# Health expenditure per capita

The level of health spending in a country and how this changes over time is determined by a wide range of demographic, social and economic factors, as well as the financing arrangements and organisational structure of the health system itself. The COVID-19 pandemic has shown that the extent to which a country was impacted by the crisis may also affect overall spending levels.

Given these factors, there are large variations in the level and growth of health spending across Europe. With spending at EUR 4 997 per person, Switzerland was the biggest spender in Europe, followed by Germany (EUR 4 831). Spending levels in the Netherlands, Austria and Sweden were also well above the population-weighed EU average of EUR 3 159. At the other end of the scale, Romania, Croatia and Bulgaria were the lowest spending countries in the EU, below half the EU average (Figure 5.1). This means that on a per capita basis, there is a three-fold difference in health spending between high-income countries in Western and Northern Europe and some low spending countries in Central and Eastern Europe.

## Definition and comparability

Expenditure on health, as defined in the System of Health Accounts (OECD/Eurostat/WHO, 2017[1]), measures the final consumption of health goods and services. This refers to current spending on medical services and goods, public health and prevention programmes, and overall administration of health care provision and financing irrespective of the type of financing arrangement. Subsidies paid to providers as part of targeted programmes to support the health sector should also be included in the figures.

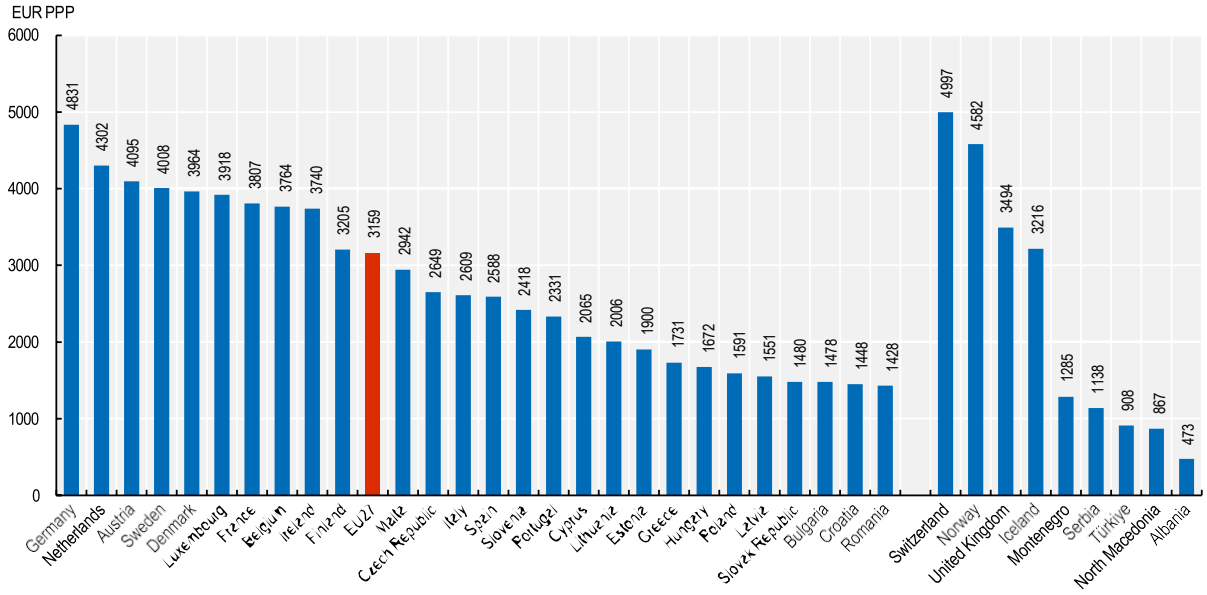
Countries' health expenditures are converted into a common currency (Euro) and are adjusted to take account of the different purchasing power of the national currencies. Economy-wide Actual Individual Consumption (AIC) PPPs are used to compare relative expenditure on health in relation to the rest of the economy.

For the calculation of growth rates in real terms, economy-wide AIC deflators are used. Although some countries produce their own health-specific deflators, these are not currently used due to the limited availability and comparability for all countries.

## References

OECD/Eurostat/WHO (2017), *A System of Health Accounts 2011: Revised edition*, OECD Publishing, Paris, https://doi.org/10.1787/9789264270985-en. [1]

### Figure 5.1. Health expenditure per capita, 2020 (or nearest year)




Note: The EU average is weighted.
Source: OECD Health Statistics 2022; Eurostat Database; WHO Global Health Expenditure Database.

StatLink https://stat.link/2agu6e

# Health expenditure in relation to GDP

How much a country spends on health care in relation to all other goods and services in the economy, and how that changes over time, depends not only on the level of health spending but also on the size of the economy. During the 1990s and early 2000s, EU countries generally saw health spending outpace the rest of the economy, leading to an almost continual rise in the ratio of health expenditure to gross domestic product (GDP), but this trend was disrupted with the financial and economic crisis of 2008/09. The COVID-19 pandemic also led to fundamentally diverging growth patterns of health spending and economic output resulting in a major adjustment of this indicator.

In 2020, an unprecedented 10.9% of the GDP of the European Union was devoted to health care (Figure 5.3). Germany and France dedicated the highest shares to health at over 12% of their respective GDP. Sweden, Austria, the Netherlands and Belgium also spent over 11% of their GDP on health. The lowest shares of the overall economic output allocated to health were in Luxembourg (5.8%), Romania (6.3%), Poland (6.5%) and Ireland (7.1%). Across the whole of Europe, the United Kingdom and Switzerland were additional high spenders on health (with shares at around 12%), while Türkiye allocated the lowest share (4.6%).

Between 2013 and 2019, health expenditure per capita growth was broadly in line with GDP per capita growth in EU member countries (Figure 5.4). Following years of austerity and slow growth caused by the global financial crisis of 2008/09, health expenditure and GDP both grew between 2013 and 2019 at around the same rate, with both averaging an annual 2.5% growth in real terms. Consequently, health expenditure as a share of GDP remained relatively stable over the same period in many countries (Figure 5.5), at around 10% across the European Union.

However, the COVID-19 crisis had significant consequences for both economic and health spending growth in 2020. The pandemic saw a new array of direct and indirect costs for the health sector, associated with the treatment and management of COVID-19 patients and the scaling up of treatment capacity. At the same time, lockdown measures and restrictions on economic activity caused GDP to plummet across nearly all EU countries. Between 2019 and 2020, average health expenditure per capita grew by 5.5% across EU member countries, while GDP per capita fell rapidly by nearly 5% on average over the same period. As a result, health expenditure as a share of GDP increased substantially by 1 percentage point to 10.9% in 2020 across the European Union.

Preliminary estimates for 2021 point to further volatility in the evolution of health expenditure and GDP. Further increases in health expenditure can be observed for a handful of EU member countries for 2021 as countries face continuing pandemic-associated costs. These include the financing of vaccination programmes, testing and

surveillance, and increased demand for health services. On the other hand, subsidies to health providers are expected to be much more limited in 2021 compared to the previous year. Further uncertainties beyond 2021 lie ahead, as EU member countries experience growing economic challenges in light of the war in Ukraine, high inflation and disruptions in supply chains.

