimum space requirements for the activity rooms and

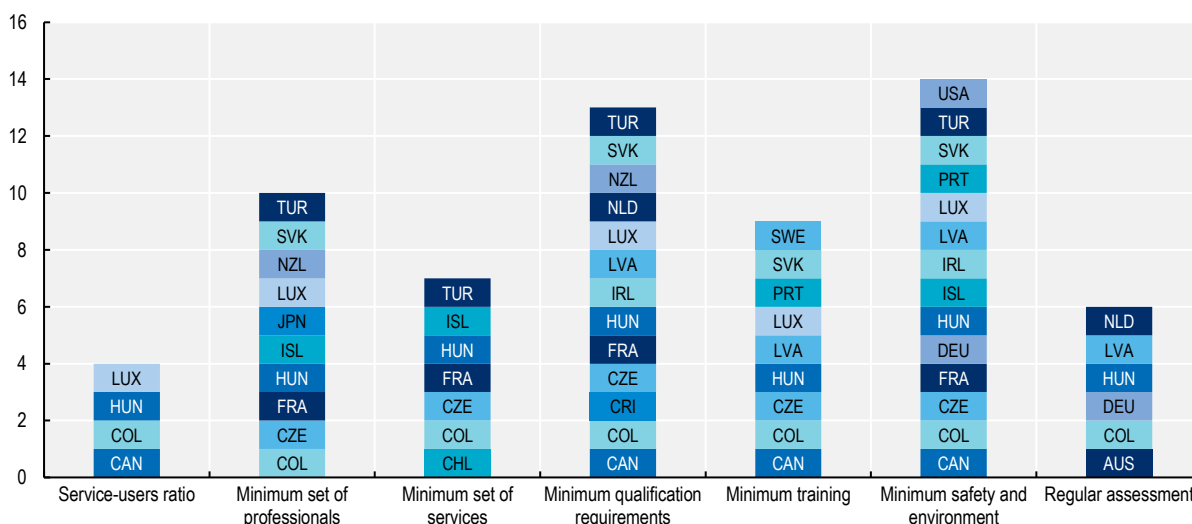
eating areas (1.5 m² per user), as well as specific requirements regarding accessibility and minimum sanitation facilities. With respect to the qualifications, there is a need to have people trained for emergencies and one qualified person for food preparation (per 20 older people). Similarly, there needs to be at least one qualified person responsible for cognitive stimulation and social interaction, one for physical activity, and one for cultural and recreational activities per 30 people. In **Hungary**, the *Decree 1/2000 (I.7.)* of the Ministry of Social and Family Affairs on the professional duties and operating conditions of social institutions providing personal care requires that day-care centres should be easily accessible by public transport, that the buildings should be barrier-free, and that the furniture and the institution is suitable for providing day care if it has rooms for community living, recreation, personal hygiene, personal laundry, and meals. In the **United States**, virtually all states have both orientation and initial and ongoing training requirements, but they are minimal. However, in-service training sessions of 4 hours per quarter for a total of 16 hours per year are required for all direct care staff. In Portugal, there must be a team with a technical director, activity leaders, drivers, and helpers, with minimum qualifications for the technical director and activity leaders.

Staff-to-user ratio requirements are less common in adult day-care, but many countries regulate the type of professionals and training. Four countries have indicated that they have official staff-user ratios. **Colombia** requires a minimum of one personal carer/nurse assistant per 20 older people (who are expected to be independent functionally and cognitively). Similarly, **Hungary** requires two caregivers (or nurses) for 50 users, according to *Annex 2 of Decree 1/2000* of the Ministry of Social and Family Affairs. In **Canada** (New Brunswick), a minimum ratio of 1 to 12 must be maintained. In **Luxembourg**, day care centres require a minimum of 3 FTE staff for carers and if there are more than 12 users, an additional half-time equivalent staff member is necessary for every four users.¹ While not directly mandating specific ratios, requirements on the type of professionals that must be available often lead to similar minimum personnel requirements in other countries. In the **United States**, for instance, most states specify minimum staff-to-participant ratios ranging between one to four and one to ten while some states require lower ratios when serving participants with greater needs but allow providers to self-determine what level of need requires the lower ratio. **Japan** requires at least one full-time manager, one social worker, one care worker (two or more if the number of care recipients is more than 15), one full-time or part-time nurse if the facility size can host more than 10 care recipients (if not at least one social worker or nurse). In **Ireland**, in addition to the requirement to have one full-time consultant and nurse, there needs to be one caregiver per 15 users and an additional 0.2 person if there are more than 15 users.

All but two countries impose sanctions if the minimum requirements are not fulfilled (Chile and Türkiye). In many countries, the sanction is severe and implies the loss of authorisation to operate, contract termination, or funding. This is the case in Canada (New Brunswick), Iceland, Ireland, Luxembourg and New Zealand. In **Costa Rica**, it implies the closure of the establishment. In other countries the sanction depends on the nature of the infringement: In **Colombia**, it can range from a verbal reprimand to suspension of authorisation or closure and there are yearly inspections. This is also the case in **Hungary** but there is also a time limit given to remedy the deficiency in terms of standards before moving to more severe sanctions.

Figure 6.4. Quality regulations focus on the environment and staff qualifications

Quality control regulations across OECD countries in adult daycare, by type



Note: The data for Canada refer to New Brunswick.

Source: OECD Questionnaire on Healthy Ageing and Community Care (2023^[52]).

