

Financing of health care in Spain: a comparative analysis

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Resumen

Los países de la OCDE gastan cantidades cada vez mayores en servicios de salud y, por tanto, es vital para los decisores políticos comprender la forma en que las diversas actividades o funciones de la atención de la salud se financian. Dado que los países con alto gasto privado de salud pueden requerir distintos instrumentos de política que aquellos en los que el gasto público juega el papel dominante, el análisis de la financiación de las tres funciones principales de la atención de la salud: atención con internamiento, atención ambulatoria y medicamentos y productos sanitarios es de gran importancia para los encargados de formular políticas. En este trabajo se analiza la estructura del sistema de atención de salud de España y su financiación, en un contexto internacional, a partir de la información recogida conjuntamente por la OCDE, EUROSTAT y la OMS para confeccionar las cuentas de salud de España y otros trece países de la OCDE. El Sistema de Cuentas de Salud (SHA) propone un sistema completo de cuentas comparables a nivel internacional para la presentación de informes datos sobre los gastos sanitarios. A partir de los resultados que se analizan, se pone de relieve tanto la riqueza de los datos del SHA como la importancia de la coherencia y el cumplimiento sus definiciones.

Abstract

OECD countries are spending increasing amounts on health services and thus an understanding of how the various activities or functions of health care are financed is vital. Policy makers are interested in the role played by the public and private sector, including households, in financing the three main functions of health care: in-patient care, out-patient care and medical goods. Since areas with high private spending may require different health policy tools than those areas where public expenditure plays the dominant role, this is of great relevance to policy makers. *The System of Health Accounts (SHA)* proposes a system of comprehensive and internationally comparable accounts for reporting health expenditure data. Using results from the Joint OECD, Eurostat and WHO collection of health accounts data for Spain and 13 other OECD countries, this paper highlights both the richness of the SHA data and the importance of consistency and compliance with the SHA definitions. The results also enable an analysis of the financing and the structure of the Spanish health care system in an international context.

Key words: Health expenditure, health care financing.

JEL Classification: H51.

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1. Introduction

The System of Health Accounts (OECD, 2000) proposes an integrated system of comprehensive and internationally comparable accounts for reporting health expenditure data. In this paper, we analyse key results from the joint OECD, Eurostat and WHO collection of health accounts data undertaken in 2006 and 2007. Analysis of the data allows for a better understanding of the role of public and private financing and provides more reliable information on the functional structure of health expenditure. Policy makers are interested in the role played by public and private sector agents, including households in financing the three main functions of health care of in-patient care, out-patient care and medical goods.

Based on an analysis of SHA-based health accounts, we present a detailed breakdown of health spending in Spain in 2005¹ compared with 13 other OECD countries that would not have been possible using pre-SHA statistics. This comparative analysis provides a reasonably good picture of the various health funding and spending patterns across OECD countries. It includes 4 non-European countries (Australia, Canada, Japan and Korea), 7 members of the European Union, in addition to Spain, with varying health financing models (France, Germany, Luxembourg, Netherlands, Portugal as well as 2 newer members, namely the Czech Republic and Poland); and 2 European non EU members of Norway and Switzerland.

2. Background to the *System of Health Accounts*

The *System of Health Accounts* can assist policy makers by providing internationally comparable information regarding the overall level of spending on health care. Because the system is based on comprehensive and internationally comparable accounts for reporting health expenditure, it allows for a multifaceted analysis of how financial resources in health care systems are raised (by different financing programmes/agents), how these resources are allocated among functions and service providers, as well as how they are utilised by regional and social groups in the population. Functions in the SHA refer to the goals and purposes of health care such as disease prevention, health promotion, treatment, rehabilitation and long-term care. In addition, the SHA:

- Provides information about changes in the composition of spending, the factors that drive growth in health spending and how such growth differs across countries. OECD countries use international comparisons extensively for evaluating the national situation and possible policy options, therefore reliable international comparability can directly serve national policy-making.
- Provides a tool to monitor the effects of particular health reform measures over time. Specific features of a given health care system may justify the need for national health accounts to have additional, country-specific elements within the broader SHA framework.
- Enables analysts to monitor changes in health care systems from an economic point of view and to describe the place of health care within the national economy.

Countries' pre-SHA system of health statistics, with their national definitions of health care and total expenditure on health care, may have deviated in several important aspects from the borders proposed by the SHA. In implementing SHA, countries have faced a number of different challenges. Mapping national classifications to the International Classification for Health Accounts (SHA-ICHA) has required countries to find new data sources, redesign national classifications or add new components to their existing statistical system, as well as undertake new data processing. Some countries have gone even further and started to change the way data are reported by providers and financing agents.

Furthermore, SHA distinguishes between functions of health care and health related functions. This distinction was not usually applied in national statistics before the implementation of SHA. In response, countries have adopted two different approaches: some countries have harmonised their national definition of health care with the SHA and now report the same total health expenditure figure for national and international purposes; while others have retained their old definition of health care for national purposes (often with some elements of health related expenditure in total health expenditure) and report different (SHA based) figures for international purposes.