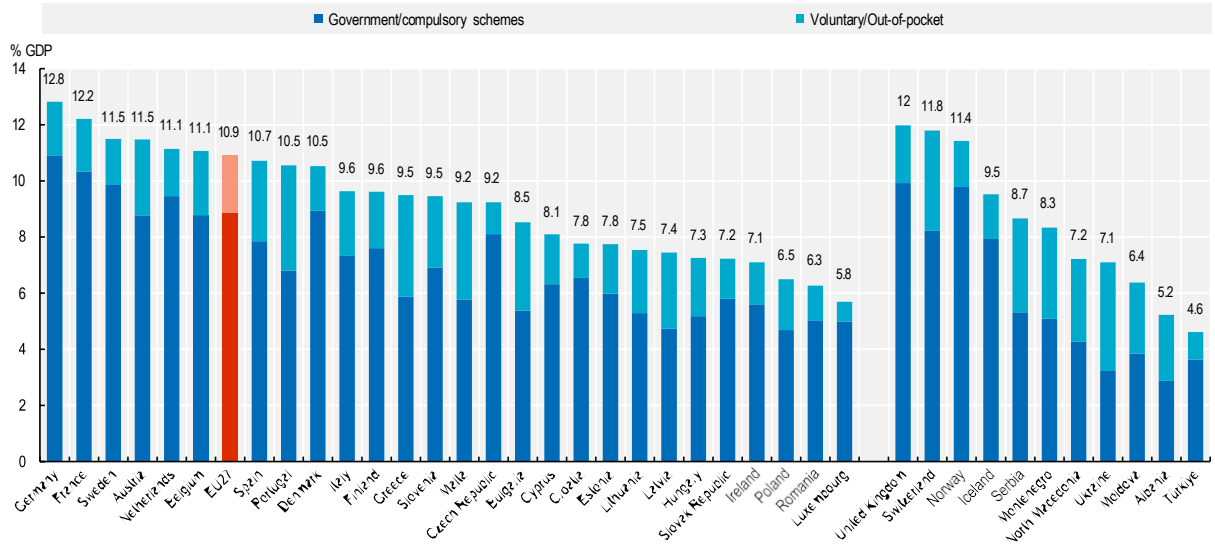
### Definition and comparability

Gross domestic product (GDP) is the sum of final consumption, gross capital formation and net exports. Final consumption includes all the goods and services used by households or the community to satisfy their needs. It includes final consumption expenditure of households, general government and non-profit institutions serving households.

The GDP figures used to calculate the indicator health expenditure to GDP are based on official GDP data available as of mid-June 2022.

In countries such as Ireland and Luxembourg, where a significant proportion of GDP refers to profits exported and not available for national consumption, gross national income (GNI) may be a more meaningful measure than GDP, but for international comparability, GDP is used throughout.

## Figure 5.3. Health expenditure as a share of GDP, 2020 (or nearest year)




Note: The EU average is weighted.
Source: OECD Health Statistics 2022; Eurostat Database; WHO Global Health Expenditure Database.

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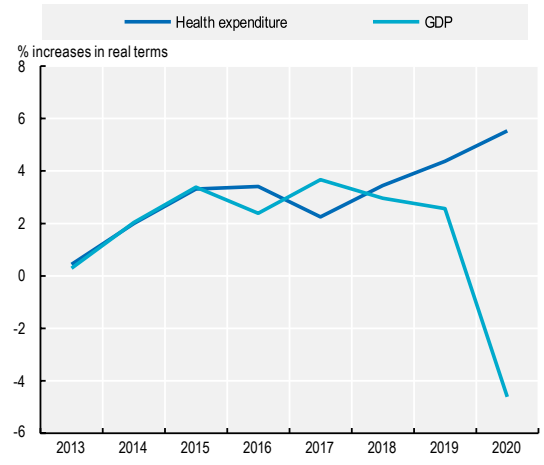
## Figure 5.4. Annual growth in per capita health expenditure and GDP, EU27, 2013-20




Note: The EU average is unweighted.
Source: OECD Health Statistics 2022; Eurostat Database.

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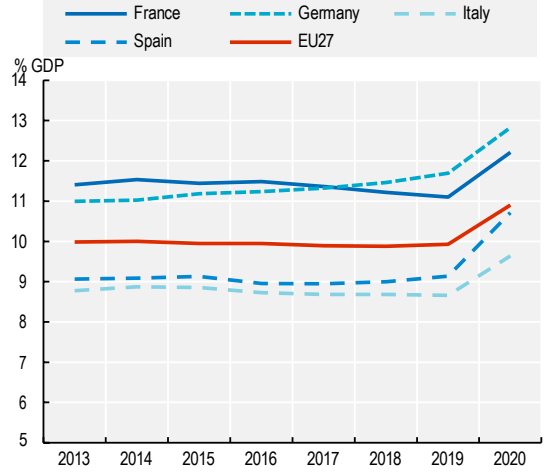
## Figure 5.5. Health expenditure as a share of GDP, EU27 and selected countries, 2013-20




Note: The EU average is weighted.
Source: OECD Health Statistics 2020; Eurostat Database.

StatLink https://stat.link/zykoie

# Financing of health expenditure

Health care is purchased through a variety of financing arrangements. In countries where individuals are entitled to health care services based, for example, on their residency, government schemes are the predominant arrangement. In others, some form of compulsory health insurance (either social health insurance or one organised through private insurers) usually covers the bulk of health expenditure. In addition, out-of-pocket payments by households as well as various forms of voluntary health insurance intended to replace, complement or supplement automatic or compulsory coverage make up the rest of health spending.

In 2020, 81% of total health spending in the EU was financed through governments and compulsory insurance (Figure 5.6). In Sweden and Denmark, government schemes covered around 85% of all health spending. In Luxembourg, Croatia, Germany, France, the Slovak Republic and the Netherlands, compulsory health insurance financed more than three-quarters of all health expenditure.

The share of health spending financed through households' out-of-pocket payments was 15% across EU countries. In three EU countries – Bulgaria, Greece and Malta – households' out-of-pocket payments accounted for at least one-third of all health spending in 2020. Only in Slovenia did voluntary health insurance finance more than 10% of health spending, compared to the EU weighted average of 3%.

To purchase health care goods and services, financing schemes rely on different types of revenues. In 2020, public sources (which includes government transfers and social insurance contributions) funded 77% of all health spending on average across EU countries (Figure 5.7). While this share is comparable to that seen in Figure 5.6, there are differences for some countries. For example, compulsory private health insurance is generally financed from private revenues, which explains why the share of publicly-sourced health spending in Germany, France and Switzerland is substantially lower than their respective share of health spending financed from government and compulsory schemes.

Public budgets finance many different services and health care is competing for funds with other sectors such as education, defence and housing. The COVID-19 pandemic caused major upward pressure on health budgets during 2020 but similar pressures were felt across many other public spending priorities, with governments providing substantial support to firms and households. As a result, the share of total government expenditure allocated to health remained at 14% on average across EU countries (Figure 5.8) compared to 2019. In Ireland and Germany, the share of public spending dedicated to health care was around 20%, while in Hungary, Greece and Poland, it was around 10%. Since 2015, these shares have risen in most EU countries, but the increases have been mainly moderate.

## Definition and comparability

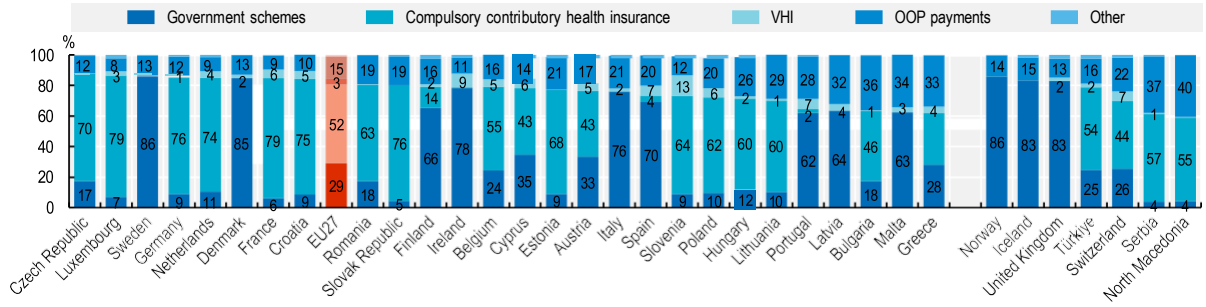
The financing of health care can be analysed from the point of view of financing schemes (financing arrangements through which health services are paid for and obtained by people, e.g. social health insurance) and types of revenues of financing schemes (e.g. social insurance contributions) (OECD/Eurostat/WHO, 2017[1]).

