This article presents key statistics on expenditure and financing aspects of healthcare in the European Union (EU). Healthcare systems are organised and financed in different ways across the EU Member States, but most Europeans would agree that universal access to quality healthcare, at an affordable cost to both individuals and society at large, is a basic need; moreover, this is one of the common values and principles in EU health systems.

Statistics on healthcare expenditure and financing may be used to evaluate how a healthcare system responds to the challenge of universal access to quality healthcare, through measuring financial resources within the healthcare sector and the allocation of these resources between healthcare activities (for example, preventive and curative care) or groups of healthcare providers (for example, hospitals and ambulatory centres).

This article forms part of an online publication on Health in the European Union.

Health care expenditure

Germany, Sweden and France had the highest current healthcare expenditure relative to GDP among the EU Member States in 2015.

The level of current healthcare expenditure in Germany was EUR 338 billion in 2015 — the highest value among the EU Member States — equivalent to 11.2 % of gross domestic product (GDP), which was also the highest ratio to GDP among the Member States. The United Kingdom recorded the second highest level of current healthcare expenditure (EUR 255 billion), followed by France (EUR 241 billion). Relative to GDP, Germany was followed by Sweden and France, both of which recorded current healthcare expenditure equivalent to 11.0 % of GDP; note that current healthcare expenditure in Switzerland was equivalent to 11.4 % of GDP (2014 data) — see Table 1. By contrast, current healthcare expenditure accounted for less than 6.5 % of GDP in Poland, Luxembourg and Latvia, with Romania recording the lowest ratio (5.0 %).
Relative to population size and in euro terms, current healthcare expenditure was highest among the EU Member States in Luxembourg (EUR 5.6 thousand per inhabitant), Sweden (EUR 5.0 thousand per inhabitant) and Denmark (EUR 4.9 thousand per inhabitant) in 2015; it is interesting to note that Luxembourg had the highest per capita ratio given that it recorded one of the lowest ratios of healthcare expenditure to GDP. Three of the EFTA countries included in Table 1 — Norway, Liechtenstein and Switzerland (2014 data) — each reported higher levels of healthcare expenditure per inhabitant than in any of the Member States.

Aside from Luxembourg, Sweden and Denmark, Ireland, the Netherlands, Germany and Austria were the only other EU Member State to record current healthcare expenditure above EUR 4.0 thousand per inhabitant, while the United Kingdom, Belgium, France and Finland, each recorded a ratio within the range of EUR 3.6 thousand—EUR 3.9 thousand per inhabitant. By contrast, there were seven EU Member States where the average spend on healthcare was less than EUR 1.0 thousand per inhabitant in 2015 and the lowest levels of expenditure per inhabitant were recorded in Bulgaria (EUR 518 per inhabitant) and Romania (EUR 400 per inhabitant). As such, the ratio between the highest and lowest levels of expenditure per inhabitant in Luxembourg and Romania was 13.9 : 1.

These disparities were less after adjusting for price differences, by expressing expenditure in purchasing power standards (PPS): Luxembourg, Germany (both PPS 4.1 thousand per inhabitant), the Netherlands (PPS 3.9 thousand per inhabitant), Sweden and Austria (both PPS 3.8 thousand per inhabitant) recorded the highest ratios of healthcare expenditure per capita in PPS terms, while Latvia (PPS 1.1 thousand per inhabitant) and Romania (PPS 0.9 thousand per inhabitant) had the lowest ratios and were the only EU Member States to report healthcare expenditure below PPS 1.2 thousand per inhabitant. Taking account of price level differences, the ratio between the highest and lowest levels of healthcare expenditure per inhabitant — based on a comparison between Luxembourg and Romania — narrowed to 4.8 : 1.

### Healthcare expenditure by financing scheme

Government schemes and compulsory contributory health care financing schemes highest in Germany in 2015

Figure 1 provides an analysis of healthcare expenditure by financing scheme, distinguishing: government
schemes, compulsory contributory health care financing schemes, voluntary health care payment schemes and household out-of-pocket payments expenditure. With the exception of Cyprus, the combined expenditure from government schemes and compulsory contributory health care financing schemes exceeded the combined expenditure from voluntary health care payment schemes and household out-of-pocket payments in all of the EU Member States (no data for Malta) in 2015 and this was also true in the three EFTA countries shown in Figure 1 (2014 data for Switzerland). In most of the Member States either government schemes or compulsory contributory health care financing schemes dominated, with only a limited number of cases where these two types of financing scheme were relatively balanced, for example, in Greece or to a lesser extent in Austria.

