INTERNATIONAL RESEARCH INSTITUTE — POLICY BRIEF

Healthcare Financing and System Reform in Ageing Societies

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Executive summary

The health systems of high-income and upper-middle-income countries are entering a period in which their financing arrangements — designed largely in the post-war decades for younger populations and acute episodic care — must carry a very different burden. The share of the world's population aged 65 and over is on a path from roughly one in ten today toward one in six by 2050, and among the oldest societies the ratio of retirees to working-age adults is set to reach levels without historical precedent. This is not a distant projection but a demographic fact already embedded in the current age structure: the people who will be old in 2040 are already alive and, in most countries, already middle-aged. The policy question is therefore not whether costs will rise, but how they will be financed, by whom, and at what cost to fiscal sustainability and equity.

How old are we getting?

PERIOD	VALUE (%)
World, today	10
World, 2050	16.7
Oldest society, today	30

Population aged 65+ as a share of the total. 'One in ten' today rising toward 'one in six' by 2050; close to 'three in ten' already in the most-aged society (Executive summary; §1). Approximate.

This report examines the mechanics of that cost pressure and the reform options available. Our central argument is that ageing raises health costs through a compounding of three forces — longer lives, a rising prevalence of chronic and multiple conditions, and input prices (labour, drugs, devices) that grow faster than general inflation — rather than through the passage of years alone. Much of an individual's lifetime health spending is concentrated in the final period of life regardless of the age at which it occurs, which means that longevity shifts costs later rather than simply multiplying them. The distinction matters for policy: reforms that improve how the last years of life are managed, and that shift care from hospitals toward community and preventive settings, can bend the cost curve in ways that crude demographic extrapolation misses.

We find that financing strain is unevenly distributed. It is most acute in long-term care and pharmaceuticals, where public coverage is thinnest, cost growth fastest, and households most exposed to out-of-pocket risk. It is least tractable where the binding constraint is people rather than money: across most ageing economies the shortage of nurses, care workers and generalist physicians will limit capacity more than any budget ceiling. And it is most dangerous in the middle-income countries now ageing at income levels far below those at which today's rich countries grew old — a compression of the reform window that leaves little margin for gradual adjustment.

Our overall assessment is measured rather than alarmist. The fiscal arithmetic is demanding but not, on current evidence, unmanageable for well-governed systems willing to combine revenue reform, purchasing discipline and a deliberate reallocation of care away from the hospital. The greater risk is political: the reforms that matter are unglamorous, their benefits accrue over long horizons, and their costs are visible and immediate. Systems that delay will not avoid the adjustment — only make it later, more abruptly and less equitably.

Headline messages

- **Ageing compounds cost; it does not act alone.** The interaction of longevity, chronic-disease prevalence and above-inflation input prices drives spending growth. Isolated demographic projections that hold everything else constant systematically overstate the "pure ageing" effect and understate the role of technology and prices, which historically explain the larger share of health-spending growth.
- **Long-term care is the fastest-growing and least-prepared segment.** Public long-term care spending across advanced economies is on a trajectory that could roughly double as a share of GDP by 2050 on unchanged policy. Coverage is fragmented, reliant on unpaid family labour, and poorly insured against catastrophic cost — making it the segment most likely to force reform.

- **The financing-model debate is largely settled and largely beside the point.** Comparative evidence does not establish that tax-funded (Beveridge) systems outperform social-insurance (Bismarck) systems or vice versa on cost control or outcomes. Governance quality, purchasing arrangements, price negotiation and the breadth of the contribution base explain more of the variation than the headline model.
- **Workforce is the binding constraint.** A projected global shortfall of health and care workers — concentrated in, but not limited to, lower-income settings — means that capital and coverage expansions will be throttled by staffing. Migration, task-shifting, retention and productivity are the levers that matter most this decade.
- **Middle-income countries face a compressed window.** Several large economies are ageing faster, and at lower income per head, than the high-income countries did. They must build long-term care and chronic-disease financing systems from a thin base while their demographic dividend is still closing.
- **Out-of-pocket exposure remains a structural equity failure.** Even in wealthy systems, dental, pharmaceutical and long-term care costs push a non-trivial minority of older households toward financial hardship. This is a coverage-design problem, not merely a spending-level problem.
- **Prevention and care reconfiguration are the highest-return, slowest-acting reforms.** Shifting the locus of care from hospitals to primary, community and home settings, and investing in the compression of late-life morbidity, offer the most durable route to affordability — but they demand sustained investment before they yield savings.

