7.3. Health expenditure by function

The allocation of health spending across the different types of health services and medical goods is influenced by a range of factors, including the availability of resources such as hospital beds, physicians and access to new technology, the financial and institutional arrangements for health care delivery, as well as by national clinical guidelines and the disease burden within a country.

In 2007, curative and rehabilitative care provided in either an in-patient (including day care) or out-patient setting accounted for 60% of current health spending on average across OECD countries (Figure 7.3.1). The ratio of in-patient to out-patient spending depends on the institutional arrangements for health care provision. Austria and France, for example, report a relatively high proportion of expenditure for in-patient care (amounting to more than a third of total health spending) which is associated with a high level of hospital activity (see Indicator 4.4). Conversely, countries such as Portugal and Spain, with low levels of hospital activity, allocate less than a quarter of health care resources to in-patient care.

Large differences remain between countries in their expenditure on long-term care. Switzerland, Norway and Denmark, with established formal arrangements for elderly care, allocate up to a quarter of total health spending to long-term care. In Korea and Portugal, where care tends to be provided in more informal or family settings, the expenditure on long-term care occupies a much smaller share of total spending (OECD, 2005a).

The other major category of health expenditure is on medical goods, mostly accounted for by pharmaceuticals (see Indicator 7.4). Although over 20% on average, the share of health spending on medical goods can be as low as 11-13% in Luxembourg, Switzerland, Norway and Denmark, and as high as 36-38% in Hungary and the Slovak Republic.

Curative-rehabilitative care covers not only medical services requiring hospitalisation, but also those services provided either as day care, or as an out-patient in hospitals, the ambulatory sector, or in a patient's own home. Changes in medical practice, new technologies and more efficient allocation of resources can all affect the balance between different types of care delivery. Day (ambulatory) surgery is one area that has been expanding in many OECD countries in recent years.

The use of day surgery for procedures such as cataract removal (see Indicator 4.9) or hernia repairs may result in higher throughput and decreased unit costs. In many countries day care has accounted for an increasing share of the total spending on curative care in recent years (Figure 7.3.2). There are, however, wide variations in spending – partly reflecting data limitations – but also national policies and regulations. In France, spending on day care now accounts for around 11% of curative care spending. By contrast, Germany, where day surgery in public hospitals was prohibited until the late 1990s (Castoro *et al.*, 2007), reported only 2% of curative care expenditure as services of day care.

Figure 7.3.3 shows the share of health expenditure allocated to public health and prevention activities. On average, OECD countries allocated 3% of their spending on health to a wide range of activities such as vaccination programmes and public health campaigns on alcohol abuse and smoking. The wide variation reflects to a great extent the national organisation of prevention campaigns. Where such initiatives are carried out at the primary care level, such as in Spain, the prevention function is not captured separately and may be included under the spending on curative care. Other countries adopting a more centralised approach to public health and prevention campaigns tend to be able to identify spending on such programmes.

