ISBN 92-64-01262-1
Health at a Glance: OECD Indicators 2005

Executive Summary

Health systems are of growing size and importance in OECD countries. Progress in health care and the development of new medicines have contributed to the steady improvements in health status that OECD countries have enjoyed in recent decades. At the same time, spending on health care has never been higher, consuming an ever-increasing share of national income.

There is obviously more to health than health care and health spending. A large body of evidence shows that population health in developed countries is determined more by socio-economic and lifestyle determinants than by the provision of health care itself. Well-designed public health programmes may contribute to the prevention of illness and help relieve some of the cost pressures on health care systems. Risk factors to health are also changing. For example, while many OECD countries have achieved remarkable progress over the past few decades in reducing tobacco consumption, obesity rates have increased in all OECD countries, reflecting changes in eating habits and more sedentary lifestyles.

Health at a Glance – OECD Indicators 2005 provides a comparable and up-to-date collection of indicators related to different aspects of the performance of health systems. It takes as its basis *OECD Health Data 2005*, a comprehensive database containing more than 1 000 statistical series on health and health systems across OECD countries. This third edition of *Health at a Glance* focuses not only on the resources and activities of health care systems, but also includes an increased number of indicators related to health promotion and disease prevention. For instance, the chapter on health status includes more information on children's health, including their dental health. Indicators related to nutrition have also been added to indicators of tobacco consumption, alcohol consumption and overweight and obesity in the chapter on risk factors. Influenza immunisation coverage among elderly people complements the traditional indicators on childhood immunisation, as examples of preventive health services that can reduce ill health and related health care needs. And health spending is now broken down to show spending for organised public health programmes in different OECD countries.

This publication provides striking evidence of large variations across the 30 OECD member countries in indicators of health status, health risks, and in the costs, allocation of resources and outputs of their health systems. While some basic population breakdown by sex and age are presented for a number of indicators, it does not provide in most cases a more detailed breakdown by (sub-national) region, by socio-economic group or by different ethnic/racial group. The reader should therefore bear in mind that for many indicators shown in this publication, there may be as much variation *within* a country as there is *across* countries.

The following summarises some of the main findings of this publication as they relate to the performance of health systems.

Health status has improved dramatically in OECD countries

- **Life expectancy at birth has increased substantially in OECD countries in recent decades,** thanks to rising living standards, improved lifestyle and better education, as well as advances in access to care and the efficacy of medicine. On average across OECD countries, life expectancy at birth reached 77.8 years in 2003, up from 68.5 in 1960. In 2003, Japan enjoyed the highest life expectancy, with 81.8 years for the whole population, followed by Iceland, Spain, Switzerland, Australia and Sweden (Chart 1.1).
- It is difficult to estimate the relative contribution of the numerous non-medical and medical factors that might affect variations in life expectancy across countries and over time. **Higher national income is generally associated with higher life expectancy at birth across OECD countries**, although the relationship is less pronounced at higher levels of national income. There are also notable differences in life expectancy between OECD countries with similar income per capita. For instance, Japan and Spain have higher life expectancies than would be predicted by their GDP per capita alone, while the United States and Hungary have lower life expectancies than predicted based on income (Chart 1.3).
- **Life expectancy at age 65 has also increased substantially over the past few decades in OECD countries.** In 2003, life expectancy at age 65 stood, on average across OECD countries, at 19.3 years for women and 15.9 years for men. This is up by more than 3 years since 1970 for both women and men. As with life expectancy at birth, Japan enjoys the longest life expectancy at age 65 in 2003 (Chart 1.5). **Life expectancy at age 65 is expected to continue to increase in coming decades.** OECD calculations project that, by 2040, life expectancy at age 65 will, on average in OECD countries, reach 21.6 years for women and 18.1 years for men.
- All OECD countries have made **remarkable progress in reducing infant mortality rates** in recent decades, thanks to overall improvements in economic and social conditions, as well as improvements in health services for post-natal care, including access to childhood immunisation. Portugal has seen its infant mortality rate reduced by over 90% since 1970, going from the country with the highest rate in Europe to one among the lowest in 2003. Large reductions in infant mortality rates have also been achieved in Mexico, Turkey and in some southern European countries, such as Italy, Spain and Greece. In 2003, Japan and some of the Nordic countries had the lowest infant mortality rates among OECD countries (Chart 1.20).

OECD countries face rising health costs

- While there have been impressive gains in longevity over the past decades in OECD countries, health costs have also risen over time, and in most countries health expenditure increased at a faster rate than overall economic growth. **In 2003, OECD countries devoted, on average, 8.8% of their GDP to health spending, up from 7.1% in 1990 and just over 5% in 1970.** However, the share of GDP allocated to health spending varies considerably across countries, ranging from 15% in the United States to less than 6% in the Slovak Republic and Korea. Following the United States, in terms of

highest health spending as a percentage of GDP in 2003, were Switzerland and Germany which spent 11.5% and 11.1% of their GDP on health, respectively (Chart 3.7).