1. Context and why it matters

For most of the twentieth century, health systems in industrialised countries were built around a particular reality: populations were relatively young, mortality was dominated by acute events and infectious disease, and the characteristic act of medicine was a discrete intervention — a surgery, a course of antibiotics, a delivery. Financing followed function: tax-funded national health services and contributory social-insurance funds alike were engineered to pool the risk of expensive but episodic acute care across a broad base of working-age contributors.

That world has receded. In the high-income countries, and increasingly in the large middle-income economies, the dominant health challenge is now chronic: cardiovascular disease, diabetes, cancer, dementia and musculoskeletal conditions managed rather than cured, often over decades and frequently in combination. Non-communicable diseases account for the large majority of deaths globally, and their prevalence rises steeply with age. Multimorbidity — two or more chronic conditions in the same person — becomes the norm rather than the exception among the over-75s. The characteristic act of medicine is no longer the intervention but the ongoing management of complexity across many providers and settings.

Demography sits underneath this shift. The global population aged 65 and over is expanding both in absolute numbers and as a share of the total, and the group growing fastest is the "oldest old" — those aged 80 and above, who consume health and long-term care resources at the highest per-capita rates. The oldest societies illustrate the destination: in the most-aged country, close to three in ten residents are already over 65, and the old-age dependency ratio — retirees relative to working-age adults — is approaching one-to-two. Southern Europe and parts of East Asia are on similar paths. The significance is fiscal as well as clinical: a shrinking working-age share must finance a growing dependent share through some combination of taxes, contributions and private outlays.

The demographic backdrop, by the numbers

INDICATOR	VALUE
World population aged 65+, today → 2050	1 in 10 → 1 in 6
Aged 65+ in the most-aged society today	≈3 in 10
Old-age dependency ratio nearing in the oldest societies — retirees to working-age adults	≈1 : 2
Annual global health spending — ≈ one-tenth of global output (§2)	USD 9–10tn

Why this matters beyond the health ministry is straightforward. Health and long-term care are among the largest and fastest-growing claims on public budgets in advanced economies, rivalling or exceeding pensions in their projected upward pressure.

Decisions taken now about coverage design, provider payment and revenue sources will shape sovereign fiscal trajectories, household financial security in old age, labour-market participation (as informal caregiving pulls working-age adults, disproportionately women, out of paid work), and the investment case for a large private sector spanning insurance, pharmaceuticals, medical technology and care provision. It is simultaneously a public-finance question, a social-policy question and a market question.

2. Market structure and scale

Global spending on health is large, concentrated and growing faster than the economy that funds it. Drawing on internationally comparable expenditure statistics, total health spending worldwide is on the order of one-tenth of global output — roughly nine to ten trillion US dollars annually in recent years — with high-income countries accounting for the clear majority despite holding a minority of the world's population. Spending is heavily skewed by age: in most systems, per-capita outlays for those over 65 run several times those for working-age adults, and outlays for the over-80s several times higher again.

The table below sets out an indicative segmentation of health-system spending for a representative advanced economy, expressed as approximate shares. These are **estimates** synthesised from the typical distribution reported across OECD systems; individual countries vary materially, and the ranges are wide by design. They are offered to show relative magnitudes and growth pressure, not to state any single country's accounts.

SPENDING SEGMENT	APPROX. SHARE OF HEALTH SPEND	RELATIVE AGE-SKEW	INDICATIVE COST-GROWTH PRESSURE	BASIS / CONFIDENCE
Hospital / inpatient acute	28–38%	High	Moderate	Established, cross-OECD averages
Outpatient & primary care	20–28%	Moderate	Moderate	Established
Pharmaceuticals & devices	15–22%	High	High	Established level; growth estimated
Long-term care (health + social)	10–18%	Very high	Very high	Estimate; definitions vary widely
Prevention & public health	2–6%	Low	Low–moderate	Established; often under-recorded
Administration & governance	3–6%	Neutral	Low	Established

The same segmentation, seen as shares of the whole:

Where the health money goes

SEGMENT	SHARE
Hospital / inpatient acute	34%
Outpatient & primary care	24%
Pharmaceuticals & devices	19%
Long-term care (health + social)	14%
Prevention & public health	4%
Administration & governance	5%

Indicative composition of health spend for a representative advanced economy; each segment plotted at the midpoint of the report's stated ranges — hospital 28–38%, outpatient & primary 20–28%, pharmaceuticals & devices 15–22%, long-term care 10–18%, prevention 2–6%, administration 3–6%. Estimates; see §2 and Methodology.

