Health at a Glance 2019 - OECD Indicators

Released on November 7, 2019
http://www.oecd.org/health/health-at-a-glance.htm
Overview

Benchmarking
How does my country compare with other OECD members?

Time trends
Has performance improved over time?

H@G as groundwork for deeper policy analysis

- Identifies relative strengths and weaknesses
- Highlights country policy reforms
- Summarises findings from related OECD reports

...with all data made as comparable as possible and subjected to rigorous checks
New indicators in the 2019 edition

- Avoidable mortality
- Chronic diseases
- Opioids – use, deaths, prescribing
- Extent of health care coverage
- Safe care – hospital-acquired infections, safe prescribing, safe LTC
- Patient-reported outcomes – hip and knee, breast cancer
- Breast cancer survival by stage
- Prices in the health sector
- Public funding of health spending
- Health expenditure projections
- LTC workers, LTC costs

- Inequality indicators (health status, risk factors, access)
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Information on data for Israel: [http://oe.cd/israel-disclaimer](http://oe.cd/israel-disclaimer)
1. Indicator overview: OECD snapshots and country dashboards

- e.g. Risk factors for health
Example of dashboard: Risk factors for health

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<th>Overweight / obese</th>
<th>Air pollution</th>
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<td>Population with BMI ≥ 25 (% population aged 15+)</td>
<td>Deaths due to pollution (per 100 000 people)</td>
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Example of dashboard:
Risk factors for health

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Note: ☑ Better than OECD average; ☘ Close to OECD average; ☐ Worse than OECD average. Hungary, Latvia and Lithuania excluded from standard deviation calculation for air pollution. * Likely under-estimate of obesity as self-reported.

There is a clear positive association between health spending per capita and life expectancy as well as breast cancer five-year net survival.

**Source:** Health at a Glance 2019.
The average patient reported improvement in their health-related quality of life following a hip replacement.

**Hip replacement: adjusted mean change between pre- and post-operative EQ-5D-3L scores (US valuation), 2013-16 (or nearest years)**

*Note:* ^ results converted from SF-12v1 instrument; ~converted from SF-12v2 instrument; *6-month post-op collection - lighter shade blue (all others are 12 months). H lines show 95% confidence intervals.

*Source:* PaRIS Hip/Knee Replacement Pilot Data Collection.

*Source: Health at a Glance 2019.*
Results suggest that – all other things being equal – the average 65-year-old patient undergoing a knee replacement in the contributing programmes gained an additional (incremental) 3.3 quality adjusted life years (QALYs), and 4.3 QALYs for hip replacement.

Both hip and knee replacements generate additional QALYs for patients.

Note: ^ results converted from SF-12v1 instrument; ~converted from SF-12v2 instrument; *6-month post-op collection (all others are 12 months).
Source: PaRIS Hip/Knee Replacement Pilot Data Collection.

3. HEALTH STATUS

- Trends in life expectancy
- Avoidable mortality (preventable and treatable)
- Prevalence of diabetes
- Self-rated health
Comparing the last five years (2012-17) with a decade earlier (2002-07), 27 OECD countries experienced slower gains in life expectancy.

Slowdown in life expectancy gains, 2012-17 and 2002-07

1. Three-year average.

Some cancers that are preventable through public health measures were the main causes of preventable mortality (32% of all preventable deaths), particularly lung cancer.

Main causes of avoidable mortality, OECD countries, 2017 (or nearest year)

![Pie chart showing preventable and treatable causes of mortality. Preventable causes include cancer (32%), external causes of death (25%), circulatory system (19%), and others (7%). Treatable causes include cancer (26%), circulatory system (36%), diabetes/other endocrine diseases (9%), and others (20%).]

Note: The 2019 OECD/Eurostat list of preventable and treatable causes of death classifies specific diseases and injuries as preventable and/or treatable. For example, lung cancer is classified as preventable; whereas breast and colorectal cancers are classified as treatable. Source: OECD calculations, based on WHO Mortality Database.

