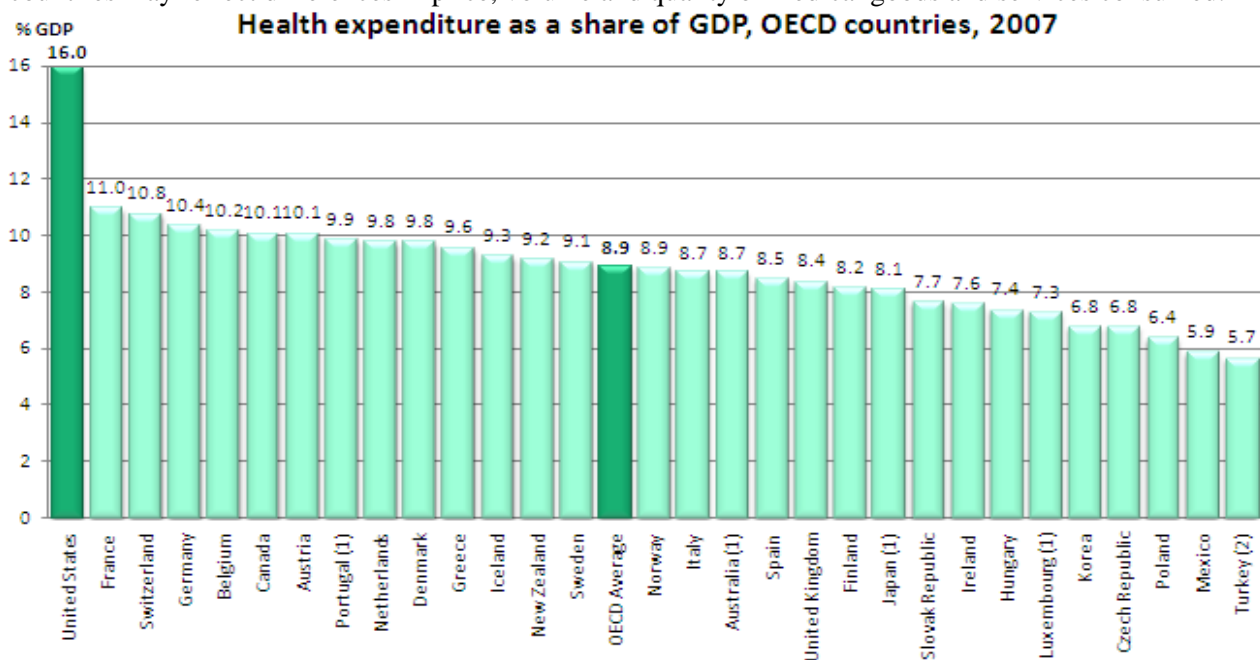




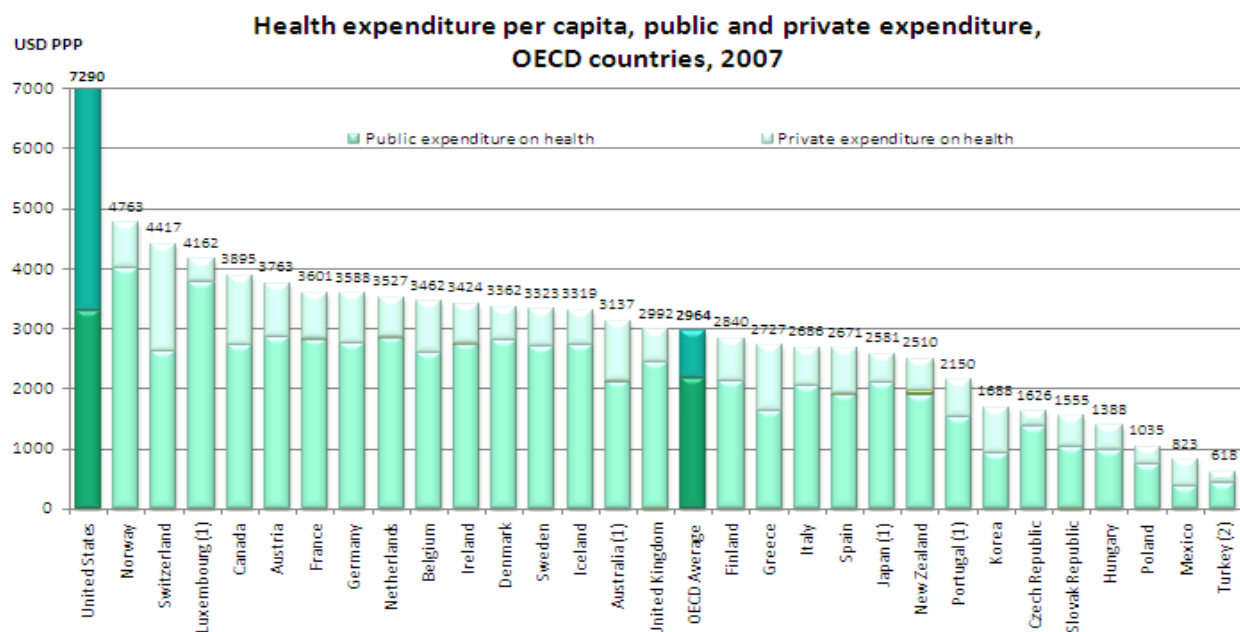
## OECD Health Data 2009 How Does the United States Compare

Total health spending accounted for 16.0% of GDP in the **United States** in 2007, by far the highest share in the OECD. Following the **United States** were France, Switzerland and Germany, which allocated respectively 11.0%, 10.8% and 10.4% of their GDP to health. The OECD average was 8.9% in 2007.

