All European countries use a mix of public and private financing of health care, but to differing degrees. Public financing is confined to government revenues in countries where central and/or local governments are primarily responsible for financing health services directly (*e.g.* Sweden and the United Kingdom). It consists of both general government revenues and social contributions in countries with social insurance based-funding (*e.g.* France and Germany). Private financing, on the other hand, covers households' out-of-pocket payments (either direct or as co-payments), third-party payment arrangements effected through various forms of private health insurance, health services such as occupational health care directly provided by employers, and other direct benefits provided by charities and the like.

Figure 4.5.1 shows the public share of health financing across European countries in 2008. The public sector is the main source of health financing in all European countries, except Cyprus. On average, the public share of health spending was 73.6% in 2008. In Luxembourg, the Czech Republic, the Nordic countries (except Finland), the United Kingdom, the Netherlands and Romania, public financing accounted for more than 80% of all health expenditure. There has been a convergence of the public share of health spending among European countries over recent decades. Many of those countries with a relatively high public share in the early 1990s, such as Poland and Hungary, have decreased their share, while other countries which historically had a relatively low level (*e.g.* Portugal, Turkey) have increased their public share, reflecting health system reforms and the expansion of public coverage.

The fact that the health system is primarily publicly funded in most countries does not imply that the public sector plays the dominant role in every area of health care. Figure 4.5.2 shows the public share of financing separately for medical services and medical goods. The public sector pays for around 82% of medical services in European countries on average. However, a further sub-division of medical services shows an increasingly important role of private financing in the area of out-patient services (Orosz and Morgan, 2004), especially dental care, where around two-thirds of spending comes from private sources. In the financing of medical goods (pharmaceuticals and other goods), private payments also play an important role, most evident in Bulgaria, Latvia and Cyprus but also in other central and eastern European countries.

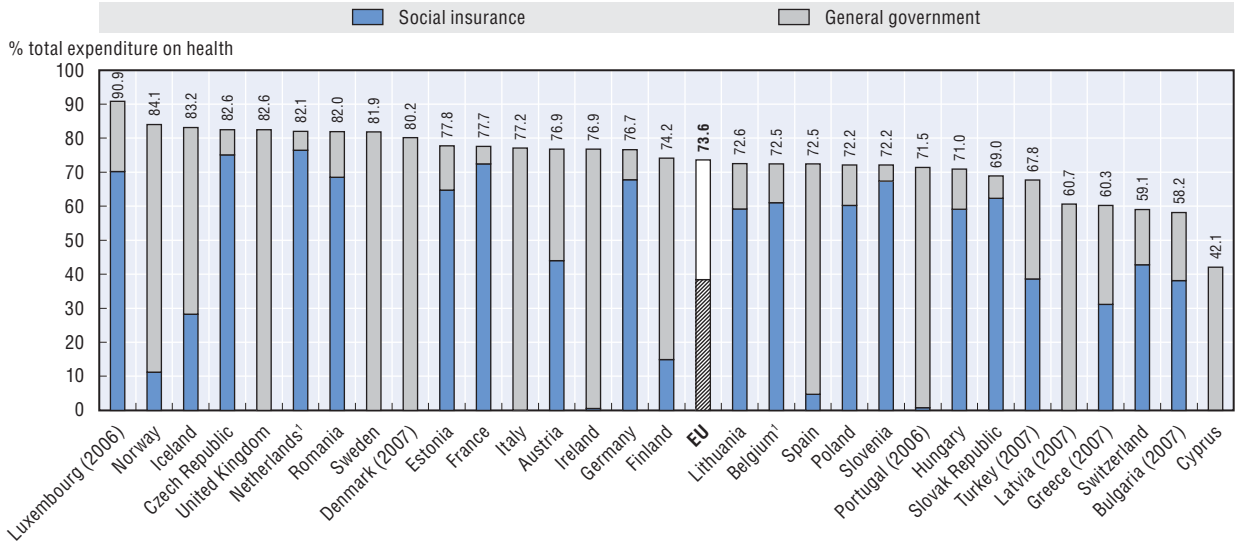
The size and composition of private financing for all health services and goods differs considerably across countries. On average, more than two-thirds of private funding is accounted for by out-of-pocket payments, including any cost-sharing arrangements (Colombo and Morgan, 2006). In some central and eastern European countries, the practice of unofficial supplementary payments means that the level of out-of-pocket spending is probably underestimated. Private health insurance is around 3-4% of total health expenditure on average across European Union countries (Figure 4.5.3). For some countries, it plays a significant financing role. It provides primary coverage for certain population groups in Germany. In France, private health insurance finances 13% of overall spending, providing both complementary and supplementary coverage in a public system with universal reach.

