The allocation of health spending across the different types of health services and goods is influenced by a range of factors, including the availability of resources such as hospital beds, physicians and access to new technology, the financial and institutional arrangements for health care delivery, as well as by national clinical guidelines and the disease burden within a country.

In 2008, curative and rehabilitative care provided for either in-patients or out-patients accounted for just over 60% of current health spending on average across EU countries (Figure 4.3.1). The ratio of in-patient to out-patient spending depends on the institutional arrangements for health care provision. Austria and France, for example, report a relatively high proportion of expenditure for in-patient care (amounting to more than a third of total health spending) which is associated with a high level of hospital activity. Conversely, countries such as Portugal and Spain, with low levels of hospital activity, allocate only around a quarter of health care resources to in-patient care.

There are large differences between countries in their expenditure on long-term care. Norway and Denmark, with established formal arrangements for elderly care, allocate more than 20% of total health spending to long-term care. In Portugal, where care tends to be provided in more informal or family settings, the expenditure on long-term care accounts for a much smaller share of total spending.

The other major category of health expenditure is on medical goods, mostly accounted for by pharmaceuticals (see Indicator 4.4). On average, one-quarter of the share of health spending is on medical goods but it can be as low as 12-13% in Switzerland, Norway and Denmark, and as high as 38% in the Slovak Republic and Bulgaria.

Curative-rehabilitative care covers not only medical services requiring hospitalisation, but also those services provided as an out-patient or in a patient's own home. Changes in medical practice, new technologies and more efficient allocation of resources can all affect the balance between different types of care delivery. Day surgery is one area that has been expanding in many European countries in recent years.

The use of day surgery for procedures such as cataract removal (see Indicator 3.10) or hernia repairs may result in higher volumes and decreased unit costs. In many countries, day care has accounted for an increasing share of the total spending on curative care in recent years (Figure 4.3.2). There are, however, wide variations in spending, partly reflecting data limitations, but also national policies and regulations. In France, spending on day care now accounts for around 11% of curative care spending. By contrast, Germany, where day surgery in public hospitals was prohibited until the late 1990s (Castoro *et al.*, 2007), reported only 2% of curative care expenditure as services of day care.

Figure 4.3.3 shows the share of health expenditure allocated to organised public health and prevention programmes. On average, EU countries allocated 2.9% of their spending on health to a wide range of activities such as vaccination programmes and public health campaigns on alcohol abuse and smoking. The wide variation reflects to a great extent the national organisation of prevention campaigns. Where such initiatives are carried out at the primary care level, as in Spain, the prevention function is not captured separately and may be included under the spending on curative care. Other countries adopting a more centralised approach to public health and prevention campaigns are more able to identify spending on such programmes.

