

Health and long-term care expenditure in EU member states has increased rapidly up until the 2008 economic and financial crisis. At the same time, three-quarters of health spending on average is financed from public sources. Given that health and long-term care expenditure represents a sizeable share of government spending, it is often difficult to exempt it from any comprehensive budgetary consolidation efforts. In many countries, there are concerns that ageing populations may lead to growing health and long-term care spending while at the same time reducing the share of the working-age population to finance these public spending, creating pressures around the fiscal sustainability of health and long-term care systems (OECD, 2015).

Projections of both public expenditure on health and long-term care are regularly carried out by the Ageing Working Group of the Economic Policy Committee, using the European Commission services' models (EC and EPC, 2014). In both health and long-term care projection models, a series of scenarios tests the potential impact of different determinants of public spending (including both demographic and non-demographic factors) to indicate how each may contribute to the evolution of public spending over the next 50 years. The results presented here are based on the baseline (or reference) scenario, which uses a certain set of assumptions to examine possible future trends in public spending on health and long-term care.

In the baseline scenario for health care expenditure, some of the main assumptions include that half of the future gains in life expectancy will be spent in good health and that the income elasticity of health care spending will converge from 1.1 in 2013 to 1 in 2060. The main result of the 2015 projection exercise, based on these and other assumptions, is an increase of public spending on health of 0.9 percentage point of GDP in total among the 28 EU countries by 2060 (Figure 8.17). Public expenditure on health is projected to rise by only 0.1 percentage point in Belgium and Lithuania, while it may rise by more than 2 percentage points of GDP in Portugal and Malta (EC and EPC, 2015).

Long-term care expenditure represents a growing share of GDP in many EU countries and as such is an important item for the long-term sustainability of public finances. The EC projection model includes a number of determinants of long-term care expenditure, including in the baseline scenario the assumption again that half of the projected gains in life expectancy will be spent in good health (without disability). The main result from the baseline scenario is a projected increase in public spending on long-term care of 1.1 percentage points in total across the 28 EU countries, up from 1.6% of GDP in 2013 to 2.7% of GDP in the European Union by 2060 (Figure 8.18). The results vary widely across countries, from only 0.1 percentage point of GDP in Croatia and Latvia up to as much as 3.0 percentage points of GDP in the Netherlands (EC and EPC, 2015).

OECD studies have shown that different policy and institutional factors (such as financing mechanisms, decentralisation, organisation of health provision, etc.) can have a substantial impact on the growth in public spending on health care (de la Maisonnette et al., 2016).

Definition and comparability

Public expenditure on health is defined as the “core” health care categories [SHA 1.0 categories (HC.1 to HC.9), excluding long-term nursing care (HC.3), but including capital investment in health (HC.R.1)]. It excludes private expenditure in the form of direct out-of-pocket payments by households and private health insurance.

Long-term care is defined as a range of services required by persons with reduced degree of functional capacity (physical or cognitive) and who are consequently dependent for an extended period of time on help with basic and/or instrumental activities of daily living. Basic activities of daily living (ADL) or personal care services are frequently provided in combination with help with basic medical services such as nursing care, prevention, rehabilitation or services of palliative care. Instrumental activities of daily living (IADL) or assistance care services are mostly linked to home help (Colombo et al., 2011).

The data, methodology and assumptions used for the health and long-term care expenditure projections are explained in detail in the 2014 report of the European Commission (DG ECFIN) and the Economic Policy Committee (Ageing Working Group). The “reference scenario” is used as the baseline scenario when calculating the overall budgetary impact of ageing. The EU averages are weighted according to GDP.

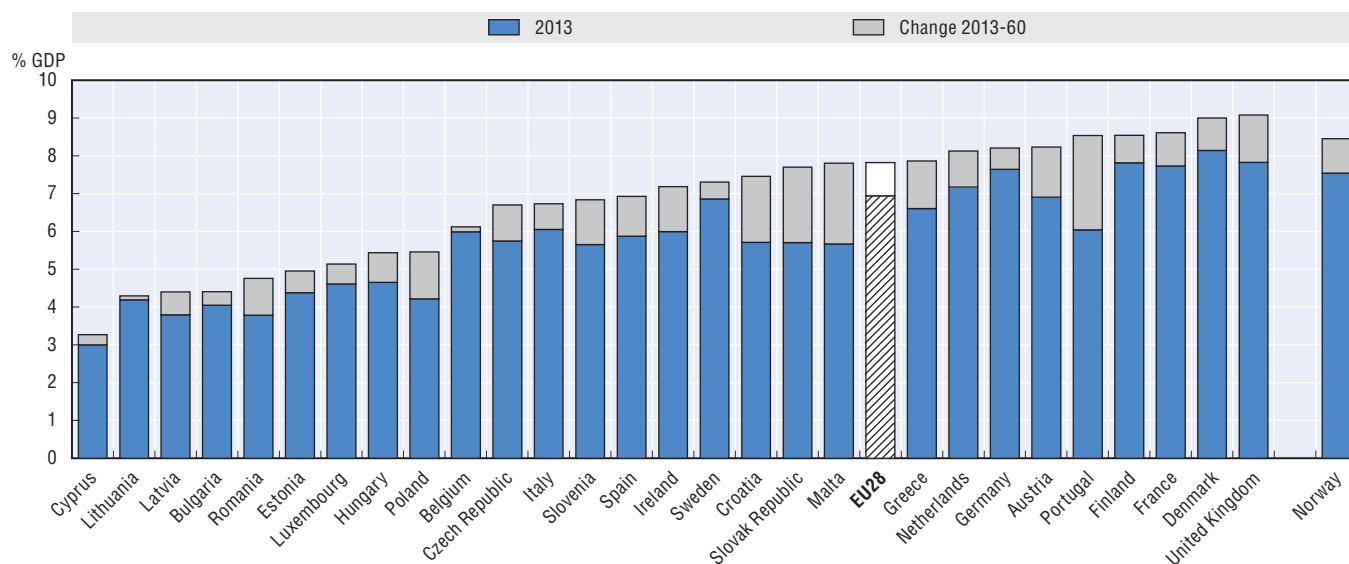
The OECD also produces forecasts of public spending on health and long-term care, covering OECD member states and major emerging economies. The European Commission model is used here because of its exhaustive coverage of EU countries.

