Spending on inpatient care and outpatient care covers the major part of health expenditure across EU member states – almost two-thirds of current health expenditure on average in 2012 (Figure 6.3.1). A further quarter of overall health spending was allocated to medical goods (mainly pharmaceuticals), while 10% went towards long-term care and the remaining 6% to collective services, including public health and prevention services and administration.

Greece stands out as the European country with the highest share of spending on inpatient care (including day care in hospitals): it accounted for almost half of total health spending in 2012, a significant increase from 2011 as a consequence of a larger decrease in spending on outpatient care and pharmaceuticals. In France, Romania, Austria and Poland, the hospital sector also plays an important role, with inpatient spending comprising more than a third of total cost. On the other hand, Portugal, Cyprus and Sweden have a high share of outpatient spending representing more than 40% of health expenditure in those countries.

The other major category is spending on medical goods. Differences in the consumption patterns of pharmaceuticals and relative prices are some of the main factors explaining the variations in medical goods spending among countries. In the Slovak Republic and Hungary, medical goods represent the largest spending category at more than a third of overall health expenditure. They also account for 30% or more in Lithuania, Croatia, Romania and Latvia. In Denmark, Norway and Switzerland, on the other hand, spending on medical goods represents only 10-11% of total health spending.

There are also differences among countries in their expenditure on long-term care. Countries such as Norway, the Netherlands and Denmark, which have established formal arrangements for the elderly and the dependent population, allocate around a quarter of all health spending to long-term care. In many southern and central European countries with a more informal long-term care sector, the expenditure on formal long-term care services accounts for a much smaller share of total spending.

The economic crisis affected health spending growth in many EU countries, resulting in substantially lower spending growth since 2009. In order to curb public spending, governments introduced a number of measures, such as cuts in health sector workforce and salaries, reductions in the fees paid to health providers and the prices for pharmaceuticals, and increases in co-payments for patients (Morgan and Astolfi, 2013).

The resulting slowdown in health expenditure experienced in many European countries affected all health spending categories to varying degrees (Figure 6.3.2). Both inpatient and outpatient care saw average spending growth decrease significantly, especially from 2010 onwards, in contrast to the high growth rates seen prior to the economic crisis. Pharmaceutical spending has continued to shrink, on average, for the last three years from 2010 to 2012, mainly due to government price reduction policies (see also Indicator 6.4). Many countries also took early measures to reduce or postpone spending on prevention and public health services, with a slight recovery in spending observed since 2011. The strong increase in 2009 is due partially to the H1N1 influenza pandemic which led to significant one-off expenditures for the purchase of large stocks of vaccines in many countries. Administration was another category immediately targeted in cost-cutting efforts. Cuts in administrative budgets were an initial response to the financial crisis in many countries, such as in the Czech Republic, where the budget of the Ministry of Health was reduced by 30% between 2008 and 2010. Across all EU member states, administrative expenditure stagnated in 2010 and 2011 before growing again in 2012.

Definition and comparability

The *System of Health Accounts* (OECD, 2000; OECD, Eurostat, WHO, 2011) defines the boundaries of the health care system. Current health expenditure comprises personal health care (curative care, rehabilitative care, long-term care, ancillary services and medical goods) and collective services (prevention and public health services as well as health administration). Curative, rehabilitative and long-term care can also be classified by mode of production (inpatient, day care, outpatient and home care). Concerning long-term care, only the health aspect is normally reported as health expenditure, although it is difficult in certain countries to separate out clearly the health and social aspects of long-term care. Some countries with comprehensive long-term care packages focusing on social care might be ranked surprisingly low based on SHA data because of the exclusion of their social care. Thus, estimations of long-term care expenditure are one of the main factors limiting comparability across countries.

References

Morgan, D. and R. Astolfi (2013), "Health Spending Growth at Zero: Which Countries, Which Sectors Are Most Affected?", *OECD Health Working Papers*, No. 60, OECD Publishing, Paris, *http://dx.doi.org/10.1787/5k4dd1st95xv-en*.