In 2017, about 98 million adults – or 6.4% of the adult population – were living with diabetes across OECD countries.

Almost 9% of adults consider themselves to be in poor health, on average across OECD countries.

Adults rating their own health as bad or very bad, 2017 (or nearest year)

1. Results for these countries are not directly comparable with those for other countries, due to methodological differences in the survey questionnaire resulting in a bias towards a more positive self-assessment of health. EU-SILC for European countries.

*Source: Health at a Glance 2019.*
4. RISK FACTORS FOR HEALTH

- Smoking among adults
- Alcohol consumption among adults
- Opioids use
- Overweight and obesity among adults
Across OECD countries, 18% of adults smoke tobacco daily. Men smoke more than women in all countries except Iceland – on average across the OECD, 23% of men smoke daily compared with 14% among women.

*Source: Health at a Glance 2019.*
Overall alcohol consumption averaged 8.9 litres of pure alcohol per person per year (equivalent to almost 100 bottles of wine) across OECD countries in 2017, down from 10.2 litres in 2007.

Recorded alcohol consumption among adults, 2007 and 2017 (or nearest year)

On average across 25 OECD countries for which data are available, there were 26 opioid-related deaths per million inhabitants in 2016. However, death rates were over five times higher in the United States, followed closely by Canada.

Opioid-related deaths, 2011 and 2016 (or nearest year)

Note: Canada's data corresponds to 2018.
Source: EMCDDA for European countries and country responses to OECD opioid data questionnaire 2018.

Based on measured data, 58% of adults were overweight or obese in 2017 on average across 23 OECD countries with comparable data. For both measured and self-reported data, men are more likely than women to be overweight.

Overweight including obesity among adults by sex, measured and self-reported, 2017 (or nearest year)

Note: Left- and right-hand side estimates utilise measured and self-reported data, respectively. OECD36 average includes both data types.

5. ACCESS TO CARE

- Population coverage for health care
- Use of primary care services
- Financial hardship and out-of-pocket expenditure
Most OECD countries have achieved universal (or near universal) coverage for a core set of health services

Population coverage for a core set of services, 2017 (or nearest year)

On average just under 80% of individuals aged 15 or over reported visiting a doctor in the past year, adjusting for need.

Note: OECD estimates based on EHIS-2 and other national survey data.

Across all countries, poorer households (i.e. those in the bottom consumption quintile) are most likely to experience catastrophic health spending, despite the fact that many countries have put in place policies to safeguard financial protection.

Share of households with catastrophic health spending by consumption quintile, latest year available

Source: WHO Regional Office for Europe, 2019.

6. QUALITY OF CARE

- Volume of antibiotics prescribed
- Safe acute care: health care-associated infections
- Avoidable hospital admissions: asthma & COPD
- Mortality following acute myocardial infarction (AMI)
- Breast cancer 5-year net survival
Unnecessary use of antibiotics contributes to antimicrobial resistance. Total volumes of antibiotics prescribed in primary care in 2017 vary more than three-fold across countries, while volumes of second-line antibiotics vary more than 24-fold.

Overall volume of antibiotics prescribed, 2017 (or nearest year)

1. Three-year average.
2. Data from European Centre for Disease Prevention and Control as OECD Health Statistics data are not available.

Health care associated infections (HAIs) are the single most deadly and costly adverse event, representing up to 6% of public hospital budgets. On average, across OECD countries, just under 4.9% of hospital patients had an HAI in 2015-17.

Percentage of hospitalised patients with at least one health care-associated infection and proportion of bacteria isolated from these infections resistant to antibiotics, 2015-17

Note: No resistance data available for Iceland, Norway and the United States.
1. Under 5% of patients from ICUs. 2. Over 5% of patients from ICUs.
Source: ECDC 2016-17 Point prevalence survey. CDC 2015 point prevalence study.

Admission rates specifically for asthma vary 12-fold across OECD countries, while admission rates specifically for COPD vary 15-fold across OECD countries.

