7.3. Health expenditure by function

Spending on the various types of health care services and goods is influenced by a wide range of factors: health system constraints, such as access to hospital beds, medical staff and new technology, the financial and institutional arrangements for health care delivery, as well as national clinical guidelines and the disease burden within a country.

In 2009, curative and rehabilitative care provided either as inpatient (including day care) or outpatient care accounted for more than 60% of current health spending on average across OECD countries (Figure 7.3.1). The ratio of inpatient to outpatient spending can vary according to the different organisational arrangements of health care providers and clinical practice variation between countries. Austria and France, for example, report a relatively high proportion of expenditure on inpatient care (amounting to more than a third of health spending) which is mirrored by them having the highest levels of hospital activity (see Indicator 4.4 "Hospital discharges"). Conversely, countries such as Portugal and Spain, with relatively low levels of hospital activity, allocate around a quarter of health care resources to inpatient care.

Large differences remain between countries in their expenditure on long-term care. Norway, Denmark and the Netherlands, with established and extensive formal arrangements for elderly and disabled care, allocate around a quarter of their total health spending to long-term care. By contrast, in eastern and southern European countries, where care tends to be provided in more informal or family settings, expenditure on long-term care accounts for a much smaller share of total health spending (see Indicator 8.8 "Long-term care expenditure").

The other major category of health expenditure is on medical goods, mostly accounted for by pharmaceuticals (see Indicator 7.4 "Pharmaceutical expenditure"). At 19%, on average, the share of health spending on medical goods can be as low as 11-12% in New Zealand, Denmark and Norway, but accounts for more than a third of all health spending in Hungary and the Slovak Republic.

The growth in the various components of care reflects in part the relative stage of development of health systems. With inpatient care highly labour intensive and, therefore, expensive, certain high income countries with developed health systems have sought to reduce the share of spending in hospitals by shifting to more day surgery, outpatient or home-based care. However, this shift can also reflect regulatory issues. Public spending in the United States is largely Medicare and Medicaid related for which prices are tightly controlled. Thus, it can be in the interest of hospitals to shift patients to ambulatory care where there are no controls of the price of interventions (OECD, 2010b). Estimates of spending on ambulatory surgery performed by independent physicians suggested that this has been the fastest growing area of health care between 2003 and 2006 in the United States (McKinsey Global Institute, 2008). On the other hand, lower income OECD countries seeking to invest in and expand their health systems have generally seen the growth in hospital inpatient care outpace other areas of spending such that it has been the main contributor to overall health expenditure growth (Figure 7.3.2).

Figure 7.3.3 shows the share of health expenditure allocated to health care administration. On average, OECD countries allocated 3% of their spending to the management and regulation of the health system. This also includes the administration and operation of health insurance funds which goes some way to explaining the wide variations. Generally those countries operating single payer tax-based health financing systems (*e.g.* Denmark and Sweden) show a lower share of health spending allocated to administration compared to countries with multi-payer social insurance models, such as the United States, France and Germany.

Definition and comparability

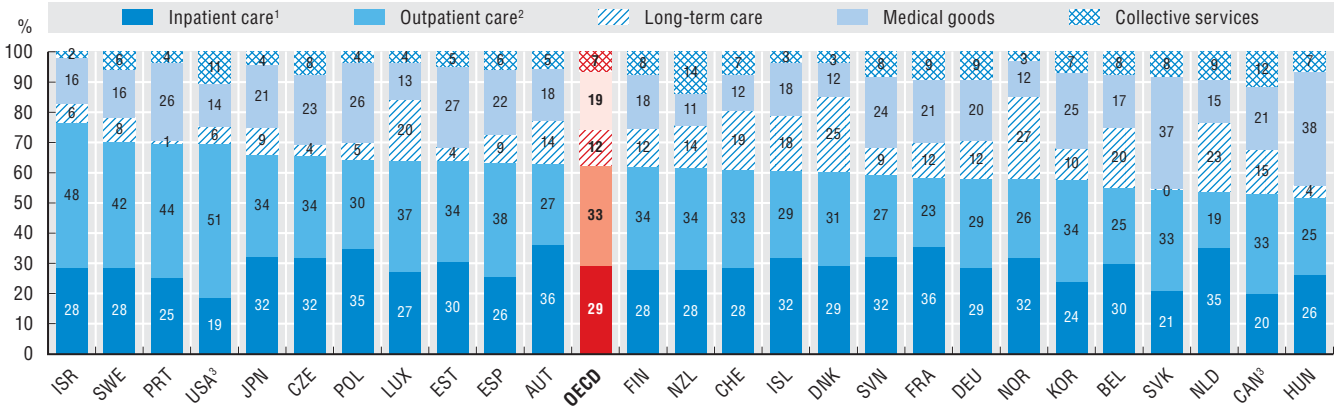
The functional approach of the *System of Health Accounts* defines the boundaries of the health system. Total health expenditure consists of current health spending and investment. Current health expenditure comprises personal health care (curative care, rehabilitative care, long-term care, ancillary services and medical goods) and collective services (public health services and health administration). Curative, rehabilitative and long-term care can also be classified by mode of production (inpatient, day care, outpatient and home care).