Quality monitoring in adult day care could be improved

Countries use a variety of mechanisms for the quality assurance of adult day care, with quality standards being most frequently reported. Twelve countries report having quality standards, while four of them also have a quality framework (Luxembourg, the Netherlands, New Zealand, the Slovak Republic) and Slovenia only has a framework. In the **United States**, standards require that unannounced visits be made either at specified intervals or at any time to ensure compliance with rules or to investigate complaints. In addition, many states require day care providers to have an internal evaluation process. Seven countries have in place a system of external auditing. This includes **Germany**, which regularly publishes quality requirements that day care centres must meet, such as providing adequate transportation and meals, minimum opening hours of 6 hours a day for 5 days a week, always having a qualified nurse on site, and more. It also outlines the aims of day care, which include meeting users' social, emotional, and cognitive needs and enabling them to age autonomously and with dignity (GKV-Spitzenverband, 2023^[84]).

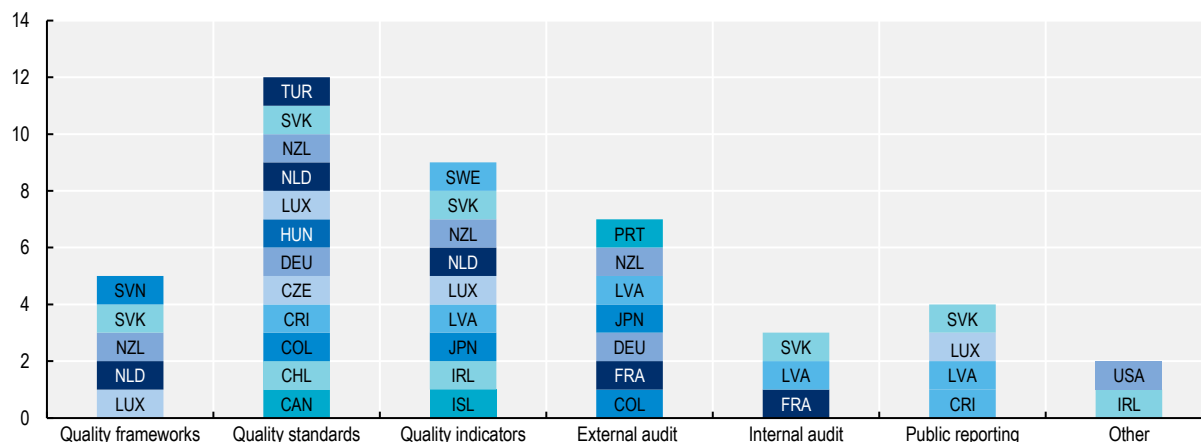
Nine countries collect quality indicators for adult day care. In terms of indicators, most of them focus on organising surveys for collecting information on user satisfaction (Iceland, Latvia, Luxembourg, Slovenia, the Slovak Republic, Sweden). While it is important to monitor the users, such indicators might be constrained by low response rates and might not always be informative if carried out internally (Cès and Coster, 2019^[85]). In addition, analysis of the correlation of user satisfaction with indicators of the quality of long-term care suggests that family and user satisfaction correlate only slightly with quality-of-care indicators, based on user outcomes on autonomy and patient safety and any quality-of-life deficiencies (Palimetaki, Woutersen and Pot, 2023^[86]). In **Japan**, user outcomes are monitored in terms of their condition and facilities need to keep the response to complaints as well as have monitoring mechanisms for abuse. In **Luxembourg**, every two years an evaluation report is published monitoring user outcomes including pressure ulcers, falls, nutritional follow-up and pain.²

Public reporting is rare and only available in a few countries. In **Latvia**, *Regulation No. 338³ (13 June 2017)* specifies that there should be reporting on user satisfaction and the provider's self-assessment. Public reporting of long-term care indicators has been associated with improving quality over time (Poldrugovac

et al., 2022^[87]). In **Poland**, legal provisions do not specify the standards and principles of the functioning of day-care centres, including, for example, required infrastructure, qualifications of the personnel, and standards regarding the number of attendees per worker. Day-care centres also do not have a formalised way of assessing their functioning (Mazurek et al., 2020^[51]). In **Luxembourg**, while the reports on outcomes are published highlighting the share of users experiencing adverse events, there is no disaggregated information by provider.

Figure 6.5. Quality standards are the most prevalent mechanism while audits and public reporting exist less often

Mechanisms for the quality assurance of adult day care across OECD countries, by type



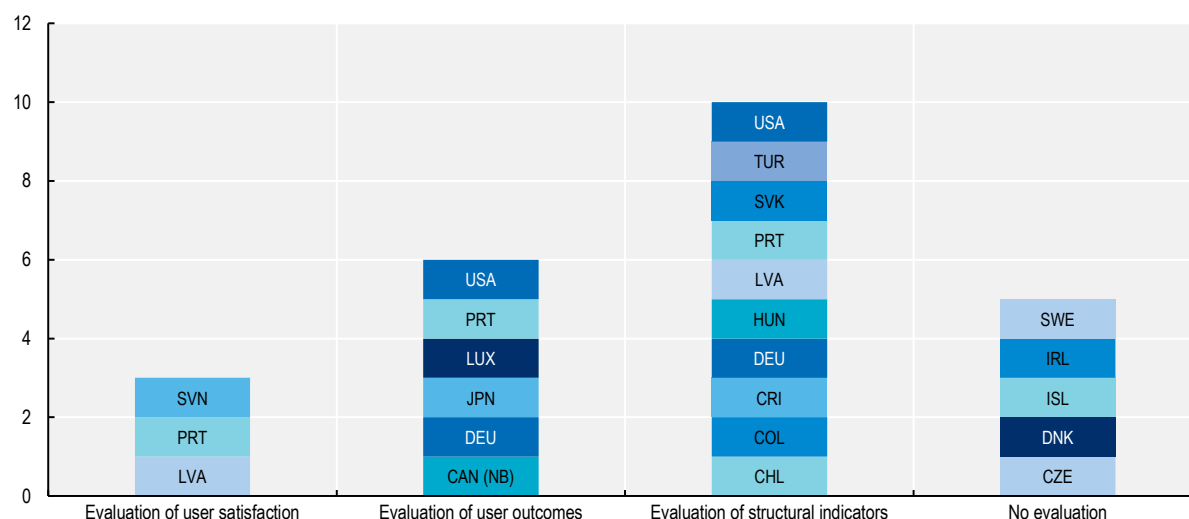
Note: The data for Canada refer to New Brunswick.

