

Health expenditure per capita

The amount that each country spends on health, for both individual and collective services, and how this changes over time can be the result of a wide array of social and economic factors, as well as the financing and organisational structures of a country's health system.

In 2013, the United States continued to outspend all other OECD countries by a wide margin, with the equivalent of USD 8 713 for each US resident (Figure 9.1). This level of health spending is two-and-a-half times the average of all OECD countries (USD 3 453) and nearly 40% higher than the next biggest spender, Switzerland (adjusted for the different purchasing powers – see “Definition and comparability” box). Compared with some other G7 countries, the United States spends around twice as much on health care per person as Germany, Canada and France. Countries spending less than half the OECD average include many of the central European members of the OECD, such as Hungary and Poland, together with Chile. The lowest per capita spenders on health in the OECD were Mexico and Turkey with levels of less than a third of the OECD average. Outside of the OECD, among the key partner countries, China and India spent 13% and 4% of the OECD average on health in per capita terms in 2013.

Figure 9.1 also shows the breakdown of per capita spending on health into public and private sources (see the indicator on “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 all other OECD countries, with the exception of Norway and the Netherlands.

Per capita spending on health across the OECD edged up slightly in 2013 continuing a trend of recent years. This slow rise comes after health spending growth ground to a halt in the wake of the global financial and economic crisis. Between 2009 and 2013, average annual health spending growth across the OECD was 0.6%, in contrast to the 3.4% in the period between 2005 and 2009 (Figure 9.2). There has been a difference of health spending growth between Europe and the rest of the OECD with some European countries facing dramatic reductions in health spending from 2010 onwards.

There have been some significant changes in the annual growth rates in health spending in the years before and during the financial crisis in a number of countries. Annual increases have been reversed in Greece (5.4% vs. -7.2%) and Ireland (5.3% vs. -4.0%) and have slowed down in the vast majority of OECD countries. Only six countries – Hungary, Mexico, Switzerland, Israel, Japan and Chile – recorded higher average growth following the crisis than pre-2009.

Chile, Korea and Turkey saw health spending increase by more than 5% in real terms in 2013. For Chile and Korea,

this level of spending growth has been constant since 2009. Preliminary estimates for 2014 point towards a slight slowdown in health spending in Japan, after recent strong growth.

In the United States, health spending grew by 1.5% in 2013, less than half the average annual growth rate prior to 2009. The latest forecasts from the Centers for Medicare and Medicaid Services point to faster growth in 2014 as more Americans gain health insurance coverage (Keehan et al., 2015).

Canada has seen a sustained period of low growth since 2010. This is in contrast to the average 3.5% growth per year between 2005 and 2009. With health spending growth estimated to have continued below economic growth, health spending as a share of GDP has also declined from a high of 10.6% in 2009 to 10.2% in 2013.

Definition and comparability

Expenditure on health measures the final consumption of health goods and services (i.e. current health expenditure). This includes spending by both public and private sources on medical services and goods, public health and prevention programmes and administration, but excludes spending on capital formation (investments).

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

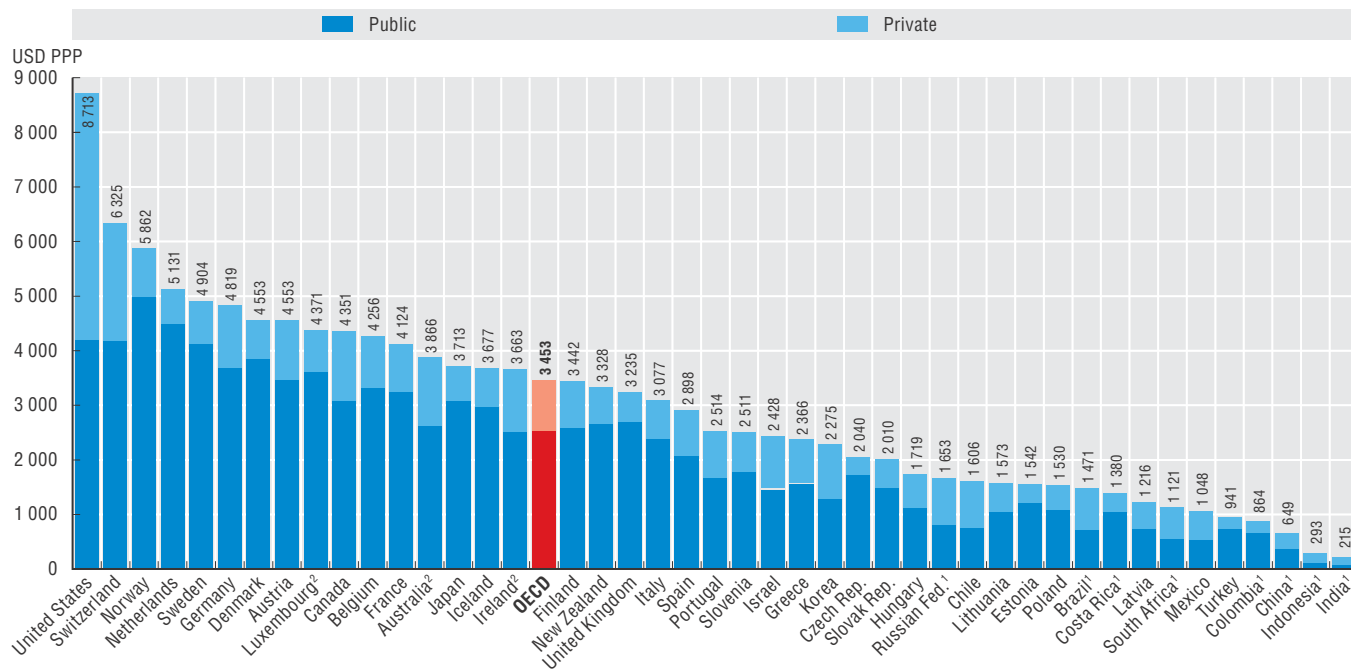
For the calculation of growth rates in real terms, economy-wide GDP deflators are used. In some countries (e.g. France and Norway) health-specific deflators exist, based on national methodologies, but these are not used due to limited comparability.