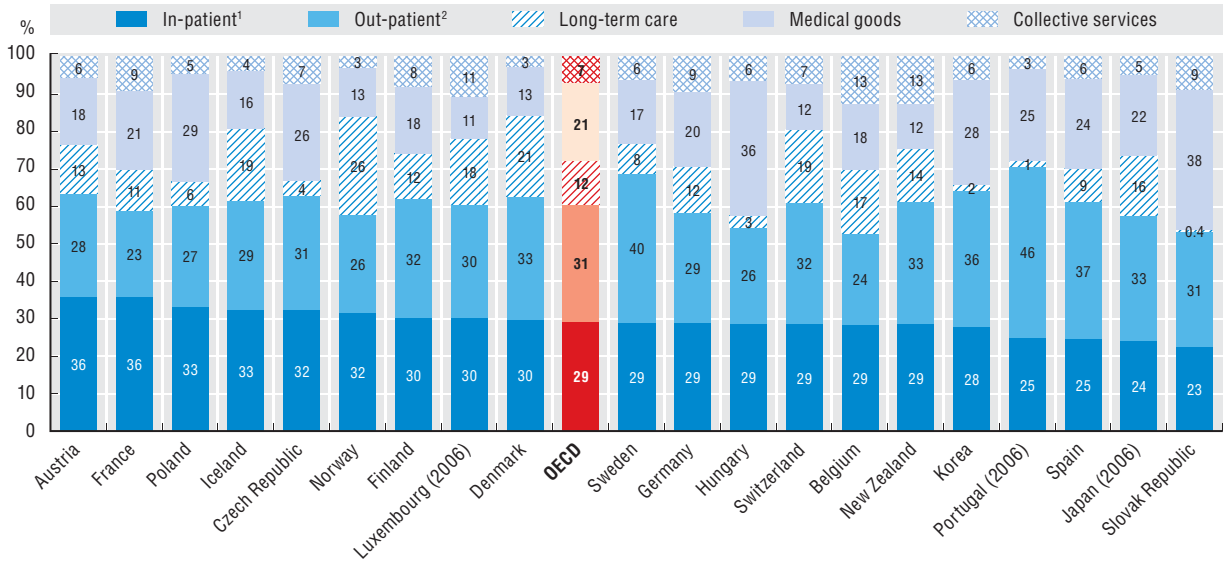
Definition and deviations

The functional approach of the *System of Health Accounts* defines the boundaries of the health system. Total health expenditure consists of current health spending and investment. Current health expenditure comprises personal health care (curative care, rehabilitative care, long-term care, ancillary services and medical goods) and collective services (public health services and health administration). Curative, rehabilitative and long-term care can also be classified by mode of production (in-patient, day care, out-patient and home care.)

Factors limiting the comparability across countries include estimations of long-term care expenditure. Also, in some cases, expenditure in hospitals is used as a proxy for in-patient care services, although hospital expenditure may include spending on out-patient, ancillary, and in some cases drug dispensing services (Orosz and Morgan, 2004).

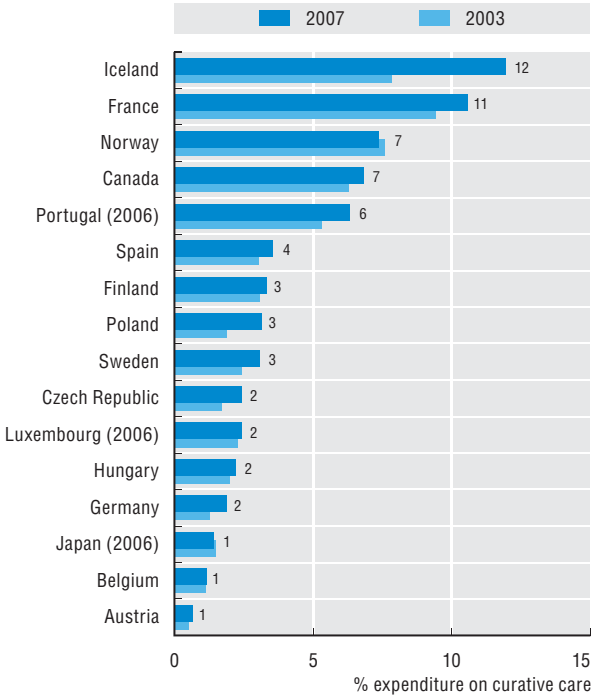
7.3.1 Current health expenditure by function of health care, 2007

Countries are ranked by in-patient curative care as a share of current expenditure on health

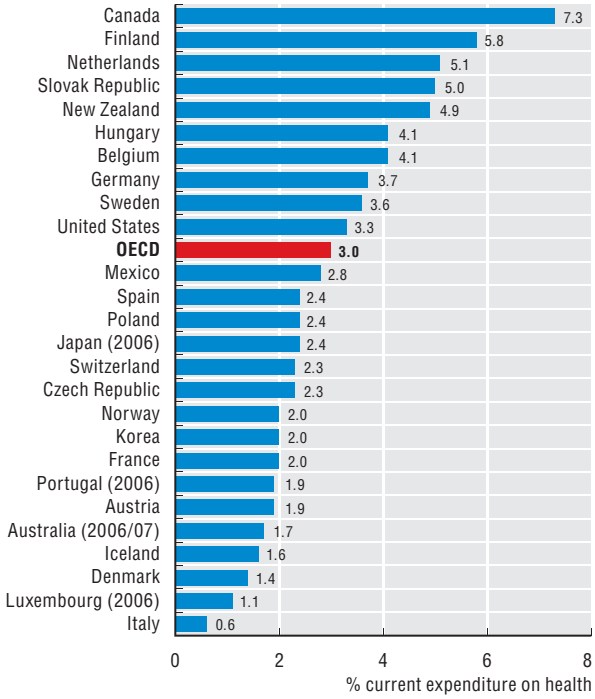


1. Refers to curative-rehabilitative care in in-patient and day-care settings.
2. Includes home-care and ancillary services

7.3.2 Day care as a share of total curative care expenditure, 2003 and 2007

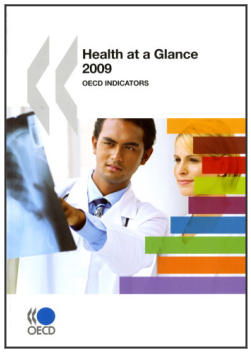


7.3.3 Expenditure on organised public health and prevention programmes, 2007



Source: OECD Health Data 2009.

StatLink http://dx.doi.org/10.1787/720355408522



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