Total government expenditure is as defined in the System of National Accounts and includes as major components: intermediate consumption, compensation of employees, interest, social benefits, social transfers in kind, subsidies, other current expenditure and capital expenditure payable by central, regional and local governments as well as social security funds.

## References

OECD/Eurostat/WHO (2017), *A System of Health Accounts 2011: Revised edition*, OECD Publishing, Paris, https://doi.org/10.1787/9789264270985-en. [1]

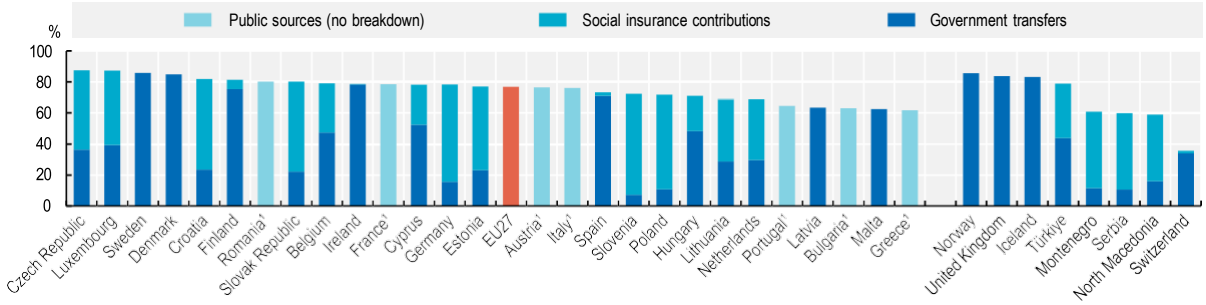
## Figure 5.6. Health expenditure by type of financing, 2020 (or nearest year)




Note: Countries are ranked by government schemes and compulsory health insurance as a share of health expenditure. The EU average is weighted. The "Other" category refers to charities, employers, foreign and undefined schemes. OOP refers to out-of-pocket payments.
Source: OECD Health Statistics 2022; Eurostat Database; WHO Global Health Expenditure Database.

StatLink https://stat.link/xszdnl

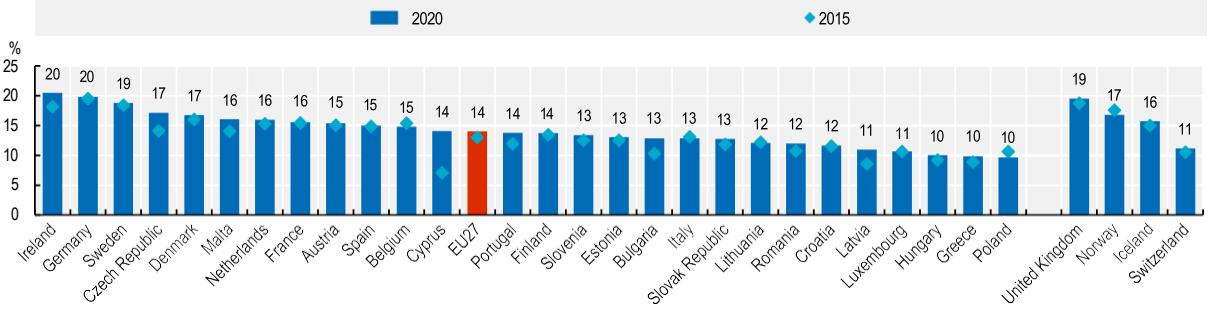
## Figure 5.7. Health expenditure from public sources as share of total health spending, 2020 (or nearest year)




Note: The EU average is weighted. 1. Public sources include spending by government schemes and social health insurance schemes.
Source: OECD Health Statistics 2022; WHO Global Health Expenditure Database.

StatLink https://stat.link/rw39pj

## Figure 5.8. Health expenditure from public sources as a share of total government expenditure, 2015 and 2020 (or nearest year)




Note: For those countries without information on sources of revenues, data from financing schemes are used. The EU average is unweighted.
Source: OECD Health Statistics 2022; OECD National Accounts Database; Eurostat database.

StatLink https://stat.link/e3y7k6

# Health expenditure by type of good and service

A variety of factors, from disease burden and system priorities to organisational aspects and costs, help determine the allocation of resources across the various types of health care goods and services. In 2020, the EU spent around three-fifths of its total health spending on curative and rehabilitative care, around 20% on retail medical goods, and one-sixth on health-related long-term care. The remaining 7% was spent on collective services, such as prevention and public health, as well as the administration of health care systems (Figure 5.9).

In 2020, the share of current health expenditure going to curative and rehabilitative care ranged from just over half of all health spending in Malta and the Netherlands to around three-quarters in Cyprus and Portugal. Breaking it down further, Romania had the highest proportion of spending on inpatient care (including day care in hospitals), accounting for 46% of health spending. For most EU countries (16), spending on outpatient care (including home-based curative and rehabilitative care and ancillary services) exceeded that on inpatient care.

The other major category of health spending is retail medical goods (mainly pharmaceuticals) consumed in outpatient settings. In 2020, the share of medical goods spending was highest in Bulgaria, the Slovak Republic and Greece, where it represented around a third of health spending. In contrast, Denmark, Sweden and the Netherlands spent only 10-11% of total health spending on medical goods.

Countries' spending on health-related long-term care also varies considerably across the EU. The Netherlands, Sweden and Norway allocated more than a quarter of their health spending to long-term care in 2020. In many Southern as well as Central and Eastern European countries, with more informal arrangements, expenditure on formal long-term care services accounts for a much smaller share of total spending.

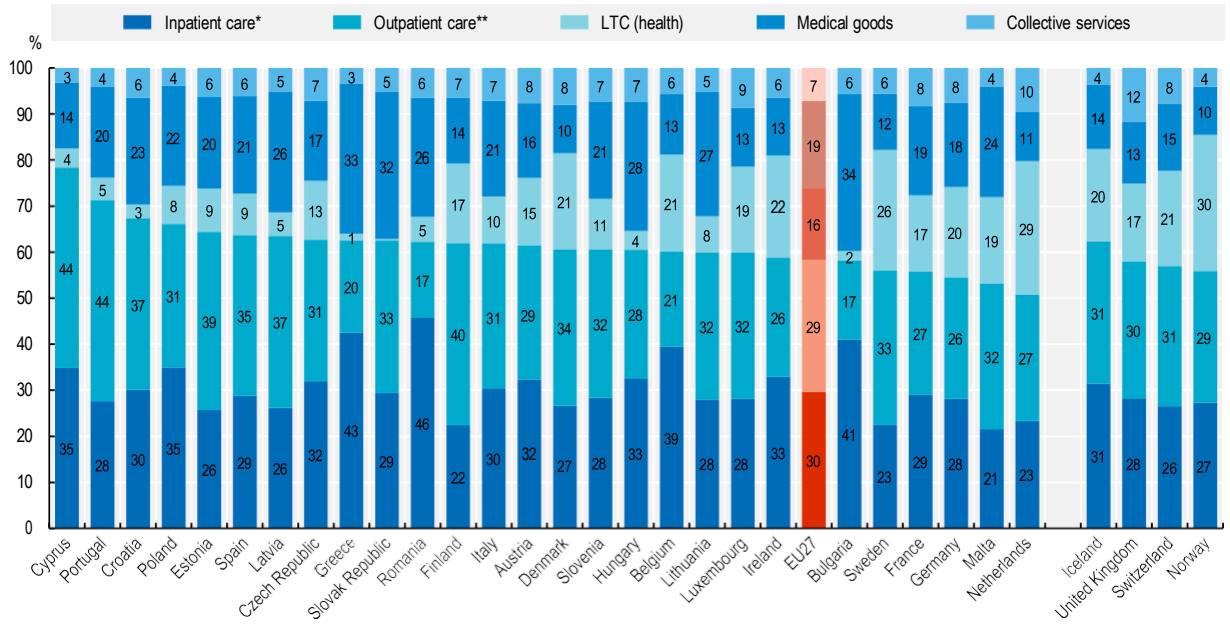
Figure 5.10 compares the per capita spending growth rates for key health goods and services for the years 2013-19 with 2019-20 across the EU. Prior to the COVID-19 crisis, spending growth for inpatient care, pharmaceuticals, and administration averaged around 2-3% per year, while annual spending increases for long-term care, outpatient care, and prevention averaged above 4%. In 2020, the pandemic triggered exceptional spending growth for most health care functions. Spending on preventive care increased by nearly one-third, with countries dedicating resources to testing, tracing, surveillance, and public information campaigns related to the pandemic. Spending growth on inpatient care reached nearly 9%, driven by COVID-19-related expenditures including additional staff and input costs (e.g. personal protective equipment) and substantial subsidies targeted at hospitals. Only outpatient care experienced lower growth in 2020 compared to the 2013-19 period. This can be attributed to the deferral of visits to outpatient facilities during the pandemic, in efforts to reduce transmission and free up health system capacity.