Note: Ireland is currently implementing a project to report increased detail on health expenditure and financing data in accordance with international guidelines. Data for 2013 is therefore not available and revisions to this and the following indicators will be made available on completion of the project.

References

Keehan, S.P. et al. (2015), “National Health Expenditure Projections, 2014-24: Spending Growth Faster Than Recent Trends”, *Health Affairs*, Vol. 34, No. 8, pp. 1407-1417.

9.1. Health expenditure per capita, 2013 (or nearest year)



Note: Expenditure excludes investments, unless otherwise stated.

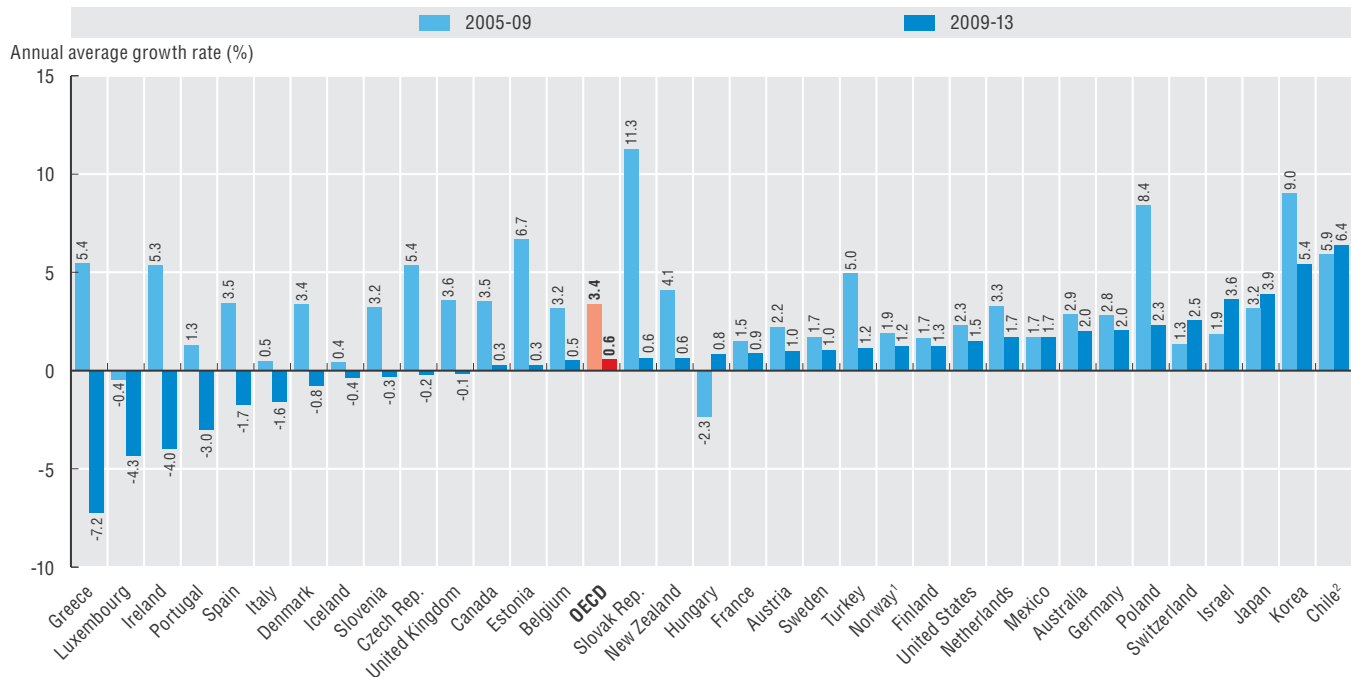
1. Includes investments.

2. Data refers to 2012.

Source: OECD Health Statistics 2015, <http://dx.doi.org/10.1787/health-data-en>; WHO Global Health Expenditure Database.

StatLink <http://dx.doi.org/10.1787/888933281252>

9.2. Annual average growth rate in per capita health expenditure, real terms, 2005 to 2013 (or nearest years)

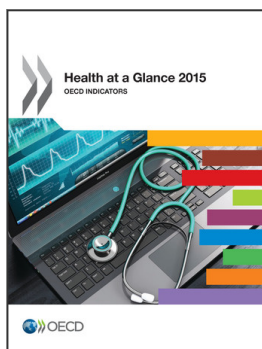


1. Mainland Norway GDP price index used as deflator. 2. CPI used as deflator.

Source: OECD Health Statistics 2015, <http://dx.doi.org/10.1787/health-data-en>.

StatLink <http://dx.doi.org/10.1787/888933281252>

Information on data for Israel: <http://oe.cd/israel-disclaimer>



From:
Health at a Glance 2015
OECD Indicators

Access the complete publication at:
https://doi.org/10.1787/health_glance-2015-en

Please cite this chapter as:

OECD (2015), "Health expenditure per capita", in *Health at a Glance 2015: OECD Indicators*, OECD Publishing, Paris.

DOI: https://doi.org/10.1787/health_glance-2015-59-en

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