Source: OECD Questionnaire on Healthy Ageing and Community Care (2023^[52]).

Across the OECD, evaluation of adult day care centres is scarce and focussed on structural indicators. Over half of the countries focus on structural indicators. **Colombia** requires reporting that the building complies with safety standards, the qualifications of the director and staffing levels in total and their shifts and sends an annual plan for centres to be inspected. In addition, the resolution includes reporting on users that have a care plan, which should be reviewed every six months and reporting any changes to the healthcare sector and on evaluations on the functional capacity of users to be carried out on a yearly basis. One-third of countries do not perform regular evaluations of day care. Close to 40% of countries have an evaluation of structural indicators. Only three countries perform an evaluation of user satisfaction (Latvia, Portugal, Slovenia). This can be challenging given the growing desire from users to ensure the responsiveness of services and more people-centredness. Just under 30% of the countries perform evaluations of user outcomes. Such outcome indicators would be desirable as they represent changes in health status and conditions (physical and cognitive functions) attributable to care provided or not provided and can give directions for desirable results of care provided to residents and beneficiaries. In the **United States**, a study of adult day care centres shows that they collect clinical data infrequently and less than 20% collect quality of life indicators while just over a third indicated that the state required them to collect data on cognitive impairment (Sadarangani et al., 2022^[88]). On the other hand, autonomy levels are measured often with 88.1% reporting that they screened for users' abilities to carry out activities of daily living and 72.3% screened for instrumental activities of daily living, with just under half being state-mandated (Sadarangani et al., 2022^[88]). A large proportion (74.6%) screened for fall risks, but most did not track actual falls, while depression was screened for in just under half and pain level in over a third (Sadarangani et al., 2022^[88]).

Figure 6.6. Evaluation of adult day care is often not very user-centric

Adult daycare centre evaluation across countries, by type of indicator(s) used across OECD countries



Note: The data for Canada refer to New Brunswick.

Source: OECD Questionnaire on Healthy Ageing and Community Care (2023^[52]).

6.3. Innovative residential solutions are emerging as an option to make communities more age-friendly

In addition to individual homes, residential buildings can be designed and adapted to help older people maintain independence and age in place. OECD countries are developing a number of innovative living arrangements which include small-scale living, shared housing arrangements, intergenerational living, senior villages, the Green House model, and dementia villages (Brouwers et al., 2023^[89]). Such innovative models of living aim to create small-scale and/or homelike environments and overcome the shortcomings of nursing homes in terms of being impersonal. One of the underlying ideas is that the physical, social, and organisational environments of living arrangements is important for achieving positive outcomes for residents. In addition, such living arrangements also have the goal of supporting autonomy, potentially delaying greater care needs, and improving quality of life for older people. Across OECD countries, different innovative housing models are emerging across countries and Table 6.3 reports which countries include intergenerational housing, community-led housing initiatives, and assisted living for older adults.

Table 6.3. Co-housing and intergenerational housing are available in one-third of countries

Co-housing programmes	Intergenerational housing	Assisted living
7	6	24
AUT*	AUS*	AUS
FRA	CAN*	AUT
NLD	DEU	CAN*
NZL*	JPN*	COL
PRT	NLD	CRI
SVK	POL*	FRA
	SVL	DEU

Co-housing programmes	Intergenerational housing	Assisted living
7	6	24
SWE*		HUN
		ICE
		IRL
		JPN
		LVA
		LUX
		NLD
		NZL
		NOR
		POL
		PRT
		SVK
		SWE
		CHE
		TUR
		GBR
		USA

Note: *=at subnational level.

Source: OECD Questionnaire on Healthy Ageing and Community Care (2023^[52]).

6.3.1. *There is renewed interest for people-centred settings with promising results in terms of health and quality of life*

Shared living arrangements such as co-housing or co-operatives were reported in about one-third of OECD countries. In co-housing or co-operative programmes, people live in residential buildings with common areas shared by all tenants, where social activities are organised to support tenants and to involve them in the social life of the building. Services can include support with housekeeping and activities to socialise with other tenants, which can be particularly helpful for older people who might have limitations and be particularly exposed to the risk of loneliness. They exist at the national level in France, the Netherlands, Portugal and the Slovak Republic, and at the subnational/local level in Austria, Denmark, the Netherlands, New Zealand, the Slovak Republic and Sweden (OECD questionnaire, 2023). The programmes are often led by the third sector and civil society, but public subsidies are available to fund such initiatives. In France, Portugal, the Slovak Republic and Sweden, there is public funding for the organisation of services and social activities within community-led housing options. Additionally, in Portugal and the Slovak Republic, public funding is also available to provide financial support for less privileged groups, to incentivise their participation in such programmes (OECD questionnaire, 2023).