Figure 1: Current healthcare expenditure, 2015

Source: Eurostat (hlth_sha11_hf)

Table 2 provides a similar analysis of healthcare expenditure by financing scheme and Figure 2 shows the distribution among two of the main financing schemes — government schemes; compulsory contributory health insurance schemes and compulsory medical saving accounts — and all other types of financing scheme.
The share of government schemes and compulsory contributory health care financing schemes expenditure in total current healthcare expenditure was in excess of 80.0 % in the Netherlands, Luxembourg, the Czech Republic, Sweden, Denmark and Germany (where the highest share was recorded, at 84.5 %), as well as in Iceland and Norway (which reported a share that was above that registered in any of the EU Member States, at 85.4 %).
Compulsory contributory health insurance schemes and compulsory medical saving accounts (which are generally part of the social security system) accounted for three quarters or more of overall spending on healthcare in Germany (77.9 %), Slovakia (75.4 %) and France (75.0 %) in 2015, but less than 5.0 % in Spain, Portugal, Cyprus, Italy, Ireland, the United Kingdom, Denmark, Latvia and Sweden. By contrast, the United Kingdom (79.5 %), Sweden (83.7 %) and Denmark (84.1 %) reported that government schemes accounted for more than three quarters of their total current expenditure on healthcare, while shares of 65.0-75.0 % were registered in Portugal, Spain, Ireland and Italy.

Another major source of healthcare funding was household out-of-pocket payments, whose shares peaked in Bulgaria (47.7 %), Cyprus (43.9 %) and Latvia (42.1 %), while household out-of-pocket payments also accounted for more than one third of total healthcare expenditure in Greece in 2015. France (6.8 %) was the only EU Member State where household out-of-pocket payments accounted for a single-digit share of healthcare expenditure, while there were seven other Member States that recorded shares within the range of 10.0-15.0 %.

Voluntary health insurance schemes generally represented a small share of healthcare financing among the EU Member States in 2015; their relative share peaked at 14.5 % in Slovenia, while double-digit shares were also recorded in France (13.6 %) and Ireland (12.3 %), while the next highest share for this source of funding was recorded in Croatia (8.0 %). There were seven Member States where voluntary health insurance schemes provided less than 1.0 % of the finance for healthcare expenditure in 2015, with the lowest share recorded in the Czech Republic (0.1 %).
Curative care and rehabilitative care services accounted for more than half of current healthcare expenditure in a majority of EU Member States.

Table 3: Healthcare expenditure by function, 2015(% of current healthcare expenditure) Source: Eurostat (hlth_sha11_hc)

By contrast, at the upper end of the range, close to two thirds of total healthcare expenditure was incurred by curative and rehabilitative care services in Portugal (65.8%) and Cyprus (63.6%) in 2015, while Greece and Poland also recorded shares that were above 60.0%, with Finland (59.9%) just below this level.
Medical goods accounted for around one fifth of total current healthcare expenditure in 2015

Medical goods were generally the second largest function, although with a significant degree of variation between the EU Member States: the lowest shares — less than 15.0 % — were recorded for Finland, the United Kingdom, Ireland, the Netherlands, Sweden and Luxembourg, falling to a low of 10.2 % in Denmark. By contrast, the highest shares — where medical goods accounted for 30.0-40.0 % of healthcare expenditure in 2015 — were recorded for Lithuania, Latvia, Hungary, Slovakia and Romania, with this share peaking at 43.5 % in Bulgaria.

The proportion of current healthcare expenditure incurred by ancillary services (such as laboratory testing or the transportation of patients) varied considerably among EU Member States, ranging in 2015 from a low of 1.8 % in the United Kingdom and the Netherlands up to 9.1 % in Croatia, with Estonia (10.8 %), Latvia (10.9 %) and Cyprus (11.5 %) each reporting double-digit shares.

Expenditure related to preventive care exhibited less variation between EU Member States. Its highest share of current healthcare expenditure in 2015 was recorded in the United Kingdom (5.2 %), while at the other end of the range, a share of less than 1.0 % was recorded in Cyprus (0.7 %).

