

OECD Health Data 2005

How Does the United States Compare

Health spending and financing

Total health spending accounted for 15% of GDP in the **United States** in 2003, the highest share in the OECD and more than six percentage points higher than the average of 8.6% in OECD countries. By comparison, Switzerland and Germany allocated 11 and 11.5% of their GDP to health, respectively, and Canada and France about 10%.

The **United States** also ranks far ahead of other OECD countries in terms of total health spending per capita, with spending of 5,635 USD (adjusted for purchasing power parity), more than twice the OECD average of 2,307 USD in 2003. Switzerland and Norway come just after with spending of about 3,800 USD per capita. Differences in health spending across countries may reflect differences in price, volume and quality of medical goods and services consumed.

Between 1998 and 2003, health spending per capita in the **United States** increased in real terms by 4.6% per year on average, a growth rate comparable to the OECD average of 4.5% per year.

Over the past decade, the share of health expenditure spent on pharmaceuticals in the **United States** increased from 8.6% of total health spending in 1993 to 12.9% in 2003. This remained below the OECD average of 17.7%. In 2003, the **United States** was the top spender on pharmaceuticals (with 728 USD per capita, adjusted for purchasing power parity), followed by France, Canada and Italy.

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. 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.

In the **United States**, private insurance accounts for 37% of total health spending, by far the largest share among OECD countries. Beside the **United States**, Canada, France and the Netherlands also have a relatively large share of funding coming from private insurance (more than 10%).

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 2002, the **United States** had 2.3 practising physicians per 1 000 population, below the OECD average of 2.9.

There were 7.9 nurses per 1 000 population in the **United States** in 2002, which is slightly lower than the average of 8.2 across OECD countries.

The number of acute care hospital beds in the **United States** in 2003 was 2.8 per 1 000 population, also 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 has fallen over the past twenty years, from 4.4 beds per 1 000 population in 1980 to 2.8 in 2003. This decline has coincided with a reduction in average length of stays in hospitals and an increase in day-surgery patients.

Health status and risk factors

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 7.3 years between 1960 and 2002, which is less than the increase of 14 years in life expectancy in Japan, or of 8.4 years in Canada. In 2002/3, life expectancy in the **United States** stood at 77.2 years, below the OECD average of 77.8 years. Japan, Iceland, Spain, Switzerland and Australia were among the top 5 countries registering the highest life expectancy among OECD countries.

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 7 deaths per 1 000 live births in 2002, above the OECD average of 6.1.¹ Among OECD countries, infant mortality is the lowest in Japan and in the Nordic countries (Iceland, Sweden, Finland and Norway), all below 3.5 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 smokers among adults has fallen from 33.5% in 1980 to 17.5% in 2003, the lowest rate among OECD countries along with Canada and Sweden.

At the same time, obesity rates have increased in recent decades in all OECD countries for which trend data is available. There remain however notable differences in obesity rates across countries. In the **United States**, the obesity rate among adults (30.6% in 2002) is the highest in OECD countries, followed by Mexico (24.2% in 2000) and the United Kingdom (23% in 2003).² 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 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 2005* is available at www.oecd.org/health/healthdata.

For more information on OECD's work on the United States, please visit www.oecd.org/us.

¹ 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 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.

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.