### Definition and comparability

The *System of Health Accounts* defines the boundaries of the health care system. Current health expenditure comprises personal health care (curative and 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 provision (inpatient, day care, outpatient and home care). Concerning long-term care, only care that relates to the management of the deterioration in a person's health is reported as health expenditure, although it is difficult in certain countries to clearly separate out the health and social aspects of long-term care.

Some countries can have difficulties separating spending on pharmaceuticals used as an integral part of hospital care from those intended for use outside of the hospital, potentially leading to an underestimate of pharmaceutical spending and an overestimate of inpatient and/or outpatient care.

### Figure 5.9. Health expenditure by function, 2020 (or nearest year)




Note: Countries are ranked by curative-rehabilitative care as a share of health expenditure. The EU average is weighted. *Refers to curative-rehabilitative care in inpatient and day care settings. **Includes home care and ancillary services and can be provided in ambulatory care settings or hospitals.
Source: OECD Health Statistics 2022.

StatLink https://stat.link/a9toqv

# Expenditure on primary health care

Effective primary health care is the cornerstone for efficient, people-centred, and equitable health systems. The COVID-19 pandemic has shown that for health systems to be resilient in the face of health crises, strong primary and community health care – the frontline of all health systems – is essential.

In 2020, primary health care accounted for around 13% of all health spending on average across EU countries, ranging from 8% in Romania to around 18% in Lithuania (Figure 5.11). In most EU countries, primary health care spending as a share of total health spending remained relatively constant between 2015 and 2019 suggesting expenditure growth was in line with overall health spending. Yet, there was a slight drop in this proportion in 2020 as a result of strong growth in spending on inpatient care and a widespread reduction in dental care spending.

Analysing the composition of primary care spending reveals that around half of it refers to general outpatient care services on average across EU countries. A further 36% is related to dental care. Prevention services (9%) make up most of the remaining part. Looking at specific country examples, the share of general outpatient care in ambulatory settings is particularly high in Poland and Cyprus, reaching 13% of all health spending. In Germany, Austria, Romania and Luxembourg, spending on general outpatient care is much lower in relative terms, accounting for less than 5% of total health spending (Figure 5.11).

While only accounting for a moderate share of overall health spending, spending on prevention and public health increased significantly in some EU countries with the onset of the COVID-19 crisis (see indicator "Health expenditure by type of good and service"). Yet, even after the strong one-off growth in 2020 – mainly related to COVID-19 public health management, extensive testing to detect the virus, pandemic surveillance and emergency co-ordination, spending on preventive measure still only accounts for around 3% of overall health spending (Figure 5.12). While there is some variation in this proportion across EU countries – ranging from more than 5% in Italy, Finland and Luxembourg to around 1% in the Slovak Republic – it is generally perceived to be insufficient. An important lesson of the COVID-19 pandemic is that the health status of populations needs to be improved to make people more resilient against future health system emergencies. Cross-country analysis has shown that countries where the population was less obese and less likely to smoke generally had better health outcomes during the pandemic (OECD, forthcoming[1]).

## Definition and comparability

The OECD has developed a methodological framework based on the System of Health Accounts to estimate primary health care spending on which the results presented here are based (Mueller and Morgan, 2018[2]).

The following functions are identified as basic care services: (i) General outpatient curative care (e.g. routine visits to a GP or nurse for acute or chronic treatment); (ii) Dental outpatient curative care (e.g. regular control visits as well as more complex oral treatment); (iii) Home-based curative care (mainly referring to home visits by GPs or nurses); (iv) Preventive care services (e.g. immunisation or health check-ups).

Where basic care services are provided by ambulatory health care providers such as medical practitioners, dentists, ambulatory health care centres and home health care service providers, this may be considered a proxy for primary health care. Yet primary health care is a complex concept and no definitive consensus exists on which services or providers should be included.

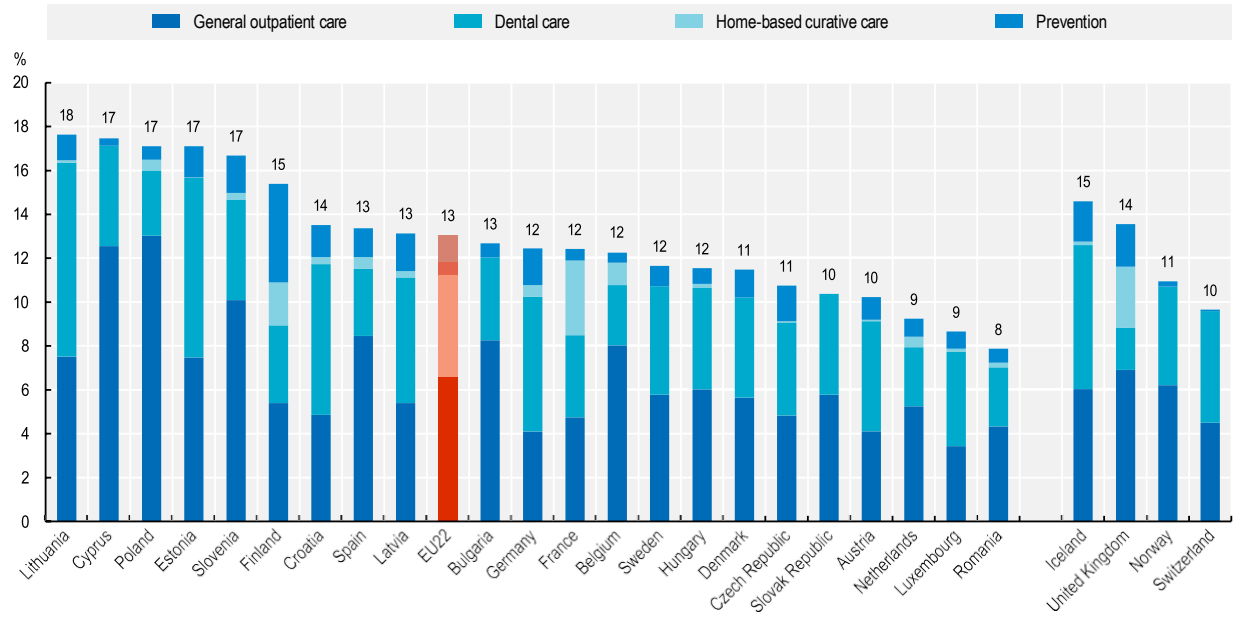
Comparability for this indicator is still limited and depends on countries' capacity and methods used to distinguish between general outpatient and specialist services.

