OECD Health Data 2005
How Does Denmark Compare?

Health spending and financing

Total health expenditure in **Denmark** in 2003 accounted for 9% of GDP, slightly more than the average of 8.6% in OECD countries. Among all OECD countries, health spending as a share of GDP is the highest 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).

In 2003, **Denmark**'s per capita health expenditure was higher than the OECD average, with 2763 USD (adjusted to purchase power parity), compared with an OECD average of 2307 USD. Health spending per capita in Denmark remains nonetheless much lower than in the United States (5635 USD), and in Norway and Switzerland (about 3800 USD).

Between 1998 and 2003, health expenditure per capita grew by 2.8% in real terms per year on average in **Denmark**, well below the OECD average of 4.5%.

The rise in pharmaceutical spending has been one of the factors behind the rise in total health spending in most OECD countries in recent years. Drug spending has also increased in **Denmark**, but less rapidly than in many other OECD countries. In 2003, spending on pharmaceuticals accounted for 9.8% of total health expenditure in **Denmark**, much less than the average of 17.7% in OECD countries.

The public sector is the main source of health funding in all OECD countries, except the United States, Mexico and Korea. In **Denmark**, 83% of health spending was funded by public sources in 2003, which is well above the OECD average of 72%.

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

Denmark is relatively comparable to the average among OECD countries for several indicators of resources in the health sector. In 2002, there were 2.9 practising physicians per 1 000 population in **Denmark**, which is equal to the OECD average. There were 10.3 practising nurses per 1 000 population, a higher number than the OECD average of 8.2.

The number of acute care beds in **Denmark** was 3.4 beds per 1 000 population, which is higher than in other Scandinavian countries, but lower than the OECD average of 4.1.

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 **Denmark**, the number of MRIs also increased over time, to reach 9.1 per million population in 2003, higher than the OECD average of 7.6. The number of CT scanners in **Denmark** stood at 14.5 per million population in 2003, slightly below the OECD average of 17.9. Japan has, by far, the greatest number of MRIs and CT scanners per capita among OECD countries.

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 2003, life

expectancy at birth in **Denmark** was 77.2 years, slightly lower than the OECD average of 77.8 years. Life expectancy in Denmark is much lower than in Japan (81.8 years) and in other Scandinavian countries.

Infant mortality rate in **Denmark** is among the lowest in OECD countries, with 4.4 deaths per 1000 live births in 2003, whereas the OECD average is 6.1[1]. Denmark's infant mortality rate is nonetheless higher than in other Scandinavian countries and in Japan.

The proportion of daily smokers among adults has shown a marked decline over the past two decades in most OECD countries. In **Denmark**, the percentage of adults who report to smoke everyday has come down from 48% in 1983 to 28% in 2003. Despite this marked reduction, smoking rates among adults in Denmark remain slightly higher than the OECD average of 26.5%. Sweden, the United States and Canada provide examples of countries that have achieved remarkable success in reducing tobacco consumption, with current smoking rates among adults at about 17%.

Alcohol consumption is also higher in **Denmark** than the OECD average, with 11.5 litres of alcohol consumed per adult per year in 2003, compared with an OECD average of 9.5.

Obesity rates have increased in recent decades in all OECD countries, although there remain notable differences across countries. In 2003 (or the most recent year available), the prevalence of obesity among adults varied from a low of 3.2% in Japan and in Korea to a high of 30.6% in the United States. Countries like the United Kingdom, Australia and Mexico also report relatively high obesity rates among adults (over 20%)[2]. The obesity rate among adults in **Denmark** (measured as a body mass index of 30 or more) was 9.5% in 2000, up from 5.5% in 1987. The time lag between the onset of obesity and increases in related chronic health problems (such as diabetes or asthma) suggests that the rise in obesity that has occurred in Denmark and most other OECD countries will have substantial implications on the 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 Denmark, please visit www.oecd.org/denmark.

[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.