There are large variations in the levels and rates of growth of health spending across Europe. How much a country spends on health and the rate at which this expenditure grows reflect a wide array of economic and social factors, as well the financing and organisational structures of its health system.

There is a strong relationship between the overall income level of a country and how much the country spends on health. It is therefore not surprising that Norway and Switzerland are the two European countries that spent the most on health in 2012 (Figure 6.1.1), with spending of over EUR 4 500 per person (adjusted for countries' different purchasing powers – see the box on "Definition and comparability"). Among EU member states, the Netherlands (EUR 3 829), Austria (EUR 3 676) and Germany (EUR 3 613) were the highest per-capita spenders, well above the EU average (EUR 2 193). Romania (EUR 753) and Bulgaria (EUR 900) were the lowest-spending countries among EU members. Of the other European states outside the European Union, health spending per capita was of a similarly low level in Montenegro, the Former Yugoslav Republic of Macedonia and Turkey.

Figure 6.1.1 shows the breakdown of per capita spending on health into public and private sources (see also Indicator 6.5 "Financing of health care"). On average, around three-quarters of health spending comes from public sources and the ranking by public share of spending is similar to overall health spending. Of the EU member states, only Cyprus sees private spending on health outweighing public financing, though Latvia and Bulgaria also have high levels of private spending. By contrast, the Netherlands, United Kingdom and most of the Nordic countries have levels of public financing exceeding 80%.

Since the onset of the economic crisis in 2008, health spending has slowed markedly across Europe after years of continuous growth. Between 2009 and 2012, expenditure on health in real terms (adjusted for inflation) fell in half of EU countries and significantly slowed in the rest (Figure 6.1.2). On average across the European Union, health spending decreased by 0.6% each year between 2009 and 2012, compared with annual growth of 4.7% between 2000 and 2009. Of the countries outside the European Union, only the Former Yugoslav Republic of Macedonia and Switzerland have seen growth rates increase since 2009.

While health budgets were maintained at the start of the economic crisis in many countries, health spending per capita began to fall in 2009 in some of the countries hardest hit by the economic crisis (e.g. Estonia and Iceland). More widespread reductions were observed in 2010 and 2011 in response to fiscal pressures and the need to reduce large deficits and debts (Morgan and Astolfi, 2014).

By 2012, a number of countries began to experience renewed growth in health spending, albeit at much lower rates compared to the pre-crisis period. However, health spending continued to fall in 2012 in Greece, Italy, Portugal and Spain, as well as in the Czech Republic and Hungary.

Greece has seen per capita health spending fall by 9% each year since 2009 after yearly growth of more than 5% between 2000 and 2009, leaving the per capita level 25% lower in 2012 than in 2009. Ireland and the Slovak Republic also suffered significant reversals in per capita health spending after previously strong growth.

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.

For the calculation of growth rates in real terms, economy-wide GDP deflators are used for all countries. In some countries (e.g. France and Norway) health-specific deflators exist, based on national methodologies, but these are not used in this publication due to limited comparability.

References

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OECD (2000), *A System of Health Accounts*, Version 1.0, OECD Publishing, Paris, *http://dx.doi.org/10.1787/9789264181809-en*.