Factors limiting the comparability across countries include estimations of long-term care expenditure. Also, in some cases, expenditure in hospitals is used as a proxy for inpatient care services, although hospital expenditure may include spending on outpatient, ancillary, and in some cases drug dispensing services (Orosz and Morgan, 2004).

Information on data for Israel: *http://dx.doi.org/10.1787/888932315602*.

7.3.1 Current health expenditure by function of health care, 2009

Countries are ranked by curative-rehabilitative care as a share of current expenditure on health

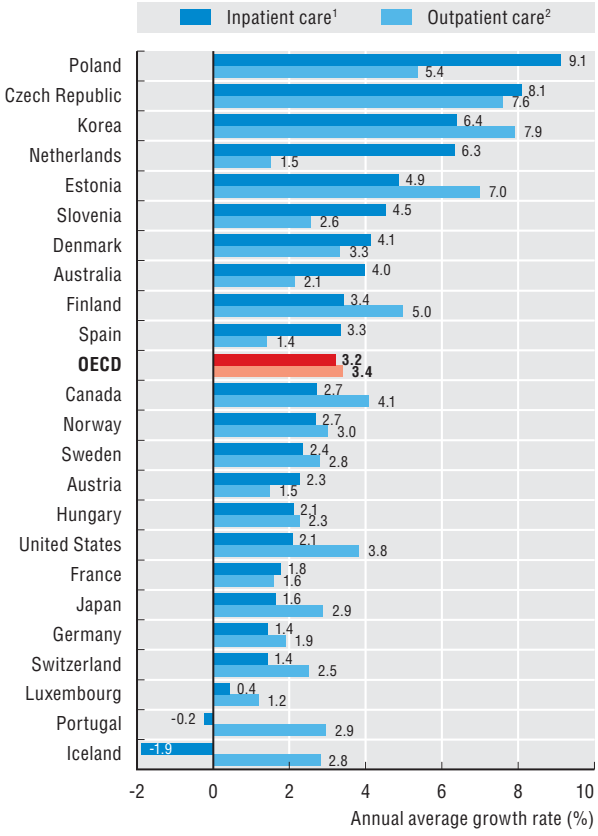


1. Refers to curative-rehabilitative care in inpatient and day-care settings.
2. Includes home-care and ancillary services.
3. Inpatient services provided by independent billing physicians are included in outpatient care for the United States and Canada.

Source: OECD Health Data 2011.

StatLink http://dx.doi.org/10.1787/888932526160

7.3.2 Growth in inpatient and outpatient care expenditure per capita, in real terms, 2000-09 (or nearest year)

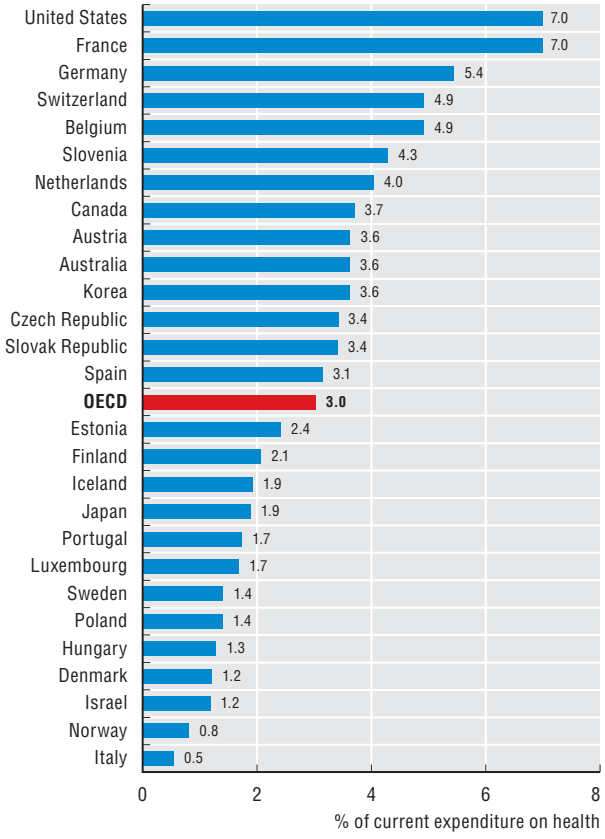


1. Including day care.
2. Including home-care and ancillary services.

Source: OECD Health Data 2011.

StatLink http://dx.doi.org/10.1787/888932526179

7.3.3 Expenditure on health care administration and insurance, 2009 (or nearest year)



Source: OECD Health Data 2011.

StatLink http://dx.doi.org/10.1787/888932526198