Policy Brief

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OECD Health at a Glance – How Canada Compares

Introduction

This *Policy Brief* presents some of the key indicators contained in the OECD publication *Health at a Glance*, with a focus on how Canada compares with other OECD countries. It is a contribution to the OECD Conference *Measuring Up: Improving Health Systems Performance in OECD countries* in Ottawa on 5-7 November 2001.

In many respects, Canada fares well among OECD countries in terms of indicators of health status and resources allocated to its health care system. Canadians enjoy relatively high life expectancy at birth and at older ages compared with most other OECD countries. Canada's public health programmes have contributed to a steady reduction in tobacco and alcohol consumption, so that Canada is now one of the OECD countries with the lowest proportion of daily smokers. Furthermore, Canada's predominantly publicly financed health care system provides universal access to physician and hospital services to all Canadians. And the overall expenditure on health care in Canada, although relatively high in comparison with other OECD countries, is at the level that might be expected given the country's standard of living.

On the other hand, over the last decade there have been signs of growing public dissatisfaction with the health care system in Canada. For instance, in 1988 a public opinion poll indicated that 56% of Canadians thought that only minor changes were needed to their health care system while 5% were calling for a complete rebuilding of the system. By 1998, the percentage of respondents calling for a complete rebuilding of the system had gone up to 23%, exceeding those who thought that only minor changes were needed (20%). Canada is not unique in having seen a decline in public satisfaction with health care during that period.

Like many other OECD countries, Canada has gone through significant changes in the financing and delivery of health care services over the last decade. Following the recession of the early 1990s, federal and provincial governments in Canada focussed their efforts on reducing public deficits by cutting spending, of which health was the largest single item (at least for provincial governments). These cost-control measures led to a temporary halt in the growth of real health expenditures per capita in Canada between 1992 and 1997. Combined with the growth of GDP, the restraint measures over this

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five-year period led to the largest decline in health expenditure as a share of GDP across all OECD countries, with the exception of Finland. Since 1998, federal and provincial governments have substantially increased their financial contributions to Canada's health care system, and total health expenditure per capita has started to rise again.

Physicians and nurses are the primary resource for delivering health care in any health system. The number of practising physicians and nurses per capita is generally low in Canada by OECD standards, and this gap has widened during the cost-containment period of the mid-1990s. Between 1992 and 1997, the number of practising physicians per capita in Canada remained unchanged, while the number of nurses per capita actually declined. In most other OECD countries, these numbers continued to go up, albeit at a slower rate than in previous years. Fewer numbers of physicians per capita can result in longer waiting times for both outpatient and inpatient services, although the method of remuneration of physicians also matters. Several provincial governments in Canada have taken steps in recent years to increase the number of practising physicians and nurses and to alter their geographical distribution, in response to a perceived medical workforce shortage in some regions. The careful management and planning of the medical workforce to respond to current and future health care needs is an important issue in all OECD countries. ■

Health status

Canada ranks well among OECD countries in terms of health status and mortality indicators. The life expectancy of Canadians is one of the highest among OECD countries. It reached a level of 81.4 years for women and 75.8 years for men in 1997 (it increased again in 1998 to 81.5 years for women and 76.1 years for men). For the population as a whole, only Japan, Sweden, Switzerland, and Iceland register a higher life expectancy than Canada.

As in other countries, there have been remarkable gains in life expectancy for both men and women in Canada over the last four decades. These gains in longevity have been made possible by rising standards of living, public health interventions and progress in medical care. Across all OECD countries, life expectancy at birth has increased on average by 7 ½ years for men and almost 9 years for women between 1960 and 1998. In Canada, the gains have been respectively 7.7 years for men and 7.2 years for women. As a result, while the gender gap in longevity widened across most OECD countries over the last four decades, it narrowed in Canada, given the relatively larger gains for men. The narrowing of the gender gap in life expectancy in Canada can be attributed at least partly to the progressive move to more healthy lifestyles among Canadian men, as illustrated for instance by the sharp reduction in their smoking rates over the last few decades (see below).

The life expectancy of people at age 65 has also been steadily improving over the last few decades in most OECD countries, including Canada. Canadian women and men at age 65 can now expect to live an additional 20 and 16 years respectively, one year more than the OECD average.

Another important indicator that people are becoming healthier and living longer in OECD countries is the marked reduction in premature mortality. Since 1960, premature mortality, as measured by potential years of life lost due to deaths prior to age 70, has more than halved in Canada and in most other OECD countries. These improvements were driven partly by the steady decline in infant mortality rates across all OECD countries. By the end of the 1990s, Japan, Sweden and Iceland registered the lowest levels of premature mortality for both females and males, and the lowest levels of infant mortality. Premature mortality (including infant mortality) in Canada continues to be much lower than in the United States and several other OECD countries.