Two features of this structure drive the ageing-cost story. First, the segments with the steepest age-skew — long-term care and pharmaceuticals — are also those with the fastest underlying cost growth and the thinnest public coverage. Second, the hospital sector, though large, is not where the marginal ageing pressure is most efficiently absorbed; a substantial body of comparative work suggests much acute activity involving older patients could be prevented or managed in lower-acuity settings, which is why care reconfiguration recurs as a central reform theme.

On the financing side, systems can be grouped into a small number of archetypes, though most real systems are hybrids. The table below summarises the main models and their characteristic pressure points under ageing. Shares of revenue by source are **broad estimates** reflecting the modal case within each archetype.

FINANCING ARCHETYPE	PRIMARY REVENUE SOURCE	TYPICAL PUBLIC SHARE OF SPEND	CHARACTERISTIC AGEING PRESSURE POINT
Tax-funded national service (Beveridge)	General taxation	75–85%	Fiscal competition with other public priorities; waiting lists as rationing device
Social health insurance (Bismarck)	Payroll contributions	70–85%	Narrowing contribution base as workforce shrinks relative to retirees
Mixed / regulated multi-payer	Blended tax + premiums	55–75%	Fragmentation raises administration and weakens purchasing power
Predominantly private / out-of-pocket	Households + private insurance	Under 50%	Direct financial hardship risk concentrated on older, sicker households

How much of the bill the state carries

CATEGORY	LOWER BOUND (%)	UPPER BOUND (%)
Beveridge (tax)	75	85
Bismarck (payroll)	70	85
Mixed multi-payer	55	75

Typical public share of health spending by financing archetype (§2). Predominantly private / out-of-pocket systems fall under 50% and are omitted for scale. Broad estimates of the modal case; most real systems are hybrids.

The important analytical point is that the archetype label predicts far less about performance than is commonly assumed. Cost control, outcomes and equity vary widely within each category. What distinguishes the better performers is not whether they raise money through taxes or contributions but how they spend it: a strategic purchaser able to negotiate prices, set the benefit package on evidence and steer volume; a broad, stable revenue base; and governance that keeps procurement honest and capital allocation rational. Payroll-financed systems face a specific structural vulnerability as ageing proceeds — the contribution base shrinks relative to the beneficiary base — which is pushing several toward supplementary tax financing. But this is a design detail to be managed, not a verdict on the model.

3. What actually drives the cost curve

It is tempting to attribute rising health spending in ageing societies to age itself, and to project future costs by applying today's age-specific spending profiles to tomorrow's age structure. This "pure demographic" method is a useful lower bound but a poor forecast, and understanding why is central to sound policy.

The most important correction is **cost concentration at the end of life**. A large share of any individual's lifetime medical spending is incurred in the final one to two years before death, relatively independent of the age at which death occurs. Because longevity postpones death rather than abolishing it, much of the apparent "cost of ageing" is in fact the cost of dying being pushed to later ages. Where the final period is managed well — timely palliative provision, honest conversations about goals of care, less low-value acute intervention — the per-death cost can be contained even as the number of older people rises. This is why several careful studies find that "time to death" explains more of the variation in health spending than chronological age.

The second correction concerns **technology and prices**, which historically account for a larger share of health-spending growth in advanced economies than demography does. New drugs, devices and procedures expand what medicine can do, often at high unit cost, and their diffusion is only weakly disciplined by evidence of value. Labour, the dominant input, tends to track or exceed wage growth while resisting the productivity gains seen in goods-producing sectors — the classic "cost disease" of labour-intensive services. Because prices and technology matter more than raw demography, the levers that most affect the cost curve are those that discipline them — health-technology assessment, value-based pricing, competitive procurement, generic and biosimilar uptake — rather than anything that can be done about the age structure.

The third driver is the shift toward **chronic and multiple conditions**. Multimorbidity is expensive not only because each condition carries cost but because fragmented, single-disease care duplicates effort, generates avoidable admissions and produces poorly coordinated prescribing. The reform response — stronger generalist primary care, integrated care models, and continuity across the health–social boundary — is well understood in principle but institutionally difficult, because it cuts across the professional, budgetary and organisational lines around which systems are built.