- **Growth in health spending can be attributed to several factors. In general, OECD countries with higher GDP per capita tend to spend more per capita on health** (Chart 3.10). However, there are significant variations across countries, which may partly reflect policy decisions regarding appropriate spending levels, different financing and organisational structures of health systems, and the perceived value of additional spending on health relative to other goods and services. **Advances in the capability of medicine to prevent, diagnose and treat health conditions are a major factor driving health cost growth.** A variety of factors affect the development and diffusion of new medical technologies and new drugs, including the decision-making process about how to finance new equipment, treatment or drug. **Population ageing also contributes to the growth in health spending.** The percentage of the population 65 years or older has risen in all OECD countries (Chart 5.3), and this is expected to continue in the years and decades ahead, particularly given the ageing of the "baby-boom" generation (which will begin reaching the age of 65 in 2010 and beyond). Since older populations tend to be in greater need of health and long-term care, population ageing can be expected to increase public expenditure in these areas.

Health costs are putting pressure on public budgets

- Given the predominance of publicly financed health insurance coverage or direct public financing of care in most OECD countries, the public sector accounts for the greatest part of health spending in all countries, except the United States, Mexico and Korea (Chart 3.17). Even in the United States, where the private sector plays a particularly large role in financing, public spending on health represents 6.6% of GDP, comparable to the OECD average.
- The last decade can be roughly divided into two periods in terms of the growth in public expenditure on health in OECD countries. The period 1992-1997 saw economic growth matched by a similar or even slower growth in public expenditure on health. In more recent years however, **public expenditure on health has increased more rapidly than economic growth in all OECD countries.** In some countries such as the United Kingdom and Canada, recent increases in public health spending have reflected deliberate policies to relieve demand pressures arising from cost containment during the mid-1990s (Chart 3.6).
- The rapid rise in drug spending in recent years – more than 5% per year growth on average since 1997 – has been an important driver in the overall rise in total health spending. In fact, **most OECD countries have seen growth in pharmaceutical spending outstrip growth in total health spending** over this period. In the United States and Australia, pharmaceutical spending has increased at more than double the rate of growth in total health spending in recent years. Significant growth has also been observed in Ireland and Korea, albeit from a relatively low per capita base at the beginning of the period. The rate of growth was much more moderate in Japan (Chart 3.16).

- On average across OECD countries, **60% of the pharmaceutical bill is borne by public funds, the remainder being met basically by out-of-pocket payments and, to a lesser extent, private insurance.** However, this average hides a very wide variation, ranging from lows of 11% in Mexico and 21% in the United States, to a high of 86% in Ireland. One reason for this is how and even whether pharmaceuticals are covered by national health programmes and publicly financed insurance (Table A.3.11).
- In 2003, **drug expenditure per person was highest in the United States (more than 700 USD per person), followed by France (just over 600 USD), Canada and Italy (about 500 USD).** The lowest spending of just over 100 USD was in Mexico and in Turkey. Variations in drug spending across countries reflect differences in volume, structure of consumption and price level. Difference in income levels across countries also affects spending on drugs (Chart 3.14).

Shortages of health care resources could pose a problem in certain countries

- **A perceived shortage of physicians is an important concern in many countries.** The size, distribution and composition of practising physicians is influenced by a number of factors, including restrictions imposed on entry into the medical profession, choice of speciality, remuneration and other aspects of working conditions, and migration. **In 2003, there were large variations in the number of practising doctors per capita across OECD countries. It ranged from highs of more than 4 doctors per 1 000 population in Italy and Greece, to lows of less than 2 per 1 000 population in Turkey, Mexico and Korea.** The number of practising doctors per capita was also relatively low in Japan, Canada, the United Kingdom and New Zealand. This latter group of countries have traditionally controlled medical school intake.
- **Foreign-trained physicians account for a substantial share of the physician workforce in certain countries.** In 2000, the share of foreign-trained physicians exceeded 20% of all practising physicians in English-speaking countries such as New Zealand, the United Kingdom, the United States and Canada. On the other hand, the share of foreign-trained physicians was much lower in Japan, Austria and France (Chart 2.4). International migration can increase the flexibility of labour markets for doctors and other health professionals in receiving countries, but it raises serious concerns about a "brain drain" when there are net long-term flows of staff from lower-income to higher-income countries.
- New data on the **remuneration of doctors** are presented in this third edition of *Health at a Glance – OECD Indicators 2005*, for general practitioners (GPs) and specialists (separated into salaried and self-employed physicians). Compared to average national income, the income of physicians varies considerably across countries. **For example, the income of self-employed specialists is relatively high in the Netherlands, the United States, Belgium and Canada.** On the other hand, specialists in Hungary and the Czech Republic (regardless of whether they are salaried or self-employed) earn relatively less, compared to average national income, than in other countries (Chart 2.9).
- There are also reports of current nurse shortages in all but a few OECD countries. **As for doctors, there are substantial variations in the number of nurses across OECD countries**, although the comparability of data is limited due to the inclusion of different

categories of nurses. Ireland, Iceland and the Netherlands report the highest number of nurses per capita, with almost or more than 13 nurses per 1 000 population in 2003. At the lower end of the scale, there were less than 4 nurses per 1 000 population in Turkey, Korea, Mexico and Greece (Chart 2.5). Looking at trends over time, between 1990 and 2003, the number of nurses per capita continued to increase at least slightly in most countries, but it started to decline in Australia, Canada, New Zealand and Poland (Chart 2.6).