At the same time, countries have had to adapt their health statistics to changes in the financing and provision of their health care services. Spain provides a good example in this instance with the recent decentralisation of the administration and financing of health care to the autonomous regions. A further example is the transformation of budget financing into a health insurance system in Poland and the privatisation of health provision also in Poland. Furthermore, countries have faced the challenge of adequately reflecting the evolution of service provision, due to changes in medical technology and practice (*e.g.*, the increasing role of day care surgeries), in their health statistics.

Countries are still in the process of developing SHA-based national health accounts and thus departures from the SHA-ICHA are possible. Therefore, despite the considerable improvements due to the implementation of the SHA, the comparability of the data still has some limitations. For example, one of the most important factors continuing to affect the comparability is the different treatment of long-term nursing care across countries. The differences have an effect on the magnitude of total health spending (and consequently the share of GDP), the public-private share, as well as the breakdown by function and provider. Any interpretation of the currently available results should take into consideration any problems with comparability.

In order to develop comprehensive and internationally comparable data on total expenditure according to the SHA manual, the following requirements need to be fulfilled: (i) The functional classification of health care (ICHA-HC) is applied in an internationally harmonised way; (ii) Expenditure by all the financing agents defined by the SHA is accounted for; (iii) All primary and secondary providers of health care are included regardless of whether they are classified as health care institutions in national industry statistics; (iv) Foreign trade of health services is estimated; (v) Similar methods for valuation of health services are applied following the SHA framework.

3. Total health expenditure

In addition to Spain, the analysis is based on data from 13 other countries: Australia, Canada, Czech Republic, France, Germany, Japan, Korea, Luxembourg, Netherlands, Norway, Poland, Portugal, and Switzerland. These 14 countries have all submitted validated health accounts data to the Joint OECD, Eurostat and WHO Health Accounts Data collection in 2006 and/or 2007. The availability of SHA tables prior to 2005 and the harmonisation of the major aggregates, such as total health expenditure, with SHA also varies by country (refer to Table 1 for a complete list of data availability by country).

Table 1
Availability of SHA Data

	Availability of SHA tables *	Harmonisation of major aggregates **
Australia	2003/04-2004/05	1998
Canada	2003-2005	1998
Czech Republic	2003-2005	1999
France	2003-2005	2002
Germany	2003-2005	1992
Japan	2003-2004	1995
Korea	2003-2005	1983
Luxembourg	2003-2005	2000
Netherlands	2003-2005	1998
Norway	2003-2004	1997
Poland	2003-2005	1999
Portugal	2000-2005	2000
Spain	2003-2005	1999
Switzerland	2003-2005	1995

* SHA Tables are published in the OECD SHA Database, available via Source OECD.

** The main aggregates of health spending are published in *OECD Health Data (OECD, 2007)*.

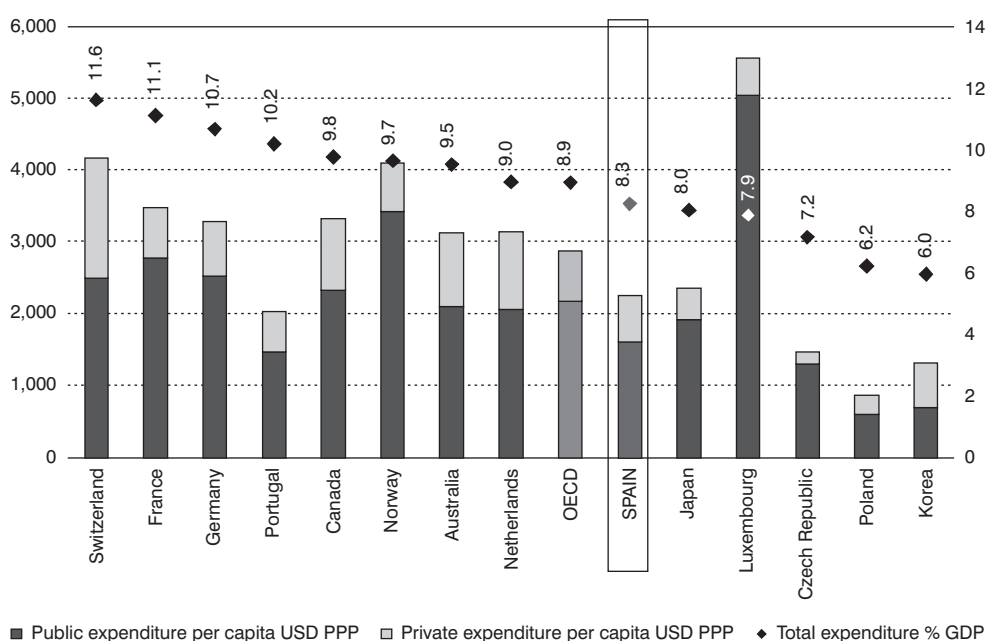
The 14 countries vary in terms of size, region and but most importantly for this analysis in the organisation and funding of their health systems. The most important difference in terms of the current analysis is the extent of the involvement of the private sector. The countries have 100 percent or close to 100 percent population coverage under their public system. Netherlands stands apart in this regard as prior to 2005, eligibility for public system coverage was determined by income, with individuals above a certain threshold required to purchase private insurance². The percentage of individuals not publicly covered was 28.9% in 2000 (Tapay and Colombo, 2004).

