# Public funding of health care

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## More than 70% of health spending across OECD countries is funded from public sources

In all OECD countries, a significant share of the economy is used to improve or preserve the health of the population. On average, 8.8% of a country's Gross Domestic Product (GDP) was dedicated to health in 2018.

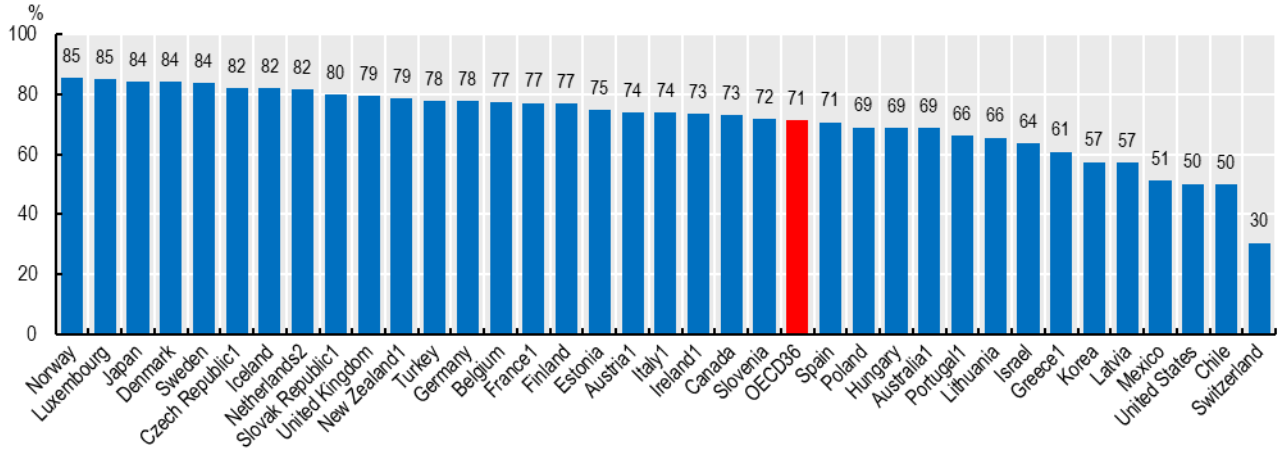
A substantial proportion of health spending is funded out of public resources – which mainly refer to funding from government revenues generated from tax income, and social insurance contributions. In 2017, they financed around 71% of health expenditure across the OECD (Figure 1). This share was particularly high in Norway and Luxembourg (85% of total spending), and lowest in Switzerland (financing less than a third of spending).

In Norway and Denmark, the high share of spending from public sources reflects exclusively governmental transfers to NHS-type financing schemes. In other countries, such as Japan (84%), public funding refers to a mix of social insurance contributions from employees and employers (43%) as well as government transfers to social health insurance schemes and government programmes.

In Switzerland and the United States, the low level of public funding is due to the fact that mandatory health coverage from private insurers is mainly financed via premium payments by households which are considered as private sources. In Mexico and Chile, households cover a substantial part of total spending from their own resources out of pocket.

These figures are primarily based on an analysis of the sources of revenue of insurers and other payers (so-called financing schemes) as the criteria to distinguish between public and private health funding (Box 1).