Taken together, these three drivers reframe the affordability question. Demographic ageing sets the direction of travel, but the slope of the cost curve is determined largely by choices about prices, technology adoption and care organisation. That is cautiously encouraging: it means the trajectory is more amenable to policy than fatalistic demographic accounts suggest.

4. The long-term care problem

If there is a single segment where the reform imperative is sharpest, it is long-term care — the personal and nursing support people need when chronic conditions and frailty erode their ability to manage daily life. It behaves differently from medical care in almost every respect that matters for financing.

First, demand is rising fastest here. The oldest-old cohort, which grows most quickly, has the highest dependency rates, and dementia — for which there is no curative therapy and whose care is intensive and prolonged — is becoming one of the largest single drivers of care need. Public long-term care spending across advanced economies, currently a modest share of GDP in most, is on a path that could roughly double by mid-century on unchanged policy, according to official long-run projections. Because the base is small, the growth rate is high; because the absolute level is becoming material, the fiscal visibility is rising.

> ***Key finding — long-term care*** *— Public long-term care spending across advanced economies is on a path that could roughly double as a share of GDP by 2050 on unchanged policy. Because the base is small the growth rate is high; because the*

> *absolute level is becoming material the fiscal visibility is rising.*

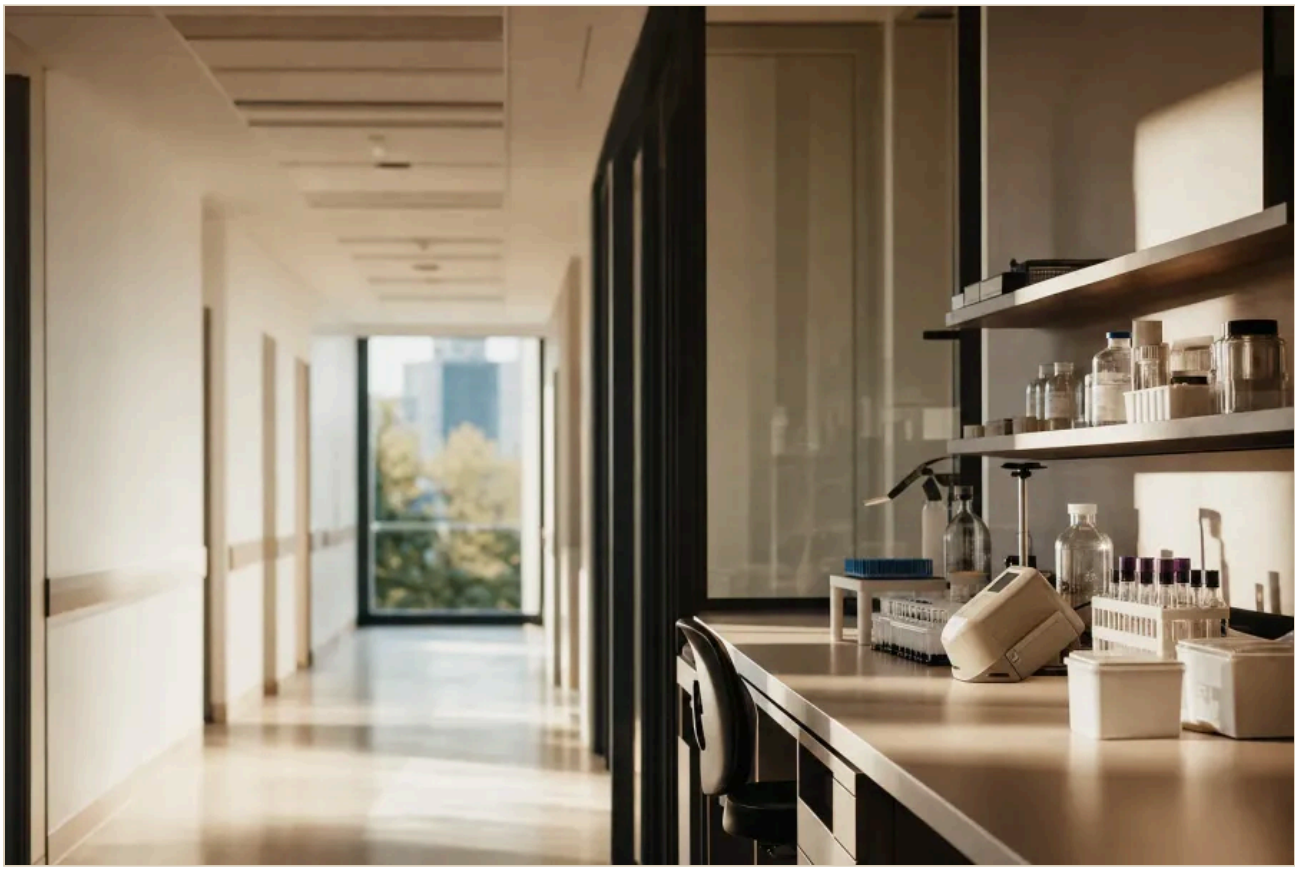
Second, the sector rests on an invisible subsidy: **unpaid family care**, overwhelmingly provided by women, whose imputed value in most economies exceeds recorded formal long-term care spending. This subsidy is eroding as female labour-force participation rises, families shrink and disperse, and the cohorts entering old age have fewer adult children. As informal care contracts, demand shifts onto formal systems not resourced to absorb it — a slow-moving but powerful pressure most public accounts do not capture.

