

Health at a Glance – OECD Indicators 2003

Briefing note (Canada)

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Health spending¹

Total health spending (public and private) accounted for 9.7% of GDP in **Canada** in 2001, more than one percentage point higher than the average of 8.4% in OECD countries (chart 3.4). Health spending as a share of GDP is lower in **Canada** than in the United States (which spent 13.9% of its GDP on health in 2001, the highest share among OECD countries), and in Switzerland and Germany, which allocated more than 10% of their GDP on health.

Canada also ranks above the OECD average in terms of total health spending per capita, with spending of 2 792 USD in 2001 (adjusted for purchasing power parity), compared with an OECD average of 2 117 USD (chart 3.1). However, health spending per capita in **Canada** remains much lower than in the United States, which spent 4 887 USD per capita.

During the 1990s, health spending per capita in **Canada** increased in real terms by 1.9% per year on average, a growth rate lower than the OECD average of 3.3% per year (table 3.4). In **Canada** as in many other countries, the past decade consisted of three different periods in terms of health expenditure growth. In the first few years of the decade (1990-1992), health spending grew fairly rapidly. During the mid-1990s, federal and provincial governments took a number of measures to curb the growth of health care spending, as part of their efforts to reduce public deficits. These cost containment measures led to a reduction in real health spending per capita between 1992 and 1997, with a growth rate of -0.3% per year. Following this period of restraint, health expenditures started to rise again rapidly at the end of the 1990s, reflecting improvements in the budgetary situation of governments and deliberate policies to relieve pressures which arose from earlier restraint measures. Health spending in **Canada** continued to rise rapidly in 2000 and 2001, at a rate of 5% per year in real terms over these two years, a higher growth rate than the 4% average across OECD countries.

The rise in pharmaceutical spending has been one of the factors behind the rise in total health spending in **Canada** as well as in several other OECD countries. Between 1990 and 2001, the share of health expenditure spent on pharmaceuticals increased from 11.5% of total health spending to 16.2%, one of the steepest increases among OECD countries (chart 3.15). In 2001, only the United States, France and Italy spent more than **Canada** on pharmaceuticals (chart 3.13).

Public and private financing

The public sector is the main source of health funding in all OECD countries, except the United States, Mexico and Korea. In **Canada**, 71% of health spending was funded by government revenues in 2001,

¹ Data on expenditures relate generally to 2001, the latest year for which comparable data are available in most countries.

slightly below the average of 72% in OECD countries (chart 3.11). The share of public spending in **Canada** declined in the 1990s. It accounted for 75% of total health spending in 1990, at that time slightly above the OECD average. In 2001, the share of public spending remained much higher than in the United States (44%) and Switzerland (56%), but it was much lower than in the Nordic countries (Denmark, Norway and Sweden) where it reaches more than 80% of total health spending.

In the United States, private health insurance accounts for 35% of total health spending, by far the largest share among OECD countries. Beside the United States, **Canada**, France, Germany and the Netherlands also have a relatively large share of funding coming from private insurance (more than 10%).

Resources and activities in the health sector

Despite the relatively high level of health expenditure in **Canada**, there are fewer physicians per capita than in most other OECD countries. In 2000, Canada had 2.1 practising physicians per 1 000 population, well below the OECD average of 2.9. Between 1990 and 2000, the number of doctors per capita remained stable in **Canada**, while it continued to increase (at least slightly) in most OECD countries (table 2.1).

The proportion of female doctors has increased strongly over time in **Canada** as in most other OECD countries. In some countries (Finland, Poland and the Czech Republic), there are now more female doctors than males (chart 2.4). In **Canada**, one doctor in ten was a woman in 1970; this proportion increased to over three in ten in 2000.

There were 9.9 nurses per 1 000 population in **Canada** in 2000, a higher figure than the average of 8.1 in OECD countries. However, the number of nurses per capita started to decline in **Canada** (as well as in Australia and Sweden) during the 1990s, while it increased in most other countries (charts 2.6 and 2.7). In **Canada**, the reduction in the number of nurses per capita during the 1990s was linked to a reduction in enrolment and graduation from nursing schools, together with a reduction in the number of hospital beds.