1. Three-year average.

*Source: Health at a Glance 2019.*
In terms of acute care, fewer people are dying following acute myocardial infarction (heart attack), but differences across countries suggest that AMI patients do not always receive recommended care in countries with the highest rates.

Thirty-day mortality after admission to hospital for AMI based on unlinked data, 2007 and 2017 (or nearest year)

1. Three-year average.

Five-year net survival for women with breast cancer has improved in recent years, reflecting overall improvement in the quality of cancer care. In all OECD countries, for women diagnosed at early or localised stage, the cumulative probability of surviving their cancer for at least 5 years is 90%.

Breast cancer five-year net survival by stage of breast cancer at diagnosis, 2010-14

Note: H line shows 95% confidence intervals. 1. Coverage is less than 100% of the national population for stage-specific survival estimates. 2. Coverage is less than 100% of the national population. 3. Survival estimates for advanced stage are not age-standardised. 4. Data for 2004-09.

Source: CONCORD programme, London School of Hygiene and Tropical Medicine.

7. HEALTH EXPENDITURE

- Health expenditure in relation to GDP
- Prices in the health sector
- Health expenditure by type of service
- Projections of health expenditure
On average, OECD countries are estimated to have spent 8.8% of GDP on health care in 2018, a figure more or less unchanged since 2013. The United States spent by far the most on health care, equivalent to 16.9% of its GDP.

Health expenditure as a share of GDP, 2018 (or nearest year)

Note: Expenditure excludes investments, unless otherwise stated.
1. Australia expenditure estimates exclude all expenditure for residential aged care facilities in welfare (social) services.
2. Includes investments.
Source: OECD Health Statistics 2019, WHO Global Health Expenditure Database.

Prices in the health sector based on the same set of goods and services are estimated to be about 10% more in Sweden, 20% more in Norway and up to 39% higher in Switzerland. Prices across all OECD countries are on average around 28% lower than in the United States.


Growth in health expenditure resumed across all areas following the general slowdown after the economic crisis. Prevention was the fastest growing area between 2013-17 at 3.2% on average, annually.

Annual growth in health expenditure for selected services (real terms), OECD average, 2009-13 and 2013-17

Health expenditure is projected to outpace GDP growth in the next 15 years in all scenarios.

Health expenditure per capita vs GDP growth trends, observed and projected, 2000-30

Source: OECD Health Division projections, 2019.

8. HEALTH WORKFORCE

- Doctors per capita
- Nurses per capita
- Ratio nurses to doctors
The number of physicians per capita has increased in nearly all OECD countries since 2000

Practising doctors per 1 000 population, 2000 and 2017 (or nearest year)

Notes:
1. Data refer to all doctors licensed to practice, resulting in a large over-estimation of the number of practising doctors (e.g. of around 30% in Portugal).
2. Data include not only doctors providing direct care to patients but also those working in the health sector as managers, educators, researchers, etc. (adding another 5-10% of doctors).

Between 2000 and 2017 the number of nurses per capita grew in almost all OECD countries, and the average rose from 7.4 per 1,000 population in 2000 to 8.8 per 1,000 population in 2017.

Notes:
1. Data include not only nurses providing direct care to patients, but also those working in the health sector as managers, educators, researchers, etc.
2. Austria and Greece report only nurses employed in hospital.
3. Data in Chile refer to all nurses who are licensed to practice.

Nurses outnumber physicians in most OECD countries, and on average there are 3 nurses to every doctor. The ratio of nurses to doctors ranges from about 1 nurse per doctor in Chile, Turkey and Greece, to more than 4 nurses per doctor in Japan, Ireland, Finland and the United States.

Notes:
1. For countries that have not provided data for practising nurses and/or practising doctors, the numbers relate to the "professionally active" concept for both nurses and doctors (except Chile, where numbers include all nurses and doctors licensed to practise). 2. For Austria and Greece, the data refer to nurses and doctors employed in hospitals. 3. The ratio for Portugal is underestimated because the numerator refers to professionally active nurses while the denominator includes all doctors licensed to practise.