- Data on the **remuneration of nurses** is available only for salaried hospital nurses. Based on data from a dozen of countries, the relative income of nurses compared to GDP per capita is highest in Portugal, followed by Australia and New Zealand. The relative income is lowest in the Czech Republic and Hungary, as well as in Norway (Chart 2.11).
- There are also concerns in some countries about a shortage of diagnostic or therapeutic equipment to ensure timely access to leading-edge technologies. **The availability of diagnostic technologies, such as CT and MRI scanners, has increased over the past decade in all OECD countries.** MRI being a newer technology than CT, the number of MRIs has increased particularly rapidly since 1990 (Table A.2.8). Nonetheless, there remain large variations in the diffusion of these medical technologies, with Japan reporting, by far, the highest number of CT and MRI scanners per capita. At the other end of the scale, not surprisingly given the high cost of these equipment, the number of MRI units per capita is the lowest in Mexico, followed by Poland, the Slovak Republic and the Czech Republic (Charts 2.13 and 2.14).

A greater focus on prevention might provide opportunities to further improve health while reducing pressure on health care systems

- Health care systems are sometimes criticised for being overly focused on "sick care": for treating the ill, but not doing enough to prevent illness. In fact, **only around 3% of current health expenditure is spent on prevention and public health programmes on average in OECD countries** (Chart 3.12).
- Childhood immunisation has been shown to be one of the most effective preventive measures for reducing childhood disease and mortality. **Around two-thirds of OECD countries have achieved DTP (diphtheria, tetanus, pertussis) vaccination coverage of 95% or more, the level needed to provide general immunity for the population. For measles, around half the OECD countries report the same level of coverage.** Some of the wealthier OECD countries, as measured by GDP per capita, such as Ireland, Norway and Austria, report below average vaccination coverage for both diphtheria and measles (Chart 2.21).
- Immunisation against influenza (or flu) among elderly people has become increasingly widespread in OECD countries over the past decade, as a way to prevent illness, hospitalisation and mortality among this population group which has a greater risk of developing serious complications from flu**. In 2003, the rate of influenza vaccination among elderly people varied from a low of less than 40% in the Czech Republic, the Slovak Republic and Hungary, to over 75% in Australia, Korea and the Netherlands.** The rate of influenza vaccination also stood at over 60% in most G7 countries, with the

exception of Germany and Japan where less than 50% of the elderly population reported having been vaccinated against influenza in 2003 (Chart 2.23).

Risk factors to health are changing

- **Many OECD countries have achieved remarkable progress over the past two decades in reducing tobacco consumption**, though it is still a leading cause of premature mortality. Much of this decline can be attributed to policies aimed at reducing tobacco consumption through public awareness campaigns, advertising bans and increased taxation. Current rates of daily smokers among adults now stand at less than 20% in Australia, Canada, Sweden and the United States, down from over 33% in the late 1970s. At the other end of the scale, more than 33% of adults in Greece, Hungary and Luxembourg continue to smoke on a daily basis (Chart 4.1).
- **Average alcohol consumption per adult has also gradually fallen in many OECD countries over the past two decades.** Curbs on advertising, sales restrictions and taxation have all proven to be effective measures to reduce alcohol consumption. Traditional wine-producing countries such as Italy and France have seen their alcohol consumption per capita drop substantially since 1980. On the other hand, alcohol consumption per capita rose by more than 40% in Ireland (Charts 4.6 and 4.7).
- In many OECD countries, the **growth in overweight and obesity rates among children and adults is rapidly becoming a major public health concern.** Obesity is a known risk factor for several health problems, including hypertension, high cholesterol, diabetes, cardiovascular diseases, asthma, arthritis and some forms of cancer. **More than 50% of adults are now defined as either being overweight or obese in ten OECD countries**: the United States, Mexico, the United Kingdom, Australia, the Slovak Republic, Greece, New Zealand, Hungary, Luxembourg and the Czech Republic (Table A.4.6).
- Focussing on obesity (which involves greater health risks than simply being overweight), **the prevalence of obesity among adults varies from a low of 3% in Japan and Korea, to a high of 31% in the United States**. However, it should be noted that estimates of overweight and obesity rates in most countries are based on self-reported data, which is not the case for the United States, Australia, New Zealand and the United Kingdom where estimates are based on the actual measurement of people's height and weight. Self-reported data on height and weight are not as reliable as actual measures, usually because of an under-estimation of weight. This means that **current estimates of obesity rates in most OECD countries under-estimate the true prevalence of obesity** because of such reporting biases (Charts 4.12 and 4.13).
- **Because obesity is associated with higher risks of chronic illnesses, it is linked to significant additional health care costs.** Estimates from the United States indicate that the cost of health care services is 36% higher, and the cost of medications 77% higher, for obese people than for people of normal weight (Sturm, 2002). There is a time lag of several years between the onset of obesity and related health problems, suggesting that the rise in obesity over the past two decades observed in most OECD countries will mean higher health care costs in the future.