The number of acute care hospital beds in **Canada** was 3.2 per 1 000 population in 2000, a higher number than in the United States (2.9), but lower than the OECD average of 4.0 beds per 1 000 population (chart 2.9). As in most OECD countries, the number of hospital beds per capita has fallen over the past twenty years, from 4.6 beds per 1 000 population in 1980 to 3.2 in 2000 (table 2.3). This decline has coincided with a reduction of average length of stays in hospitals and an increase in day-surgery patients.

Although the average length of stays in hospitals has decreased over time in OECD countries, there remain notable variations across countries. For instance, in **Canada** the average length of stay for mothers following a normal delivery is 2 days, the same length as in the United States, but much lower than in most other OECD countries (chart 2.32). The average length of stay following acute myocardial infarction (AMI) is 8.4 days in **Canada**, higher than in the United States (5.7 days, the lowest among OECD countries), but lower than in most European countries (chart 2.31). The average length of stay in hospitals is often used as an indicator of efficiency since, all other things being equal, a shorter stay will reduce the cost per episode. However, length of stay should only be used with caution as an indicator of efficiency. Shorter stays tend to be more service intensive and more costly per day. Also, if the stay is too short, there may be adverse effect on health outcomes of for the recovery of the patient.

During the past decade, there has been rapid growth in the availability of diagnostic technologies such as computed tomography (CT) scanners and magnetic resonance imaging (MRI) units in most OECD countries. In **Canada**, the number of MRIs per million population increased from 0.7 in 1990 to 2.5 in 2000. Despite this increase, it was still lagging behind the OECD average of 6.5 MRI units per million population in 2000 (chart 2.15). The number of scanners provides only an indication of the overall availability of such equipment; it does not indicate to what extent the equipment is used. Earlier studies by

Canadian researchers provided evidence of a greater use of CT and MRI tests in the United States compared with **Canada**, even when one compares hospitals with similar availability of machines. These studies found that in the United States, scanners are used much more among the elderly than in **Canada**.

Health status

Most OECD countries have enjoyed large gains in life expectancy over the past 40 years. In **Canada**, life expectancy at birth increased by 8.0 years between 1960 and 2000, more than the gains of 6.9 years registered in the United States, but less than the increase of 13.4 years in Japan (chart 1.2). In 2000, life expectancy in **Canada** stood at 79.4 years, one of the highest among OECD countries. Only Japan, Switzerland, Sweden and Iceland registered a higher life expectancy than **Canada** (table 1.1).

The infant mortality rate in **Canada**, as in other OECD countries, has fallen greatly over the past few decades (table 1.6). It stood at 5.3 deaths per 1 000 live births in 2000, lower than in the United States, but only around the median among OECD countries (chart 1.5). Infant mortality is the lowest in Japan and in the Nordic countries (Iceland, Sweden, Finland and Norway).

Risk factors

The proportion of daily smokers among the adult population has shown a marked decline over recent decades across most OECD countries. Much of this decline can be attributed to policies aimed at reducing tobacco consumption through public awareness campaigns, advertising bans and increased taxation. In **Canada**, the proportion of smokers among adults has fallen from 34% in 1980 to less than 20% in 2000. It is now among the lowest in OECD countries, along with Sweden, the United States and Australia (table 4.1).

At the same time, obesity rates have increased in recent decades in all OECD countries (chart 4.11). There remain however notable differences in obesity rates across countries. In **Canada**, the obesity rate among adults (15% in 2001) is higher than in most other OECD countries, but it remains lower than in the United States (31% en 1999), the United Kingdom (22% en 2001) and Australia (21% en 1999)². A recent review of the literature on the cost of obesity to health care systems in the United States and other countries suggests that obesity in the late 1990s accounted for about 5.5% to 7% of total health expenditure in the United States, and 2% to 3.5% in other countries such as **Canada**, Australia and New Zealand (Thompson and Wolf, 2001). Furthermore, the time lag between the onset of obesity and increases in related chronic diseases (such as diabetes and asthma) suggest that the rise in obesity that has occurred in most OECD countries, including **Canada**, will have substantial implications for future incidence of health problems and related spending.

² It should be noted however that the data for the United States, the United Kingdom and Australia are more reliable and precise than those from other countries since they are based on health examinations whereby actual measures are taken of people's height and weight, while data for other countries are based on health interview surveys, which generally under-estimate the real prevalence of obesity.