**Figure 1: Health expenditure from public sources as share of total health spending, 2017 (or nearest year)**



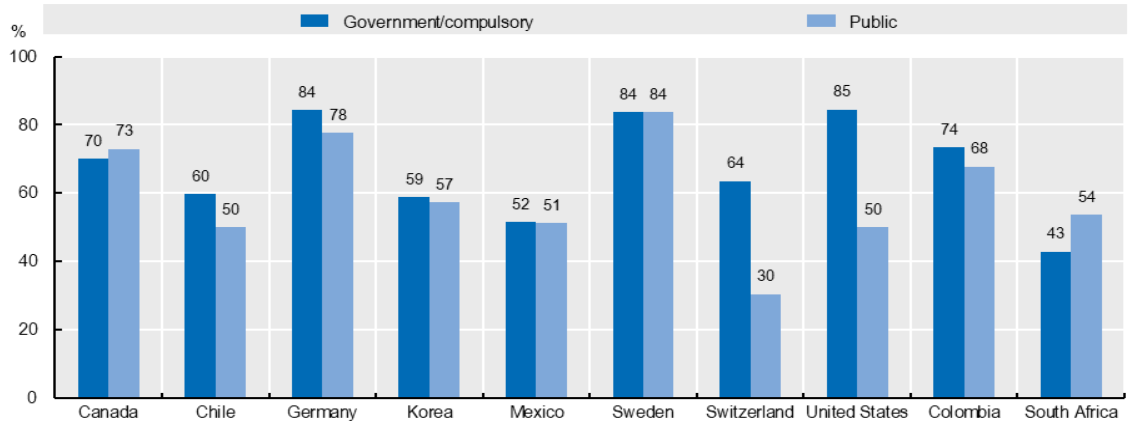

Note: 1. Public is calculated using spending by government schemes and social health insurance schemes; 2. Public is calculated using spending by government schemes, social health insurance and compulsory private insurance.
*Source: OECD Health Statistics 2019.*

## Public funding of health can differ substantially from spending by compulsory schemes

Across countries, there can be a substantial difference between public funding of health (based on the source of revenues) and spending by government or compulsory schemes. The clearest difference between the share of government/compulsory schemes in total health spending, compared with public funding of health can be seen in the United States

(Figure 2). Here, 85% of health spending comes from government or compulsory insurance schemes, but only half of total spending emanates from public revenues. Similarly, public sources only account for 30% of total spending in Switzerland, whereas nearly two-thirds of spending is made by compulsory private health insurers.

**Figure 2. Share of total expenditure through government and compulsory financing schemes compared to the share from public sources, 2017 (or nearest year)**




*Source: OECD Health Statistics 2019.*

**Box 1: What determines 'public'?**

When splitting health spending into a *public* and *private* component, two perspectives based on the financing classifications of the 'System of Health Accounts' can be taken.

*Financing Schemes* refer to the arrangements through which people obtain health care services. They can be either automatic/ mandatory (such as government programmes like the NHS, or compulsory social or private health insurance) or voluntary (such as out-of-pocket payments or voluntary health insurance).

The *Revenues of Financing Schemes* are the sources of income of these arrangements. *Public sources* refer to government transfers (e.g. from tax income) and social contributions paid by employers, employees and others. *Private sources* comprise the premiums for private insurance coverage, as well as any other funds from households or corporations.

The revenue classification is the preferred option to determine whether health expenditure is funded from public or private sources. Yet if this data is not available, the financing schemes classification is then used to operationalise such a split. In that case, by default, spending by government schemes and social insurance schemes are considered 'public' with the remaining schemes being 'private'.

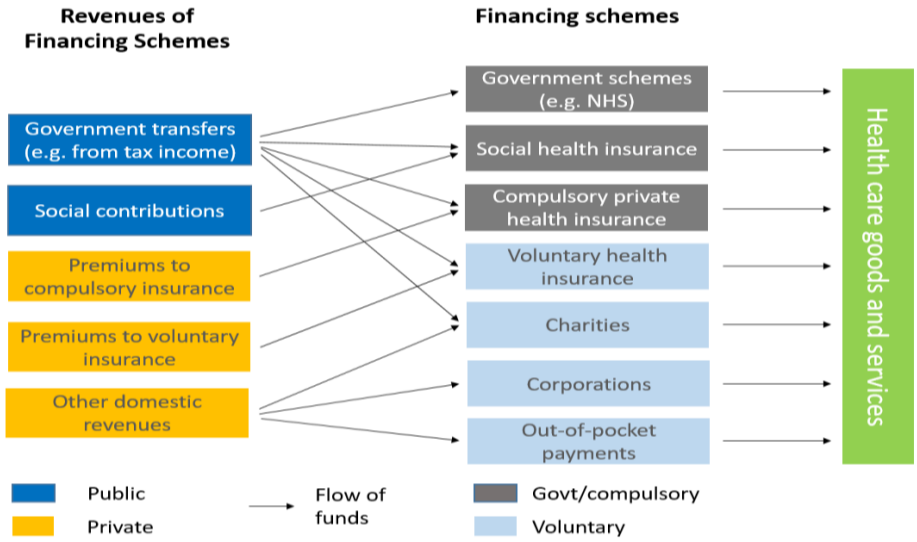
In Canada and South Africa, where governments provide subsidies for voluntary health insurers, the proportion of total spending from public sources is higher than would otherwise be concluded if looking exclusively at spending by government or mandatory financing schemes.