While they constitute a small share of living options for seniors, there is renewed interest in such forms of living. In **Denmark**, there are 250 co-housing communities exclusively for older people and, in co-operation with municipalities, most of the facilities (55%) were established as rental social housing and tend to have around 20 dwellings in the form of cluster houses with a common house kitchen and a combined dining and living room (Pedersen, 2015^[90]). In comparison, there are 19 established co-housing communities in the **United Kingdom** and over 600 in **Germany** (Quinio and Burgess, 2019^[91]). In the **Netherlands**, the Ministry of Housing and Urban Planning issued specific guidelines on co-housing or so-called clustered housing options, anticipating a growing demand for senior housing and with the ambition to have 80 000 of such housing for seniors (Platform 31, 2023^[92]). Grants are available in the Netherlands to develop such construction and the guidelines point to the need for developing social spaces.

Co-housing has several benefits, but developing such solutions has been hampered by a number of challenges. Combatting loneliness is often found to be one of the main benefits associated with co-housing, along with improved mental and physical health. Studies also found a positive association with social support and emotional and economic security, although none of the studies had causal evidence (Carrere et al., 2020^[93]). Some of the challenges are that a certain involvement of all residents is expected in the running and maintenance of common areas, residents can run into conflicts or suffer from a lack of privacy, and many decisions usually require consensus. Developing co-housing projects for tenants, as it is the case in some countries such as Germany, the Netherlands and Sweden appears to favour the inclusion of less socially privileged seniors (Labit, 2015^[94]). Finding solutions to provide care support as residents age is also important, as they can help prevent people from leaving due to growing dependency needs (Platform 31, 2023^[92]).

Administratively, there might be a lack of funding, an inappropriate legal framework and support for developing such solutions (Quinio and Burgess, 2019^[91]). A research project *Collaborative Housing in a Pandemic Era* (CO-HOPE) looked at such solutions in Austria, France, Spain and Sweden and found that without adequate policy support, groups wanting to establish such co-operatives required lots of hours to secure funding and physical space and that many groups in society lack the resources to undertake such projects. Because of the lack of a legal definition, co-operatives cannot access certain benefits such as reduced interest rates or subsidies, particularly to finance common spaces. In France, the *law ALUR of 2014* created a legal status for collaborative housing and AGIR-ARRCO can subsidise common spaces for retired people (CO-HOPE, 2025^[95]).

Intergenerational housing options can be defined as residential solutions designed to host people of different ages, which often host older adults and younger residents (e.g. students), with the goal of fostering interaction and support across different generations and reducing isolation. There are different types of intergenerational housing, based on the number of spaces that residents share, which can span from gardens, garages, dining rooms and laundry rooms, to most of the housing environment. The type of intergenerational housing also varies in terms of ownership, with some initiatives being public (e.g. social housing), others being provided by private companies, and others being community-led. As older people often experience loneliness and isolation when living alone in their homes, existing evidence has shown that intergenerational housing arrangements can provide older adults with more social contacts and support a sense of community, reducing loneliness and isolation (Van Gasse and Wyninckx, 2023^[96]; Weeks et al., 2019^[97]; Pedersen, 2015^[90]). Older people can also benefit from living in intergenerational housing by receiving help with daily tasks such as household chores and transportation (Put and Pasteels, 2021^[98]) while younger people benefit from the low-cost accommodation (Quinio and Burgess, 2019^[91]).

Nevertheless, challenges also arise in the setting of intergenerational housing. Privacy concerns and cultural differences among residents have been highlighted by recent literature as possible concerns to consider when planning for intergenerational housing (Van Gasse and Wyninckx, 2023^[96]). There have also been concerns regarding the acceptance of the concept of intergenerational housing among the general population, which may have represented a barrier to the establishment of such projects (Weeks et al., 2019^[97]). Decision making processes sometimes also create difficulties, as they can become complex and time-consuming due to the higher number and variety of people involved in the residential environment (Leviton-Reid and Lake, 2016^[99]). Finally, older people tend to develop additional social and health needs, which might in some cases pose challenges within the residential environment over time, putting a heavier burden on the younger residents (e.g. people developing dementia, severe depression or other forms of mental or physical health issues requiring more intense and professional support) (Weeks et al., 2019^[97]).

Examples of multigenerational housing exist in several countries and are growing in recent years. For instance, in **Austria** (Tyrol), intergenerational housing schemes have been established in many places to bring together older and younger generations: the Housing for Help (*Wohnen für Hilfe*) project, for instance,

promotes shared accommodation, mutual assistance and intergenerational dialogue (OECD questionnaire, 2023). Intergenerational housing also exists in **France**, often in the form of social housing where students, young workers, families and older adults share common living areas. One example of intergenerational housing is the “Cayol residence” (*Résidence Cayol*), a residential building that aims at fighting isolation and loneliness while providing affordable housing to residents of different ages. A dedicated webpage has been set up on the website of the French Government to provide information on the opportunity of living in intergenerational housing (French Government, 2024^[100]). Since 2021, there has been additional government support for inclusive housing, which includes intergenerational housing facilities, in the form of the Shared Living Assistance (*Aide à la Vie Partagée*, AVP). This aims to support older people with some care needs to remain more independent and retain a home environment while benefiting from high-quality and long-term support on-site and building intergenerational ties outside of their family. In total, EUR 20 million in funding was set aside for around 600 projects during the first phase (Ministère du Travail, 2021^[101]). In the **Netherlands**, numerous multigenerational social housing projects exist, with older people and young students living in the same buildings, supporting each other and enabling each other to be independent. For instance, the *Humanitas retirement home* in Deventer hosts students and older people. Students are allowed to live in apartments rent free, in exchange for spending 30 hours helping older residents and keeping them company. Another multigenerational social housing programme in Beekmos allows older people and young mothers to live together and support each other in affordable housing. The social housing is located in the city centre to allow older people to easily reach the services they need (International Observatory on Social Housing, 2023^[102]). In Canada, HomeShare is available in several cities and matches older adults over 55 years-old with a spare bedroom with post-secondary students.