The Czech Republic, Luxembourg, Norway and Poland have private insurance schemes but with negligible coverage. The private insurance coverage of populations in other countries is larger but also variable. In Spain, as well as in Australia, private insurance provides a private alternative to public coverage, giving insurees access to privately financed providers, separate from public delivery systems (duplicate role), whereas in Canada the private coverage is supplementary only. Private health insurance in France is somewhat unique

within the OECD area, because its main function is to complement and “top up” reimbursements by the social security system (complementary role).

Figure 1 shows *total per capita health expenditure* for 2005 expressed in USD PPP³ and as a percentage of GDP. A wide variation in overall health spending levels can be observed, ranging from Luxembourg with total health spending per capita of 5563 USD PPP to Poland with total spending per capita of 867 USD PPP. Both in terms of per capita spending and as a share of GDP, Spain sits at a level just below the average of the group of 14 OECD countries. It should be noted that total spending for Luxembourg includes expenditure on non-residents as commuting workers account for almost one quarter of Luxembourg’s insured so the total number of people belonging to the Luxembourg health insurance scheme is higher than the resident population. Therefore, health care expenditure per capita could be misleading for it is calculated by dividing the health care expenditure only by the resident population. The impact of the population figures can be seen in the ratio of health expenditure to GDP where Luxembourg is ranked only 11th out of the 14 countries in the sample and with a health expenditure ratio below the OECD average (Chart 1).

Figure 1. Total Health Expenditure: per capita in USD PPPs and as share of GDP, 2005



Source: OECD SHA Database, Oct. 2007.

In terms of per capita spending on health, the countries can be organised in 4 groups. The first group comprises 3 countries of Luxembourg, Switzerland and Norway who have a high level of spending per capita (USD PPP). There is then a bunching of 5 countries: Australia, Canada, France, Germany and Netherlands, each with an expenditure of over 3,000 USD PPP per capita per year and above the average for the 14 countries of 2876. Spain can be included in a group of 3, alongside Portugal and Japan, with per capita health expenditure of between 2,000 and 2,500 USD PPP. The final grouping of the Czech Republic, Korea and Poland each have health expenditure per capita of less than 1,500 USD PPP⁴.

Per capita expenditure shows the overall level of consumption of health goods and services by the population across the countries. The health spending to GDP ratio reflects a macro-economic approach, comparing the share of national income devoted to health care without any information on the absolute magnitude of these resources. One can get a sense of the relative magnitude of the health and economic resources, however, by looking at the ratios for Norway (9.7%), Luxembourg (7.9%) and Portugal (10.2%). For Norway and Luxembourg (given the population issues above), the low ratio for health expenditure, alongside the high per capita health expenditure is indicative of the relatively high level of GDP in those countries. For Portugal, the reverse is true as the ratio is high but the per capita health expenditure is relatively low.

Apart from the 3 countries of Norway, Luxembourg and Portugal, the ranking in health expenditure per capita is close to their ranking in terms of the ratio of health expenditure to GDP (Figure 1).

The level of a country's national income devoted to health varied almost twofold from 6.0% in Korea up to 11.6% in Switzerland. The grouping of countries is not as apparent when health expenditure is expressed as a percentage of GDP. Compared with Portugal, Spain has a similar per capita spending on health, but as a share of GDP, Spain is significantly lower and sits below the average of the 14 OECD countries at 8.3% in 2005.

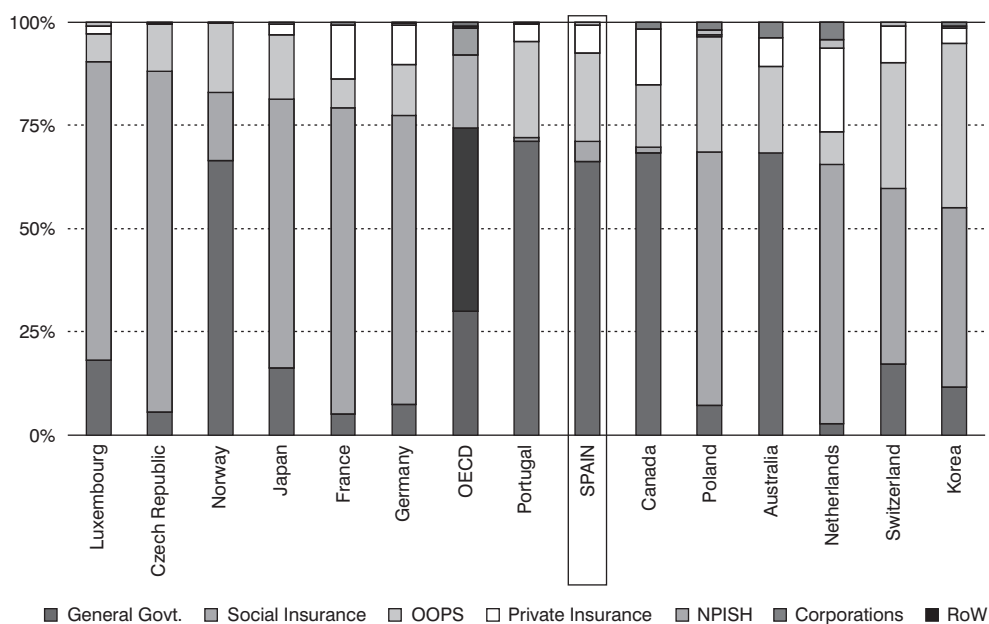
The observed differences in health spending per capita across countries appear far greater than health expenditure ratios. The figures seem to suggest that above a certain level of economic development the relationship between GDP per capita and the share of GDP spent on health care is rather weak, with other factors (*i.e.* budgetary and health policies, as well as history and structure of the health systems) perhaps exerting a larger influence⁵.