## References


Mueller, M. and D. Morgan (2018), "Deriving preliminary estimates of primary care spending under the SHA 2011 framework", OECD, Paris, https://www.oecd.org/health/health-systems/Preliminary-Estimates-of-Primary-Care-Spending-under-SHA-2011-Framework.pdf. [2]

OECD (forthcoming), *Ready for the Next Crisis? Investing in Resilient Health Systems*, OECD Health Policy Studies, OECD Publishing, Paris. [1]

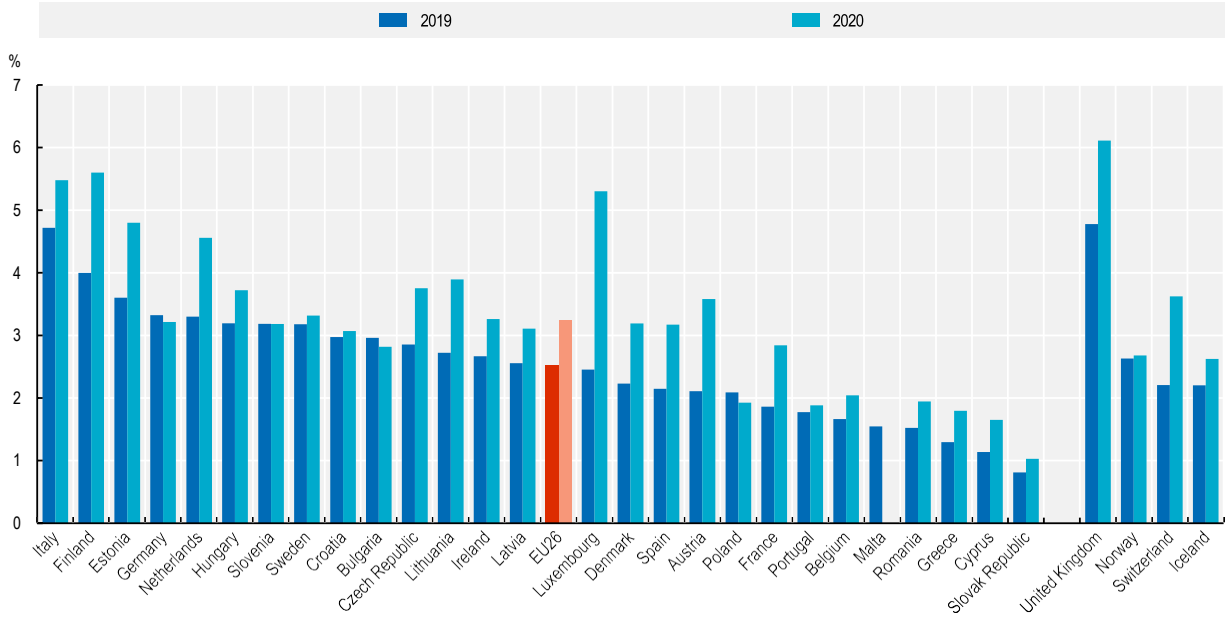
## Figure 5.137. Spending on primary health care services as share of current health expenditure,




Note: The EU average is unweighted.
Source: OECD Health Statistics 2022.

StatLink https://stat.link/dk6iu1

## Figure 5.12. Share of spending on prevention in current health expenditure, 2019-20




Note: The EU average is unweighted.
Source: OECD Health Statistics 2022.

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# Health expenditure by provider

How and where health care is delivered can have a significant impact on spending for different goods and services. Health care can be provided in many different organisational settings, ranging from hospitals and medical practices to pharmacies and even private households caring for family members. Analysing health spending by provider can be particularly useful when considered alongside the functional breakdown of health expenditure, giving a fuller picture of the organisation of health systems (see indicator "Health expenditure by type of good and service").

Activities delivered in hospitals account for the largest proportion of health care expenditure in almost all EU countries. In 2020, hospitals received 38% of EU spending on health. In Romania, Croatia, Spain, Denmark, and Cyprus, hospitals received more than 45% of their countries' entire health care budget (Figure 5.13). On the other end of the scale, hospitals account for less than 30% of Germany's total health spending.

After hospitals, the second-largest category of care providers are ambulatory providers. Across EU countries, care delivered by this category accounts for a quarter of health spending. The share stands at 30% or above in Germany and Finland, but is less than 15% in Romania and Bulgaria. This category covers a wide range of facilities and, depending on the country-specific organisation of health service delivery, most spending relates either to medical practices including offices of GPs and specialists or ambulatory health care centres.

Other main provider categories include retailers (mainly pharmacies selling prescription and over-the-counter medicines) – accounting for 17% of health spending on average across EU countries – and residential long-term care facilities (mainly providing inpatient care to long-term care dependent people), making up 10% of health spending on average.

There is a large diversity in the range of activities that may be performed by the same category of provider across countries, depending on the organisation of each health system. This variation is most pronounced in hospitals (Figure 5.4). Although the majority of hospital expenditure in almost all EU countries is allocated to inpatient (curative-rehabilitative) care, in some countries, hospitals constitute an important provider of outpatient care services – for example, through accident and emergency departments or specialist outpatient units. In Germany, Greece and Bulgaria, hospitals are generally mono-functional, with the vast majority (>90%) of spending directed to *inpatient care*, and very little spending on outpatient and day care. On the other hand, *outpatient care* accounts for over 40% of hospital expenditure in Portugal, Finland, Denmark, and Sweden.

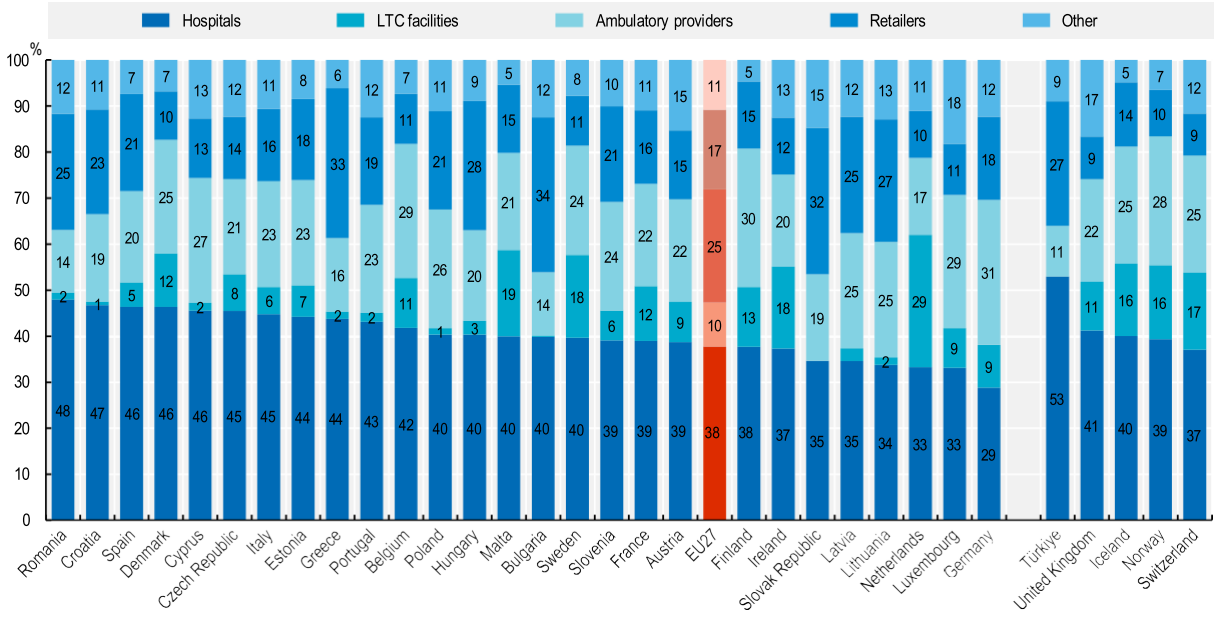
As many countries allocated additional resources to hospitals to cope with severe cases of COVID-19 and to be better prepared for future increases in demand, the total share of hospital expenditure in overall health spending increased slightly in 2020 by half a percentage point compared to 2019. The pandemic also had consequences for the composition of service delivery in hospitals. As elective day surgeries were frequently postponed during 2020, inpatient expenditure as a share of hospital expenditure increased by 1 percentage point, while day curative care fell by around half a percentage point.

