7.3. Health expenditure by function

Spending on inpatient care and outpatient care combined accounts for a large proportion of health expenditure across OECD countries – around 62% of current health expenditure on average in 2011 (Figure 7.3.1). A further 20% of health spending was allocated to medical goods (mainly pharmaceuticals, which accounted for 17% of total health spending), 12% on long-term care and the remaining 6% on collective services, such as public health and prevention services and administration.

Spending on inpatient care (including day care in hospitals) was the biggest costing component for a number of countries, including France and Greece where it accounted for 37% of total spending. While the United States consistently reports the highest share of outpatient care (and by consequence the lowest inpatient share), it should be noted that this figure includes remunerations of physicians who independently bill patients for hospital care. Other countries with a high share of outpatient spending include Israel and Portugal (48% and 45%).

The other major category of health spending is medical goods. In the Slovak Republic and Hungary, medical goods represent the largest spending category at 38% and 37% of current health expenditure respectively. In Denmark, New Zealand, Norway and Switzerland, on the other hand, spending on medical goods represents only 11% of total health spending. Differences in the consumption pattern of pharmaceuticals and relative prices are some of the main factors explaining the variations between countries.

There are also differences between countries in their expenditure on long-term care (see Indicator 8.9). Countries such as Norway, Denmark and the Netherlands, which have established formal arrangements for the elderly and the dependent population, allocate more than 20% of current health spending to long-term care. In countries with less comprehensive formal long-term care services such as Portugal, the expenditure on long-term care accounts for a much smaller share of total spending.

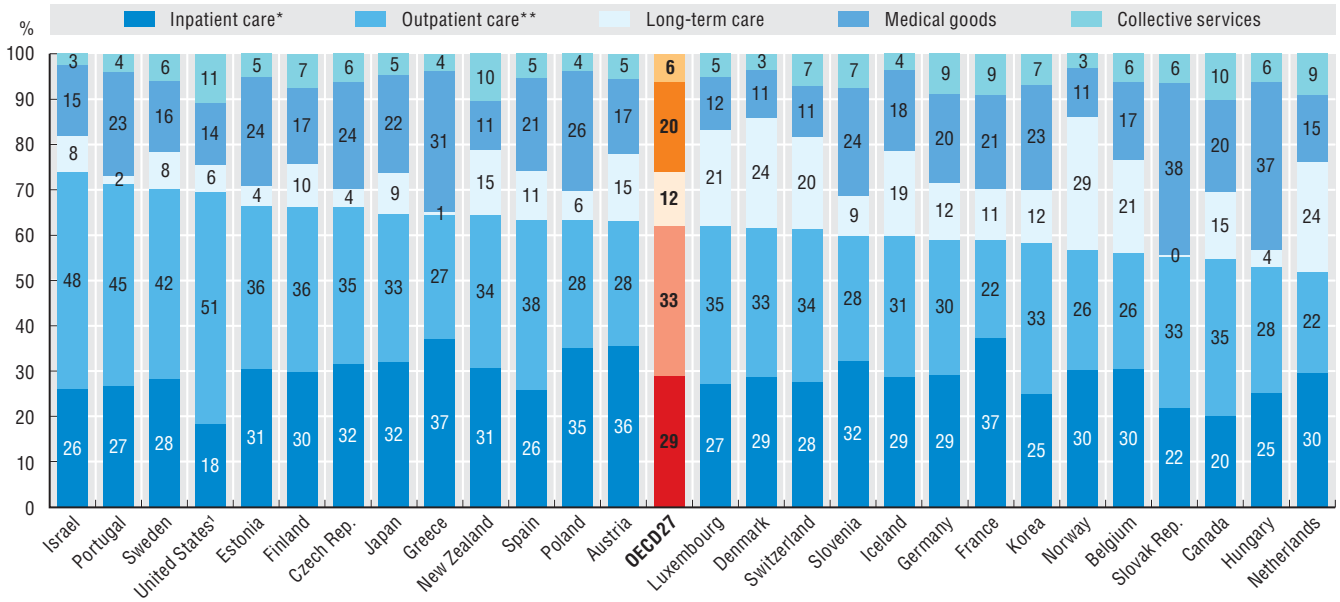
The slowdown in health spending experienced in many OECD countries in recent years has affected all spending categories, but to varying degrees (Figure 7.3.2). In more than half of OECD countries, total pharmaceutical spending fell in 2011 (see also Indicator 7.4). Many OECD countries have reduced their spending on prevention and public health services, with the reduction averaging 1.5% in 2010 and 1.7% in 2011 across all OECD countries. Whereas the decrease in 2010 can to some extent be explained by the H1N1 influenza pandemic in 2009 which led to significant one-off expenditures for the purchase of large stocks of vaccines in many countries, the reduction in 2011 is mainly due to more general cuts to public health budgets. Expenditure growth for administration also slowed down. It was negative in 2010 and went up slightly in 2011, but the growth rate was lower than in 2008 and 2009. Cuts in administrative budgets were frequently an initial response to the financial crisis in many countries, such as in the Czech Republic where the budget of the Ministry of Health was reduced by 30% between 2008 and 2010.