Expenditure on governance and health system and financing administration ranged from highs of 6.0 % in France, 4.8 % in Germany and 4.3 % in Luxembourg down to 1.3 % in Bulgaria and 0.9 % in Finland. Note the share of current healthcare expenditure dedicated to governance and health system and financing administration was even lower in Norway, at 0.6 %.
Services related to long-term healthcare (see Figure 4) accounted for less than 10.0 % of current healthcare expenditure in half of the EU Member States in 2015 (again no data for Malta); these relatively low shares could be due to the main burden of long-term care (health) residing with family members, with no payment being made for providing these services. On the other hand, more than one fifth of healthcare expenditure was attributed to long-term healthcare in Ireland, Luxembourg, Belgium, Denmark and the Netherlands, rising to more than one quarter in Sweden (26.3 %); an even higher share (27.9 %) was recorded in Norway. It should be noted that limitations within the data compilation exercise make it difficult to separate the medical and social components of expenditure for long-term care, leading to an inevitable impact on cross-country comparisons.

Figure 4: Long-term care as a share of current healthcare expenditure, 2015(%) Source: Eurostat (hlth_sha11_hc)

The high shares of long-term healthcare in total healthcare expenditure in Sweden and the Netherlands are reflected in the data presented in Table 4: long-term healthcare expenditure in Sweden was equivalent to 2.9 % of GDP in 2015, with this share reaching 2.6 % in the Netherlands and Belgium, and 2.5 % in Denmark; no other EU Member States recorded ratios of long-term healthcare to GDP above 2.0 %, while a further seven Member States recorded ratios of long-term healthcare to GDP above 1.0 %. There were 11 Member States which reported that long-term healthcare expenditure was equivalent to less than 0.5 % of their GDP in 2015, with this ratio falling to 0.2 % or less in Cyprus, Portugal, Croatia and Greece, and to 0.01-0.02 % of GDP in Slovakia and Bulgaria.
Table 4: Long-term care expenditure, 2015

Source: Eurostat (hlth_sha11_hp)

Long-term healthcare expenditure reached EUR 1.3 thousand per inhabitant in Sweden and Luxembourg in 2015

Relative to population size and in euro terms, long-term healthcare expenditure in 2015 was highest among the EU Member States in Sweden and Luxembourg (both EUR 1.3 thousand per inhabitant); among the EFTA countries, Norway (EUR 1.9 thousand per inhabitant) and Switzerland (EUR 1.4 thousand per inhabitant; 2014 data) reported higher ratios than those recorded for any of the Member States. A total of 12 EU Member States reported less than EUR 100 of long-term healthcare expenditure per inhabitant in 2015, with two of these — Slovakia and Bulgaria — recording average levels of expenditure that were less than EUR 10.00 per inhabitant.

There were considerable disparities between EU Member States in relation to their long-term healthcare expenditure: the ratio between the highest and lowest levels of expenditure per inhabitant in Sweden and Bulgaria was almost 2200:1. Even after adjusting for price level differences, the ratio between the highest and lowest levels of healthcare expenditure per inhabitant in PPS terms — also comparing Sweden and Bulgaria — remained extremely high, at almost 700:1.

Healthcare expenditure by provider

In most EU Member States, hospitals were the main provider of healthcare in expenditure terms

An analysis of current healthcare expenditure by provider is shown in Table 5 and Figure 5. It should be borne in mind that healthcare providers classified under the same group do not necessarily perform the same set of activities. For example, hospitals may offer day care, out-patient, ancillary or other types of service, in addition to in-patient services.

Hospitals generally accounted for the highest proportion of current healthcare expenditure in 2015 among EU Member States, ranging from 29.2% of the total in Germany to 47.2% in Estonia. Four Member States (no data for Malta) reported that hospitals did not have the highest share of healthcare expenditure, as ambulatory health care providers accounted for a greater share of total healthcare expenditure in Belgium and Germany.
while retailers and other providers of medical goods accounted for a higher share in Bulgaria and Slovakia.

