

OECD Health Data 2005

How Does Canada Compare

Health spending and financing

Total health spending accounted for 9.9% of GDP in **Canada** in 2003, more than one percentage point higher than the average of 8.6% in OECD countries. Health spending as a share of GDP is lower in **Canada** than in the United States (which spent 15% of its GDP on health in 2003), in Switzerland and Germany (which allocated more than 11% of their GDP on health), and in Iceland, Norway and France (which spent between 10.1-10.5% on health in 2003).

Canada also ranks above the OECD average in terms of total health spending per capita, with spending of 3003 USD in 2003 (adjusted for purchasing power parity), compared with an OECD average of 2307 USD. Health spending per capita in **Canada** remains nonetheless much lower than in the United States (which spent 5635 USD per capita in 2003) and in Norway and Switzerland (which spent about 3800 USD).

Between 1998 and 2003, health spending per capita in **Canada** increased in real terms by 4.2% per year on average, a growth rate comparable to the OECD average of 4.5% per year. Following a period of strict cost containment measures between 1992 and 1997, health expenditures in **Canada** has risen steadily since 1998, reflecting improvements in the budgetary situation of governments and deliberate policies to relieve pressures which arose from earlier restraint measures.

The rise in pharmaceutical spending has been one of the factors behind the rise in total health spending in **Canada** as well as in many other OECD countries. In 2003, spending on pharmaceuticals accounted for 16.9% of total health spending in **Canada**, up from 15.2% in 1998. This remained below the OECD average of 17.7%. In 2003, only the United States and France spent more on pharmaceuticals per capita than **Canada**.

The public sector is the main source of health funding in all OECD countries, except the United States, Mexico and Korea. In **Canada**, 70% of health spending was funded by public sources in 2003, slightly below the average of 72% in OECD countries. The share of public spending in **Canada** decreased from 74.5% in 1990. In 2003, the share of public spending among OECD countries was the lowest in the United States (44%) and Mexico (46%), and relatively high (over 80%) in several Nordic countries (Denmark, Norway and Sweden), the United Kingdom and Japan.

Resources in the health sector (human, physical, technological)

Despite the relatively high level of health expenditure in **Canada**, there are fewer physicians per capita than in most other OECD countries. In 2003, Canada had 2.1 practising physicians per 1 000 population, well below the OECD average of 2.9. Between 1990 and 2003, the number of doctors per capita remained stable in **Canada**, while it continued to increase at least slightly in most OECD countries.

There were 9.8 nurses per 1 000 population in **Canada** in 2003, a higher figure than the average of 8.2 in OECD countries. However, the number of nurses per capita *decreased* in **Canada** since 1990, while it has increased in most other countries. The reduction in the number of nurses per capita over the past decade or so in **Canada** is 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 2002, a higher number than in the United States (2.8 in 2003), but lower than the OECD average of 4.1 beds per 1 000 population. As in most OECD countries, the number of hospital beds per capita in **Canada** has fallen over time. This

decline has coincided with a reduction of average length of stays in hospitals and an increase in the number of surgical procedures performed on a same-day (or ambulatory) basis.

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 also increased over time, to reach 4.5 per million population in 2003. Despite this increase, Canada was still lagging behind the OECD average of 7.6 MRI units per million population. Similarly, the number of CT scanners in Canada stood at 10.3 per million population in 2003, below the OECD average of 17.9.

Health status and risk factors

Most OECD countries have enjoyed large gains in life expectancy over the past 40 years, thanks to improvements in living conditions, public health interventions and progress in medical care. In 2002, life expectancy at birth in **Canada** stood at 79.7 years, about two years higher than the OECD average. Still, a number of countries (e.g., Japan, Switzerland, Sweden and Australia) registered a higher life expectancy than **Canada**.

The infant mortality rate in **Canada**, as in other OECD countries, has fallen greatly over the past decades. It stood at 5.4 deaths per 1 000 live births in 2002, lower than in the United States and the OECD average. Infant mortality is the lowest in Japan and in Nordic countries (Iceland, Sweden, Finland and Norway)¹.

The proportion of daily smokers among adults has shown a marked decline over the past two decades in most OECD countries. **Canada** provides an example of a country that has achieved remarkable progress in reducing tobacco consumption, with current rates of daily smokers among adults down from 34% in 1980 to 17% in 2003, the lowest rate among all OECD countries along with Sweden and the United States. Much of this decline in **Canada** and in other countries can be attributed to policies aimed at reducing tobacco consumption through public awareness campaigns, advertising bans and increased taxation.

At the same time, obesity rates have increased in recent decades in all OECD countries, although there remain notable differences across countries. In **Canada**, the obesity rate among adults, at 14.3% in 2003, up from 12.7% in 1994/5. It remains much lower however than in the United States (30.6% in 2002), in the United Kingdom (23% en 2003) and Australia (21.7% en 1999)². The cost of obesity to health care systems has been estimated to account for about 5.5% to 7% of total health expenditure in the United States in the late 1990s, and 2% to 3.5% in other countries such as **Canada**, Australia and New Zealand (Thompson and Wolf, 2001). There is a time lag of several years between the onset of obesity and related health problems (such as diabetes and asthma), suggesting that the rise in obesity that has occurred in most OECD countries, including **Canada**, will mean higher health care costs in the future.

More information on *OECD Health Data 2005* is available at www.oecd.org/health/healthdata.

For more information on OECD's work on Canada, please visit www.oecd.org/canada.

¹ Some of the international variation in infant mortality rates is due to variations among countries in how premature infants are registered. In Canada, the United States and the Nordic countries, very premature babies (with 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.

² It should be noted however that the data for the United States, the United Kingdom and Australia are more accurate than those from other countries since they are based on *actual measures* of people's height and weight, while estimates for other countries are based on *self-reported* data, which generally under-estimate the real prevalence of obesity.