Health care reform in the Netherlands in 2006 resulted in the government heavily regulating the market for compulsory health insurance: insurers are obliged to accept anybody and the insurance premium is unrelated to individual risks. At the same time, the day-to-day operation of health insurance is now organised under private law (Schäfer *et al.*, 2010). Because of its obligatory nature, this is considered as a social insurance scheme and therefore counted under public health spending, even though it is managed by private insurance corporations. Voluntary private health insurance accounts for around 6% of health spending in the Netherlands, and is used mainly to pay for complementary services such as dental care, glasses and physiotherapy (for people without recognised chronic conditions).

Definition and deviations

There are three elements of health care financing: sources of funding (households, employers and the state), financing schemes (*e.g.* compulsory or voluntary insurance), and financing agents (organisations managing the financing schemes). Here "financing" is used in the sense of financing schemes as defined in the *System of Health Accounts* (OECD, 2000). Public financing includes general government revenues and social security funds. Private financing covers households' out-of-pocket payments, private health insurance and other private funds (NGOs and private corporations). Out-of-pocket payments are expenditures borne directly by the patient. They include cost-sharing and, in certain countries, estimations of informal payments to health care providers.

4.5.1. Public share of total expenditure on health, 2008

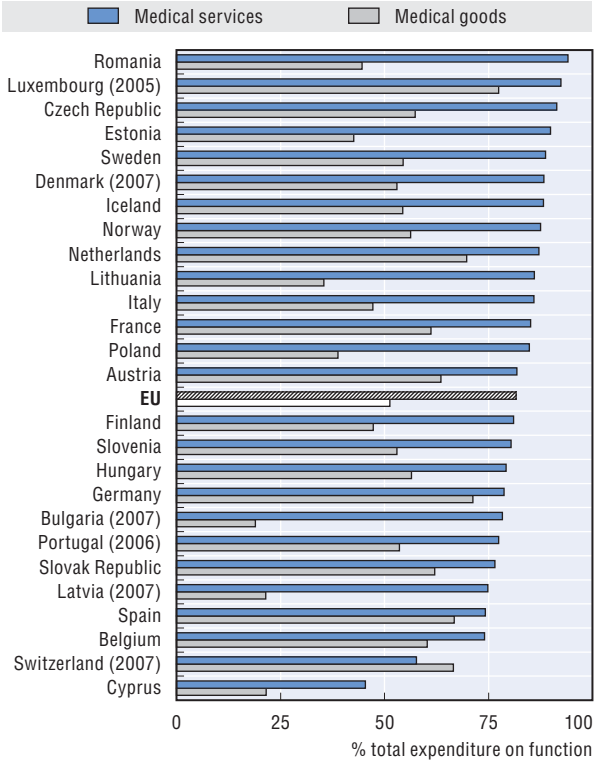


1. Share of current health expenditure.

Source: OECD Health Data 2010; Eurostat Statistics Database.

StatLink http://dx.doi.org/10.1787/888932337528

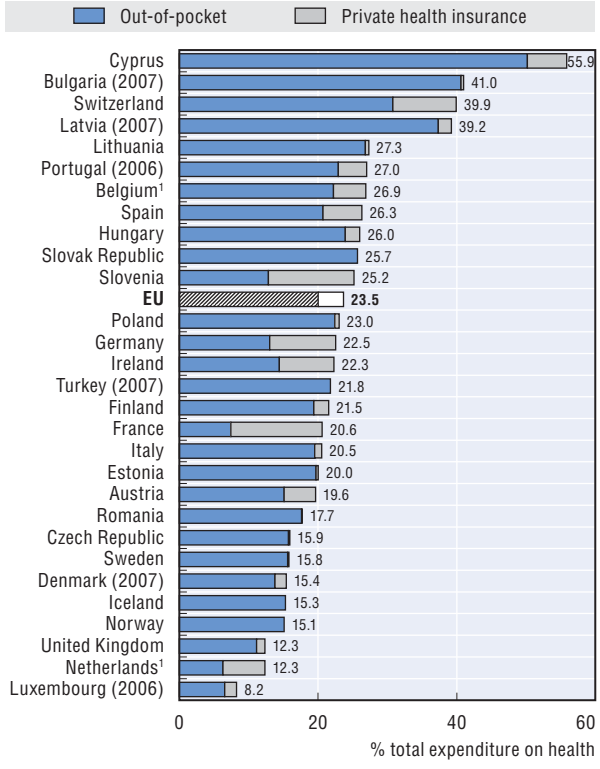
4.5.2. Public share of expenditure on medical services and goods, 2008



Source: OECD Health Data 2010; Eurostat Statistics Database.

StatLink http://dx.doi.org/10.1787/888932337547

4.5.3. Out-of-pocket and private health insurance expenditure, 2008



1. Current expenditure.

Source: OECD Health Data 2010; Eurostat Statistics Database.

StatLink http://dx.doi.org/10.1787/888932337566