Figure 1 also shows the public and private health spending shares. For the OECD 14 country average, 6.6% of GDP is public and 2.4% of GDP is private. Overall for the 14 countries, 76% of health spending is public. Public spending is significantly lower than the average in Switzerland and Korea with less than 60% of spending publicly financed. At the other end of the scale around 90% of health spending is from the public purse in the Czech Republic and Luxembourg. At 71%, Spain sits just below the average of the 14 countries.

4. Health expenditure by financing agent

Figure 2 breaks down current health expenditure by financing agent. The major categories of financing health care are general government, social security schemes (which are both public) and the remainder of private insurance, out of pocket payments and all other private funds. Between the various financing agents on a simple public versus private spending level, for all countries, general government continues to be the main funding agent, accounting for around 73.5% of current expenditure on health. Also, as seen above, there is a wide range between the countries in the sample ranging from 90% in Luxembourg to 55% in Korea. The variation between countries on the share of public funding from the central government or from social security funds depends on the institutional arrangements for funding health care in the country in question. Spain, together with a group of countries covering Australia, Canada, Norway and Portugal are predominantly central or locally tax-funded health systems with little or no funding from social insurance funds. Most of the other countries in this sample raise their funds through some kind of social insurance scheme. Examples are Germany, the Netherlands, Poland, France and Japan.

Figure 2. Current expenditure on health by financing agent, 2005



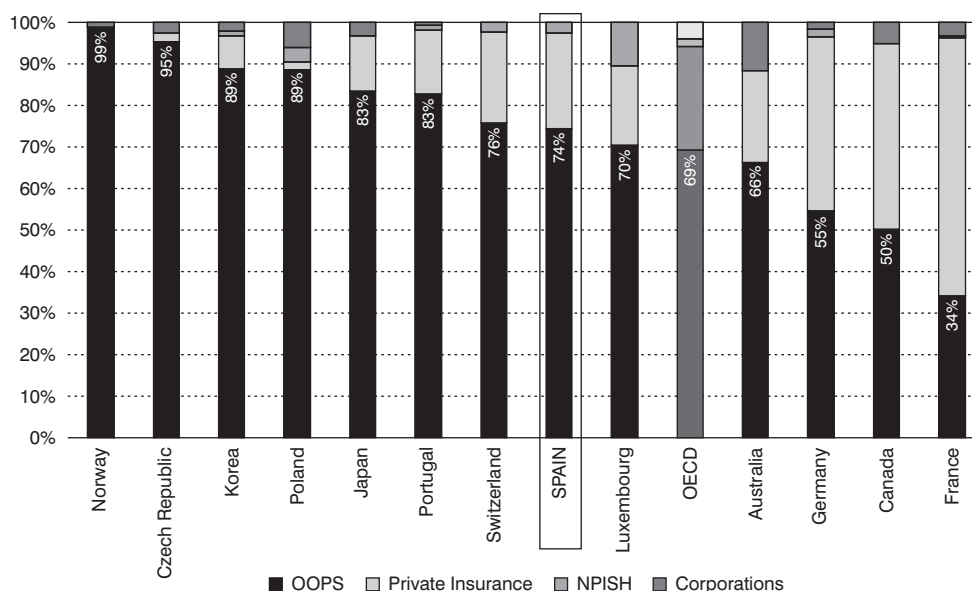
Source: OECD SHA Database, Oct. 2007.

In general, private household out-of-pocket payments, comprising direct payments, cost-sharing and co-payments, form the largest part of private funding sources. Of all sources of funding, out-of-pocket expenditure requires the closest monitoring as it can create a burden for citizens on low incomes and those with poor health states. Such monitoring requires more detailed analysis than we are able to perform with the current data.