Table 5: Healthcare expenditure by provider, 2015(% of current healthcare expenditure)

<table>
<thead>
<tr>
<th>Provider</th>
<th>Belgium</th>
<th>Bulgaria</th>
<th>Czech Republic</th>
<th>Denmark</th>
<th>Germany</th>
<th>Estonia</th>
<th>Ireland</th>
<th>Greece</th>
<th>Spain</th>
<th>France</th>
<th>Croatia</th>
<th>Italy</th>
<th>Cyprus</th>
<th>Latvia</th>
<th>Lithuania</th>
<th>Luxembourg</th>
<th>Malta</th>
<th>Netherlands</th>
<th>Austria</th>
<th>Poland</th>
<th>Portugal</th>
<th>Romania</th>
<th>Slovenia</th>
<th>Slovakia</th>
<th>Finland</th>
<th>Sweden</th>
<th>United Kingdom</th>
<th>Iceland (1)</th>
<th>Liechtenstein</th>
<th>Norway</th>
<th>Switzerland (2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals</td>
<td>33.2</td>
<td>33.6</td>
<td>41.1</td>
<td>44.1</td>
<td>29.2</td>
<td>47.2</td>
<td>35.2</td>
<td>42.3</td>
<td>41.5</td>
<td>40.9</td>
<td>42.2</td>
<td>45.5</td>
<td>43.5</td>
<td>32.6</td>
<td>34.2</td>
<td>31.3</td>
<td>39.0</td>
<td>37.8</td>
<td>38.7</td>
<td>35.7</td>
<td>42.0</td>
<td>39.1</td>
<td>41.1</td>
<td>34.1</td>
<td>35.2</td>
<td>38.4</td>
<td>41.6</td>
<td>40.5</td>
<td>8.4</td>
<td>40.5</td>
<td>35.2</td>
</tr>
<tr>
<td>Residential long-term care facilities</td>
<td>10.3</td>
<td>0.4</td>
<td>7.4</td>
<td>10.1</td>
<td>8.9</td>
<td>5.8</td>
<td>19.3</td>
<td>0.9</td>
<td>5.6</td>
<td>6.9</td>
<td>0.4</td>
<td>6.0</td>
<td>1.4</td>
<td>3.3</td>
<td>1.5</td>
<td>10.7</td>
<td>0.7</td>
<td>24.5</td>
<td>6.4</td>
<td>1.4</td>
<td>2.0</td>
<td>1.6</td>
<td>0.9</td>
<td>0.0</td>
<td>2.2</td>
<td>16.4</td>
<td>11.5</td>
<td>10.4</td>
<td>1.0</td>
<td>10.4</td>
<td>10.8</td>
</tr>
<tr>
<td>Providers of ambulatory health care</td>
<td>35.3</td>
<td>14.6</td>
<td>21.8</td>
<td>30.4</td>
<td>31.4</td>
<td>21.6</td>
<td>19.9</td>
<td>21.5</td>
<td>24.4</td>
<td>22.7</td>
<td>20.1</td>
<td>22.5</td>
<td>28.1</td>
<td>23.5</td>
<td>21.6</td>
<td>28.6</td>
<td>22.2</td>
<td>14.4</td>
<td>21.9</td>
<td>27.3</td>
<td>27.5</td>
<td>15.4</td>
<td>22.8</td>
<td>17.2</td>
<td>20.5</td>
<td>24.1</td>
<td>23.5</td>
<td>31.6</td>
<td>31.8</td>
<td>31.8</td>
<td>27.5</td>
</tr>
<tr>
<td>Providers of ancillary services</td>
<td>2.6</td>
<td>3.7</td>
<td>3.7</td>
<td>1.6</td>
<td>1.3</td>
<td>1.8</td>
<td>1.5</td>
<td>3.9</td>
<td>1.6</td>
<td>2.9</td>
<td>3.7</td>
<td>4.4</td>
<td>8.4</td>
<td>7.6</td>
<td>2.8</td>
<td>3.8</td>
<td>3.0</td>
<td>2.1</td>
<td>5.0</td>
<td>4.5</td>
<td>5.0</td>
<td>5.2</td>
<td>4.7</td>
<td>6.9</td>
<td>7.8</td>
<td>4.0</td>
<td>14.2</td>
<td>3.0</td>
<td>3.1</td>
<td>3.1</td>
<td>3.1</td>
</tr>
<tr>
<td>Retailers and other providers of medical goods</td>
<td>12.3</td>
<td>43.2</td>
<td>17.0</td>
<td>10.2</td>
<td>10.5</td>
<td>20.9</td>
<td>13.4</td>
<td>28.3</td>
<td>22.3</td>
<td>18.9</td>
<td>28.2</td>
<td>15.6</td>
<td>16.9</td>
<td>28.8</td>
<td>30.3</td>
<td>36.3</td>
<td>32.1</td>
<td>13.2</td>
<td>18.8</td>
<td>10.6</td>
<td>9.6</td>
<td>32.9</td>
<td>31.9</td>
<td>36.0</td>
<td>30.0</td>
<td>32.1</td>
<td>25.3</td>
<td>15.3</td>
<td>10.8</td>
<td>15.5</td>
<td>13.2</td>
</tr>
<tr>
<td>Providers of preventive care</td>
<td>0.9</td>
<td>0.0</td>
<td>0.4</td>
<td>1.2</td>
<td>0.6</td>
<td>1.1</td>
<td>1.2</td>
<td>0.4</td>
<td>0.7</td>
<td>1.2</td>
<td>1.7</td>
<td>3.1</td>
<td>0.5</td>
<td>0.3</td>
<td>0.7</td>
<td>0.9</td>
<td>0.4</td>
<td>1.9</td>
<td>2.9</td>
<td>0.1</td>
<td>0.1</td>
<td>2.6</td>
<td>1.9</td>
<td>2.0</td>
<td>0.9</td>
<td>0.4</td>
<td>2.3</td>
<td>2.3</td>
<td>0.0</td>
<td>0.0</td>
<td>0.5</td>
</tr>
<tr>
<td>Providers of health care system administration and financing</td>
<td>4.0</td>
<td>1.3</td>
<td>2.7</td>
<td>2.4</td>
<td>5.4</td>
<td>1.9</td>
<td>2.8</td>
<td>2.6</td>
<td>2.9</td>
<td>6.0</td>
<td>0.4</td>
<td>0.0</td>
<td>0.0</td>
<td>0.6</td>
<td>0.4</td>
<td>0.5</td>
<td>2.1</td>
<td>0.4</td>
<td>4.3</td>
<td>1.9</td>
<td>1.3</td>
<td>3.6</td>
<td>0.5</td>
<td>0.6</td>
<td>0.4</td>
<td>0.4</td>
<td>0.2</td>
<td>0.6</td>
<td>0.1</td>
<td>0.1</td>
<td>0.2</td>
</tr>
<tr>
<td>Rest of the economy</td>
<td>0.4</td>
<td>1.8</td>
<td>0.9</td>
<td>0.0</td>
<td>0.5</td>
<td>0.5</td>
<td>0.2</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.4</td>
<td>0.1</td>
<td>0.0</td>
<td>0.2</td>
<td>0.7</td>
<td>0.2</td>
<td>0.1</td>
<td>0.9</td>
<td>0.2</td>
<td>0.3</td>
<td>0.5</td>
<td>1.7</td>
<td>0.1</td>
<td>0.1</td>
<td>1.4</td>
<td>0.1</td>
<td>0.1</td>
<td>0.2</td>
<td>0.0</td>
<td>0.0</td>
<td>0.3</td>
</tr>
<tr>
<td>Rest of the world</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(1) Definitions differ.
(2) 2014
Source: Eurostat (online data code: hlth_sha11_hp)