9. HEALTH CARE ACTIVITIES

- Consultations with doctors
- Hospital beds
- Occupancy rate of curative care beds
- Average length of stay in hospitals
The average number of doctor consultations per person across OECD countries has remained relatively stable since 2000. In 2017, the number of doctor consultations per person ranged from less than 3 in Mexico and Sweden, to almost 17 in Korea.

Number of doctor consultations per person, 2000 and 2017 (or nearest year)

Across OECD countries, there were on average 4.7 hospital beds per 1 000 people in 2017. Since 2000, the number of beds per capita has decreased in nearly all OECD countries.

**Source:** Health at a Glance 2019.
The occupancy rate was over 90% in Ireland, Israel and Canada in 2017. Occupancy rates were comparatively low in Greece, the United States, the Netherlands and Hungary (around 65% or less). Around half of OECD countries have bed occupancy rates of 70-80%, and the OECD average is 75%.

In 2017, the average length of stay in hospitals was slightly less than 8 days across OECD countries. Since 2000, the average length of stay has decreased in most countries, potentially indicating efficiency gains.

Notes: 1. Data refer to average length of stay for curative (acute) care (resulting in an under-estimation). In Japan, the average length of stay for all inpatient care was 28 days in 2017 (down from 39 days in 2000).

10. PHARMACEUTICAL SECTOR

- Pharmaceutical expenditure
- Share of generic market
Across OECD countries, funding from governments and compulsory insurance schemes played the largest role in purchasing pharmaceuticals. On average, these schemes covered 58% of spending on retail pharmaceuticals.

Expenditure on retail pharmaceuticals\(^1\) by type of financing, 2017 (or nearest year)

Notes: "Other" includes financing from non-profit-schemes, enterprises and the rest of the world.
1. Includes medical non-durables.

In 2017, generics accounted for more than three-quarters of the volume of pharmaceuticals sold in the United Kingdom, Chile, Germany and New Zealand, but less than one-quarter in Luxembourg and Switzerland.

**Notes:** 1. Reimbursed pharmaceutical market. 2. Community pharmacy market.

**Source:** Health at a Glance 2019.
11. AGEING AND LONG-TERM CARE

- Demographic trends
- Informal carers
- Long-term care costs
The speed of population ageing has varied markedly across OECD countries, with Japan in particular experiencing rapid ageing over the past three decades. In the coming years, Korea is projected to undergo the most rapid population ageing among OECD members.

Trends in the share of the population aged over 80 years, 1990-2050

Note: 1. Partner countries include Brazil, China, Colombia, Costa Rica, India, Indonesia, the Russian Federation and South Africa.

On average across OECD countries, 61% of those providing daily informal care are women. Greece and Portugal have the greatest gender imbalance, with over 70% of informal carers being women.

Share of women among informal daily carers aged 50 and over, 2017 (or nearest year)

1. The United Kingdom refers to England.

*Note:* The definition of informal carers differs between surveys (see the “Definition and comparability” box).

*Source:* Survey of Health, Ageing and Retirement in Europe, wave 7 (2017); Survey of Disability, Ageing and Carers for Australia (2015); English Longitudinal Study of Ageing, wave 8 (2017); Health and Retirement Survey for the United States, wave 13 (2016); Census 2016 for Ireland.

For institutional care, the costs for a person with severe LTC needs represent between just under one the median disposable income for individuals of retirement age and more than four times that income, depending on the country or region.

Costs of institutional long-term care for an older person with severe needs, as a share of the median income among people of retirement age and older, 2018 (or nearest year)

Note: Belgium refers to Flanders, Iceland refers to Reykjavik, Canada refers to Ontario, Estonia refers to Tallinn, Austria refers to Vienna, the United States refers to (a) California and (b) Illinois, Italy refers to South Tyrol, and the United Kingdom refers to England.


More information

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