Intergenerational houses are particularly well-established in **Germany** with around 530 establishments across the country with significant support and funding from the federal programme for multigenerational houses enacted in 2021, especially for structurally weak regions. Eligible facilities can get federal funding of up to EUR 40 000 annually from 2021 to 2028 for material and personnel costs (Bundesministerium für Familie, 2020^[103]). However, the German multigenerational houses usually do not qualify as housing facilities but primarily serve as community spaces for facilitating structured and unstructured intergenerational exchanges through various projects and events.

Data on the number of multigenerational housing projects, the number of people living in them, and the funding systems are not widely available. Among the 29 countries that participated in the *OECD Questionnaire on Healthy Ageing and Community Care*, only four countries reported information on the funding systems (Germany, Japan, Poland, the Slovak Republic), reporting that in most cases, intergenerational housing programmes rely on subsidies to fund such projects (OECD questionnaire, 2023).

Retirement villages are another form of communities built to cater to the needs and lifestyles of older people, enabling residents to live independently while enjoying a sense of community and having access to a range of services. Villages tend to require a membership fee and tend to be self-funded, although there are some donations, while services are run by a mix of volunteers and staff, allowing for free or low-cost services (Hou and Cao, 2021^[104]). They have been found to improve well-being, a sense of purpose and reduce social isolation (Hou and Cao, 2021^[104]). The first village model opened in the United States, which is the country with the largest number of retirement villages in the world, with around 18 810 communities, followed by the United Kingdom with 3 366; Australia with 2 200; and New Zealand with 488 (Russell, McIndoe and Schulze, 2024^[105]). Ownership forms for retirement villages include some form of an outright purchase model, like in Australia, the licence to occupy model (common in New Zealand, Australia, and the United Kingdom), and a rental model (common in Canada, the United States and Germany) (Russell, McIndoe and Schulze, 2024^[105]). Sustainable long-term financing appears to be a challenge as it relies extensively on membership fees (Scharlach, Graham and Amanda Lehning, 2012^[106]). Promoting other forms of acquiring access (loans, leases, company options), having better building standards and support for the rights of older people navigating disputes with retirement

village operators have been recommended in Australia (Travers et al., 2022^[107]). In **Canada** (Québec), tax credits are available for such options to pay for services (meal preparation or delivery services, nursing care services, home and personal care services) (Wyonch, 2024^[108]).

6.3.2. Assisted living for older adults is widely available, but it often requires out-of-pocket contributions

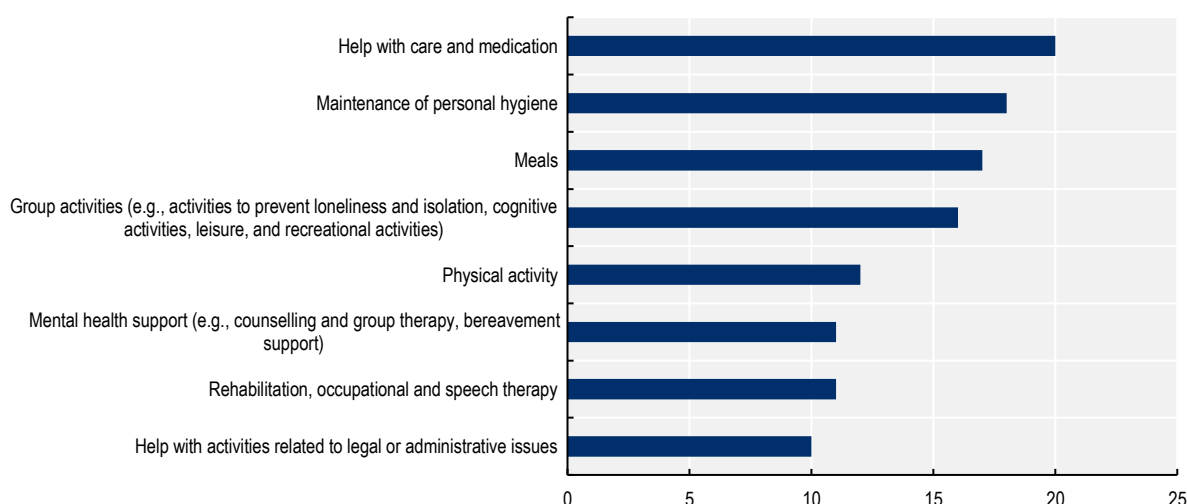
Among OECD countries, assisted living facilities are quite widespread. Assisted living refers to housing options where older people can receive help with activities of daily living and instrumental activities of daily living. Many countries have such an option available, with 24 out of 26 OECD countries reporting the existence of assisted living as of 2023. The services received can vary based on needs and on the fees paid by residents. Among the services available in assisted living facilities, help with care and medication, maintenance of personal hygiene, provision of meals, and group activities are the most common, with between 66% and 83% of OECD countries reporting the availability of such services in assisted living facilities. Services related to physical activity and rehabilitation, mental health, and support with legal and administrative tasks are less common, with less than 50% of OECD countries reporting such services in the *OECD Questionnaire on Healthy Ageing and Community Care*. In general, assisted living is a more cost-effective solution for people with moderate care needs who do not require the degree of care offered by nursing homes and allows residents to maintain a higher degree of autonomy, but it is still often unaffordable for the low-income older people (Christiansen and Sompayrac, 2015^[109]).

