In 2008, Norway recorded the highest spending per person on health goods and services among European countries at about EUR 4 300 (Figure 4.1.1) – almost twice the average of European Union countries. This was nonetheless far below the health spending per capita in the United States. Switzerland, Luxembourg and Austria were the next highest spending countries in Europe. Most northern and western European countries spent between EUR PPP 2 500 and 3 500 per person, that is, between 10% and 60% more than the EU average. Those countries spending below the EU average are eastern and southern European countries such as Turkey, Romania, Bulgaria, Poland and Hungary.

Figure 4.1.1 shows the breakdown of per capita spending on health into public and private components (see also Indicator 4.5). Both the ranking and the variation in the levels of public spending on health is similar to that observed for total spending on health.

Over the past ten years (1998-2008) per capita health spending is estimated to have grown in real terms by 4.6% annually on average across the EU countries (Figure 4.1.2). In many countries, the growth rate reached a peak around 2001-02 and has slowed in more recent years.

In general, the countries that have experienced the highest growth in health spending over this period are those that had relatively low levels at the beginning of the period. Health expenditure per capita growth in Turkey, for example, has generally been more than twice the EU average over the past ten years. Other countries, such as Ireland and the United Kingdom, pursued specific policy objectives to increase public spending on health, meaning that overall health spending has outpaced economic growth (Department of Health and Children, 2001; Secretary of State for Health, 2002).

In contrast, health spending per capita in Germany increased in real terms by only 1.8% per year on average over the past decade, reflecting the effect of cost-containment policies. These measures have included budget or spending caps for sectors or individual providers, promoting the use of generic drugs, restricting the number of hospital beds and high cost medical equipment, and introducing or increasing co-payments for certain services (Busse and Riesberg, 2004).

Health spending per capita in Norway in *nominal terms* grew at a fairly strong rate of nearly 7% per year over the past ten years. However, when deflated by the economy-wide price index, growth in *real terms* was relatively low (0.8%). This is because the economy-wide price index in Norway is heavily influenced by the price of oil which increased rapidly during that period.

Figure 4.1.3 shows the positive association between GDP per capita and health expenditure per capita across European 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 European countries with low GDP per capita than among countries with a higher GDP per capita. Even for countries with similar levels of GDP per capita there are substantial differences in health expenditure. For example, Spain and France have similar GDP per capita, but Spain spends less than 80% of the level of France on health.

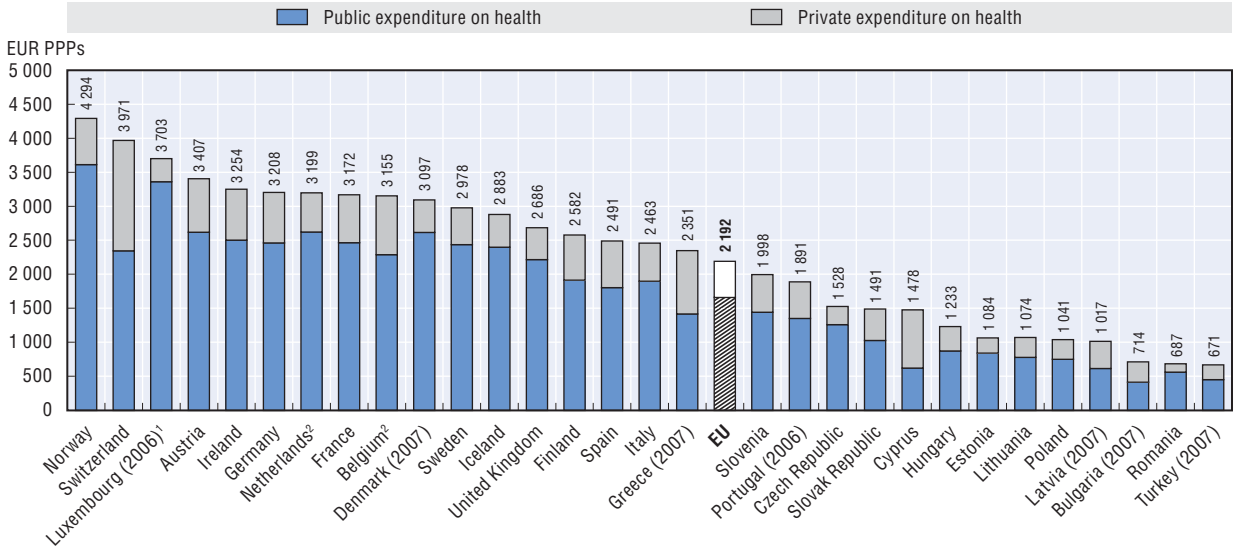
Definition and deviations

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, as defined in the System of Health Accounts manual (OECD, 2000). This includes spending by both public and private sources on medical services and goods, public health and prevention programmes, and administration.