### Definition and comparability

The different categories of health care providers are defined in the System of Health Accounts.

The main categories of health care providers are hospitals (acute and psychiatric), residential long-term care facilities, ambulatory providers (practices of GPs and specialists, dental practices, ambulatory health care centres, providers of home health care services), providers of ancillary services (e.g. ambulance services, laboratories), retailers (establishments whose primary activity is the retail sale of medical goods, e.g. pharmacies), and providers of preventive care (e.g. public health institutes).

## Figure 5.139. Health expenditure by provider, 2020 (or nearest




Note: The EU average is weighted.
Source: OECD Health Statistics 2022.

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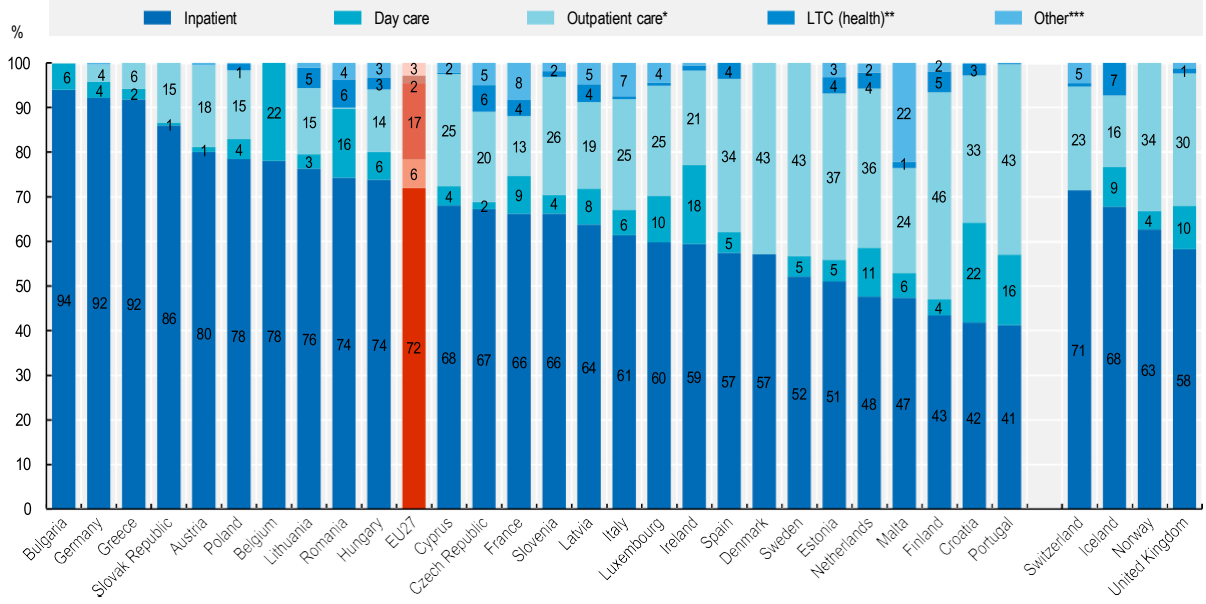
## Figure 5.14. Hospital expenditure by type of service, 2020 (or nearest year)




Note: The EU average is weighted. *Refers to curative-rehabilitative care provided to outpatients or at their homes and ancillary services. **Refers to LTC services for people with LTC needs. ***Includes medical goods and collective health services.
Source: OECD Health Statistics 2022.

StatLink https://stat.link/1wl9jm

# Population coverage for health care

The share of the population covered by a public or private scheme provides an important measure of access to care and the financial protection against the costs associated with health care. The COVID-19 pandemic demonstrated the importance of universal health coverage as a key element for the resilience of health systems, as gaps in insurance coverage and high levels of out-of-pocket payments may deter people from seeking care, and thus contribute to virus transmission. Higher population coverage through public and primary private health insurance have been associated with lower COVID-19 death and lower excess mortality in EU and other OECD countries (OECD, forthcoming[1]).

However, population coverage is only a partial measure of access and coverage: the range of services covered and the degree of cost-sharing for those services also define how comprehensive health care coverage is in a country (see indicator "Extent of health care coverage").

Most European countries have achieved universal (or near-universal) coverage of health care costs for a core set of services, usually including consultations with doctors, tests and examinations, and hospital care (Figure 7.4). Yet, in some countries, coverage of these core services may not be universal. In Ireland, for example, only Medical Card and GP Card holders (less than 50% of the population) were covered for the costs of all GP services in 2020. However, since the beginning of the pandemic in March 2020, some GP services such as remote COVID-19 consultations are provided free of charge for all the population.

Two EU countries (Bulgaria and Romania) still had at least 10% of their population not covered for health care costs in recent years. In both countries, the main groups of uninsured people are those living abroad but still counted as residents; long-term unemployed people; those who chose not to pay health insurance premiums; and people without a valid identity card which is a prerequisite for health insurance registration. This last issue particularly affects the Roma population and undocumented migrants (OECD/European Observatory on Health Systems and Policies, 2021[2]; 2021[3]). In general, people without insurance nonetheless have free access to some services, like care in emergency departments or care during pregnancy, but need to cover all other costs out of pocket.

Although basic primary health coverage generally covers a defined set of benefits, in many countries accessing health services entails some degree of cost-sharing for the majority of users. In most countries, additional health coverage can be purchased through private insurance to cover any cost-sharing left after basic coverage (complementary insurance), add additional services (supplementary insurance) or provide faster access or larger choice of providers (duplicate insurance). In most EU countries, only a small proportion of the population has an additional private health insurance, with the exception of Belgium, France, Slovenia, the Netherlands and Luxembourg, where more than half of the population has private insurance coverage (Figure 7.5).

### Definition and comparability

Population coverage for health care is defined as the share of the population covered for a set of health care goods and services (covering at least hospital care and outpatient medical care) under public programmes and through private health insurance. Public coverage refers both to government programmes, generally financed by taxation, and social health insurance, generally financed by payroll taxes.