The OECD-14 average for out-of-pocket funding by households is 18.3%. The share varies from a low of 6.7% in Luxembourg, followed by France and the Netherlands on 7.1% and 7.9% respectively, to highs of 40% in Korea and 30.5% in Switzerland. The remaining countries can be assigned into 2 groups. Australia, Canada, Germany, Japan⁶, Norway and the Czech Republic have out-of-pocket expenditures ranging between 10 and 20% of total expenditure. Spain forms parts of the second group of countries, alongside Portugal and Poland, with out-of-pocket expenditure between 20 and 30% of the total. However, the estimation of households' out-of-pocket payments is an area which is prone to inaccuracy due to variations in methods of compilation. In particular, data derived from household expenditure surveys is exposed to considerable measurement problems. As an example, out-of-pocket payments should include under-the-table payments or so called gratitude-money.

Chart 3 shows the breakdown of private expenditure only by financing agent. The private sector comprises private insurance, private household out-of-pocket spending, non-profit institutions (NPISHs) and corporations. Out of pocket spending and private insurance in all countries are the two major components of private funding. The extent of these two types of private funding varies considerably across countries. For almost all countries, out-of-pocket spending makes up the greater proportion (69% on average) of private spending, with Spain just above the average at 74%. Only France sees a much higher share covered by private insurance for the reasons already stated above. Chart 3, as it concentrates on private expenditure only, enables a clearer picture of some of its components to be gleaned. The second largest component of private spending after out-of-pocket expenditure is private insurance.

The OECD-14 average for private insurance is 6.5% of total health expenditure. Substantial differences can also be observed in the role of private insurance, as noted earlier. Its share of total health expenditure exceeded the OECD-14 average in Australia, Canada, France, Germany, the Netherlands and Switzerland (Figure 3). With the exception of Norway and Japan, the higher income countries tend to fund a greater share of their private health expenditure through private insurance than the lower income countries. For many higher income countries, the share of funding through private insurance reflects reform processes which attempt to meet objectives of increased efficiency, equity of access and financial sustainability. In light of continued cost pressures and strains on public finances, health systems across the OECD are striving to increase value for money.

Figure 3. Private Expenditure by Financing Agent, 2005

Source: OECD SHA Database, Oct. 2007.

5. Health expenditure by function

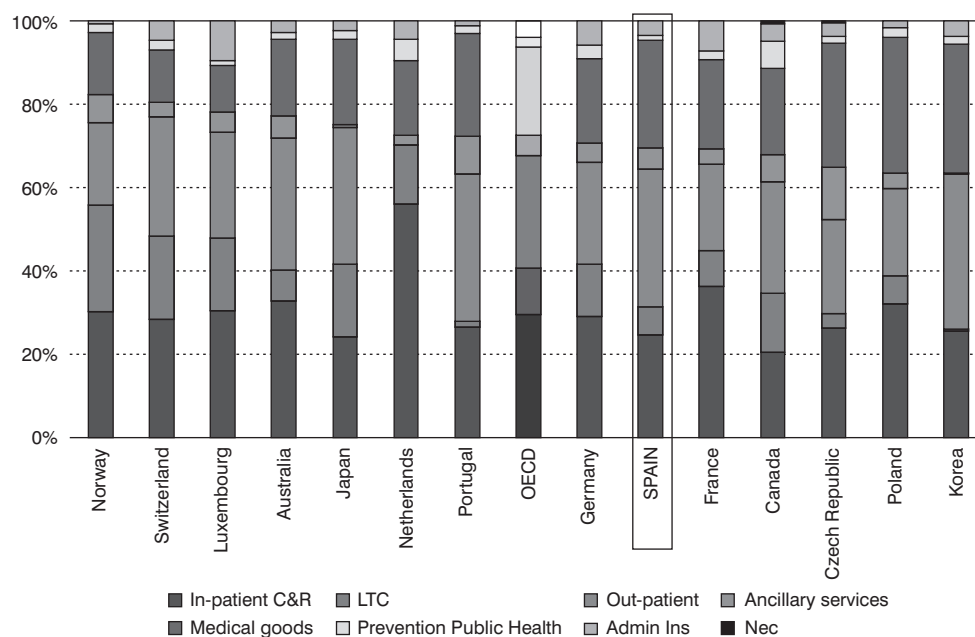
For international comparability of data, the functional classification is the most crucial element of the SHA ⁷ as it removes the effect of country-specific institutional arrangements. To illustrate this importance, let us consider that for many pre-SHA health accounts only hospital expenditure is presented and there is no separation of the different functions (out-patient care, long-term care, etc.) within hospitals. The SHA-based health accounts revealed that a higher share of hospital expenditure in country A than in country B does not necessarily involve higher in-patient expenditure in country A. Health care functions, defined and estimated in an internationally harmonised way, are crucial to the production of comparable health expenditure figures for countries with differing institutional arrangements.