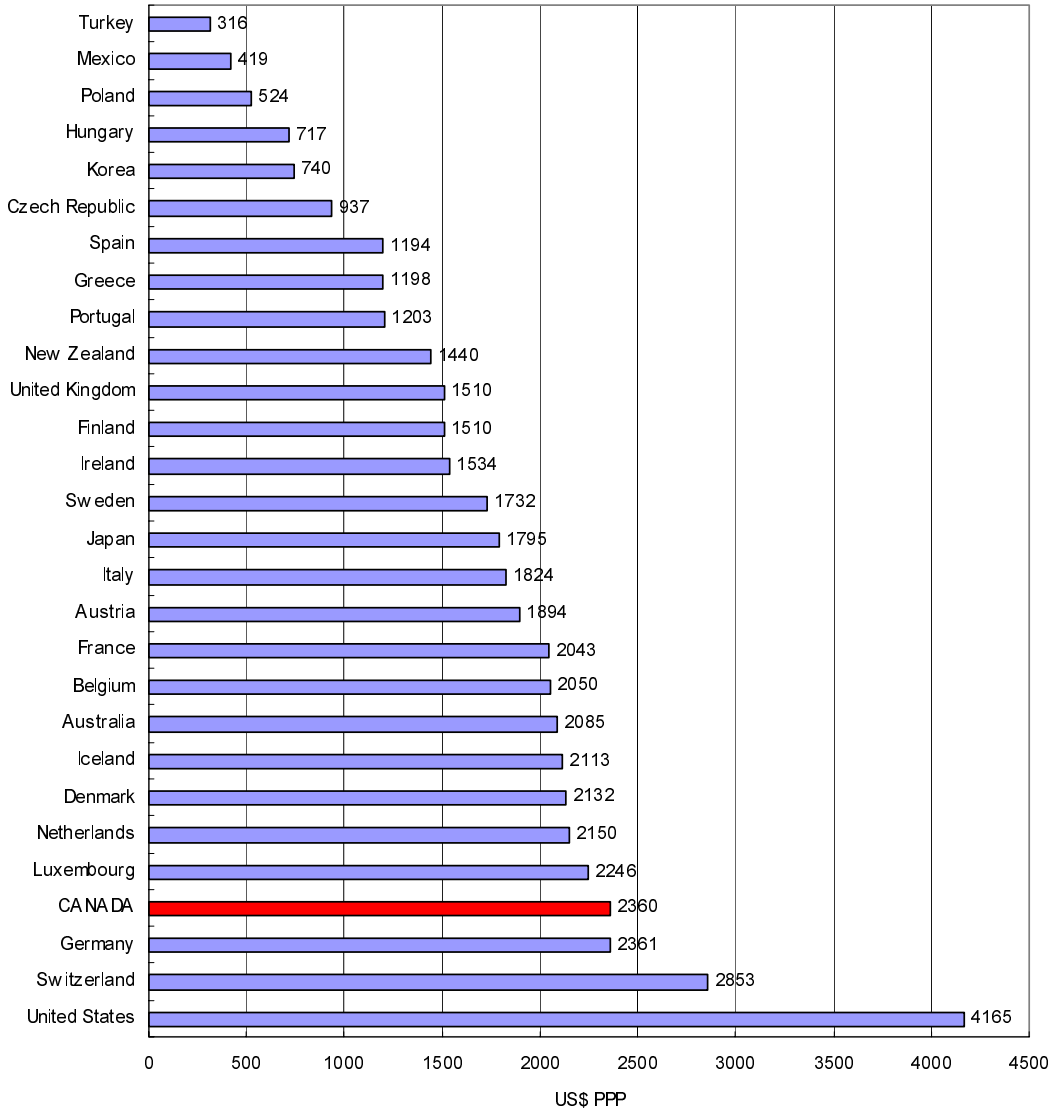
Most OECD countries conduct regular health interview surveys which allow respondents to report on their health status generally and on specific chronic problems or activity limitations. In over half of OECD countries, 75% or more of the adult population report their health to be "good" or better. The United States and Canada have the highest percentage of people assessing their health to be "good" or better, with over 90% of the adult population in these two countries reporting being in "good/very good/excellent" health. Caution is required however in making cross-country comparisons of self-reported general health, for at least two reasons. First, there are variations in the question and answer categories used to measure self-rated general health across surveys/countries. Second, people's overall assessment of their own health is subjective and can be affected by a number of factors, such as cultural background, socio-

economic milieu, education and access to health care services.

Health expenditure

Although a number of measures were taken in the mid-1990s to curb the growth of health care spending in Canada, the Canadian health system remains relatively expensive by international standards. Chart 1 shows how health expenditure per capita (converted to US$ and adjusted for purchasing power parity) vary across OECD countries. In 1998 (the latest year for which comparable figures are available), the United States was still, by far, the largest spender on health care on a per capita basis, with spending of $4,165. Switzerland was the second