There is a growing demand for assisted living facilities across OECD countries. In Canada, there appears to be a steady growth over time: for instance, the number of licensed assisted living facilities (mostly private for profit) increased in Ontario from 383 in 2012 to 768 in 2020 (Manis et al., 2022^[110]), with 37% of people 75 and above living in a residence for senior citizens (Hou and Ngo, 2021^[111]). In the United Kingdom, there are more than 500 000 units for supported living properties and by 2040, it is expected to require an additional 167 329 units (Ryeder et al., 2024^[112]). In Spain, senior living has 70 types of resorts, with 3 650 places, targeting not only seniors near big cities but also the coastal areas for foreigners wishing to retire in Spain and forecasting high growth in this sector (Observatorio Sectorial DBK, 2023^[113]). In the United States, more than 900 000 people are in assisted living (Zimmerman et al., 2024^[114]), up from 800 000 10 years ago and projected to continue increasing (Fabius et al., 2022^[115]). Assisted living is also quite prevalent in Germany but there is no general register of facilities or people living in them, also because a clear definition is lacking. Rothgang et al. (2018^[116]) estimated around 300 000 assisted living units (i.e. individual rooms or flats) and 3 891 assisted shared houses across Germany, with large differences between regions. These numbers are likely to have increased, since a significant share of providers reported planning to expand their assisted living offers. For assisted shared housing, a large share of the offer is targeted towards people with dementia, meaning that there are only a few facilities for older people with other care needs. (Klie et al., 2017^[117]).

In some cases, national and local governments are developing legislation and guidelines to incentivise and improve the provision of assisted living facilities. In Ireland, the 2022 Framework Toolkit, *How to Develop a Housing with Support Scheme for Older People*, has been published to share insights from the Dublin City Age Friendly project. It serves as a guide primarily for social housing providers, including local authorities and approved housing bodies, while also being a resource for private developers interested in adopting this model. The goal of the ongoing project is to reduce the number of admissions to residential care facilities by offering a safe, affordable, and community-integrated alternative for those with lower care requirements (OECD questionnaire, 2023). In Austria, assisted living is available and several recent initiatives have aimed at making assisted living facilities more accessible and safer for older people. In some cases, for instance, homes have been provided with ambient assisted living systems, namely technological tools able to support older people to freely move around the housing environment (OECD questionnaire, 2023).

Figure 6.7. Help with ADLs and IADLs are the most common services provided in assisted living facilities

Number of countries providing a given type of services in assisted living facilities



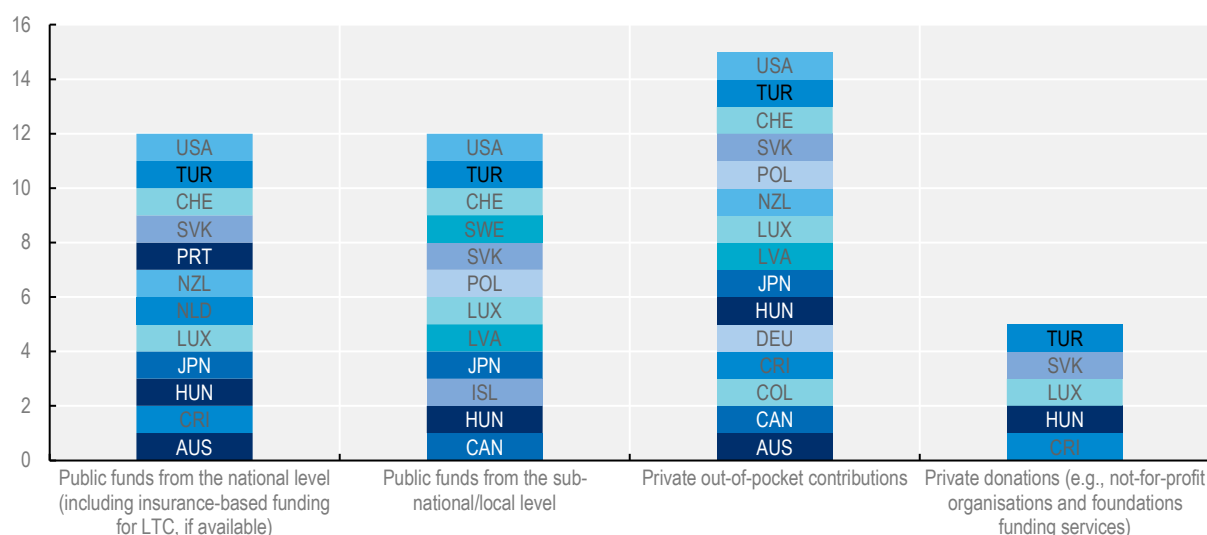
Note: N=24.

Source: OECD Questionnaire on Healthy Ageing and Community Care (2023^[52]).

