Health spending

Total health spending (public and private) accounted for 7.6% of GDP in the United Kingdom in 2001, less than one percentage point below the average of 8.4% in OECD countries (chart 3.4). Health spending as a share of GDP was also lower in the United Kingdom than the average among the 15 European Union countries (which was 8.3% of GDP). The United States continued to spend the highest proportion of its GDP on health, reaching 13.9% in 2001, a full three percentage points above the second placed country, Switzerland. Germany, Canada and France followed, spending 10.7%, 9.7% and 9.5% respectively of their GDP on health in 2001.

However, in terms of public expenditure, the United Kingdom spent 6.2% of its GDP on health in 2001, compared with 5.9% on average among OECD countries and 6.1% among European Union countries.

The United Kingdom ranked slightly below the OECD average in terms of total health expenditure per capita in 2001, with spending of 1 992 USD (adjusted for purchasing power parity) compared with an OECD average of 2 117 USD (chart 3.1). The United States again topped the OECD ranking of health spending per capita, with 4 887 USD per capita. Differences in health spending across countries may reflect differences in price, volume and quality of medical goods and services consumed.

During the 1990s, health spending per capita in the United Kingdom grew in real terms by 3.8% per year on average, a growth rate higher than the OECD average of 3.3% per year (table 3.4) and the European Union average of 3.2%. In the United Kingdom, as in many other countries, the past decade consisted of three different periods in terms of health expenditure growth. In the early 1990s, health spending grew fairly rapidly (4.7% per annum on average), coinciding with the introduction of the internal market and GP fund-holding. After relative stagnation in growth during the mid-1990s, health spending has accelerated in recent years, as a result of government commitments to improving the health service. Health spending increased by 4.9% per year in real terms from 1998-2001, second only to Ireland among the European Union countries. The bulk of this growth has been met by increases in public financing, rising by 5.6% on average from 1998 to 2001, compared with OECD-wide public health expenditure growth rate of 4.4% per annum.

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 the United Kingdom, 82% of health spending is funded by government revenues,

\footnote{Data on expenditures relate generally to 2001 (the latest year for which comparable data are available in most countries).}
above the average of 72% in OECD countries (chart 3.11). The share of public spending on health ranges from a low of 44% in the US to over 85% in countries such as Norway and Luxembourg. In France and Germany around 75% of health expenditure is financed through public funds. From a peak of 90% in the mid-1970s the public share of health spending in the United Kingdom declined to a low of 80% in the late 1990s, reflecting a steady rise in out-of-pocket payments and take up of private medical insurance over the same period. The government’s commitment to increase public health expenditure over recent years has seen the public share increase again.

**Resources and activities in the health sector**

The United Kingdom continues to face acute doctor shortages; there are fewer physicians per capita than in most other OECD countries. Amid efforts to recruit and maintain doctors in the health service, the United Kingdom reported 2.0 practising physicians per 1,000 population in 2000, well below the OECD average of 2.9, and the European Union average of 3.3.

In terms of practicing nurses there were 8.8 nurses per 1,000 population in the United Kingdom in 2000, in line with the European Union average, and slightly above the average of 8.1 across OECD countries. Following a period of relative stability, the number of nurses started to increase rapidly in the latter half of the 1990s (charts 2.6), when active recruitment policies were introduced to increase the nursing workforce, including from abroad. Reflecting also the relatively low density of UK physicians, the nurse to physician ratio in the United Kingdom is relatively high at 4.4, in line with Canada, Australia and New Zealand. At the other end of the scale, Southern European countries report much lower nurse-physician ratios (down to below 1.0 in Greece). These variations raise as much the question as to whether the appropriate skill mix between doctors and nurses in health care delivery is being adopted across countries.

The number of acute care hospital beds in the United Kingdom in 2000 was 3.9 per 1,000 population, close to OECD and European Union averages of 4.0 beds per 1,000 population (chart 2.9). In most OECD countries, the number of hospital beds per capita has fallen over recent decades, although comparable data for the United Kingdom is only available from 1995. Since then the number of beds in the United Kingdom has been stable. The current government’s stated policy is to increase acute bed availability in order to reduce blockages caused when beds are not available.

Although the average length of stays in hospitals has decreased over time in OECD countries, there remain notable variations across countries. In the United Kingdom the average length of stay for acute care is 6.9 days, the same as the OECD average, but lower than in some other European countries such as Germany and the Netherlands where the average length of stay for acute care is over 9 days (chart 2.29).

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 the United Kingdom, the number of MRIs per million population increased from 1.0 in 1990 to 4.6 in 2000. Despite this rapid increase, it still ranks around the median with regards to OECD countries (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.
Health status

Most OECD countries have enjoyed large gains in life expectancy over the past 40 years. In the United Kingdom, life expectancy at birth increased by 7.0 years between 1960 and 2000, below the average gain of 8.6 years registered across OECD countries, and far less than the increase of 13.4 years in life expectancy in Japan (chart 1.2). In 2000, life expectancy in the United Kingdom stood at 77.8 years, just below the median in terms of OECD ranking. Japan, Switzerland, and Sweden register the highest life expectancy in the OECD at 81.2, 79.8 and 79.7 years respectively (table 1.1).

As in other OECD countries, infant mortality rates in the United Kingdom have fallen dramatically over the past few decades (table 1.6). It stood at 5.6 deaths per 1 000 live births in 2000, lower than the OECD average of 6.5 but above the corresponding average of European Union 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 the United Kingdom, the proportion of smokers among adults has fallen from 39% in 1980 to 27% in 2000. It continues to be around the average of OECD countries; the lowest current rates are reported in Sweden, the United States, Canada and Australia, all at fewer than 20% of the adult population (table 4.1).

At the same time, obesity rates have increased in recent decades in all OECD countries for which trend data is available (chart 4.11). There remain however notable differences in obesity rates across countries. In the United Kingdom, the obesity rate among adults has tripled over the last twenty years to stand at 22% in 2001. This is higher than in nearly all other OECD countries, but lower than in the United States (31% in 1999) and Mexico (24%, 2000), and comparable to Australia (21% in 1999)³. 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 the United Kingdom, will have substantial implications for future incidence of health problems and related spending.

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² Data on indicators of health status and risk factors generally relate to 2000.

³ 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.