The second largest healthcare provider (in expenditure terms) was generally that of ambulatory health care providers, their share of healthcare expenditure ranging in 2015 from 14.4 % in the Netherlands to more than 30.0 % in Denmark and Germany, peaking at more than one third (36.3 %) of total healthcare expenditure in Belgium.
The share of healthcare expenditure accounted for by retailers and other providers of medical goods was often quite high among the EU Member States. However, their share varied by a factor of four to one: the lowest share — below 10.0% — was recorded in Luxembourg (9.6%); most of the EU Member States reported that retailers and other providers of medical goods accounted for 10.0-30.0% of current healthcare expenditure; somewhat higher shares were recorded in Lithuania, Hungary, Romania and Slovakia, reaching a peak of 43.2% in Bulgaria.

Source data for tables and graphs
- Healthcare expenditure: tables and figures

Data sources
No data are available in this article for Malta and for this reason, EU-28 data are not presented in this article. When available, data are also presented for the four EFTA countries.

Note on tables: the symbol ‘?’ indicates that data are not available.

Key concepts
Total healthcare expenditure quantifies the economic resources dedicated to health functions, excluding capital investment. Healthcare expenditure is primarily concerned with healthcare goods and services that are consumed by resident units, irrespective of where that consumption takes place (it may be in the rest of the
world) or who is paying for it. As such, exports of healthcare goods and services (to non-resident units) are excluded, whereas imports of healthcare goods and services for final use are included.