While options for assisted living are often private, public funds can be used for staying in such facilities in several countries. Among 24 OECD countries providing information on the funding methods for assisted living facilities, 12 reported that public funding at the national or local level is used to fund assisted living facilities. In most countries (15 out of 24), out-of-pocket spending is required to receive services in assisted living facilities, while only five countries reported private donations among the funding sources for such services (OECD Questionnaire, 2023). While there are some subsidised or NGO-run facilities specifically for low-income people and they report good outcomes in terms of health and residents' functioning, demand for affordable assisted living far exceeds the supply (Fonda, Clipp and Maddox, 2002^[118]; Jenkins, Carder and Maher, 2005^[119]). In **Colombia**, for instance, all assisted living facilities are privately provided by construction companies (OECD questionnaire, 2023). In the **United States**, most residents finance it out of their private resources (Fabius et al., 2022^[115]). Medicaid does not cover board and lodging, but the states have waivers that can be used to pay for support services in assisted living facilities. In France, people can use their benefit to fund the services of assisted living (Allocation Personnalisée d'Autonomie) and can also apply for a special housing subsidy. At the same time, the majority of facilities (*residences autonomie*) are public with only 29% being private out of 2 260 residences with availability for 114 120 people in 2019 (DREES, 2023^[120]). In **Germany**, while private contributions are required for assisted living, the exact price for users depends significantly on the type of offer, and social security also often covers a significant part of the cost. Estimates suggest that on average, assisted living requires out of pocket payments of EUR 1 368 per month, which is similar to nursing home care but significantly higher than traditional home care. Generally, most assisted living providers use their own funds and various aids, particularly from the federal states and the central insurance association (GKV-Spitzenverband) to cover start-up costs. Running expenses are largely financed by patients' out of pocket contributions as well as care and health insurance and social service proceeds, with some subsidies (e.g. for shared living facilities) (Kremer-Preis and Mehnert, 2019^[121]). While there is often public support available, the complex landscape of grants, aids, and subsidies across Germany and the many different types of assisted living without a clear definition or grouping can make it difficult for providers to know which resources they qualify for and how to get them.

Figure 6.8. Public funds are a common of funding for assisted living facilities, but out-of-pocket contributions are often needed

Type of funding for assisted living facilities, across OECD countries



Note: The data for Canada refer to New Brunswick. N=24.

Source: OECD Questionnaire on Healthy Ageing and Community Care (2023^[52]).

Monitoring and enforcement of quality might be a challenge due to the governance and funding arrangements for assisted living. A lack of quality monitoring is becoming a challenge in many countries because well-trained staff are in short supply to meet the increasing number of people in assisted living facilities who have complex needs. In the United States, 70% of the residents of assisted living facilities have cognitive impairment and three-quarters need assistance with bathing, while only 71% of facilities assist with nursing (Zimmerman et al., 2024^[114]). People in assisted living facilities have a much higher rate of hospitalisations, odds of death, falls, and emergency visits than people living in the community, thus calling for significant geriatric expertise (Bartley et al., 2018^[122]). To strengthen the quality, in France, a study issued a number of recommendations: reinforce the competences of the staff to be able to prevent and detect autonomy loss and adverse events, enhance the co-ordination with doctors for people developing cognition problems and pathologies, strengthen social links inside and outside the facility and evaluate the impact of concrete actions to foster social connectedness (Anesm, 2018^[123]).

Most OECD countries have quality mechanisms in assisted living facilities, but the type of mechanisms varies across countries (OECD questionnaire, 2023). Among the 24 OECD countries reporting information on the quality mechanisms, quality standards (Canada, Costa Rica, Hungary, Japan, Luxembourg, the Netherlands, New Zealand) and mechanisms for external or internal audit (Canada, Japan, Latvia, New Zealand, Portugal, Türkiye) are the most common. Other quality mechanisms are less common, including quality frameworks and public reporting (e.g. mandatory quality reports) available in four countries, and quality indicators in three countries (OECD questionnaire, 2023).

The absence of an agreed framework adds the challenge of controlling the quality of assistive living. In the **United States**, it appears that regulation for assisted living was often the responsibility of several agencies. There are few processes in place, little in terms of public information related to data requirements of adverse events, and of offering assistance to providers to understand regulations (Kaskie et al., 2021^[124]). In **Germany**, the wide variety of different types of assisted living and lack of a uniform definition makes quality monitoring and evaluation difficult, but efforts towards more consistent quality standards and enforcement are being made (Schölkopf, 2024^[125]). There are often quite stringent regional quality

requirements or for specific kinds of assisted living, but a uniform, nationwide quality framework is missing (Rothgang et al., 2018^[116]). The “*Freiburg model*”, a network of assisted living communities for people with dementia and care needs, developed a quality framework based on the seven principles of citizen engagement, shared responsibility, openness, central values (dignity, self-determination, social participation), equal standing of the professions, community focus and domesticity. While members of the network are obligated to apply this framework and many other assisted living providers use it, it is far from universal (Klie et al., 2017^[117]). In August 2025, the federal cabinet approved a law which contains new regulations for long-term care in assisted living arrangements. The law’s aim is to create attractive and legally secure options for operators to provide outpatient nursing care in a variety of new living arrangements. In some countries, a more structured approach is undertaken. In **New Zealand**, audits are required for certification which is reassessed between one and four years. The audits are undertaken by agencies designated by the Ministry of Health using 50 quality standards and risk ratings are granted as well as corrective action if necessary. In the **Netherlands**, the same quality framework applies to nursing homes and assisted living facilities and inspections are undertaken by the Health and Youth Care Inspectorate (*Inspectie Gezondheidszorg en Jeugd*) which reports their outcomes on their website.

