7.1. Health expenditure per capita

OECD countries vary enormously in how much they spend on health and the rate at which health spending grows. This reflects a wide array of market and social factors, as well as countries' diverse financing and organisational structures of their health systems.

The United States continues to outspend all other OECD countries by a wide margin. In 2009, spending on health goods and services per person in the United States rose to USD 7 960 (Figure 7.1.1) – two and a half times the average of all OECD countries. The next highest spending countries, Norway and Switzerland, spend only around two-thirds of the per capita level of the United States, but are still more than 50% above the OECD average. Most of the northern and western European countries, together with Canada and Australia, spend between USD PPP 3 200 and 4 400, between 100% and 130% of the OECD average. Those countries spending below the OECD average include Mexico and Turkey, but also the southern and eastern European members of the OECD together with Korea. Japan also spends less on health than the average in OECD countries, despite its above-average per capita income. By comparison the fast growing economies, China and India, spend less than 10% and 5% of the OECD average on health.

Figure 7.1.1 also shows the breakdown of per capita spending on health into public and private components (see also Indicator 7.5 "Financing of health care"). In general, the ranking according to per capita public expenditure remains comparable to that of total spending. Even if the private sector in the United States continues to play the dominant role in financing, public spending on health per capita is still greater than that in most other OECD countries (with the exception of Norway, Luxembourg and the Netherlands), because overall spending on health is much higher than in other countries. In Switzerland also, a large proportion of health care financing comes from private sources, and its public spending on health is lower than in certain other countries, although overall spending is higher. The opposite is true in Denmark where most health care is mostly financed through public sources.

Per capita health spending over 2000-09 is estimated to have grown, in real terms, by 4% annually on average across the OECD (Figure 7.1.2 and Table A.6). In many countries, the growth rate reached a peak prior to 2004 and slowed in more recent years.

In general, the countries that have experienced the highest growth in health expenditures per capita over this period are those that had relatively low levels at the beginning of the period. Health expenditure growth in the Slovak Republic and Korea, for example, has been more than twice the OECD average since 2000, resulting in a degree of convergence between OECD countries over time.

In countries such as Italy, Switzerland and Germany, health spending per capita has increased at a much slower rate over the period – at an annual average of 2% or less. This reflects, in part, a period of relatively low economic growth over the period as a whole and the effect of deliberate cost-containment policies.

Figure 7.1.3 shows the familiar association between GDP per capita and health expenditure per capita across OECD countries. While there is an overall tendency for countries with higher GDP to spend a greater amount on health, there is wide variation since GDP is not the sole factor influencing health expenditure levels. The association is stronger among countries with low GDP per capita than among OECD countries with a higher GDP per capita. Even for countries with similar levels of GDP per capita there are substantial differences in health expenditure at a given level of GDP. For example, despite Germany and Finland having similar GDP per capita, their health spending per capita differs considerably with Germany spending around 25% more than Finland. The United States spends much more on health than what might be expected based only on its GDP level.

Definition and comparability

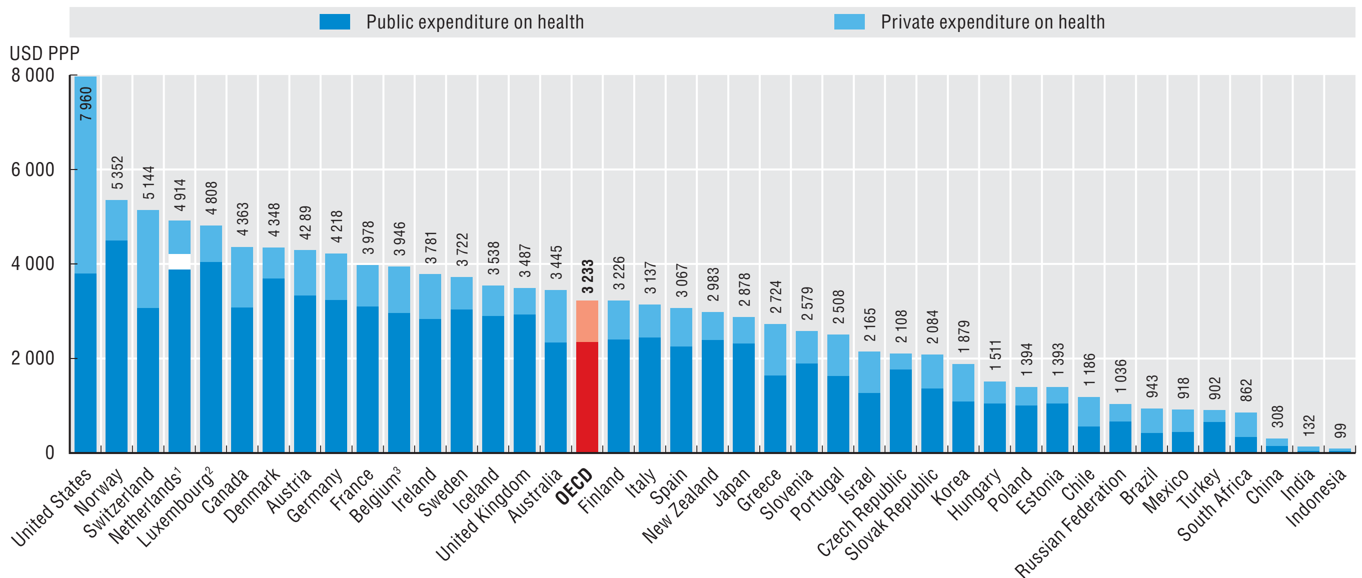
Total expenditure on health measures the final consumption of health goods and services (*i.e.* current health expenditure) plus capital investment in health care infrastructure. This includes spending by both public and private sources on medical services and goods, public health and prevention programmes and administration.