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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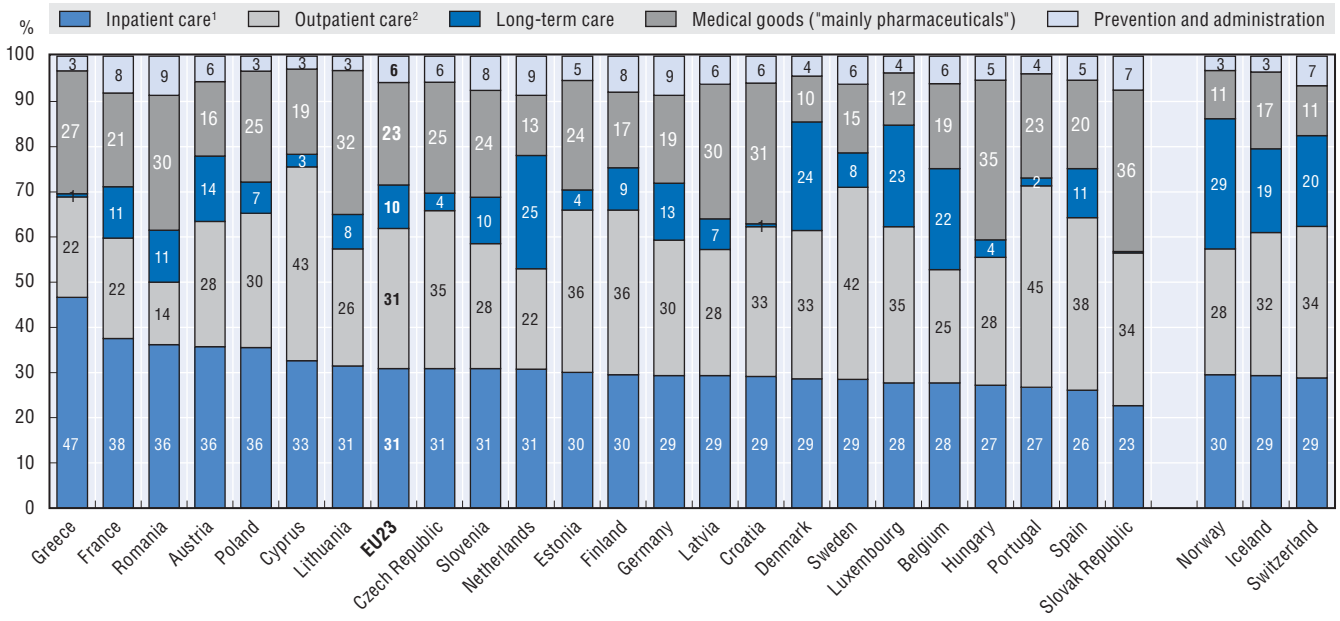
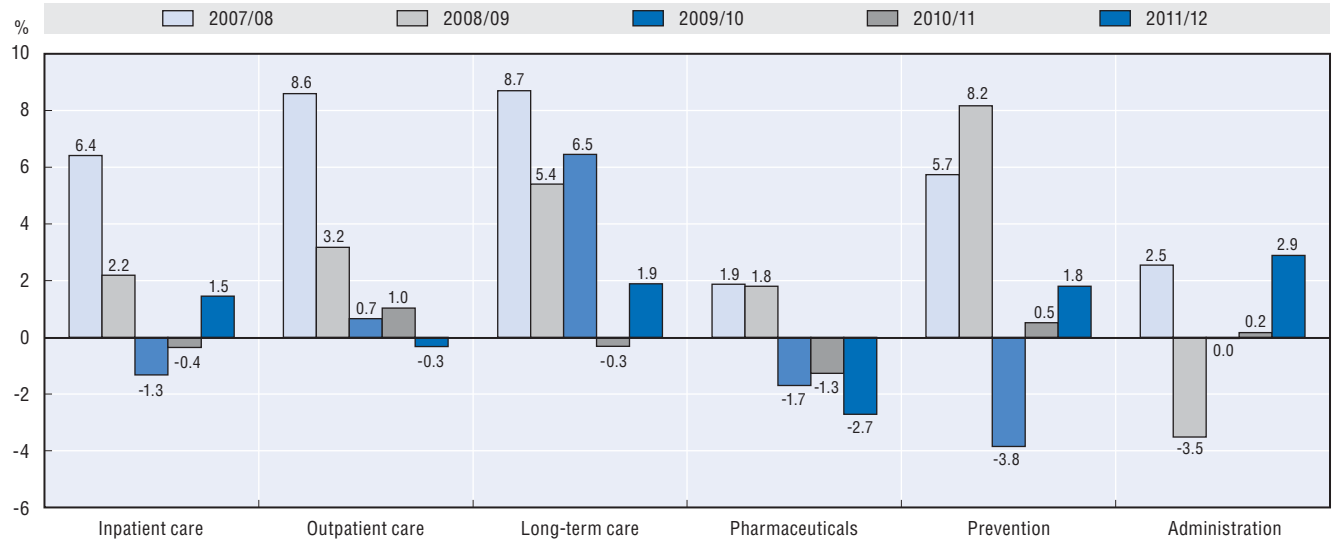
6.3.1. Current health expenditure by function, 2012 (or nearest year)



Note: Countries are ranked by inpatient care as a share of current health expenditure.
1. Refers to curative-rehabilitative care in inpatient and day care settings.
2. Includes home-care and ancillary services.

Source: *OECD Health Statistics 2014*, *http://dx.doi.org/10.1787/health-data-en*; *Eurostat Statistics Database* for non-OECD countries.

6.3.2. Average annual growth rates of spending for selected functions, EU average, in real terms



Source: *OECD Health Statistics 2014*, *http://dx.doi.org/10.1787/health-data-en*; *Eurostat Statistics Database* for non-OECD countries.

StatLink http://dx.doi.org/10.1787/888933155831