Third, long-term care is chronically **under-insured**. Unlike acute medical care, it is commonly financed through means-tested public support plus private payment, leaving households exposed to potentially catastrophic and open-ended costs. Private long-term care insurance markets have generally failed to develop at scale, undermined by adverse selection, the difficulty of pricing a risk that materialises decades after purchase, and low consumer salience. A small number of systems have introduced dedicated social long-term care insurance — mandatory, universal, contributory coverage with defined benefits — which is the closest thing to a proven template, though even these face rising contribution rates as their populations age.

The design questions are genuinely hard: where to draw the line between health and social responsibility; how to balance cash benefits (which respect choice but can entrench low-paid informal care) against in-kind services; how to protect against catastrophic cost without inducing over-use; and how to build a formal workforce for jobs that are demanding, low-paid and low-status. There is no consensus solution. But the direction of pressure is unambiguous, and systems that have not begun to build durable long-term care financing are, in effect, relying on family labour that the demographic data say will not be there.

5. Regional and comparative lens

The ageing-and-financing challenge is universal in direction but highly varied in timing, income context and institutional starting point.



Universal in direction, varied in timing: high-income East Asia, Europe, North America and fast-ageing middle-income economies face the same pressures from different institutional starting points (§5). — IRI

High-income East Asia faces the challenge in its most acute form: the fastest ageing on record, very high longevity, low fertility sustained over decades, and — in some cases — strong cultural expectations of family care now colliding with shrinking families. These societies are also wealthy, high-saving and institutionally capable, and several have moved earliest on dedicated long-term care financing. They are, in effect, the laboratory in which the rest of the world will observe what works.

Western and Southern Europe combine old populations with mature, comprehensive systems and, in the south, weaker fiscal positions and heavier reliance on family care. The advantage is universal coverage and strong purchasing institutions; the pressure is acute workforce ageing — a large share of their own doctors and nurses are themselves near retirement — and constrained fiscal space. Reform debates centre on financing sustainability, health–social care integration, and workforce retention and migration.

North America layers a predominantly public-financed system for its older population on a high-cost mixed system for the rest. Here the binding issue is less the level of ageing than the price level and the fragmentation, which make each unit of ageing-driven demand unusually expensive.

Middle-income countries face the most difficult version of the problem. Several large economies are ageing faster than the high-income countries did, and at far lower income per head — growing old before growing rich. They must build chronic-disease management and long-term care financing from a thin base, often while still contending with an unfinished agenda of infectious disease and maternal health, and while their demographic dividend is still closing. Their window for institution-building is measured in a decade or two, not the half-century today's rich countries enjoyed. The risk is that they reach high old-age dependency with neither the fiscal base nor the institutions to finance it.

The comparative lesson is that there is no template to import wholesale, but there are transferable principles: build strategic purchasing and price-negotiation capacity early; do not wait for family care to collapse before designing long-term care financing; and treat workforce as a long-lead-time investment.

6. Risks and what could change the picture

Several factors could push outcomes materially better or worse than a central expectation, and honest analysis should foreground them.

