How much a country spends on health and the rate at which that spending grows can be the result of a wide array of social and economic factors, as well as the financing and organisational structures of a country's health system. At the same time, there is a strong relationship between the overall income level of a country and how much the population of that country will spend on health.

As such, there are large variations in the level and growth of health spending across Europe and it is not surprising that high-income countries such as Luxembourg, Norway and Switzerland are the European countries that spent the most on health in 2015 (Figure 5.1). With spending in excess of EUR 6 000 per person – adjusted for differences in countries' purchasing powers – Luxembourg was by far the biggest spender in the European Union. Among the other EU member states, Germany (EUR 4 003), the Netherlands (EUR 3 983), Sweden (EUR 3 937) and Ireland (EUR 3 922) were the highest spenders. At the other end of the scale, Romania (EUR 816) and Latvia (EUR 1 030) were the lowest spending countries among EU members. Considering the EU as a whole, per capita health spending was EUR 2 781 in 2015. Among the other European states outside the European Union, Switzerland (EUR 5 354) and Norway (EUR 4 681) rank among the highest spenders overall while health spending per capita in Montenegro, the Former Yugoslav Republic of Macedonia and Turkey was on a par with Romania and Albania the lowest overall.

Figure 5.1 also shows the breakdown of per capita spending on health into public (including compulsory insurance) and private sources (see also indicator "Financing of health care"). Overall, more than three-quarters of health spending come from public sources with the ranking by public spending similar to overall health spending. Of all the EU member states, only in Cyprus does private spending on health account for more than 50% of the total, although Latvia and Bulgaria also have relatively high levels of private spending. By contrast, Germany, Luxembourg, Sweden and Denmark all have private spending at around 15% of overall spending on health.

Following the economic crisis in 2008, health spending slowed significantly across Europe after years of continuous growth. In the European Union as a whole, health spending increased by only 0.7% each year in real terms (adjusted for inflation) between 2009 and 2015, compared with an annual growth rate of 3.1% between 2005 and 2009. In eight EU countries, expenditure on health retracted since 2009 whilst it significantly slowed in almost all others (Figure 5.2). A similar pattern can be seen in the other European countries, although Switzerland has seen higher health spending growth in the years since 2009 compared with the previous period.

On a country-by-country basis, Greece experienced one of the biggest reversals of health spending growth. Over the period 2005 to 2009, per capita health spending in Greece averaged a 4.5% annual growth rate. With fiscal consolidation in place in the context of reining in public budgets, Greek health spending has seen an average annual contraction of 6.6% since 2009. Portugal, Croatia, Cyprus and Italy have also experienced significant negative growth in per capita health spending since the onset of the crisis, particularly in the years between 2010 and 2013. In the last couple of years, health spending across Europe has generally seen a slow but steady increase, albeit at much lower rates compared to the pre-crisis period and more in line with economic growth.

Definition and comparability

Expenditure on health measures the final consumption of health goods and services, as defined in the System of Health Accounts manual (OECD, Eurostat and WHO, 2011). This refers to current 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 but in some areas further progress needs to be made. For example, different practices regarding the inclusion of long-term care in health or social expenditure can be one of the factors affecting data comparability.

Data on health expenditure for 2015 is considered preliminary, either estimated by national authorities or projected by the OECD Secretariat, and is therefore subject to revision.

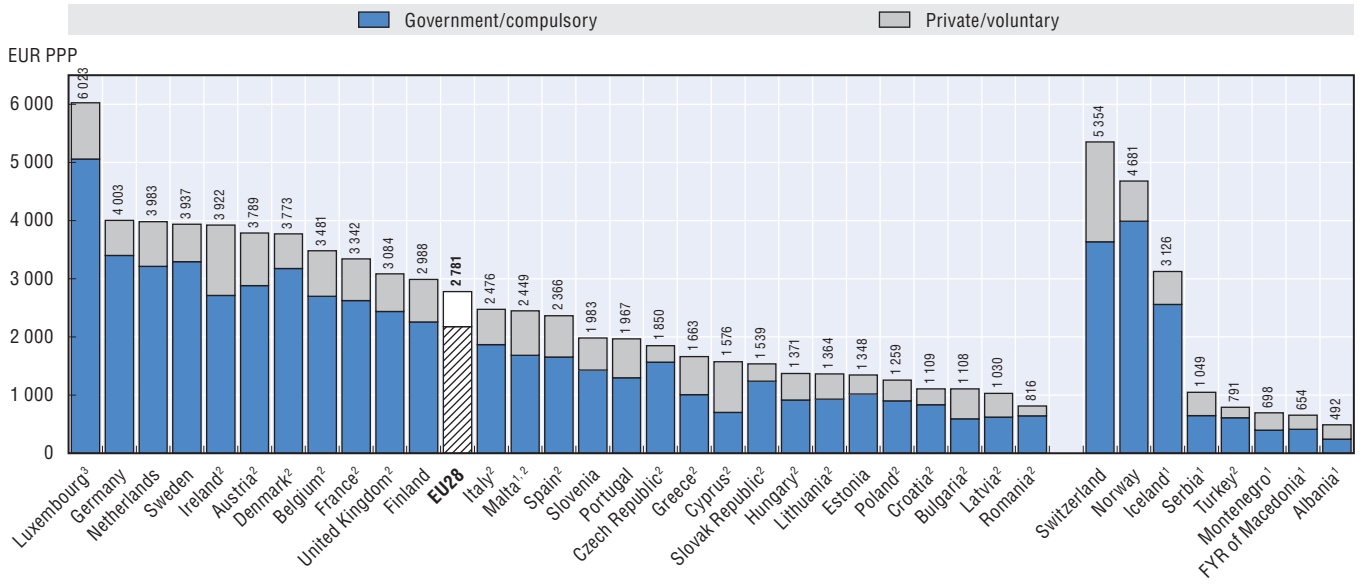
Countries' health expenditures are converted to a common currency (euro) and are adjusted to take account of the different purchasing power of the national currencies, in order to compare spending levels. Economy-wide (GDP) PPPs are used to compare relative expenditure on health in relation to the rest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