Chart 1: Health expenditure per capita (US$ economy-wide PPP), 1998



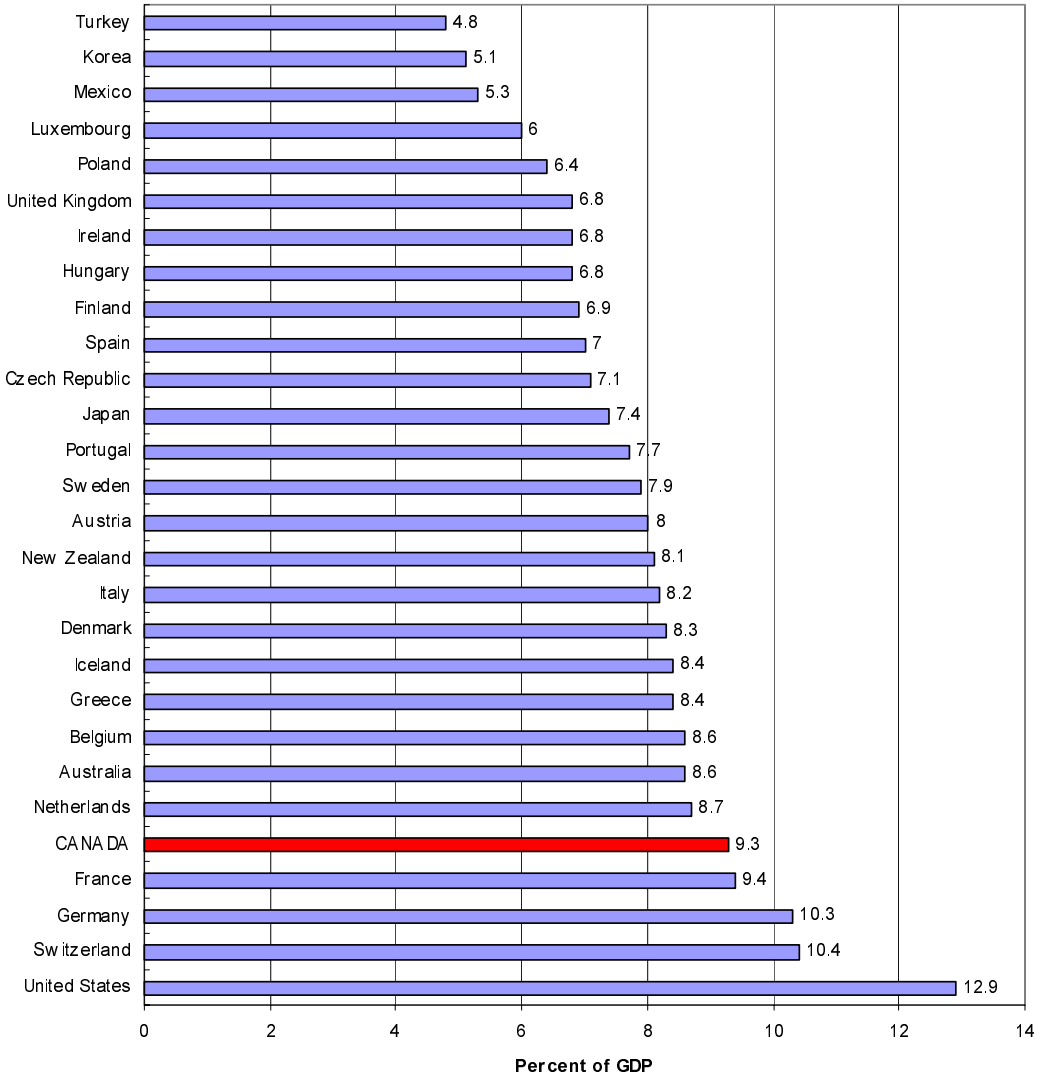
Source: Health at a Glance, OECD 2001, Chart 4.1

highest spender per capita on health care, followed by Germany and Canada, each with more than $2,300 expenditure per capita.

Real health expenditure per capita grew steadily between 1970 and 1998, on average, for the 19 OECD countries for which complete time series are available. In Canada, real health expenditure per capita also increased rather steadily between 1970 and 1992, albeit at a slightly lower rate than the 19 country average. From 1992 to 1997, the growth of real health expenditure per capita in Canada completely halted, before it started to increase again in 1998.

Chart 2 shows how expenditure on health as a percentage of GDP varies across OECD countries. In 1998, the United States had the highest share, with close to 13% of GDP spent on health care. Switzerland

Chart 2: Expenditure on health as a percent of Gross Domestic Product, 1998



Source: Health at a Glance, OECD 2001, Chart 4.5

and Germany were second and third with over 10% of GDP allocated to health care, with France and Canada following with a share of 9.4% and 9.3% of GDP respectively. The average (unweighted) was 8.2% across OECD countries.

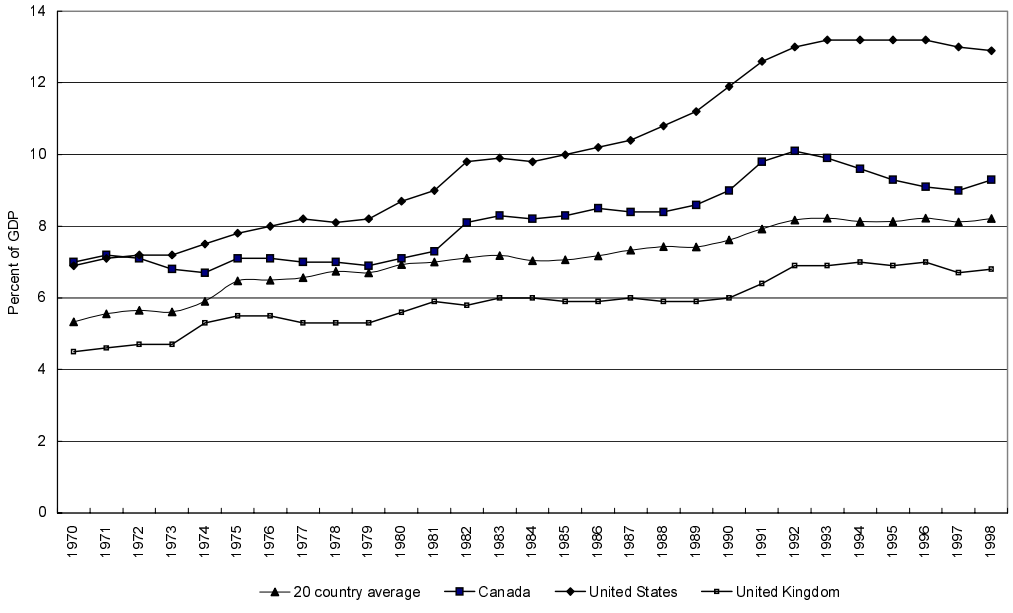
Health care spending as a proportion of GDP stabilised in many OECD countries during the 1990s (Chart 3). In Canada, it actually came down from a peak of 10.1% of GDP in 1992 to 9.0% in 1997, before moving back up to 9.3% in 1998 and in 1999. The decline of 1.1% in the share of GDP allocated to health care spending in Canada from 1992 to 1997 was the largest reduction among all OECD countries, with the exception of Finland. This sharp reduction was due partly to the tightening in the rate of growth in health expenditures during that period, and partly to the strong economic growth in Canada following the recession of the early 1990s.

