There are large variations in the level and in the rate of growth of health spending across European countries.

Health expenditure per capita tends to be related with overall income per capita. Hence, it is not surprising that Norway and Switzerland are the two European countries that spent the most on health in 2010, with spending of over EUR 4 000 per person (Figure 5.2.1). Among EU member states, the Netherlands (EUR 3 890), Luxembourg (EUR 3 607) and Denmark (EUR 3 439) were the highest spenders, exceeding by a wide margin the EU average (EUR 2 171). Romania and Bulgaria were the lowest spending countries among EU members. Health spending per capita was also relatively low in the Former Yugoslav Republic of Macedonia and Turkey.

Growth in health spending per capita slowed or fell in real terms in 2010 in almost all European countries, reversing a trend of steady increases in many countries. Health spending per capita had already started to fall in 2009 in some countries that were hardest hit by the economic crisis (*e.g.* Estonia and Iceland), but this was followed by further and deeper cuts in 2010. On average across EU member states, health spending per capita increased by 4.6% per year in real terms between 2000 and 2009, but this was followed by a reduction of 0.6% in 2010 (Figure 5.2.2). While government health spending tended to be maintained at the start of the economic crisis, cuts in spending really began to take effect in 2010 in response to budgetary pressures and the need to reduce large deficits and debts.

In Ireland, cuts in government spending drove total health spending per capita down by nearly 8% in 2010, compared with an average growth rate of 6.5% per year between 2000 and 2009. In Estonia, expenditure on health per capita dropped by 7.3% in 2010 due to reductions in both public and private spending, following an average annual growth rate of 7.2% between 2000 and 2009. In Greece, health spending per capita fell by 6.7% in 2010, after a yearly growth rate of 5.7% during the 2000-09 period. In several other countries (*e.g.* in Belgium, Finland, the Netherlands, Poland, the Slovak Republic and Sweden), there was a marked slowdown in the rate of growth of health spending per capita, although it remained positive.

Reductions in public spending on health were achieved through a range of measures. In Ireland, most of the reductions have been achieved through cuts in wages and a reduction in the number of healthcare workers as well as the fees paid to professionals and pharmaceutical companies. Estonia cut administrative costs in the Ministry of Health and the prices of publicly-reimbursed health services. Investment in health infrastructure has also been put on hold in a number of countries, including the Czech Republic, Estonia, Iceland and Ireland, while gains in efficiency have been pursued through mergers of hospitals or accelerating the move from inpatient care in hospital to outpatient care and day surgery. Other measures have been introduced to make people pay more out of their pockets. For example, Ireland increased the share of direct payments by households for prescribed pharmaceuticals and appliances, while the Czech Republic increased users' charges for hospital stays.

As a result of the slowdown or negative growth in health spending per capita in 2010, the percentage of GDP devoted to health stabilised or declined slightly in many EU member states (see Indicator 5.3 "Health expenditure in relation to GDP").