The vast majority of countries now produce health spending data according to the boundaries and definitions proposed in the System of Health Accounts manual. The comparability of the functional breakdown of health expenditure data has improved over recent years. However, limitations remain, as some countries have not yet implemented the SHA classifications and definitions. Even among those countries that are submitting data according to the SHA, the comparability of data sometimes needs to be improved. Different practices regarding the inclusion of long-term care in health or social expenditure are also a factor affecting data comparability.

Countries' health expenditures are converted to a common currency (Euro) and are 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.

4.1.1. Total health expenditure per capita, public and private, 2008

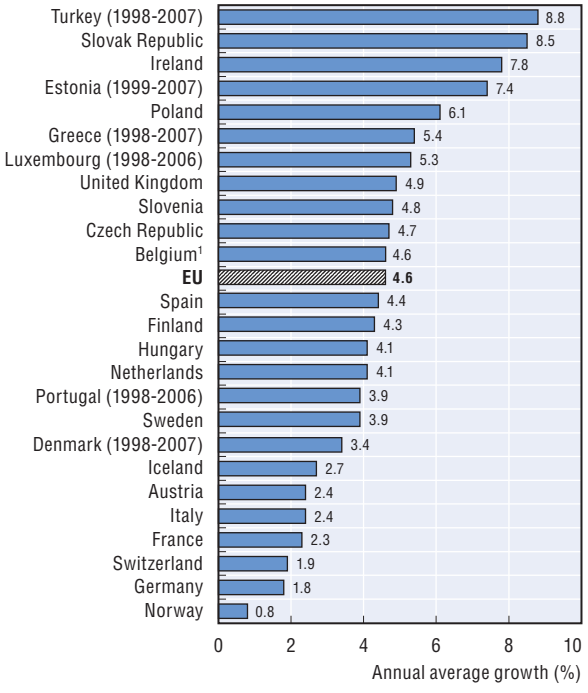


1. Health expenditure is for the insured population rather than resident population.
2. Current health expenditure (excluding investment).

Source: OECD Health Data 2010; Eurostat Statistics Database.

StatLink http://dx.doi.org/10.1787/888932337319

4.1.2. Annual average growth rate in real health expenditure per capita, 1998-2008

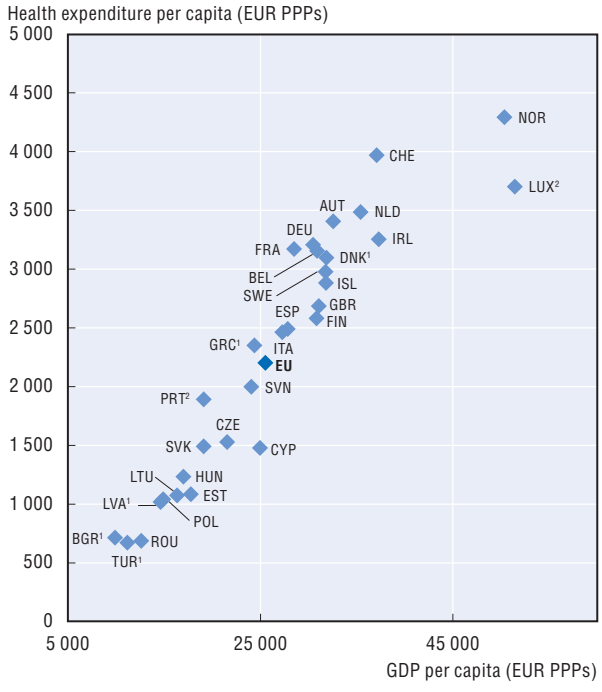


1. Current health expenditure (excluding investment).

Source: OECD Health Data 2010; Eurostat Statistics Database.

StatLink http://dx.doi.org/10.1787/888932337338

4.1.3. Total health expenditure per capita and GDP per capita, 2008



1. 2007. 2. 2006.

Source: OECD Health Data 2010; Eurostat Statistics Database; WHO National Health Accounts.

StatLink http://dx.doi.org/10.1787/888932337357

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