Although the share of GDP allocated to health care has stabilised in Canada over the last few years, it remains to be seen whether such stabilisation will be maintained in the face of growing demands for health care and the slowdown in economic growth.

The source of funding for health care and, in particular, the optimal public/private mix, remains a matter for policy debate in most OECD countries. Public funding of health care represented 70% of total health expenditures in Canada in 1998, much higher than the share of 45% in the United States, but below the OECD-wide average of 75%. Looking at trends over time, the share of public health spending in Canada increased markedly during the 1970s, stabilised during the 1980s, and declined during the 1990s. As a result, there was virtually no change in the share of public health care spending in Canada in 1998 when compared with 1970. This share has however started to rise again in 1999 and 2000, as a result of increased federal and provincial spending in health care in recent years.

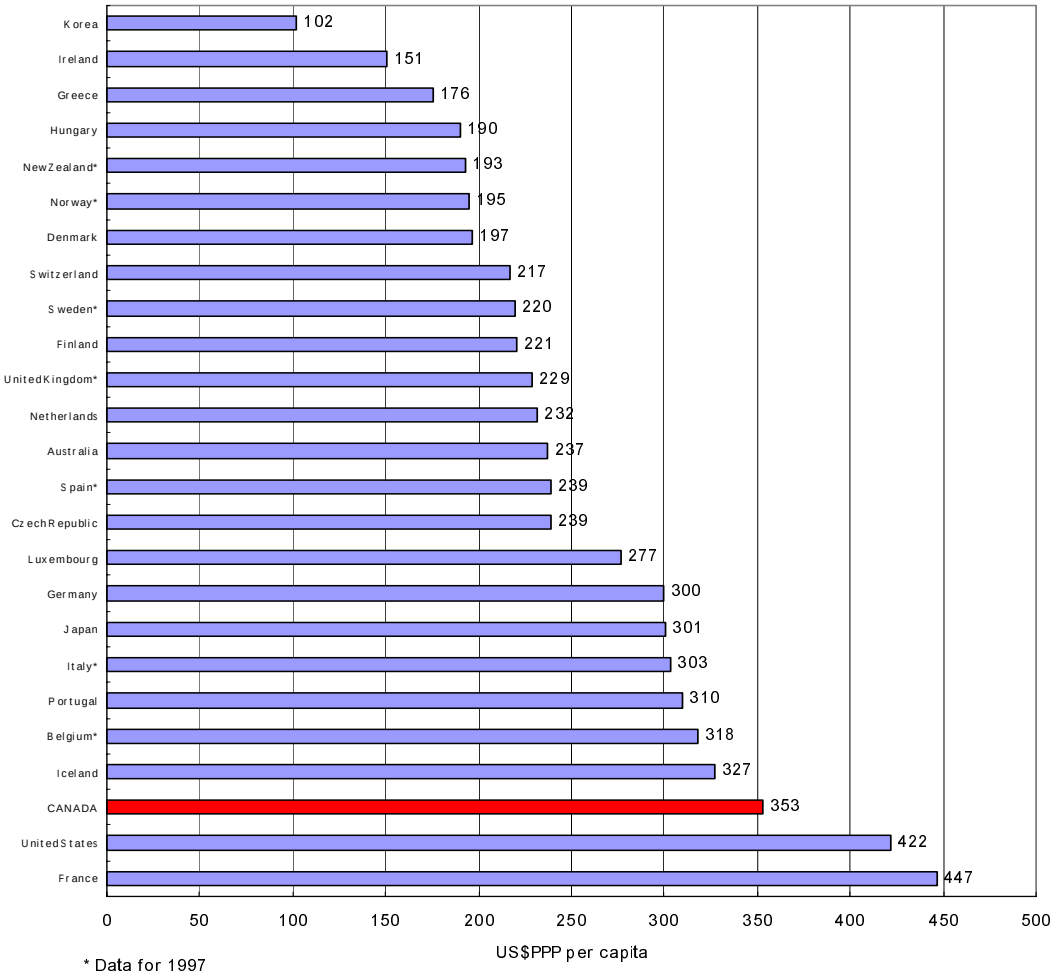
Expenditure on drugs (including both prescribed and "over-the-counter" drugs) has been one of the fastest growing health-related expenditures in Canada and in several other OECD countries over the last two decades. In real terms, average real expenditure per capita for drugs rose by a factor of 1.9 from 1980 to 1997 across the 14 OECD countries for which these time series are available. In Canada, it rose by a factor of 2.7. Over the last