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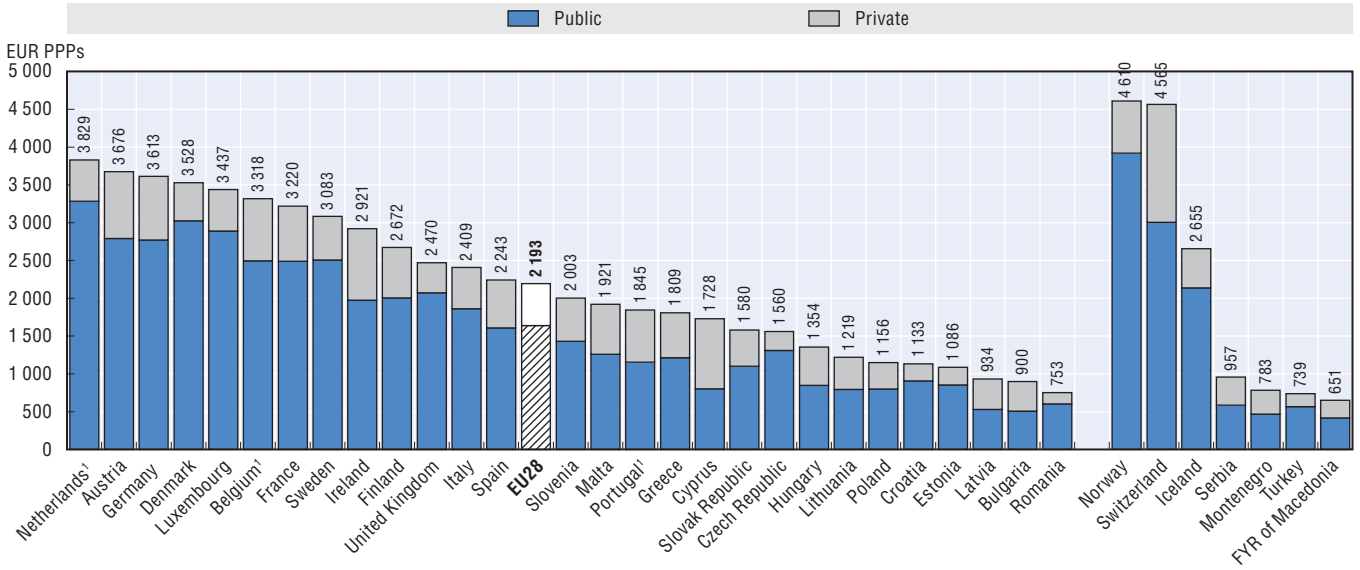
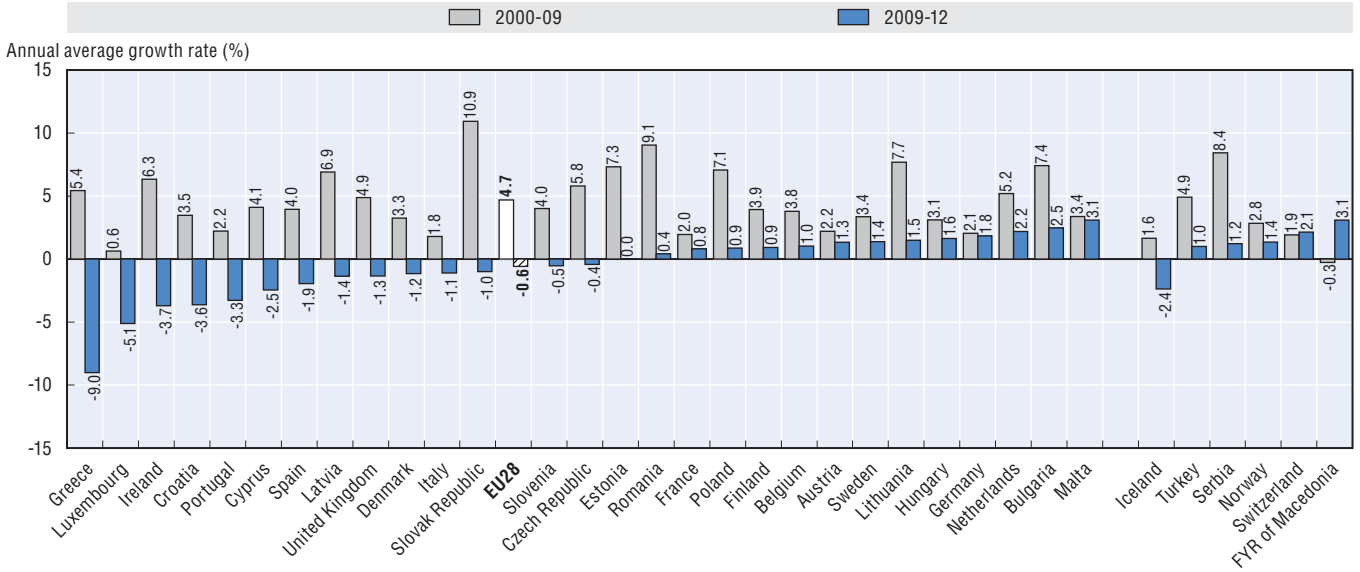
6.1.1. Health expenditure per capita, 2012 (or nearest year)



1. Current health expenditure.

Source: OECD Health Statistics 2014, http://dx.doi.org/10.1787/health-data-en; Eurostat Statistics Database; WHO Global Health Expenditure Database.

6.1.2. Annual average growth rate in per capita health expenditure, real terms, 2000 to 2012 (or nearest year)



Source: OECD Health Statistics 2014, http://dx.doi.org/10.1787/health-data-en; Eurostat Statistics Database; WHO Global Health Expenditure Database.

StatLink http://dx.doi.org/10.1787/888933155816