Although remaining positive, growth rates for inpatient care, outpatient care and long-term care spending decreased significantly in 2010 and 2011 compared to 2008 and 2009. Many governments introduced measures to curb public spending on these health care functions, such as cuts in salaries of health workers and the reduction of health workforce, reductions in the fees to health providers and increases in co-payments for patients to ease mounting budget pressures (Morgan and Astolfi, 2013).

Definition and comparability

The *System of Health Accounts* (OECD, 2000; OECD, Eurostat, WHO, 2011) defines the boundaries of the health care system. Current health expenditure comprises personal health care (curative care, rehabilitative care, long-term care, ancillary services and medical goods) and collective services (prevention and public health services as well as health administration). Curative, rehabilitative and long-term care can also be classified by mode of production (inpatient, day care, outpatient and home care). Concerning long-term care, only the health aspect is normally reported as health expenditure, although it is difficult in certain countries to separate out clearly the health and social aspects of long-term care. Some countries with comprehensive long-term care packages focusing on social care might be ranked surprisingly low based on SHA data because of the exclusion of their social care. Thus, estimations of long-term care expenditure are one of the main factors limiting comparability across countries.

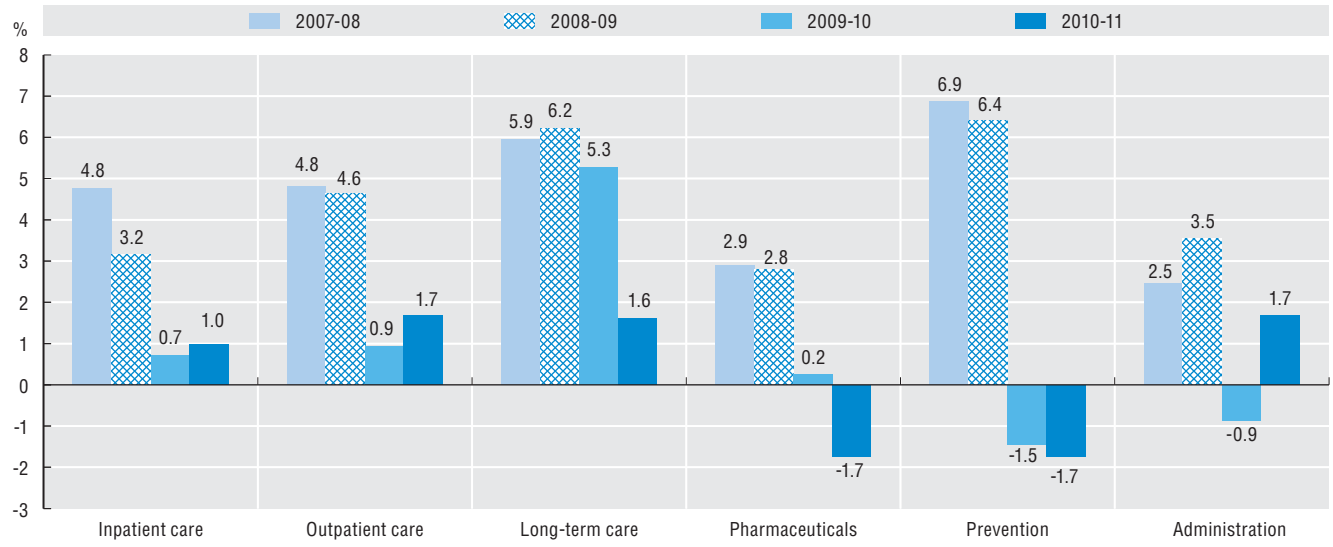
7.3.1. Current health expenditure by function of health care, 2011 (or nearest year)



Note: Countries are ranked by curative-rehabilitative care as a share of current expenditure on health.
* Refers to curative-rehabilitative care in inpatient and day care settings.
** Includes home-care and ancillary services.
1. Inpatient services provided by independent billing physicians are included in outpatient care for the United States.
Source: OECD Health Statistics 2013, http://dx.doi.org/10.1787/health-data-en.

StatLink http://dx.doi.org/10.1787/888932918928

7.3.2. Average annual growth rates of health spending for selected functions, in real terms, OECD average, 2008 to 2011



Source: OECD Health Statistics 2013, http://dx.doi.org/10.1787/health-data-en.

StatLink http://dx.doi.org/10.1787/888932918947

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