- **Morbidity compression versus expansion.** The single largest uncertainty is whether added years of life are lived in good or poor health. If healthy life expectancy rises roughly in step with total life expectancy (compression), the cost trajectory is far more benign than if extra years are years of dependency (expansion). The evidence is mixed and country-specific, and the difference between the two is worth more to long-run affordability than most financing reforms.
- **Technology as cost-raiser or cost-saver.** New therapies could add large recurrent costs (as many specialty drugs have) or relieve pressure — a genuinely effective, affordable dementia therapy would alter the long-term care outlook fundamentally. Automation and digital tools could ease the workforce constraint or add cost without productivity. The direction is not predetermined.
- **Fiscal and political tolerance.** Reforms that raise contribution rates or taxes, or ration explicitly, collide with intergenerational politics. Older cohorts vote in higher numbers, biasing systems toward protecting current beneficiaries over pre-funding for future ones. The risk is not fiscal impossibility but political paralysis that defers adjustment until it must be made abruptly.
- **Workforce migration dynamics.** Advanced economies increasingly rely on internationally trained health and care workers — efficient for destination countries but raising equity concerns for source countries and exposed to political backlash. A tightening of these flows would bind the workforce constraint harder.
- **Macroeconomic conditions.** Slower productivity growth, higher interest rates on rising public debt, or weak real wage growth would all shrink the fiscal room for health-spending growth precisely as demographic pressure peaks. The health-financing outlook cannot be separated from the wider fiscal and growth outlook.

The outlook: three scenarios to 2030

We frame the medium-term outlook through three named scenarios. These are **illustrative constructs**, not forecasts; they bracket a plausible range rather than predict a point.

Scenarios to 2030 — at a glance

A — Managed adjustment — Hard but doable

Incremental revenue reform, disciplined purchasing and a sustained, gradual shift of care toward primary, community and home settings; long-term care financing put on a more durable footing where exposure is greatest.

METRIC	VALUE
Health spend vs GDP	Rises, manageable margin
Out-of-pocket exposure	Contained
LTC financing	Durable footing

B — Muddling through — Most likely default

Reforms announced but partially implemented; care reconfiguration slow against institutional resistance; long-term care financing patched not rebuilt. The system does not break, but affordability and equity erode at the margin.

METRIC	VALUE
Spending	Drifts upward
Rationing	Implicit (waits, gaps)
Adjustment	Postponed & larger

C — Deferred reckoning — Real tail risk

Political paralysis and fiscal stress prevent meaningful reform; the workforce constraint bites hard; informal care contracts faster than formal systems expand.

METRIC	VALUE
Access	Deteriorates visibly
Older-household hardship	Rises
Adjustment	Abrupt & inequitable

Scenario A — "Managed adjustment." Governments combine incremental revenue reform (broadening contribution bases, modest earmarked taxes), disciplined purchasing (stronger health-technology assessment, competitive procurement, biosimilar uptake) and a sustained, gradual reallocation of care toward primary, community and home settings. Long-term care financing is put on a more durable footing in the systems most exposed. Health spending continues to rise faster than GDP but by a manageable margin, and out-of-pocket exposure is contained. This is achievable but demands political persistence across electoral cycles; it is the "hard but doable" path.

Scenario B — "Muddling through." The most likely default. Reforms are announced but partially implemented; care reconfiguration proceeds slowly against institutional resistance; long-term care financing is patched rather than rebuilt. Spending drifts upward, rationing occurs implicitly through waiting times and coverage gaps, and out-of-pocket burdens on older households grow. The system does not break, but affordability and equity erode at the margin, and the eventual adjustment is merely postponed and made larger.

Scenario C — "Deferred reckoning." Political paralysis and fiscal stress prevent meaningful reform; the workforce constraint bites hard; long-term care demand outruns supply as informal care contracts faster than formal systems expand. Access deteriorates

visibly, financial hardship among older households rises, and the adjustment, when forced, is abrupt and inequitable — sharp benefit reductions, rapid cost-shifting to households, or fiscal crisis. This is not the central case for well-governed high-income systems, but it is a real risk for fiscally weaker and for fast-ageing middle-income economies.

Across all three, several judgements hold with reasonable confidence to 2030: health and long-term care will claim a rising share of output and public budgets; the workforce constraint will bind before the capital constraint; long-term care will move up the political agenda; and systems that invest earliest in purchasing capacity, prevention and care reconfiguration will find the following decade materially easier than those that defer.