Chart 3: Health expenditure as a percent of Gross Domestic Product, 1970-1998



Source: Health at a Glance, OECD 2001, Table 4.2

Chart 4: Total expenditure on pharmaceuticals per capita (US$PPP), 1998



Source: Health at a Glance, OECD 2001, Chart 4.12

two decades, only Portugal registered a higher growth rate than Canada in real expenditure on pharmaceuticals. As a result, drug costs now account for 15% of total health spending in Canada, up from 8.5% in 1980, and now represent a larger share of total health care spending in Canada than expenditures for physician services (CIHI, 2001).

By 1998, the average expenditure on drugs per capita across the 25 OECD countries for which data are available was US$256, adjusted for purchasing power parity (Chart 4). Canada's expenditure, at US$353 (also adjusted for PPP), was 40% higher than this average. It was the third highest after France and the United States. On the other hand, Nordic countries (Norway, Denmark, Sweden and Finland) and Switzerland recorded expenditure on drugs below average. Total spending on drugs is affected by the volume of drugs consumption and their price. In high-spending countries like France, recent efforts to slow the growth of rising drug expenditures have included putting more emphasis on assessing the medical benefit of pharmaceuticals and encouraging the development

of the generic drugs market (Imai, Jacobzone and Lenain, 2000). ■

Health care resources

Despite the relatively high level of health care expenditure in Canada, there are fewer physicians and nurses per capita than in most other OECD countries. In fact, Canada recorded the lowest growth rate in the physician-to-population ratio among all countries over the period 1960-1999 (Table 1). Particularly noteworthy is the fact that there was no growth in the number of physicians per capita in Canada during the 1990s, while the ratio of nurses per capita actually declined over the last decade. This is in sharp contrast with the trend observed in several

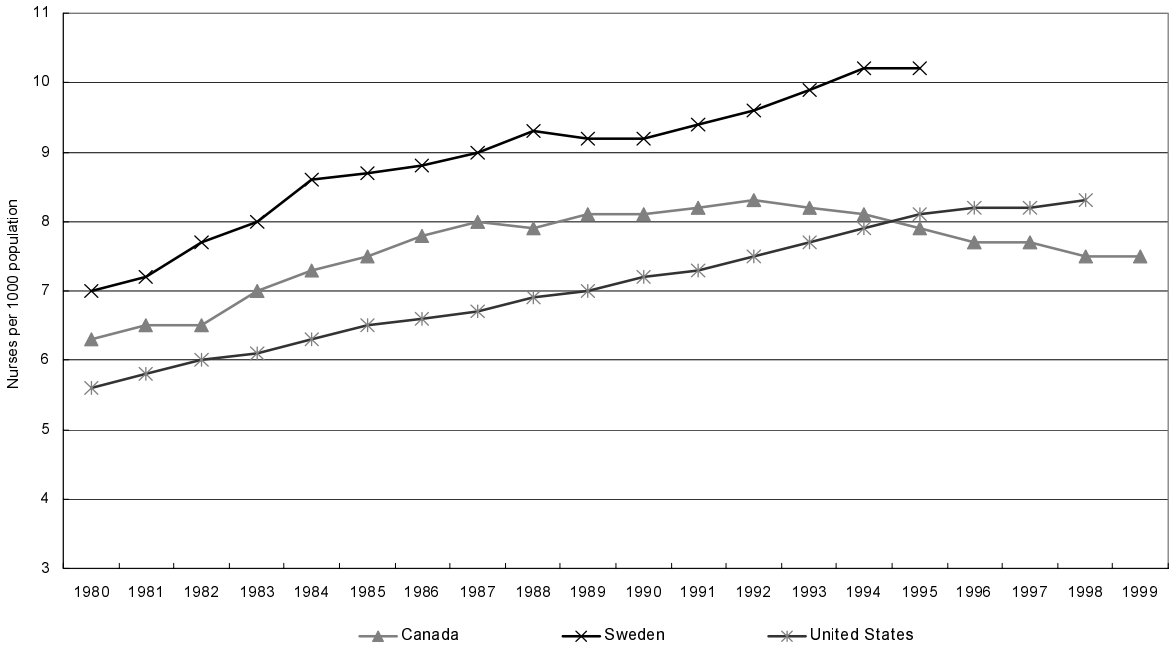
Table 1: Practising physicians per 1000 population, 1960-1999*