In addition to traditional assisted living facilities, the Green House model is available and can function as a small, personalised form of assisted living or nursing home. The model was introduced in the early 2000s in the **United States** with the goal of a more person-centred approach and has proved successful at identifying clinical changes of residents and improving their mental well-being. Green House model facilities are small-scale designs with private rooms, an open kitchen, and shared dining and outdoor space, where staff have more direct engagement with residents and promote independence (Waters, 2021^[126]). According to the Green House project website, there are about 400 such houses in the United States. Adoption of Green House models is also associated with reductions in Medicare spending for hospital costs and stays in skilled nursing facilities (the THRIVE Research Collaborative, 2016^[127]). In addition, several studies reported improved quality outcomes for residents of Green House facilities which are likely to impact overall costs and staff monitoring: residents in Green House facilities had a lower fall rate and a lower likelihood of pressure ulcers (1.9%) and using catheters (Williams and Joshi, 2023^[128]).

Those alternative living arrangements have proven to be particularly suitable for people with dementia. Promising results were found on the physical functioning, social participation, and quality of life for older adults living in small-scale home-like facilities compared to those living in conventional nursing homes (Krier et al., 2023^[129]). People with dementia displayed less aggressive behaviour in such settings and there was a lower use of antipsychotics, which can have a significant impact on care costs (Verbeek et al., 2014^[130]). Dementia villages and promoting people with dementia to live at home and at the community are important elements of a people-centred approach. A study of an innovative dementia-friendly support in the community in **Ireland** showed that personalised care in the community resulted in lower costs than using residential care (O’Shea and Monaghan, 2016^[131]). The **Netherlands** are another good practice example regarding dementia villages, which are self-contained communities that replicate real towns but provide 24/7-supervised care specialised for people with dementia. Hogeweyk, near Amsterdam, was the world’s first dementia village in 2009 and today houses 152 residents with severe dementia, with two carers per inhabitant who are dressed in everyday clothing to reduce stigma and make it feel more like any other village (Dementia Village Associates, n.d.^[132]). While the construction costs of EUR 19 million were mostly covered by the Dutch Government, residents still need to pay the usual costs of staying in a nursing home of up to EUR 5 000 per month. However, considering the unique setting and high satisfaction of inhabitants and workers, it is still largely considered more cost-efficient than standard nursing homes (Godwin, 2015^[133]).

Foster care for older adults aims at providing older adults with the possibility to live in a family setting receiving personalised support, and it can be an alternative to nursing homes or assisted living facilities for care recipients with moderate-to-severe long-term care needs. The foster family is usually approved by the local government or other institutional actors and receives a fee in exchange for supporting and hosting

one or more (e.g. a couple) older people and involves them in their family life. Foster care for older adults is available in a limited number of OECD countries. Only Canada, Costa Rica, France, Germany and the United States reported having such opportunities, out of 21 countries that replied to the question as part of the *OECD Questionnaire on Healthy Ageing and Community Care*. In **Portugal**, while such programmes are currently not available, planning is underway to offer foster care for older adults (OECD questionnaire, 2023).

Developing foster care for adults has come with challenges. For instance, in **France**, the government has attempted to expand foster care services for the older people, though with limited success. A brief report in 2008 proposed several directions for improvement, highlighting significant challenges, particularly the undervalued image of the sector, the difficulty in finding substitutes to allow caregivers time off, and recruitment issues. Among its recommendations, the report suggested establishing a support structure (potentially a public entity, possibly in partnership with NGOs and the private sector), utilising “*Chèque emploi service universel*”-vouchers, and accelerating the validation process for family caregivers. Additionally, it advocated for the creation of a quality label for foster care (Rosso-Debord, 2008^[134]).

Some country-specific experience can also represent a helpful learning opportunity. For instance, in the **United States**, recruitment efforts have proven most effective when targeting individuals with similar characteristics. Therefore targeted recruitment towards specific professions, groups or geographical areas were implemented (Casey family programs, 2014^[135]). Key recruitment strategies also involve hiring programme co-ordinators to lead community-based recruitment teams and designating staff specifically to engage with family members. Agencies frequently collaborate with NGOs to locate foster caregivers (United States Joint Economic Committee, 2020^[136]). In the **United Kingdom**, local authorities have partnered for advertising campaigns, with mixed levels of success (Baginsky, Gorin and Sands, 2017^[137]).

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Notes

¹ <https://www.medicaidlongtermcare.org/how-to-apply/wait-lists/>.

¹ Staffing requirements are under Article 46 of <https://legilux.public.lu/eli/etat/leg/loi/2023/08/23/a562/jo>.

² <https://aec.gouvernement.lu/fr/docetchiffres/rapportbiennalqualite.html>.

³ <https://likumi.lv/ta/en/en/id/291788-requirements-for-social-service-providers>.

The Economic Benefit of Promoting Healthy Ageing and Community Care

Without a stronger focus on healthy ageing, population ageing will have a strong impact on health and long-term care expenditures. This report discusses how a stronger focus on preventive interventions and reablement helps promote healthy ageing. It highlights that promoting healthcare closer to people and more integrated care are cost-effective interventions for older people. Appropriate and adapted housing and sufficiently affordable home care are also necessary to ensure that people can age well at home. Yet, for some older adults, social isolation calls for innovative community solutions to be developed such as expanding day care and communal living with services.



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