In Germany and Chile, some population groups are covered by compulsory health insurance, but the premiums payed by households to guarantee coverage are considered as private sources of funding. As a result, the share of public funding of health is below that of government/compulsory financing.

In Sweden, there is a one-to-one relationship between the revenues from public sources and government schemes. In the Swedish system, the only automatic/mandatory scheme refers to the NHS which is exclusively financed by government transfers; and there are no additional tax transfers to other schemes.

The potentially complex relationship between financing schemes – who purchase the health care goods and services - and revenues is depicted in Figure 3. Whereas government transfers can be a source of revenue for nearly all financing schemes, there is a clear one-to-one relationship between some schemes and revenues (e.g. social insurance contributions can only be made to social insurers, premiums to voluntary insurance can only be made to voluntary insurers).

**Figure 3. Relationship between financing schemes and revenues of financing schemes**




*Source: Author's compilation based on SHA 2011.*

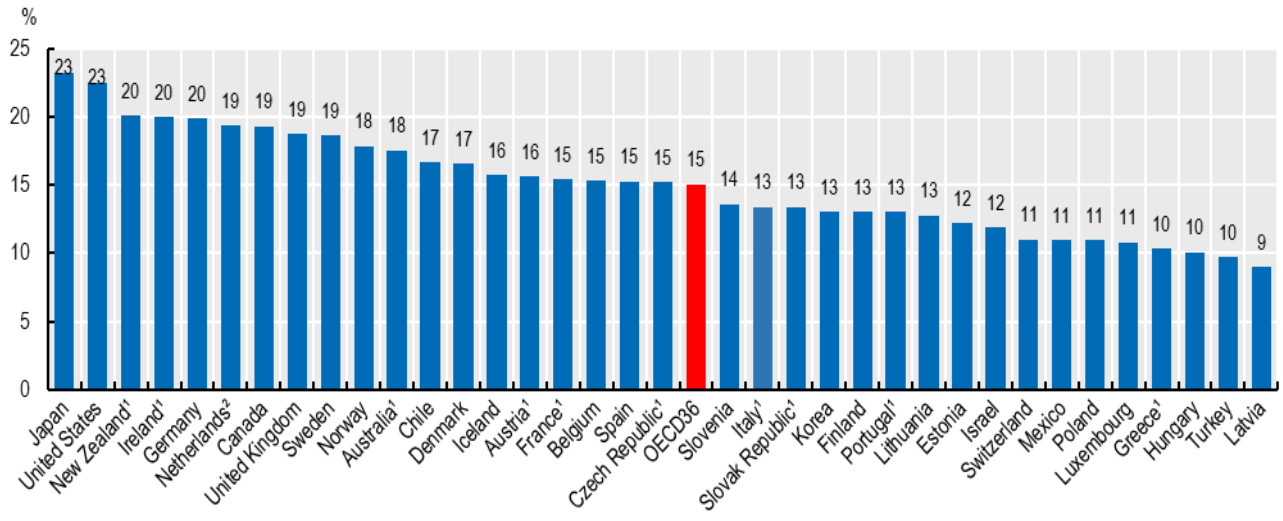
## Public funding of health accounts for 15% of total government spending

Governments finance a range of public services, and health systems compete for limited resources alongside other sectors such as education, defence and housing. The size of health in total government budgets varies depending on government priorities, as well as the organisation of health services, the demographic composition and epidemiology of the population and the level of health prices.

Public funding of health care via government transfers and social insurance contributions accounted for 15% of total government expenditure across OECD countries in 2017 (Figure 4). This figure is higher - 20% or more of public spending - in Japan, the United States, New Zealand, Ireland and Germany, while it is only around 10% in Greece, Hungary, Turkey and Latvia.

Across OECD countries, the share of public spending on health in total government expenditure has slightly increased since 2005 (up from 14%), reflecting the fact that health plays an increasingly important role in government budgets.