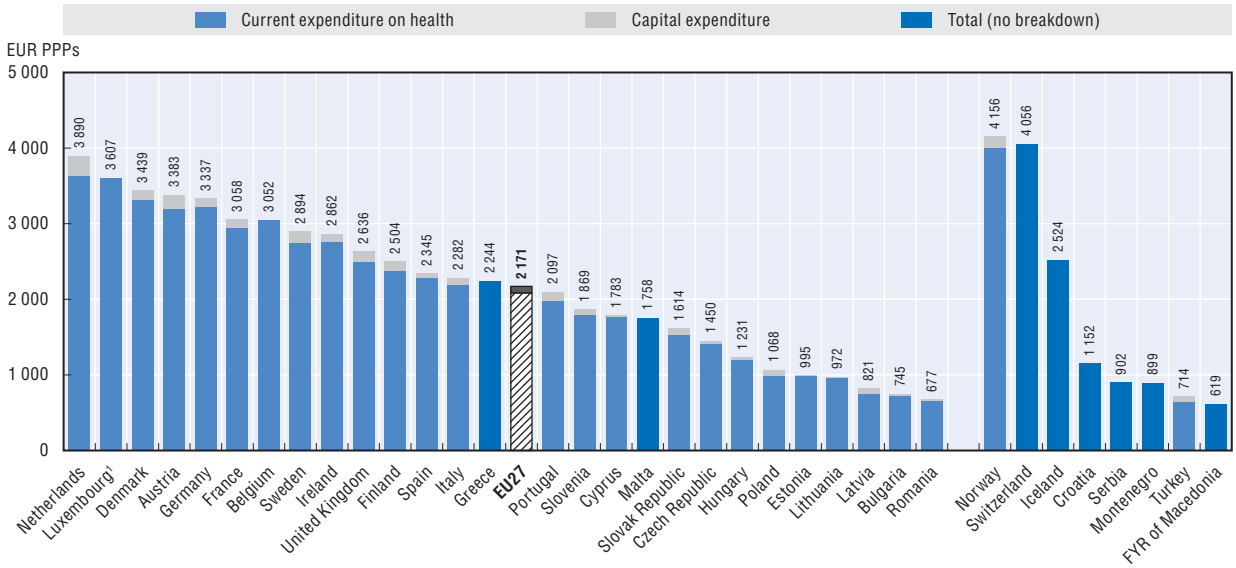
Definition and comparability

Total expenditure on health measures the final consumption of health goods and services (*i.e.* current health expenditure) plus capital investment in health care infrastructure, as defined in the System of Health Accounts manual (OECD, 2000; OECD, Eurostat and WHO, 2011). This includes spending by both public and private sources on medical services and goods, public health and prevention programmes, and administration.

The vast majority of countries now produce health spending data according to the boundaries and definitions proposed in the System of Health Accounts (SHA) manual. The comparability of the functional breakdown of health expenditure data has improved over recent years. However, limitations remain, as some countries have not yet implemented the SHA classifications and definitions. Even among those countries that are submitting data according to the SHA, the comparability of data sometimes needs to be improved. Different practices regarding the treatment of capital expenditure and the inclusion of long-term care in health or social expenditure are some of the main factors affecting data comparability.

Countries' health expenditures are converted to a common currency (Euro) and are adjusted to take account of the different purchasing power of the national currencies, in order to compare spending levels. Economy-wide (GDP) PPPs are used to compare relative expenditure on health in relation to the rest of the economy.

5.2.1. Health expenditure per capita, 2010 (or nearest year)

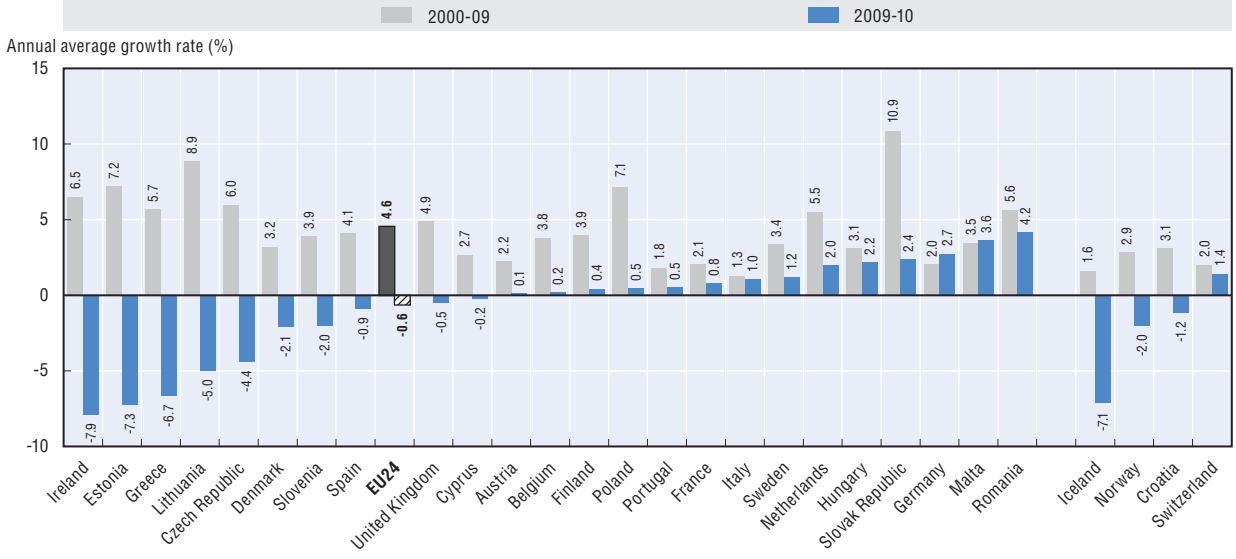


1. Health expenditure is for the insured population rather than resident population.

Source: OECD Health Data 2012; Eurostat Statistics Database; WHO Global Health Expenditure Database.

StatLink http://dx.doi.org/10.1787/888932705425

5.2.2. Annual average growth rate in health expenditure per capita, in real terms, 2000 to 2010 (or nearest year)



Source: OECD Health Data 2012; Eurostat Statistics Database; WHO Global Health Expenditure Database.

StatLink http://dx.doi.org/10.1787/888932705444