The most important factor continuing to limit comparability is the differing treatment (both definition and estimation methods) of long-term care across countries. Expenditure on long-term nursing care is 11% of total health expenditure on average in the 14 countries (Figure 4). Reported expenditure on long-term nursing care ranges widely from 0.5% in Korea to 25% in Norway (Figure 4). This wide difference is due to a combination of real differences in health and social care provision and variations in estimation methods. However, by moving towards international reporting guidelines on estimating long-term care, there has been an improvement in comparability of estimations in recent years. For example, for Spain,

closer adherence to the guidelines has led to an increase in the long-term rising share of current expenditure from less than 2% to close to 7%.

Applying the mode of production approach, the health accounts reveal a rather different spending pattern than is usually supposed. From a health policy perspective this is one of the most important findings of the study. In-patient curative-rehabilitative care occupies a smaller share of health expenditure than is usually assumed. Its share ranges from 20.5% of current health expenditure in Canada up to 36% in France (Figure 4). The average of 13⁸ OECD countries is around 28% with Spain at a relatively low value of 24.5%.

Figure 4. Current Expenditure on Health by Function, 2005



Source: OECD SHA Database, Oct. 2007.

Out-patient care together with ancillary services represent consultations with medical and health specialists outside of hospitals. All the countries in the sample, which spend a lower proportion on in-patient services than the OECD-13 average, spend more on out-patient services than the OECD-13 average of 32.5%. Thus, as expected substitution occurs between hospitals and out-patient services across the OECD, but the analysis of the OECD-13 sample indicates that the substitution differs between countries. Thus it appears that the institutional and administrative structures of countries impact on both the actual proportion of

spending by function and also the relative proportions spent on different functions. Spain, along with Portugal, is notable in that the spending on out-patient services is considerable higher than that on in-patient services.

Medical goods (pharmaceuticals and therapeutic goods) consisted on average 22% of the total current health expenditure, although again with wide variation which ranged from 11% and 13% in Luxembourg and Switzerland to 34% in Poland. Spain reports spending on medical goods at 26% of current health expenditure, making it above the average and again on a par with Portugal. It is important to note that differences in per capita spending on pharmaceuticals across countries are far smaller than differences observed for total health expenditure. This is mainly due to the fact that pharmaceuticals have international market prices and as a result, lower income countries tend to spend a greater share of their health expenditure on pharmaceuticals.

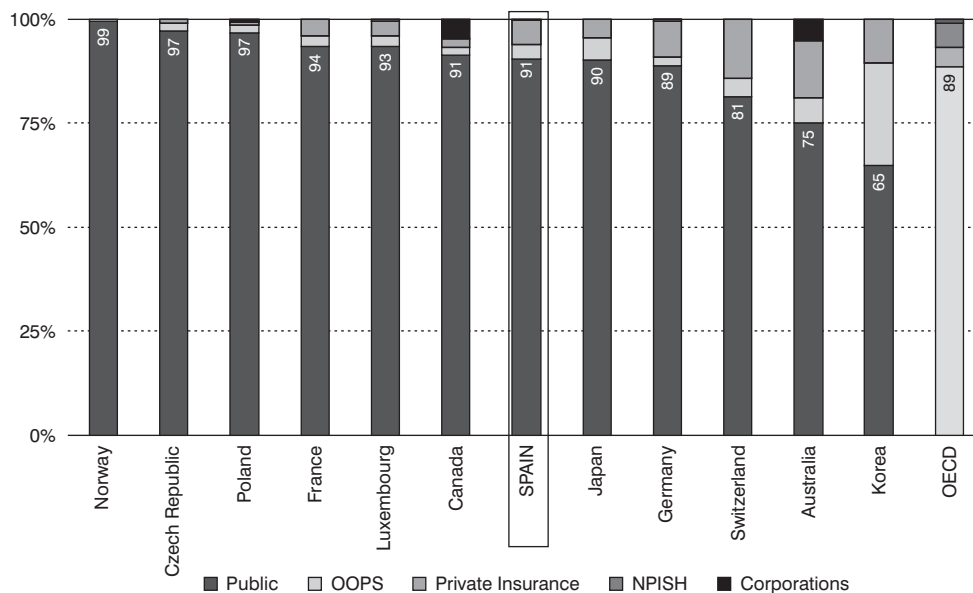
6. Current Health expenditure by function and financing agent

How are the different functions financed?

