

Comparisons of health spending reflect both differences in the prices of health care goods and services, and the quantity of care individuals are using (“volume”). By breaking down health spending into the two components, policy makers gain a better understanding of what is driving the differences; this guides them to the policy responses that can be put in place.

Cross-country comparisons require spending to be expressed in a common currency, and the choice of currency conversion measure can greatly affect the results and interpretation. While market exchange rates are commonly used, they are not ideal for the health care sector. Exchange rates are determined by the supply and demand for currencies, which can be influenced by currency speculation and interest rates, among other factors. Then, for predominantly non-traded sectors, such as health care, exchange rates are unlikely to reflect the relative purchasing power of currencies in national markets (OECD/Eurostat, 2012[2]). Finally, market exchange rates are updated continuously and are subject to volatility. In contrast, purchasing power parities (PPPs) are point estimates that are usually calculated once a year and are available at an economy-wide level, industry level (for example, health or education), and for selected spending aggregates (such as actual individual consumption and government consumption).

Actual Individual Consumption (AIC) PPPs are the most widely used conversion rates for health expenditure (see indicator “Health expenditure per capita”). However, using AIC PPPs means that the resulting measures reflect not only variations in the volume of health care goods and services but also any variations in the prices of health care goods and services relative to prices of other consumer goods and services across countries. Therefore, Figure 7.6 shows health price levels using a representative basket of health care goods and services for each OECD country. Iceland and Switzerland have the highest health prices among OECD countries: on average, the same basket of goods and services would cost 72% more than the OECD average in Switzerland and 67% more in Iceland. Health care prices also tend to be relatively high in Norway. In contrast, prices for the same mix of health care goods and services in Chile and Greece are around two-thirds of the OECD average. The lowest health care prices among OECD countries are in Turkey, at around 20% of the OECD average.

Adjusting for health prices gives a measure of the amount of health care goods and services being consumed by the population (“the volume of care”). Comparing relative levels of health expenditure and volumes provides a way to look at the contribution of volumes and prices. Volume measures are a useful addition to comparisons of spending to analyse health care use.

Volumes of health care use vary less than health expenditure (Figure 7.7). The United States is the highest spender on health care, at nearly three times the OECD average, but in volume terms it stand at around twice the OECD average due to the

relatively high prices in the United States. Taking account of their high health price levels, Ireland, Norway, Sweden and Switzerland also see lower relative measures of the volume of care. On the other hand, the Czech Republic has a higher level based on volume of care due to the relatively lower prices in its health sector. While Mexico and Turkey have similar low levels of health spending, the difference in price levels means that the volume of care in Turkey is almost double that of Mexico. Differences in the per capita volume of care are influenced by the age and disease profile of a population; the organisation of service provision; use of prescribed pharmaceuticals; and issues with access, leading to lower levels of care being used.

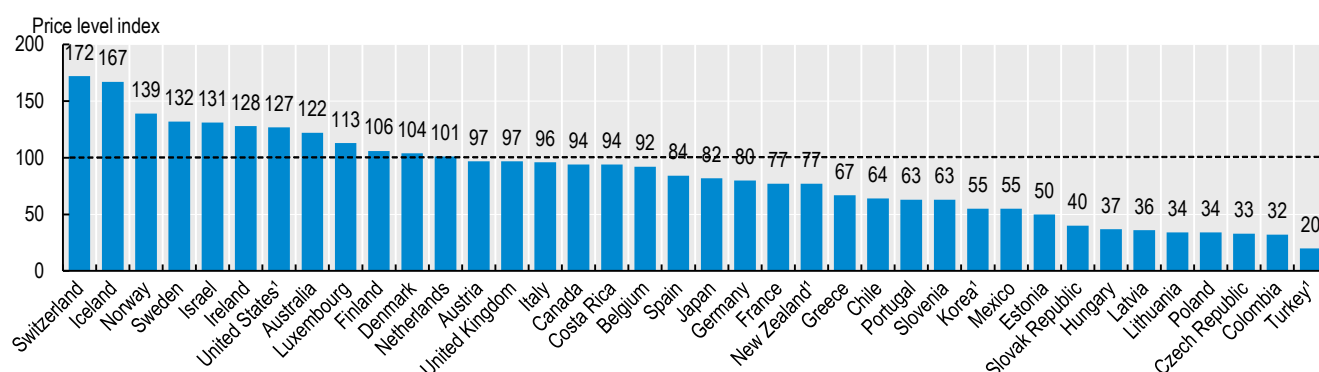
The variation in prices of hospital services is greater compared to that in the health sector as a whole. As with health prices, hospital prices tend to be higher in higher-income economies: the hospital sector is more labour intensive than the health sector as a whole (typically, 60-70% of hospital spending is staff costs). Service prices in hospitals are heavily determined by local (national) wage levels, but may also be influenced by hospital financing mechanisms and funding arrangements, the structure of service provision, the market structure and competition among payers and among providers, and the way prices are set (Barber, Lorenzoni and Ong, 2019[3]). Estimates for 2017 suggest that average hospital prices in Switzerland are more than double the average level calculated across OECD countries, whereas prices in Turkey are only around one-eighth of the OECD average (Figure 7.8).