	Year**									Growth rate***
	1960	1970	1980	1990	1995	1996	1997	1998	1999	1960-1999
Australia	1.1	1.2	1.8	2.3	2.5	2.5	2.5	2.5		2.2%
Austria	1.4	1.4	1.6	2.2	2.7	2.8	2.9	3.0	3.0	2.0%
Belgium	1.3	1.5	2.3	3.3	3.5	3.6	3.7	3.7	3.8	2.8%
CANADA	**1.2**	**1.5**	**1.8**	**2.1**	**2.1**	**2.1**	**2.1**	**2.1**	**2.1**	**1.5%**
Czech Republic	1.7	1.9	2.3	2.8	2.9	2.9	3.0	3.0	3.0	1.5%
Denmark	1.2	1.4	2.2	3.1	3.3	3.3	3.3	3.3	3.4	2.7%
Finland	0.6	0.9	1.7	2.4	2.8	2.8	3.0	3.0	3.1	
France	1.0	1.3	2.0	2.6	2.9	3.0	3.0	3.0		2.9%
Germany	1.4	1.6	2.3	3.1	3.4	3.4	3.4	3.4		2.4%
Greece	1.3	1.6	2.4	3.4	3.9	4.0	4.1	4.2		3.1%
Hungary	1.5	2.0	2.3	2.9	3.0	3.1	3.1	3.1	3.2	2.0%
Iceland	1.2	1.4	2.1	2.8	3.0	3.1	3.3	3.3		2.7%
Ireland				1.6	2.1	2.1	2.1	2.2	2.3	
Italy	0.7	1.1	2.6	4.7	5.4	5.5	5.8	5.8	5.9	
Japan	1.0	1.1	1.3	1.7	1.8	1.8	1.9	1.9		1.7%
Korea			0.5	0.8	1.1	1.2	1.2	1.3	1.3	
Luxembourg	1.0	1.1	1.7	2.0	2.8	2.9	3.0	3.0	3.1	2.9%
Mexico			0.8	1.1	1.6	1.6	1.6	1.6	1.7	
Netherlands	1.1	1.2	1.9	2.5				2.9	3.1	2.7%
New Zealand	1.1	1.1	1.6	1.9	2.1	2.1	2.2	2.2	2.3	1.9%
Norway	1.2	1.4	2.0	3.1	2.8	2.8	2.5	2.7	2.8	2.2%
Poland	1.0	1.4	1.8	2.1	2.3	2.4	2.4	2.3	2.3	2.2%
Portugal	0.8	0.9	2.0	2.8	3.0	3.0	3.1	3.1	3.2	3.6%
Slovakia										
Spain	1.2	1.3	2.3	3.8	2.5	2.9	2.9	2.9	3.1	2.5%
Sweden	1.0	1.3	2.2	2.9	3.1	3.1	3.1	3.1	3.1	2.9%
Switzerland	1.3	1.4	2.4	3.0	3.2	3.2	3.3	3.3	3.4	2.5%
Turkey	0.3	0.4	0.6	0.9	1.1	1.1	1.2	1.2	1.2	3.6%
United Kingdom	0.8	0.9	1.3	1.4	1.6	1.6	1.7	1.7	1.8	2.1%
United States	1.4	1.6	2.0	2.4	2.6	2.6	2.7	2.7		1.7%
25 country average****	1.1	1.3	1.9	2.6	2.8	2.9	2.9	2.9	3.0	2.6%

* Data for Finland, Italy and Spain refer to physicians entitled to practice and therefore is an over-estimation of the actual number of practising physicians.
** Note that physician data for 1960 refers to 1961 for Canada
Data for 1970 refers to 1971 for Australia, Belgium and NZ
Data for 1980 refers to 1981 for Australia and Korea
Data for 1990 refers to 1991 for Australia
*** Growth rate refers to the average annual growth rate and is for the period 1960 to 1999 or the latest available year.
**** The 25 country average includes: Australia, Austria, Belgium, Canada, Czech Republic, Denmark, Finland, France, Germany, Greece, Hungary, Iceland, Italy, Japan, Luxembourg, New Zealand, Norway, Poland, Portugal, Spain, Sweden, Switzerland, Turkey, United Kingdom, United States

Source: Health at a Glance, OECD 2001, Table 2.1

Chart 5: Trends in number of certified nurses (per 1000 population)



Source: Health at a Glance, OECD 2001, Chart 2.4

other countries where the number of doctors and nurses per capita has continued to increase in the 1990s, albeit at a lower rate than in previous decades.

In 1999, there were only 2.1 practising physicians per 1 000 population in Canada. This was significantly below the OECD average of 3.0 physicians per 1 000 population. It should be noted however that this OECD average includes data for some countries referring to both practising and non-practising physicians. While there are fewer practising physicians per capita in Canada than in most other OECD countries, physicians tend to receive higher incomes (relative to the national average income) than their counterparts in other countries, with the exception of the United States and Germany.

In Canada as in other OECD countries, nurses represent the largest category of health care providers. The number of nurses per capita varies significantly across countries, although caution is required in comparing data across countries because of definitional problems. *Health at a Glance* shows that the number of practising certified nurses per capita has increased in the 1990s in almost all countries, but not in Canada where it declined after 1992 (Chart 5).

The number of hospital and nursing home beds per population has been declining steadily in most OECD countries over the past two decades. In the case of hospital beds, this reflects the development of new medical technologies and growing pressures for cost containment, which have led to shorter hospital stays and an increasing proportion of day-surgery patients. The average number of inpatient care beds across OECD countries has dropped from 8.9 per 1 000 population in 1980 to 6.9 in 1998. In Canada, there were 4.1 inpatient beds per 1 000 population in 1998, down from 6.8 in 1980. ■

Health care utilisation

Health care utilisation includes the use of ambulatory services and inpatient hospital admissions and length of stay.