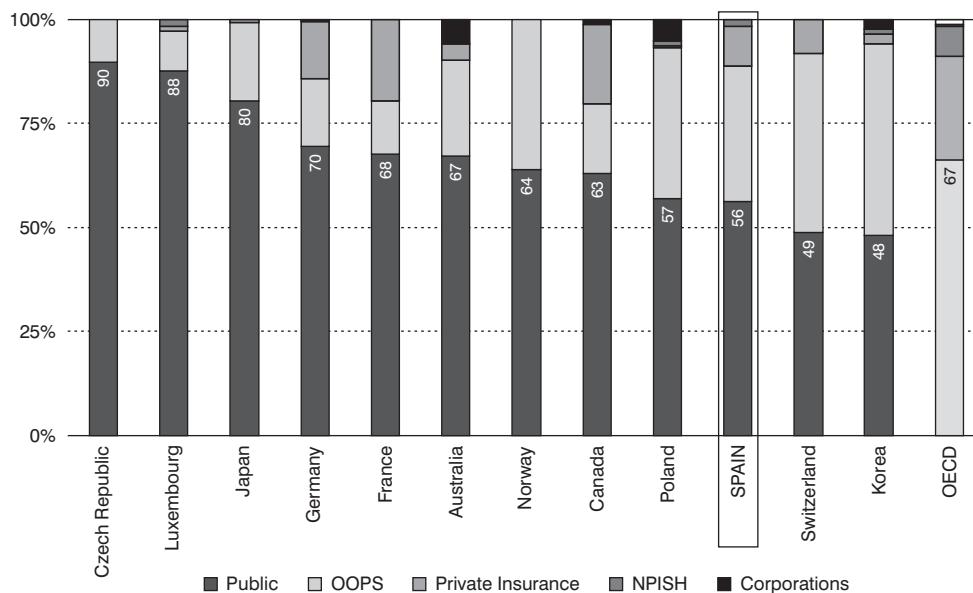
One of the most important questions to which SHA-based health accounts can provide an insight is how are the different functions financed? That is, what are the roles played by the various financing agents in financing the main spending components of in-patient care, out-patient care and medical goods? This information is obviously of great interest for health policy-making as influencing those areas with high private spending requires different health policy tools than those areas where public expenditure plays the dominant role.

In financing in-patient care, public funds are the dominant source contributing, on average, for OECD-12⁹, 89% of the costs, leaving the private sector funding the remaining 11% (Figure 5). For Spain, as in most of the 12 OECD countries, around 90% of the costs of in-patient care are borne by the public purse. In addition, most of the private component is covered by private insurance in these countries. Spain is typical with 60% of the small private component of total in-patient spending covered by private insurance. On the other hand, for Switzerland, Australia and Korea, the public funding of in-patient care is significantly below the average. In the case of Switzerland, much of the private contribution can be attributed to the costs of long-term care being met by the individual, while in Korea some lump sum insurance payments for in-patient care are attributed to households' costs rather than private insurance.

SHA-based health accounts reveal that out-patient care is financed in a substantially different way than is the case for in-patient care. On average, across the sample providing the breakdown, 67% of out-patient care was financed out of public sources. The 12 countries can be placed into 3 groups. The Czech Republic, Luxembourg and Japan continue to see 80% or more of out-patient care spending covered by public sources. Most countries, including Spain, still see public funds bearing the brunt of out-patient spending, albeit with Spain at the

Figure 5. Expenditure on In-patient Care by Financing Agent, 2005

Source: OECD SHA Database, Oct. 2007.

Figure 6. Expenditure on Out-patient Care by Financing Agent, 2005

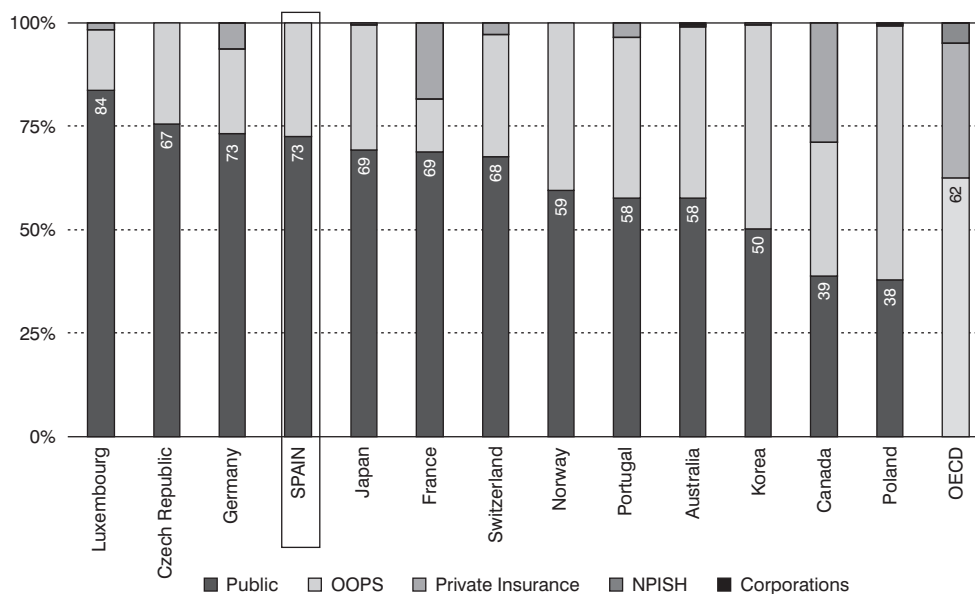
Source: OECD SHA Database, Oct. 2007.

lower end of this group with 44% of spending coming from private sources. Switzerland and Korea again see the private sector financing the majority of out-patient care.

Private sector funding of out-patient care is largely paid by households out-of-pocket. The average of total expenditure on out-patient services for the 12 countries is 25%. In France, Canada and to a lesser extent Germany, private insurance tends to cover an important part of the private component. In Spain, the households' burden for out-patient services is around a third of total out-patient spending – a similar level to that of Norway and Poland, although well below the 40% plus reported for Switzerland and Korea.