**Long-term healthcare** consists of a range of medical and personal care services that are consumed with the primary goal of alleviating pain and suffering and reducing or managing the deterioration in health status in patients with a degree of long-term dependency. The aim of **long-term social care** is to provide services and support, by formal and informal care givers, to individuals who, for reasons of disability, illness or other dependency, need help to live as normal a life as possible. Social care covers a wide range of services, including professional advice and support, accommodation, various types of assistance in carrying out daily tasks, home visits, home help services, provision of meals, special equipment, house adaptation for disabled persons, as well as assessment and care management services. There may be a mixed economy of health and social care provision and this mix of services can make it difficult to separate expenditure between health and social components. For the purpose of this article, the analysis of **long-term care** (as shown in Figure 4 and Table 4) is composed solely of the health component.

**System of health accounts**

Eurostat, the Organisation for Economic Cooperation and Development (OECD) and the World Health Organisation (WHO) established a common framework for a joint healthcare data collection exercise. The data collected relates to healthcare expenditure following the methodology of the **system of health accounts (SHA)**.

The SHA shares the goals of the system of national accounts (SNA); to constitute an integrated system of comprehensive, internally consistent, and internationally comparable accounts, which should as far as possible be compatible with other aggregated economic and social statistical systems. Health accounts provide a description of the financial flows related to the consumption of healthcare goods and services from an expenditure perspective. Health accounts are used in two main ways: internationally, where the emphasis is on a selection of comparable expenditure data; nationally, with more detailed analyses of healthcare spending and a greater emphasis on comparisons over time.

In 2011, and as a result of four years of extensive and wide-reaching consultation, Eurostat, the OECD and the WHO released an updated manual for the collection of health accounts, ‘**A system of health accounts, 2011 edition revised**’. The core set of SHA tables addresses three basic questions: i) what kinds of healthcare goods and services are consumed; ii) which healthcare providers deliver them, and; iii) which financing schemes are used to deliver them?

Healthcare expenditure is recorded in relation to the **international classification for health accounts (ICHA)**, defining:

- healthcare expenditure by financing schemes (ICHA-HF) — which classifies the types of financing arrangements through which people obtain health services; healthcare financing schemes include direct payments by households for services and goods and third-party financing arrangements;
- healthcare expenditure by function (ICHA-HC) — which details the split in healthcare expenditure following the purpose of healthcare activities — such as, curative care, rehabilitative care, long-term care, or preventive care;
- healthcare expenditure by provider (ICHA-HP) — which classifies units contributing to the provision of healthcare goods and services — such as hospitals, residential facilities, ambulatory health care services, ancillary services or retailers of medical goods.

**Healthcare expenditure — methodology**

Commission Regulation (EU) 2015/359 of 4 March 2015 implementing Regulation (EC) No 1338/2008 as regards statistics on healthcare expenditure and financing paves the way for healthcare expenditure data collection according to SHA 2011 methodology. The Regulation applies to data from reference year 2014 onwards and hence the information shown in this article presents a harmonised set of data based on this methodology. Note that in some certain cases, EU Member States and non-member countries have been able to provide historical data covering one or more years prior to the 2014 reference period; these data are presented in Eurostat’s **online database**.

The data shown in this article are systematically presented for reference year 2015 (data for Switzerland refer to 2014). EU Member States submitted their data based on the 2015 legislation. The information presented is
therefore founded on common definitions and specifications as described under the SHA 2011.

SHA 2011 introduces a number of changes and improvements compared with SHA 1.0. It reinforces the tri-axial relationship that is at the root of the SHA and its description of healthcare and long-term care expenditure. SHA 2011 offers more complete coverage within the functional classification in areas such as prevention and long-term care; a more concise picture of the universe of healthcare providers; and a more precise approach for tracking financing in the healthcare sector.

Statistics on healthcare expenditure are documented in this background article which provides more information on the scope of the data, the legal framework, the methodology employed, as well as related concepts and definitions.