There are considerable differences across countries in the average number of consultations with doctors per year. In 1997, the average for the 18 countries for which data are available was almost 7 consulta-

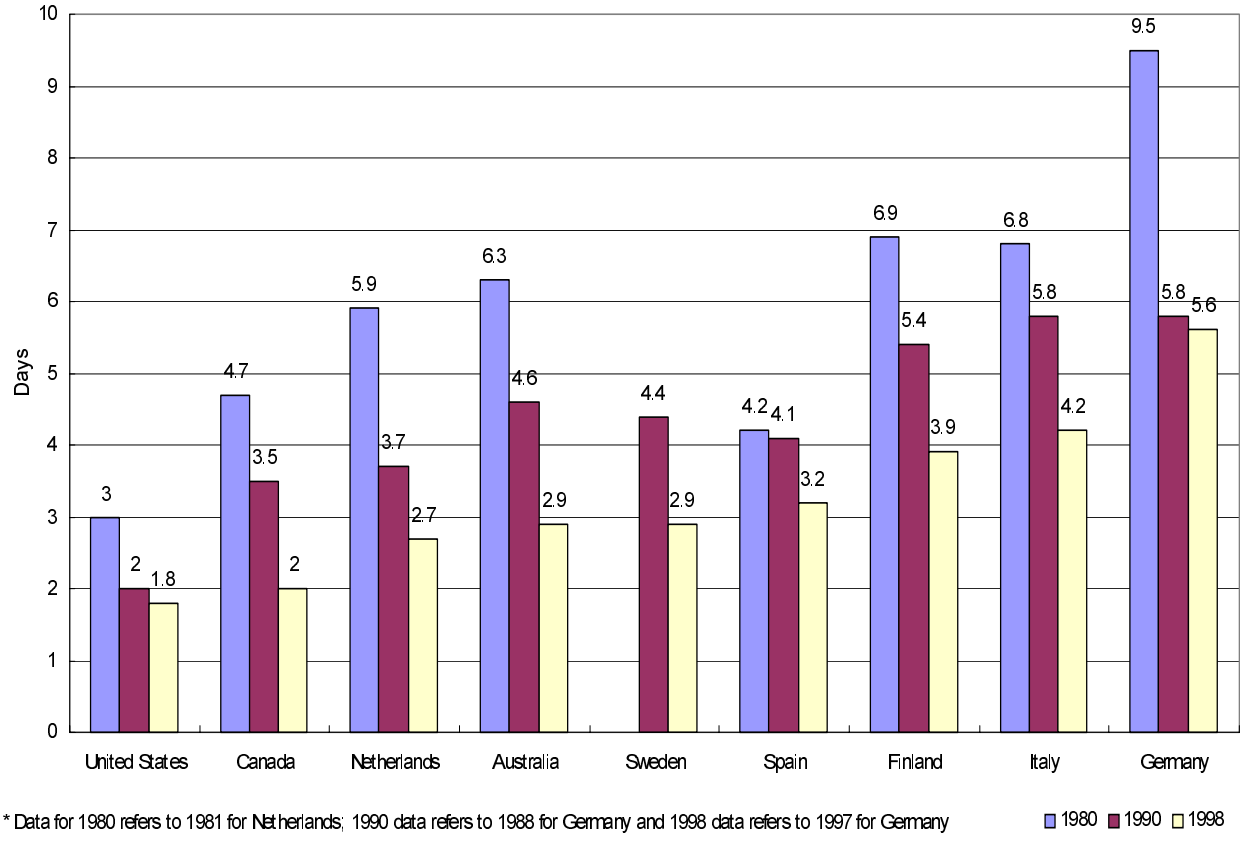
tions per person; in Canada, it was slightly lower, at 6.4 consultations per person.

The hospital inpatient admission rate in Canada stood at 101 per 1 000 population in 1998, significantly lower than the OECD average of 169. Inpatient admission is defined as the number of patients who were admitted and stayed at least one night in institutions. This means that day cases such as same-day surgery are excluded. Along with the United States, Canada was the only country to experience a reduction in inpatient admission rates between 1970 and 1998. Canadian inpatient admissions declined from about one admission for every 6th person in 1970 to one admission for every 10th person in 1998. This was probably counterbalanced by an increase in day cases, although long time series are not available for these cases.

The average length of stay for acute care in hospitals has been falling steadily over time in most OECD countries. In 1980, the average length of stay per patient was 11 days; by the end of the 1990s, this came down to an average of 8 days. Canada followed the same pattern, with the average length of stay going down from 10 days in 1980 to 7 days in 1998.

Focussing on specific conditions which lead to hospital admissions, Chart 6 presents trends in the average length of stay for women having babies. There are striking variations in the average length of