Figure 7 shows that in most countries, private funding plays an even more significant role in financing pharmaceuticals and other medical non-durables than in funding out-patient care. On average for OECD-13, the private sector share of spending on these products is 37.5% compared with 33% for out-patient services. The countries in the sample fall into one of three groups. Switzerland and Spain are the only two countries where the government funding of pharmaceuticals is significantly higher than that for out-patient services. In Australia, Canada, the Czech Republic, Japan and Poland, the public share of pharmaceutical funding is rather less than that for out-patient services. For the remaining countries, the share of government funding in both areas is approximately the same.

Figure 7. Expenditure on Pharmaceuticals by Financing Agent, 2005



Source: OECD SHA Database, Oct. 2007.

Five of the countries featured in Figure 7 have well developed private insurance systems, but nonetheless in 3 of these countries, namely Australia, Germany and Switzerland, out-of-pocket payments remain the dominant source of funding for pharmaceuticals and medical goods. Only in Canada and France are there significant reimbursements from private insurance of private payments for pharmaceutical and medical goods. Overall, household out-of-pocket payments comprise the significant portion of the private funding. For all countries apart from Switzerland, Spain and France, the out-of-pocket funding share is higher for pharmaceuticals than for out-patient services. In Canada, even though private insurance coverage is high at 29% of the total funding, out-of-pocket payments are higher at 32%.

These results reveal that in many countries, the fact that the whole health care system is primarily publicly financed does not entail that public financing plays the dominant role in every area. In several countries (*e.g.*, Australia, Canada, Poland and Spain) public financing plays the dominant role mainly in in-patient care and in out-patient care while, for medical goods, the private sector plays an almost similar or even greater role.

7. Conclusions

Taking its national income into account, Spain devotes a share of its GDP on health spending which is in line with many of the OECD countries in this study. The overall breakdown into public and private financing of health care is also close to the average. In the financing of the main areas of health care, namely in-patient, out-patient and pharmaceuticals, public expenditure is dominant in all three.

Since areas with high private spending require different health policy tools (*e.g.* cost-containment) than those areas where public expenditure plays the dominant role, this is of great interest to policy makers. Analysis reveals that, even though the overall health care system may be publicly funded in most countries, this does not imply that public financing plays the dominant role in every area. For example, private sources play a far more significant role in financing both out-patient care and medical goods (including pharmaceuticals) in many countries, and this proves to be one of the key differences between countries.

Our results highlight both the richness of the SHA data and the importance of the consistency and compliance with the SHA definitions. More importantly, the results enable countries to compare the financing and the structure of their health care system with other countries. SHA-based health accounts have been designed to enable the comparison of health spending across countries with differing health care systems, while at the same time being suitable for national policy-making purposes. In addition, SHA-based health accounts aim to provide data comparable over time, even if administrative changes in the health system affect the national boundaries of health (for example, the introduction of long-term care insurance in Japan).

Notes

1. For Japan and Norway, data refer to 2004. For Australia, data refer to the financial year 2004/05.
2. Up until 2005, health care in the Netherlands was financed through two major public sources, private insurers and out-of-pocket expenditures. From 2006 onwards the system changed motivated by expenditure increases and unbalanced supply and demand in health care. Insurable care, in particular, is now financed through one system: social insurance carried out by private insurers. The insurance is compulsory and acceptance of all risks is compulsory for the insurers. In this overview, data refer to the years before 2006, and therefore to the former financing system.
3. Data are expressed in US dollars adjusted for purchasing power parities (PPPs), which provide a means of comparing spending between countries on a common base. PPPs are the rates of currency conversion that equalise the cost of a given 'basket' of goods and services in different countries. For comparisons of spending levels over time against an OECD average constant year PPPs are used.
4. The Eurostat-OECD manual (2006) recommends grouping countries together according to GDP per capita or in this case health expenditure per capita rather using strict ranking of countries. At the level of GDP a broad rule of thumb is that differences between countries in their indexes of real final expenditure per head and comparative price levels need to be at least five percentage points to be considered statistically significant. In the case of health expenditure, the margin of error may be greater because in the absence of reliable health specific-PPPs, GDP PPPs are used to deflate health expenditure.
5. For example, despite Japan and Germany having the same GDP per capita, their health spending per capita differs considerably with Japan spending less than 75% of the level of Germany on health.
6. Private expenditure in Japan is underestimated, because data do not include private payments on medical services that are not included in the service package of social insurance.
7. Functional distribution of health expenditure is displayed from two approaches: distribution of expenditure by "functions" in terms of the purpose of health care (curative care, rehabilitation and long-term care, etc.); and by mode of service production reflecting the characteristics of technical and managerial organisation of health care.
8. The Netherlands is unable at present to separate curative-rehabilitative care into in-patient and out-patient care.
9. The Netherlands and Portugal are currently unable to separate in-patient and out-patient spending by financing agent.

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