Context

Health systems across the globe are developing in response to a multitude of factors, including: new medical technology and improvements in knowledge; new health services and greater access to them; changes in health policies to address specific diseases and demographic developments; new organisational structures and more complex financing mechanisms. However, access to healthcare and greater patient choice is increasingly being considered against a background of financial sustainability. Many of the challenges facing governments across the EU were outlined in the European Commission’s White paper titled Together for health: a strategic approach for the EU 2008-2013 (COM(2007) 630 final), which built upon Council conclusions relating to Common values and principles in European Union Health Systems (2006/C 146/01).

In February 2013, the European Commission adopted a Communication titled Towards social investment for growth and cohesion (COM(2013) 83 final). Its main axes included: ensuring that social protection systems respond to people’s needs at critical moments throughout their lives; simplified and better targeted social policies, to provide adequate and sustainable social protection systems; and upgrading active inclusion strategies in the EU Member States.

In March 2014, the third multi-annual programme of EU action in the field of health for the period 2014-2020 was adopted (Regulation (EU) No 282/2014) under the title Health for Growth. This new programme emphasises the link between health and economic prosperity, as the health of individuals directly influences economic outcomes such as productivity, labour supply and human capital. A mid-term evaluation (COM(2017) 586 final) was published in October 2017. More information is provided in the introductory article for health statistics.

In April 2014, the European Commission adopted a Communication On effective, accessible and resilient health systems (COM(2014) 215 final). Capitalising on experience and work carried out over recent years, and with a view to further developing approaches for the EU, this Communication focuses on actions to strengthen the effectiveness of health systems, increase the accessibility of healthcare and improve the resilience of health systems.

On the basis of Eurostat’s 2013 population projections (EUROPOP2013), long-run economic and budgetary projections aimed at assessing the impact of ageing population were published in 2015. This constituted the fifth release of such long-run projections since 2001. Taking account of underlying demographic and macro-economic assumptions and projections, age-related expenditures covering pensions, healthcare, long-term care, education and unemployment benefits were projected and analysed. These projections feed into a variety of policy debates in the EU, including the overarching Europe 2020 strategy. In particular, they are used in the context of the European semester so as to identify policy challenges, in the annual assessment of the sustainability of public finances carried out as part of the stability and growth pact. The next release of the long-run economic and budgetary projections is planned for spring 2018, with the underlying demographic and macro-economic assumptions and projections having already been published at the end of 2017.

In May 2016, the European Commission adopted a strategic plan for promoting health and food safety for the period 2016-2020. This reaffirmed the mission of the Directorate-General for Health and Food Safety, namely, to: improve and protect human health, and support the modernisation of Europe’s health systems; ensure that all food, feed and medicinal products marketed in the EU are safe and that EU standards are promoted globally; protect animal health and welfare and plant health; contribute to a well-functioning and fair internal market in food, feed, agricultural and medical products. As regards human health, the plan focuses on efforts for better public health and better access, effectiveness and resilience within health systems. In order
to improve the quality and effectiveness of public expenditure and contribute to prosperity and social cohesion, the European Commission seeks to provide expertise on health systems and support actions that help prevent and reduce the impact of ill-health on individuals and economies, while encouraging and supporting innovation and the uptake of modern technologies for better care delivery and cost-effectiveness.

The Directorate-General for Health and Food Safety has constituted a list of 88 European core health indicators (ECHIs) for monitoring progress in relation to health policy and broader Europe 2020 objectives. Among these, it recommends specifically following developments for:

- expenditure on healthcare as a percentage of GDP;
- expenditure on healthcare in millions of PPS.

Other articles

Online publication:
- Health in the European Union — facts and figures

Methodology

- Healthcare expenditure

General health statistics articles

- Health statistics introduced
- The EU in the world — health

Database

- Health care (hlth_care), see:
  Health care expenditure (SHA 2011) (hlth_sha11)

Dedicated section

- Health care

Methodology

- Healthcare expenditure (SHA 2011) (ESMS metadata file — hlth_sha11_esms)
- A system of health accounts — 2011 revised edition

Legislation

Healthcare expenditure and financing

External links

- European Commission — Directorate-General for Health and Food Safety — European core health indicators (ECHI)
- European Commission — Directorate-General for Health and Food Safety — Health systems performance assessment
- European economy — The 2015 Ageing Report, Underlying assumptions and projection methodologies
- European economy — The 2018 Ageing Report, Underlying assumptions and projection methodologies
• OECD report 'Health at a Glance: Europe 2017'
• OECD — Health policies and data
• WHO Global health observatory (GHO)
• World Health Organisation (WHO) — Health systems