Differing estimation methodologies for long-term care spending, in particular the allocation of spending between health and social care, continue to limit the overall comparability of total health spending. See Indicators 7.3 "Health expenditure by function" and 8.8 "Long-term care expenditure" for further details.

Countries' health expenditures are converted to a common currency (US dollar) and adjusted to take account of the different purchasing power of the national currencies, in order to compare spending levels. Economy-wide (GDP) PPPs are used as the most available and reliable conversion rates.

Information on data for Israel: *http://dx.doi.org/10.1787/888932315602*.

7.1.1 Total health expenditure per capita, public and private, 2009 (or nearest year)

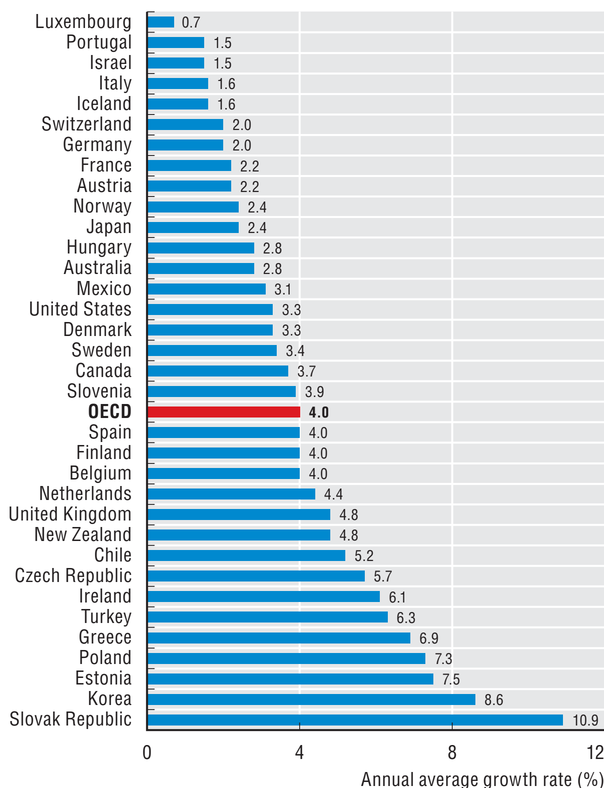


1. In the Netherlands, it is not possible to clearly distinguish the public and private share related to investments.
2. Health expenditure is for the insured population rather than the resident population.
3. Total expenditure excluding investments.

Source: *OECD Health Data 2011; WHO Global Health Expenditure Database.*

StatLink http://dx.doi.org/10.1787/888932526046

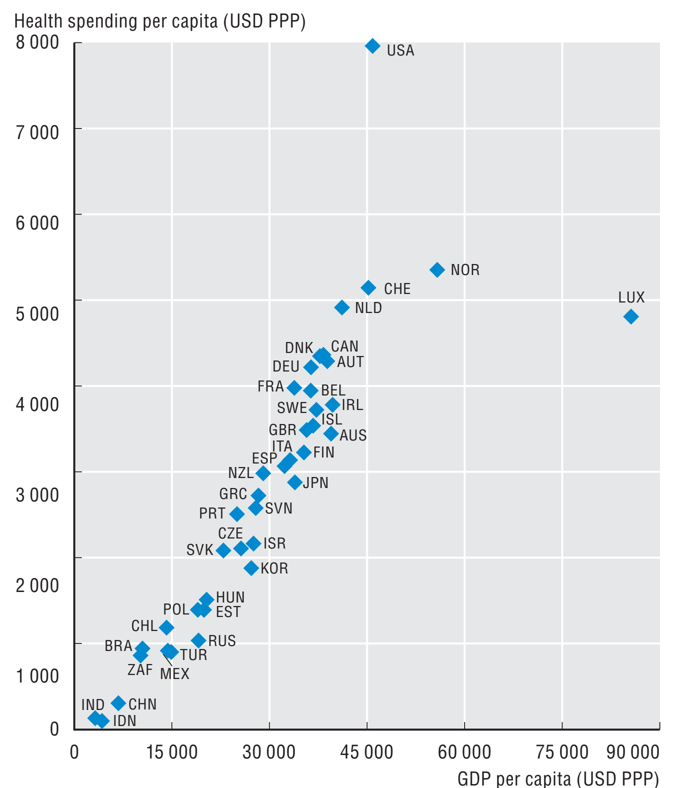
7.1.2 Annual average growth rate in health expenditure per capita in real terms, 2000-09 (or nearest year)



Source: *OECD Health Data 2011.*

StatLink http://dx.doi.org/10.1787/888932526065

7.1.3 Total health expenditure per capita and GDP per capita, 2009 (or nearest year)



Source: *OECD Health Data 2011; WHO Global Health Expenditure Database.*

StatLink http://dx.doi.org/10.1787/888932526084

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