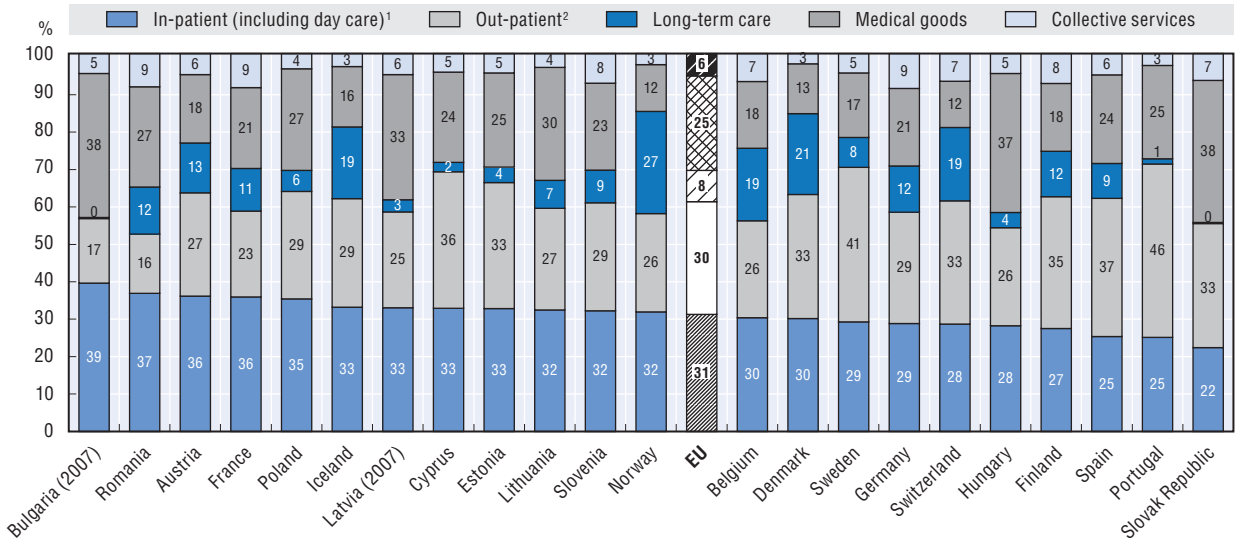
Definition and deviations

The functional approach of the *System of Health Accounts* (OECD, 2000) defines the boundaries of the health system. 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 (in-patient, day care, out-patient and home care). Day care comprises health care services delivered to patients who are formally admitted to hospitals, ambulatory premises or self standing centres but with the intention to discharge the patient on the same day. An out-patient is not formally admitted to a facility (physician's private office, hospital out-patient centre or ambulatory-care centre) and does not stay overnight.

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

4.3.1. Current health expenditure by function of health care, 2008

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

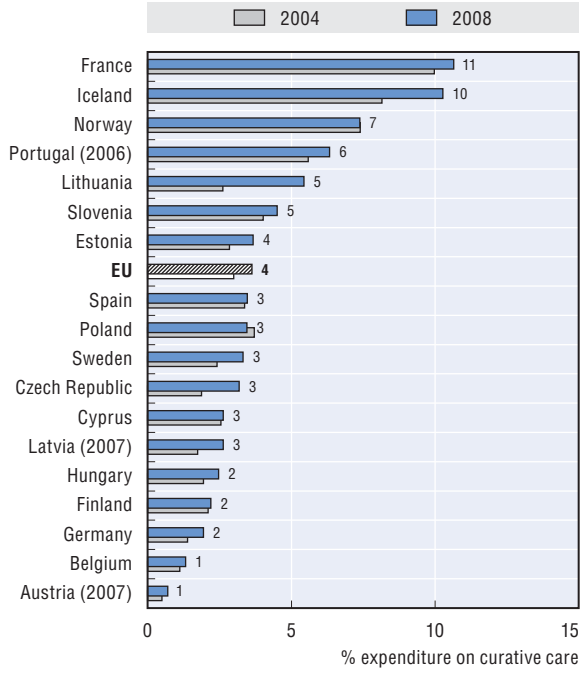


1. Refers to curative and rehabilitative in-patient and day care services provided in hospitals, day surgery clinics, etc.
2. Refers to curative and rehabilitative care in doctors' offices, clinics, out-patient departments of hospitals, home-care and ancillary services.

Source: OECD Health Data 2010; Eurostat Statistics Database.

StatLink http://dx.doi.org/10.1787/888932337433

4.3.2. Day care as a share of total curative care expenditure, 2004 and 2008

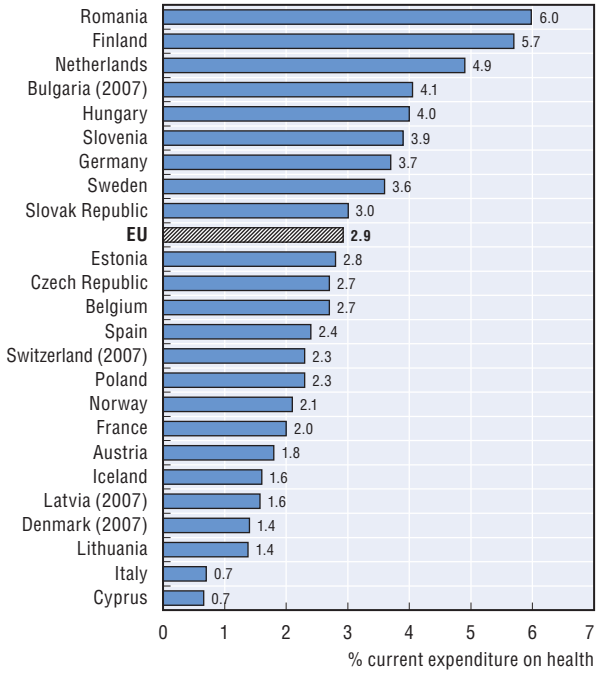


Note: Day care services provided in hospitals, day surgery clinics and other settings.

Source: OECD Health Data 2010; Eurostat Statistics Database.

StatLink http://dx.doi.org/10.1787/888932337452

4.3.3. Expenditure on organised public health and prevention programmes, 2008



Source: OECD Health Data 2010; Eurostat Statistics Database.

StatLink http://dx.doi.org/10.1787/888932337471

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