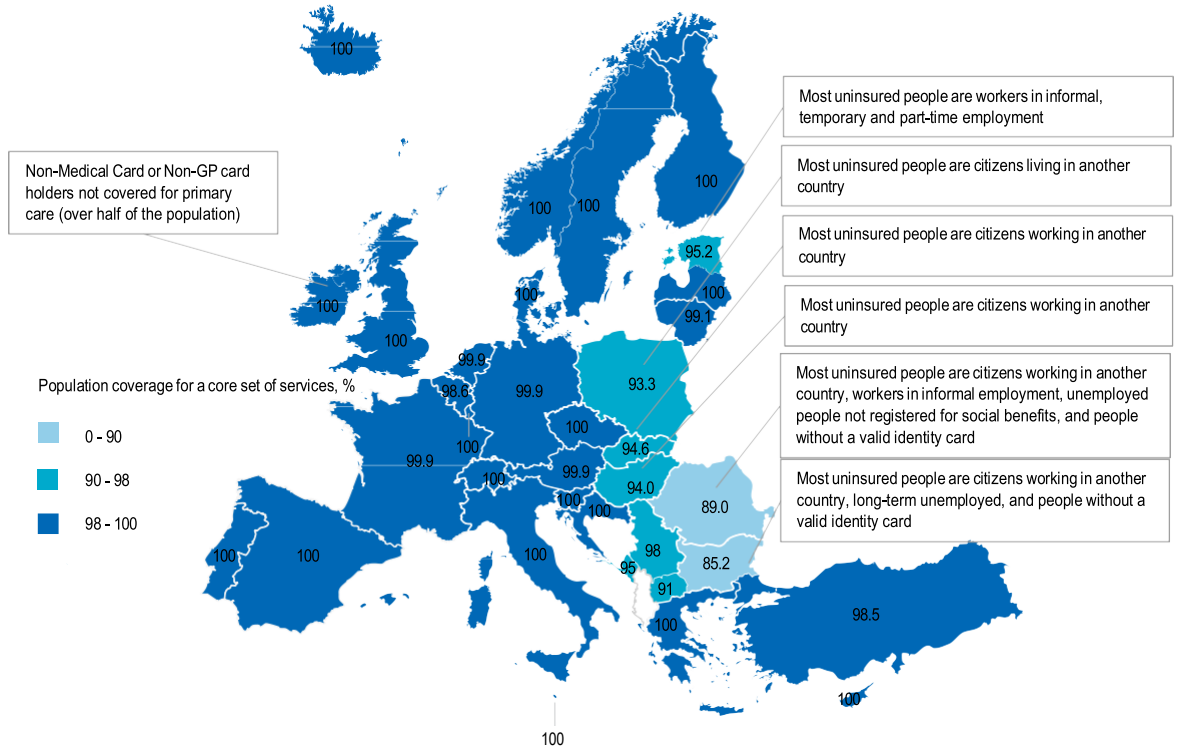
## References


OECD (forthcoming), *Ready for the Next Crisis? Investing in Resilient Health Systems*, OECD Health Policy Studies, OECD Publishing, Paris. [1]

OECD/European Observatory on Health Systems and Policies (2021), *Bulgaria: Country Health Profile 2021*, State of Health in the EU, OECD Publishing, Paris, https://doi.org/10.1787/c1a721b0-en. [2]

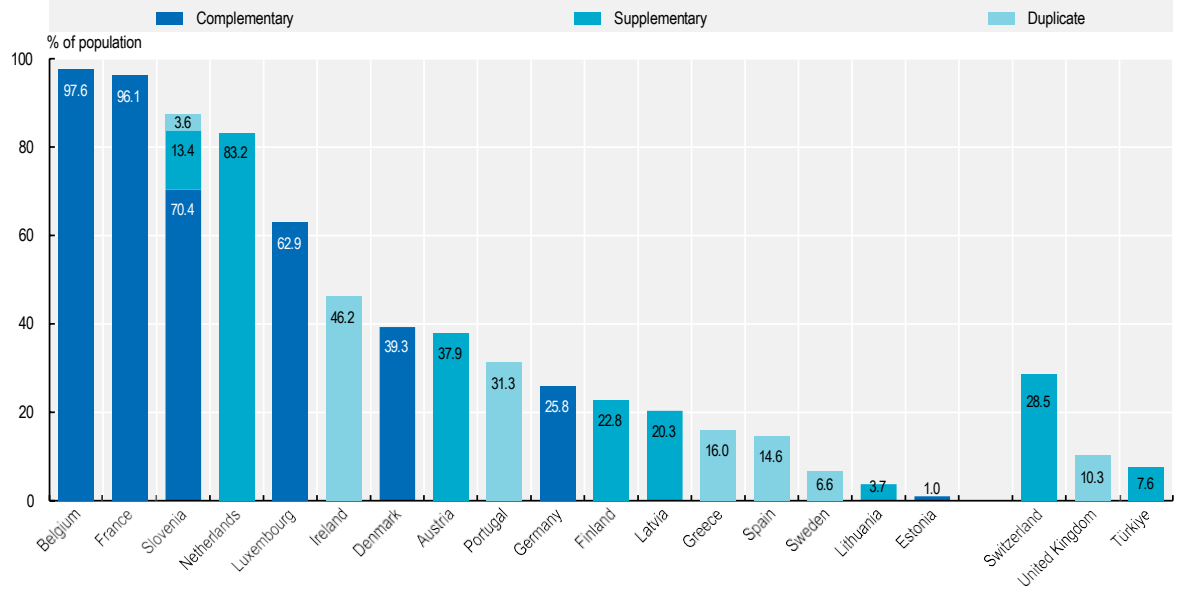
OECD/European Observatory on Health Systems and Policies (2021), *Romania: Country Health Profile 2021*, State of Health in the EU, OECD Publishing, Paris, https://doi.org/10.1787/74ad9999-en. [3]

## Figure 7.4. Population coverage for a core set of services, 2020 (or nearest year)




Note: Data include public coverage and primary voluntary health insurance coverage.
Source: OECD Health Statistics 2022; European Observatory Health Systems in Transition (HiT) Series for non-OECD countries.

## Figure 7.5. Private health insurance coverage, 2020 (or nearest year)




Note: These data exclude primary voluntary health insurance (VHI). VHI can be both complementary and supplementary in Denmark, Germany, Luxembourg and Türkiye.
Source: OECD Health Statistics 2022.

StatLink https://stat.link/j1qpt0

# Extent of health care coverage

In addition to the share of the population entitled to core health services, the extent of health care coverage is defined by the range of services included in a publicly-defined benefit package and the proportion of costs covered. Figure 7.6 assesses the extent of coverage for key health care goods and services, by computing the share of expenditure covered under government schemes or compulsory health insurance. Differences across countries in the extent of coverage can be the result of specific goods and services being included or excluded in the publicly-defined benefit package, different cost-sharing arrangements or some services only being covered for specific population groups in a country.

Across EU countries, more than three-quarters of all health care costs were covered by government or compulsory health insurance schemes in 2020 (see indicator "Financing of health expenditure" in Chapter 5), but financial protection is not uniform across all types of health care services, and the variation across countries is considerable. In nearly all EU countries, inpatient services in hospitals are more comprehensively covered than any other type of care. Across the EU, 91% of all inpatient costs were borne by government or compulsory insurance schemes in 2020. In many countries, access to acute inpatient care is free or subject to very limited cost-sharing. As a result, coverage rates were near 100% in Sweden, Estonia, Romania, the Czech Republic, Germany and France. In Greece on the other hand, financial coverage for the cost of inpatient care was only around two-thirds of total costs.

More than three-quarters (78%) of spending on outpatient medical care across the EU was borne by government and compulsory insurance schemes in 2020. Coverage ranged from less than 60% in Malta, Bulgaria and Latvia to over 90% in the Slovak Republic, Denmark, the Czech Republic and Sweden. In some countries, outpatient primary and specialist care are generally free at the point of service, but some out-of-pocket payments may still apply for specific services or if patients consult non-contracted private providers.

Public coverage for dental care costs is far more limited across EU countries due to restricted service packages (frequently limited to children) and high levels of cost-sharing. On average, only one-third of total costs are borne by government schemes or compulsory insurance. More than 60% of dental spending is covered in only two EU countries (Germany and France). In Cyprus, Greece, Romania and Spain, the level of compulsory coverage is very low. Voluntary health insurance may play an important role in providing financial protection when dental care is not comprehensively covered in the benefit package – this is the case for adults in the Netherlands, for example.