#### Definition and comparability

PPPs are conversion rates that show the ratio of prices in national currencies of the same basket of goods and services in different countries. Thus, they can be used as both currency converters and price deflators. When used to convert expenditure to a common unit, the results are valued at a uniform price level and should reflect only differences in volumes of goods and services consumed.

Assessment of differences in health volume requires health-specific PPPs. Eurostat and the OECD calculate PPPs for GDP and some 50 product groups, including health, on a regular basis. In recent years, a number of countries have worked towards output-based measures of prices of health care goods and services. The output-based methodology has then been used to produce both health sector and hospital sector PPPs, which are now incorporated into the overall calculation of GDP PPPs. Such PPPs can be used to calculate health price level indices to compare price levels and volumes across countries. These indices are calculated as ratios of health PPPs to exchange rates, and indicate the number of units of a common currency needed to purchase the same volume.

Figure 7.6. Price levels in the health care sector, 2017, OECD average = 100

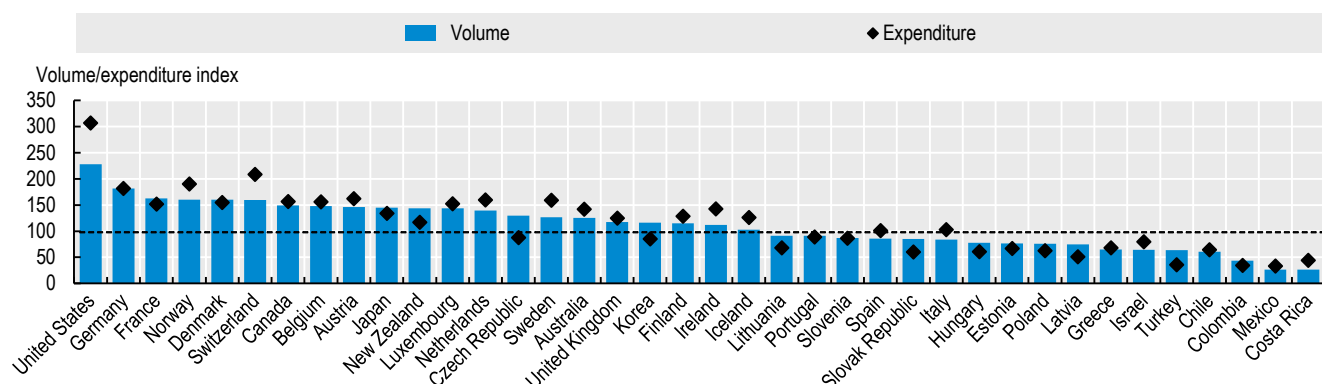


1. For hospitals, PPPs are estimated predominantly by using salaries of medical and non-medical staff (input method).

Source: OECD Health Statistics 2021.

StatLink <https://stat.link/m9ws2i>

Figure 7.7. Health care volumes per capita compared to health expenditure per capita, 2017, OECD average = 100

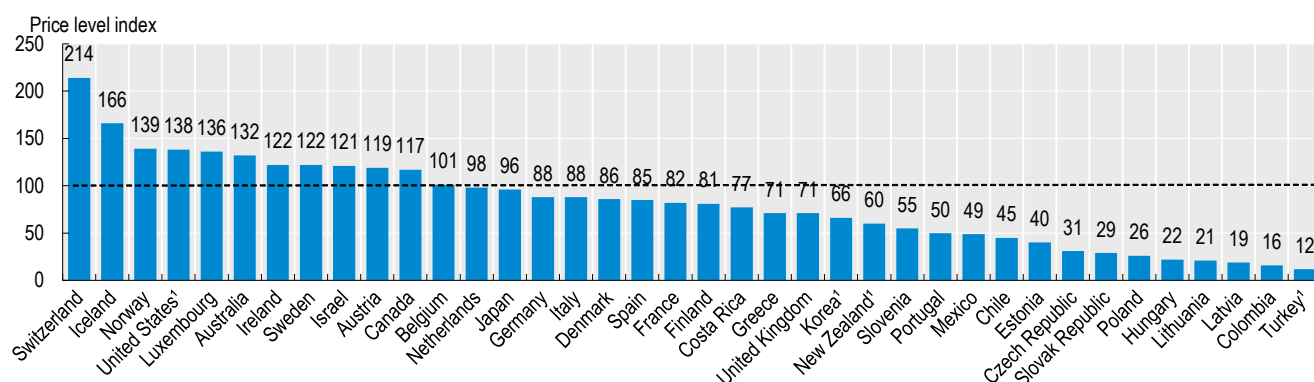


Note: Volumes are calculated using the PPPs for health. Expenditures are calculated using the PPPs for AIC.

Source: OECD Health Statistics 2021.

StatLink <https://stat.link/roufsq>

Figure 7.8. Hospital price levels, 2017, OECD average = 100



1. PPPs are estimated predominantly by using salaries of medical and non-medical staff (input method).

Source: OECD Health Statistics 2021.

StatLink <https://stat.link/ijp0qz>



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