The **United States** also ranks far ahead of other OECD countries in terms of total health spending per capita, with spending of 7,290 USD (adjusted for purchasing power parity), almost two-and-a-half times greater than the OECD average of 2,964 USD in 2007. Norway follows, with spending of 4,763 USD per capita, then Switzerland with spending of 4,417 USD per capita. Differences in health spending across countries may reflect differences in price, volume and quality of medical goods and services consumed.



(1) 2006, (2) 2005. Source: OECD Health Data 2009, June 09.



(1) 2006, (2) 2005. Data for Belgium, Denmark and the Netherlands are current expenditures (excluding investment). Source: OECD Health Data 2009, June 09. Data are expressed in US dollars adjusted for purchasing power parities (PPPs), which provide a means of comparing spending between countries on a common base. PPPs are the rates of currency conversion that equalise the cost of a given 'basket' of goods and services in different countries.

Between 2000 and 2007, health spending per capita in the **United States** increased, in real terms, by 3.7% per year on average, the same rate as the OECD average.

The public share of health expenditure in the United States (45%) is much lower than in any other OECD country (except Mexico, also 45%), but nevertheless public expenditure on health is higher than in most other OECD countries, because overall spending per capita is so much greater. For this amount of expenditure in the **United States**, government provides insurance coverage only for the elderly and disabled (through Medicare, which primarily insures persons aged 65 and over and people with disabilities) and some of the poor (through Medicaid and the State Children's Health Insurance Program, SCHIP), whereas in most other OECD countries this is enough for government to provide universal primary health insurance.

Private insurance accounts for 35% of total health spending in the **United States**, by far the largest share among OECD countries. Beside the **United States**, Canada and France are the only two other OECD countries where private insurance represents more than 10% of total health spending.

### **Resources in the health sector (human, physical)**

Despite the relatively high level of health expenditure in the **United States**, there are fewer physicians per capita than in most other OECD countries. In 2007, the **United States** had 2.4 practising physicians per 1,000 population, below the OECD average of 3.1.

There were 10.6 nurses per 1 000 population in the **United States** in 2007, which is slightly higher than the average of 9.6 across OECD countries.

The number of acute care hospital beds in the **United States** in 2007 was 2.7 per 1 000 population, lower than the OECD average of 3.8 beds. As in most OECD countries, the number of hospital beds per capita has fallen over the past twenty-five years in the **United States**. This decline has coincided with a reduction in average length of stays in hospitals and an increase in day surgeries.

### **Health status and risk factors**

Most OECD countries have enjoyed large gains in life expectancy over the past decades. In the **United States**, life expectancy at birth increased by 8.2 years between 1960 and 2006, which is less than the increase of almost 15 years in Japan, or 9.4 years in Canada. In 2006, life expectancy in the **United States** stood at 78.1 years, almost one year below the OECD average of 79.0 years. Japan, Switzerland and Australia were the three countries with the highest life expectancy.

Infant mortality rates in the **United States** have fallen greatly over the past few decades, but not as much as in most other OECD countries. It stood at 6.7 deaths per 1 000 live births in 2006, above the OECD average of 4.9. Among OECD countries, infant mortality is the lowest in some of the Nordic countries (Iceland, Sweden and Finland), Luxembourg and Japan, with rates between 2 and 3 deaths per 1 000 live births.

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 the **United States**, the proportion of daily smokers among adults has been cut by more than half over the past twenty-five years, falling from 33.5% in 1980 to 15.4% in 2007. This is the lowest rate among OECD countries after Sweden.

At the same time, obesity rates have increased in recent decades in nearly all OECD countries, although there remain notable differences in obesity rates across countries. In the **United States**, the obesity rate among adults (34.3% in 2006) is the highest in OECD countries, followed by Mexico (30.0%) and the

United Kingdom (24.0%)<sup>1</sup>. Obesity rates in Continental European countries are lower, but are also rising. The time lag between the onset of obesity and increases in related chronic diseases (such as diabetes, cardiovascular diseases and asthma) suggest that the rise in obesity that has occurred in the **United States** and other OECD countries will have substantial implications for future incidence of health problems and related spending.

More information on *OECD Health Data 2009* is available at [www.oecd.org/health/healthdata](http://www.oecd.org/health/healthdata).

For more information on OECD's work on the **United States**, please visit [www.oecd.org/us](http://www.oecd.org/us).

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<sup>1</sup> It should be noted however that the data for the United States and the United Kingdom are more accurate than those from most other countries since they are based on *actual measures* of people's height and weight, while estimates for other countries are in many cases based on *self-reported* data, which generally under-estimate the real prevalence of obesity.