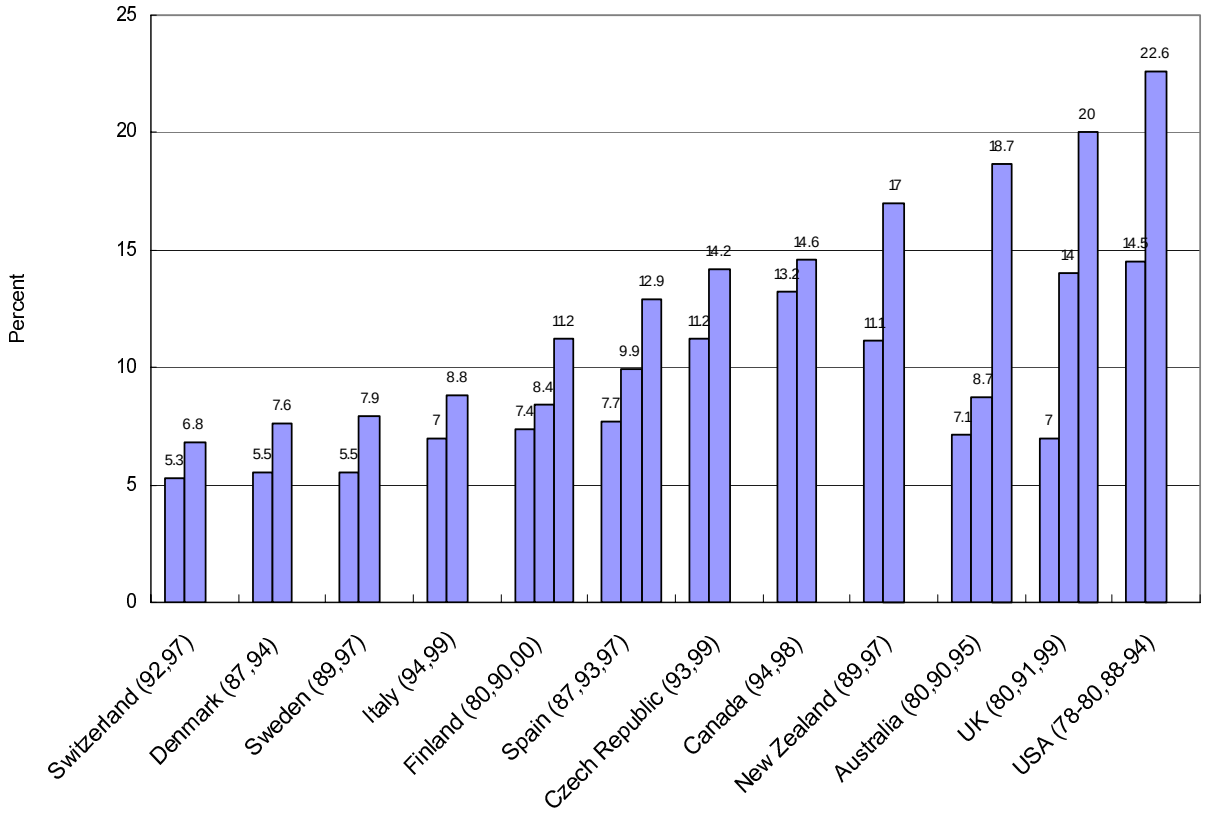
Chart 6: Average Length of Stay for normal delivery *



* Data for 1980 refers to 1981 for Netherlands; 1990 data refers to 1988 for Germany and 1998 data refers to 1997 for Germany

Source: Health at a Glance, OECD 2001, Chart 3.16

Chart 7: Obesity among the adult population



Note: Percent refers to the percentage of the population aged 15 years and over with a body mass index > 30
Source: Health at a Glance, OECD 2001, Chart 5.11

stay across OECD countries, with the United States and Canada being at the low end in terms of the duration of hospitalisation for a normal delivery. In all countries, there have been sharp reductions in the length of stay for normal delivery over the last 20 years.

The average length of stay in hospital is often treated as an indicator of efficiency. 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. Variations in length of stay may reflect variations in case mix. Also, if the stay is too short, there may be adverse effect for treatments or for the comfort and recovery of the patient. If a falling length of stay leads to rising readmission rate, costs may fall little or even rise. ■

Non-medical determinants of health

A large number of medical and non-medical factors affect the health status of populations in OECD countries. A recent OECD investigation of the determinants of health confirms that certain non-medical determinants, such as lower GDP per capita, a higher proportion of blue-collar workers, and higher consumption of tobacco, alcohol and fat are all associated with higher premature mortality (Or, 2000).

Over the last decades, there has been a sizeable reduction in the proportion of adults who smoke every day in most OECD countries. By the end of the 1990s, Portugal, Sweden the United States and Canada had the lowest smoking rates, with 20% or less adults reporting to smoke daily. In several countries, the reduction in smoking rates has been

particularly pronounced for men. This has been the case in Canada, where the proportion of men who report smoking every day came down from 39% in 1979 to 22% in 1999, substantially closing the gender gap.

Excessive alcohol consumption is a major risk factor for accidents (both fatal and non-fatal) and a number of diseases, such as liver cirrhosis and cancers of the digestive system. In Canada as in several other OECD countries, alcohol consumption per adult (as measured by sales of pure alcohol in litres) rose during the 1960s and the 1970s, but subsequently started to decline over the last two decades. By the end of the 1990s, the average annual consumption of alcohol per capita in Canada is much lower than in high-consumption countries like France, but it continues to be above levels observed in low-consumption countries such as Iceland, Norway and Sweden.

The past two decades have seen an increase in the number of obese men and women in all OECD countries for which data are available (Chart 7). In Canada, the prevalence of obesity among adults is now relatively high compared with several other OECD countries. Approximately 1 out of 7 Canadian can now be classified as obese. Whilst obesity is more common among women than among men in most OECD countries, in Canada there are slightly more obese males than females. Obesity leads to a greater propensity to diabetes and circulatory diseases. It is another risk factor that could be reduced by public health measures such as improved nutrition and more regular exercise as well as early detection of potential weight problems in children and young adults. ■

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