

**Health at a Glance – OECD Indicators 2003**  
**Briefing note (United States of America)**  
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For questions, please contact :

Elizabeth Docteur, OECD Health Policy Unit

Tel : +33 1 45 24 76 03, e-mail : [elizabeth.docteur@oecd.org](mailto:elizabeth.docteur@oecd.org)

Gaétan Lafortune, OECD Health Policy Unit

Tel : +33 1 45 24 92 67, e-mail : [gaetan.lafortune@oecd.org](mailto:gaetan.lafortune@oecd.org)

### **Health spending<sup>1</sup>**

Total health spending (public and private) accounted for 13.9% of GDP in the **United States** in 2001, the highest share in the OECD and more than five percentage points higher than the average of 8.4% in OECD countries (chart 3.4). By comparison, countries such as Switzerland, Germany and Canada allocate from 10 to 11% of their GDP to health.

The **United States** also ranks far ahead of other OECD countries in terms of total health spending per capita, with spending of 4,887 USD (adjusted for purchasing power parity), more than double the OECD average of 2,117 USD in 2001 (chart 3.1). Switzerland comes just after with spending of 3,248 USD per capita, whereas France spends 2,561 USD per capita. It should be noted that differences in health spending across countries may reflect differences in price, volume and quality of medical goods and services consumed.

One might distinguish three different periods in terms of health expenditure growth in the **United States** over the past twenty years. The **United States** saw the fastest increase in health spending growth rate over the 1980s, with an increase in real terms by 5.3% per year on average, compared to the OECD average of 3.1% per year. In the 1990s, the growth rate then stabilised to 3.3% per year, identical to the OECD average. Health spending in the **United States** started to rise again more rapidly in 1999-2001, at a rate of 4.4% per year in real terms over this period, a higher growth rate than the 4% on average across OECD countries.

Regarding the allocation of health expenditure in 2001, the **United States** spent 48% of its total health expenditure on out-patient care (including ancillary services and home care), which is the highest share devoted to out-patient care in OECD countries (the average across OECD countries was 31% spent on out-patient services). Most OECD countries allocate a greater portion of their health expenditure to in-patient care (chart 3.3).

The rise in pharmaceutical spending has been one of the factors behind the rise in total health spending in the **United States** as well as in several other OECD countries. Between 1990 and 2001, the share of health expenditure spent on pharmaceuticals increased from 9.2% of total health spending to 12.4% (chart 3.15). In 2001, the United States was the top spender on pharmaceuticals (with 605 USD per capita, adjusted for purchasing power parity), followed by France and Italy (chart 3.13).

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<sup>1</sup> Data on expenditures relate generally to 2001 (the latest year for which comparable data are available in most countries).

## Public and private financing

The public sector is the main source of health funding in all OECD countries, except for **the United States**, Mexico and Korea. In the **United States**, only 44% of health spending is funded by government revenues, well below the average of 72% in OECD countries (chart 3.11). The public share of total health spending remains the lowest of OECD countries, compared for instance with the Nordic countries (Denmark, Norway and Sweden) where it reaches more than 80% of total health spending (chart 3.12).

In the **United States**, private 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 the **United States**, there are fewer physicians per capita than in most other OECD countries. In 1999, the **United States** had 2.7 practising physicians per 1 000 population, below the OECD average of 2.9 (table 2.1). Between 1990 and 2000, the number of doctors per capita remained quite stable, while it continued to increase (at least slightly) in most OECD countries (chart 2.2).

The proportion of female doctors has increased strongly over time 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 the **United States**, the proportion of female doctors increased from 6% in 1970 to over 20% in 1999.

There were 8.1 nurses per 1 000 population in the **United States** in 1999, which corresponds exactly to the average across OECD countries. The number of nurses per capita increased in the United States (by a mean average growth rate of 2.8% over the period 1970-1999), as in most countries, but unlike Canada, Australia, Sweden and Poland, which experienced a decline during the 1990s (charts 2.6 and 2.7).

The number of acute care hospital beds in the **United States** in 2000 was 2.9 per 1 000 population, 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 4.4 beds per 1 000 population in 1980 to 2.9 in 2000 (table 2.3). This decline has coincided with a reduction in average length of stays in hospitals and an increase in day-surgery patients.

The average length of stays in hospitals has decreased over time in OECD countries, but there remain notable variations across countries. The United States has among the lowest average lengths of stay for most procedures. For instance, in the **United States** the average length of stay for mothers following a normal delivery is 2 days, which is much lower than in most other OECD countries (chart 2.32). The average length of stay following acute myocardial infarction (AMI) is 5.7 days, the lowest among OECD countries (table 2.11). 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.

Although progress has been achieved on childhood immunization, the **United States** has a relatively low overall vaccination coverage, with 82% of children immunised against diphtheria, tetanus and pertussis (DTP) in 2001, whereas more than two-thirds of OECD countries have achieved rates greater than 90% (chart 2.21).

## Health status<sup>2</sup>

Most OECD countries have enjoyed large gains in life expectancy over the past 40 years. In the **United States**, life expectancy at birth increased by 6.9 years between 1960 and 2000, which is less than the increase of 13.4 years in life expectancy in Japan, or of 8 years in Canada (chart 1.2). In 2000, life expectancy in the **United States** stood at 76.8 years, below the OECD average of 77.2 years. Japan, Switzerland, Iceland, Sweden and Canada were among the top 5 countries registering the highest life expectancy among OECD countries (table 1.1).

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 (table 1.6). It stood at 6.9 deaths per 1 000 live births in 2000, below the median among OECD countries (chart 1.5). It should be noted however that some of the international variation in infant mortality rates is due to variations in registering practices of premature infants (whether they are reported as live births or not). In several countries, such as the **United States**, Canada and the Nordic countries, very premature babies (with relatively low odds of survival) are registered as live births, which increases mortality rates compared with other countries that do not register them as live births. Among OECD countries, infant mortality is the lowest in Japan and in the Nordic countries (Iceland, Sweden, Finland and Norway), all below 4 deaths per 1 000 live births.

## 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 States**, the proportion of smokers among adults has fallen from 34% in 1980 to 19% in 2000, the lowest rate among OECD countries along with Sweden (chart 4.1 and 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 States**, the obesity rate among adults (31% in 1999) is the highest in OECD countries, with the United Kingdom registering 22% in 2001 and Australia 21% in 1999<sup>3</sup>. Obesity rates in Continental European countries are lower (e.g., 9% of adults in 2000), but are also rising. 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 the **United States** and other OECD countries, will have substantial implications for future incidence of health problems and related spending.

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<sup>2</sup> Data on indicators of health status and risk factors relate generally to 2000.

<sup>3</sup> 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.