> *"Systems that delay will not avoid the adjustment — only make it later, more abruptly and less equitably."*
>
> *— Executive summary*

What this means, by audience

Governments and policymakers

The central task is to begin the adjustment early and gradually rather than late and abruptly. First, build or strengthen the **strategic purchasing function** — the capacity to assess technologies for value, negotiate prices and set the benefit package on evidence — because this is the lever with the greatest leverage over the cost curve. Second, design durable **long-term care financing** before the informal-care subsidy erodes, adapting the social-insurance templates that already exist. Third, treat the **workforce as a long-lead-time investment**: training pipelines, retention, task-shifting toward nurses and community workers, and honest planning around migration. Fourth, protect **prevention and primary care** budgets from the perennial temptation to raid them for acute pressures, since they underpin the compression of late-life morbidity that most improves long-run affordability. Broadening and stabilising the revenue base — moving payroll-financed systems toward blended funding as the contribution base narrows — is a technical necessity best undertaken deliberately rather than in crisis.

Business and investors

The demographic direction of travel creates durable, structural demand across several segments, but the investment case is disciplined by public payers whose central objective is cost control. The most defensible positions align with what stretched systems are trying to buy: technologies and services that credibly lower total cost of care or relieve the workforce constraint (care coordination, remote monitoring, diagnostics that avert admissions, labour-augmenting tools), rather than those that add cost without demonstrable value, which face intensifying assessment and price pressure. Long-term care provision and financing represent a large, under-served and growing market — but one with thin margins, heavy labour dependence, acute staffing risk and significant regulatory and reputational exposure, demanding operational excellence rather than financial engineering. Pharmaceutical and device investors should assume continued tightening of value-based pricing and procurement. Across the board, the reimbursement environment, not underlying demand, is the decisive variable, and it is becoming more evidence-demanding, not less.

International organisations and donors

For lower- and middle-income countries ageing before they are rich, the priority is institution-building ahead of the demographic peak: early investment in chronic-disease management within primary care, the beginnings of long-term care policy, and the strategic-purchasing and revenue institutions that take years to mature. Technical support for health-technology assessment capacity and for the fiscal analysis of long-run care liabilities is high-value and under-supplied. The equity dimension of health-worker migration also warrants coordinated attention, balancing the legitimate mobility of workers against the need to protect fragile source-country systems.

Methods and evidence

This report is a **synthesis and comparative analysis**, not the presentation of new primary measurement. It draws on the kinds of sources standard to cross-national health-systems research: internationally comparable health-expenditure statistics and health-accounts frameworks published by multilateral statistical bodies; official demographic estimates and projections of population age structure and dependency ratios; national and supranational long-run fiscal and actuarial projections of health and long-term care spending; and the peer-reviewed comparative literature on health financing, end-of-life cost concentration, morbidity trends and workforce projection. Where we state established facts — the broad direction of population ageing, the concentration of spending in later life and near death, the leading role of prices and technology in historical spending growth, and the fastest growth being in long-term care — these are well supported across multiple independent sources and are presented as settled.

We have been deliberate in distinguishing established facts from estimates. All **specific quantitative figures in this report should be read as approximations, ranges or illustrative magnitudes** unless explicitly described as established. In particular: the segment and financing-share figures in the two tables in Section 2 are synthesised estimates of modal cross-country patterns and vary materially by country and by definition (long-term care especially, where the health–social boundary is drawn differently in different accounts); the aggregate global health-spending figure is an order-of-magnitude approximation; and all forward-looking statements — including the doubling of long-term care spending shares and everything in the scenarios section — are scenario constructs conditioned on stated assumptions, not predictions. Readers requiring exact figures for a specific jurisdiction should consult that country's national health accounts and official actuarial projections directly; the value of this report lies in the structure of the analysis and the relative magnitudes, not in any single number.

Two cautions deserve emphasis. First, "pure demographic" projections that hold all else constant are a lower bound on cost, not a central estimate, because they omit the price and technology drivers that have historically dominated. Second, cross-national comparison is complicated by genuine differences in how countries define the boundary between health and social care, which makes long-term care in particular difficult to compare cleanly — a limitation we have flagged rather than obscured.

Evidence and sources

The internationally comparable statistics, demographic projections and official long-run fiscal projections below were consulted directly; national health accounts inform the modal cross-country patterns in Section 2.

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- National health accounts and official actuarial projections (various jurisdictions, 2022–2025), used for the modal cross-country patterns in Section 2.

Suggested citation

Voss, H., Kjeldsen, A., and Raghavan, P. (2025). *Healthcare Financing and System Reform in Ageing Societies.* Flagship Report. International Research Institute, Health Systems Programme. Available under CC BY 4.0.