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

Reference

OECD, Eurostat and WHO (2011), *System of Health Accounts: 2011 Edition*, OECD Publishing, Paris, *http://dx.doi.org/10.1787/9789264116016-en*.

5.1. Health expenditure per capita, 2015 (or nearest year)

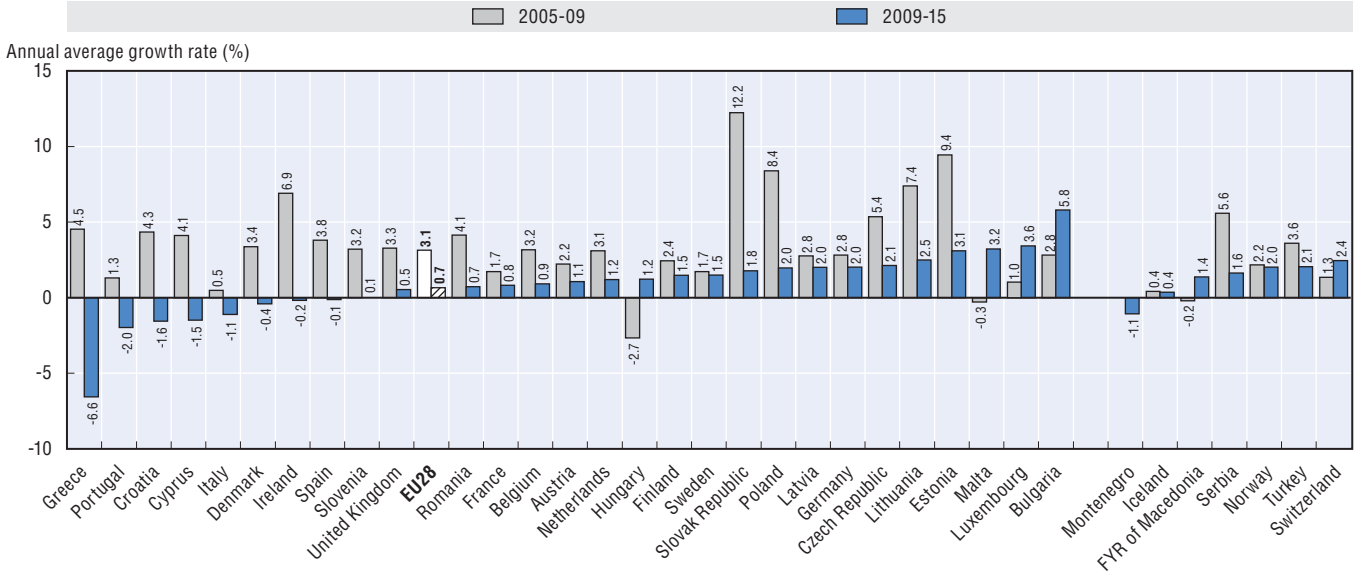


1. Includes investments.
2. OECD estimate.
3. For Luxembourg, the population data refer only to the total insured resident population, which is somewhat lower than the total population.

Source: OECD Health Statistics 2016; Eurostat Database; WHO, Global Health Expenditure Database.

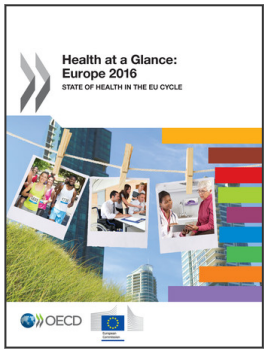
StatLink http://dx.doi.org/10.1787/888933429236

5.2. Annual average growth rate in per capita health expenditure, real terms, 2005 to 2015 (or nearest year)



Source: OECD Health Statistics 2016; Eurostat Database; WHO, Global Health Expenditure Database.

StatLink http://dx.doi.org/10.1787/888933429242



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