References

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- European Commission (DG ECFIN) and Economic Policy Committee (Ageing Working Group) (2015), *The 2015 Ageing Report: Economic and Budgetary Projections for the 28 EU Member States (2013-2060)*, European Economy, No. 3/2015.
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8.17. Public spending on health care as a percentage of GDP, 2013 to 2060

Baseline scenario



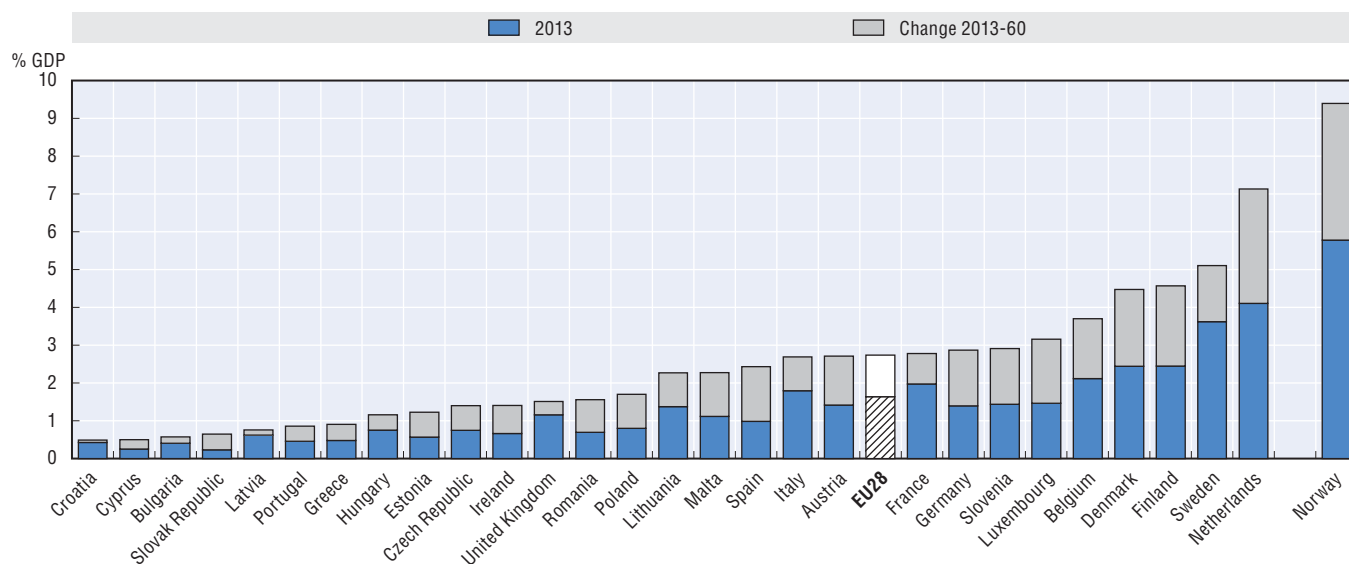
Note: The EU28 total is weighted by GDP.

Source: EC and EPC (2015).

StatLink <http://dx.doi.org/10.1787/888933430212>

8.18. Public spending on long-term care as a percentage of GDP, 2013 to 2060

Baseline scenario



Note: The EU28 total is weighted by GDP.

Source: EC and EPC (2015).

StatLink <http://dx.doi.org/10.1787/888933430224>



From:
Health at a Glance: Europe 2016
State of Health in the EU Cycle

Access the complete publication at:
<https://doi.org/10.1787/9789264265592-en>

Please cite this chapter as:

OECD/European Union (2016), “Projections of public expenditure on health and long-term care”, in *Health at a Glance: Europe 2016: State of Health in the EU Cycle*, OECD Publishing, Paris.

DOI: https://doi.org/10.1787/health_glance_eur-2016-68-en

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