**Figure 4. Health expenditure from public sources as a share of total government expenditure, 2017 (or nearest year)**




1. Public is calculated using spending by government schemes and social health insurance schemes.
2. Public is calculated using spending by government schemes, social health insurance and compulsory private insurance
Total government expenditure includes spending by social security.
*Source: OECD Health Statistics 2019.*

### The share of public funding changed little over time across OECD countries

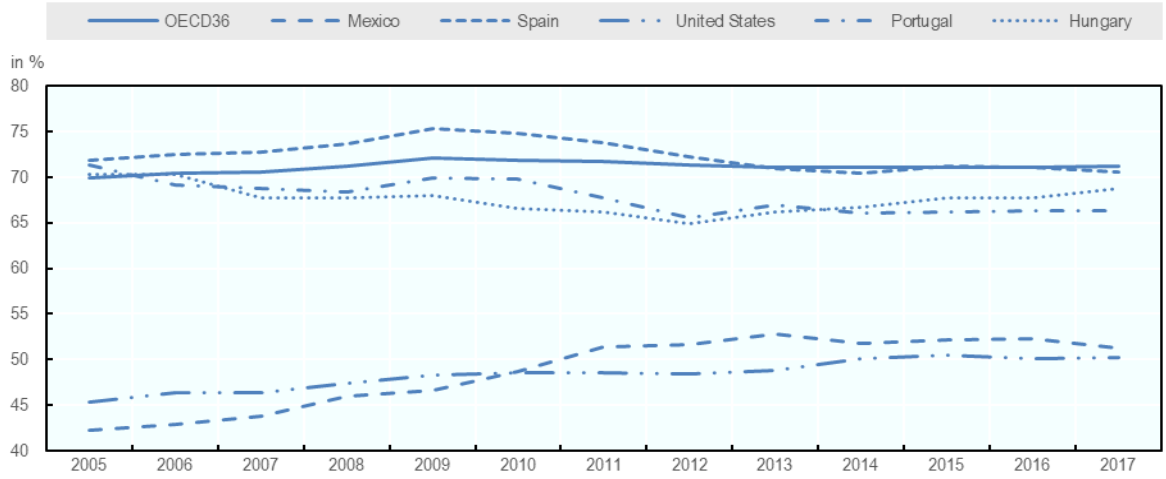
In most countries, the composition of health funding has changed very little over time. On average across OECD countries, the share of public funding of health has remained relatively constant at around 71% of total spending between 2005 and 2017.

There are some exceptions though. In Mexico, the share of public funding in health has increased by around 9 percentage points in the last decade – albeit starting from a lower initial level – as a result of deliberate policy choices to increase population coverage and expand the collectively financed benefit package. While the share of social contributions reduced slightly, the proportion of government transfers nearly doubled (reaching 28% in 2017). The share of public spending has also increased in the United States (by 5 percentage points), triggered by an increase in government transfers to Medicare and Medicaid.

Spain and Portugal were severely affected by the economic downturn in the wake of the financial crises. In these two countries, the share of public funding in health has decreased as a consequence of measures taken to rein in public spending from around 2009. As a result, the share of public funding of health went down by 5 percentage points in Spain and by 4 percentage points in Portugal between 2009 and 2014. Since then the shares have remained mainly flat.

In Hungary, the share of public funding of health has remained roughly constant but the composition has changed substantially, as a result of financing reform. In 2009, the country reorganised the funding structure of social health insurance, moving away from social insurance contributions to increase government funding to these schemes. As a result, 50% of all health spending came from government transfers in 2017 while social insurance contributions finance 19% overall.

**Figure 5. Share of public funding in total health expenditure, selected countries, 2005-17**




*Source: OECD Health Statistics 2019.*

#### References


Mueller, M. and D. Morgan (2018), "New insights into health financing: First results of the international data collection under the System of Health Accounts 2011 framework", Health Policy (121)7: 764-769.

OECD/Eurostat/WHO (2017), A System of Health Accounts 2011: Revised edition, OECD Publishing, Paris.


#### Useful Links

OECD Health Statistics 2019:
http://www.oecd.org/health/health-data.htm

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