Coverage for pharmaceuticals is also typically less comprehensive than for inpatient and outpatient care. Across the EU, around 59% of pharmaceutical costs are financed by government or compulsory insurance schemes. The most generous coverage can be found in Cyprus, Germany, France and Ireland (above 80%). On the other hand, this share is less than 40% in Bulgaria and Poland.

Finally, therapeutic appliances such as glasses and other eye products, hearing aids and other medical devices are typically covered to a lesser extent than other health care goods and services, with the exception of dental care. Government and compulsory insurance schemes cover more than 50% of these expenses in only four EU countries.

## Definition and comparability

Health care coverage is defined by the share of the population entitled to services, the range of services included in a benefit package and the proportion of costs covered by government schemes and compulsory insurance schemes. Coverage provided by voluntary health insurance and other voluntary schemes such as charities or employers is not considered. The core functions analysed here are based on definitions in the *System of Health Accounts 2011* (OECD/Eurostat/WHO, 2017[1]).

## References

OECD/Eurostat/WHO (2017), *A System of Health Accounts 2011: Revised edition*, OECD Publishing, Paris, https://doi.org/10.1787/9789264270985-en. [1]

# Financial hardship and out-of-pocket expenditure

Where health systems fail to provide adequate financial protection, people may suffer financial hardship from paying for health care, or they simply forgo health care altogether because they cannot afford it. As a result, lack of financial protection can reduce access to health care, undermine health status, deepen poverty and exacerbate health and socio-economic inequalities. On average across the EU, around 15% of all spending on health care comes directly from patients through out-of-pocket (OOP) payments. People experience financial hardship when the burden of OOP payments is large in relation to their ability to pay. Poorer households and those who have to pay for long-term treatment are particularly vulnerable.

The share of household consumption spent on health care provides an aggregate assessment of the financial burden of OOP expenditure. In 2020, around 3% of total household spending was on health care goods and services across the EU, ranging from less than 2% in Croatia, Luxembourg and Cyprus to more than 7% in Malta (Figure 7.7).

Health systems in EU countries differ in the degree of coverage for different health goods and services. Pharmaceuticals and other medical goods made up the main OOP expense for people in 2020, followed by spending on outpatient care (Figure 7.8). These two components typically account for two-thirds of household spending on health care.

The indicator most widely used to measure financial hardship associated with OOP payments for households is the incidence of catastrophic spending on health (Cylus, Thomson and Evetovits, 2018[1]). This varies considerably across EU countries, from fewer than 2% of households experiencing catastrophic health spending in Sweden, Spain, Ireland and Slovenia, to 15% of households or more in Latvia, Lithuania and Bulgaria (Figure 7.9). Across all countries, poorer households (those in the lowest consumption quintile) are most likely to experience catastrophic health spending.

Countries with comparatively high levels of public spending on health and low levels of OOP payments typically have a lower incidence of catastrophic spending. However, policy choices are also important, particularly around coverage policy (WHO Europe, 2019[2]). Population entitlement to publicly financed health care is a prerequisite for financial protection, but not a guarantee of it. Countries with a low incidence of catastrophic spending on health are also more likely to limit the use of co-payments; exempt poor people and frequent users of care from co-payments; use low fixed co-payments instead of percentage co-payments; and cap the co-payments a household has to pay over a given time period (as, for example, in Austria, Germany, Ireland, Spain and the United Kingdom).

### Definition and comparability

Out-of-pocket (OOP) payments are expenditures borne directly by a person at the time of using any health good or service. They include cost-sharing (co-payments) and other expenditure paid directly by private households.

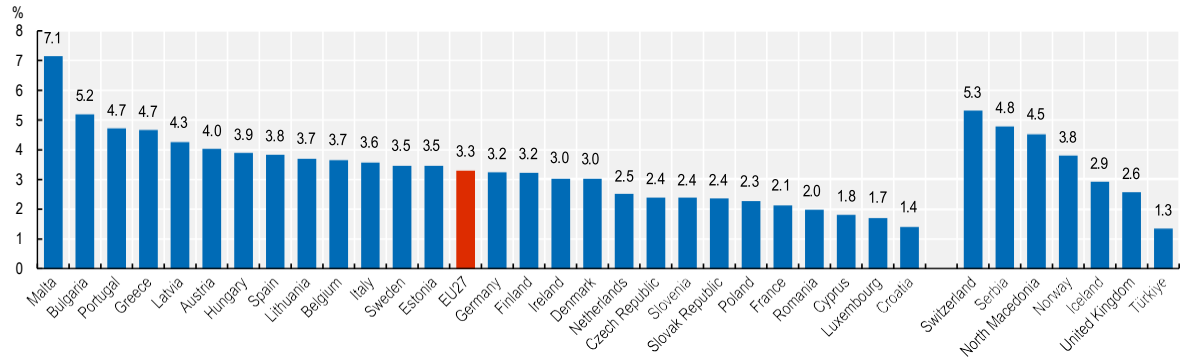
Catastrophic health spending is defined as OOP payments that exceed a predefined percentage of the resources available to a household to pay for health care. Household resources available can be defined in different ways, leading to measurement differences. In the data presented here, these resources are defined as household consumption minus a standard amount representing basic spending on food, housing and utilities. The threshold used to define households with catastrophic spending is 40% of household capacity to pay for health care. Results are disaggregated into quintiles by consumption per person using the OECD equivalence scale. Microdata from national household budget surveys are used to calculate this indicator.

## References


Cylus, S. Thomson and T. Evetovits (2018), "Catastrophic health spending in Europe: equity and policy implications of different calculation methods", *Bulletin of the World Helath Organization*, Vol. 96/9, https://doi.org/10.2471/BLT.18.209031. [1]

WHO Europe (2019), *Can people afford to pay for health care? New evidence on financial protection in Europe*, WHO Regional Office Europe, Copenhagen, https://apps.who.int/iris/handle/10665/332516. [2]

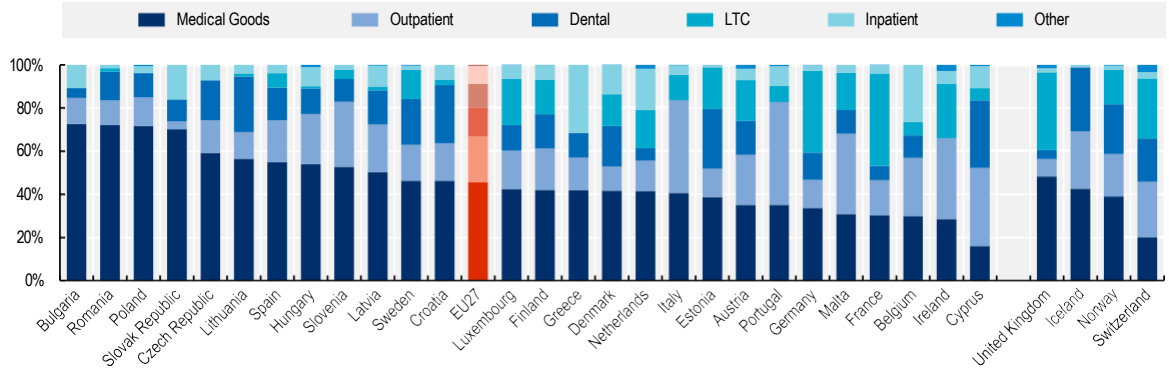
## Figure 7.7. Out-of-pocket spending on health as share of final household consumption, 2020 (or nearest year)




Note: The EU average is unweighted.
Source: OECD Health Statistics 2022, OECD National Accounts database.

StatLink https://stat.link/4g9vhd

## Figure 7.8. Out-of-pocket spending on health, by type of services, 2020 (or nearest year)




Note: The EU average is unweighted. “Medical Goods” include retail pharmaceuticals and therapeutic appliances.
Source: OECD Health Statistics 2022.

StatLink https://stat.link/t3bc7f