

## *OECD Health Data 2005* **How Does Sweden Compare**

### **Health spending and financing**

Total health spending accounted for 9.2% of GDP in **Sweden** in 2002, slightly above the latest OECD average of 8.6% for the most recent year available in different countries (2002/3). The United States is, by far, the country that spends the most on health as a share of its economy, with 15% of its GDP allocated to health in 2003. Switzerland and Germany followed with, respectively, 11.5% and 11.1% of GDP spent on health.

**Sweden** ranks above the OECD average also in terms of total health spending per capita, with an amount of 2594 USD spent in 2002 (adjusted for purchasing power parity), compared with an OECD average of 2307 USD. The largest spenders in terms of total health spending per capita are the United States (which spent 5635 USD per capita in 2003) and Norway and Switzerland (which spent about 3800 USD).

Health spending per capita in **Sweden** grew more rapidly in recent years than in most other OECD countries. Between 1998 and 2002/3, the average annual growth rate in **Sweden** reached 5.4% in real terms, compared with an OECD average of 4.5% per year.

The rise in pharmaceutical spending has been one of the factors behind the rise in total health spending in many OECD countries in recent years. Drug spending has also increased in Sweden, but less rapidly than in most other OECD countries. In 2002, spending on pharmaceuticals in **Sweden** accounted for 13.1% of total health expenditure, well below the OECD average of 17.7%.

The public sector is the main source of health funding in all OECD countries, except the United States, Mexico and Korea. In **Sweden**, 85.3% of health spending was funded by public sources in 2002, which is among the highest share in OECD countries and well above the average of 72.1%. In 2002/3, the share of public spending among OECD countries was the lowest in the United States (44.4%) and Mexico (46.4%), and relatively high (but lower than in **Sweden**) in other Nordic countries (Denmark, Iceland and Norway), the United Kingdom and Japan.

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

**Sweden** employs more human resources in the health sector than most other OECD countries. In 2002, **Sweden** had 3.3 practising physicians per 1 000 population, compared with an average of 2.9 in OECD countries. **Sweden** also has more practicing nurses per capita than the average across OECD countries with 10.2 nurses per 1 000 population, compared to an OECD average of 8.2.

The number of acute care hospital beds in **Sweden** stood at 2.4 per 1 000 population in 2000, well below the OECD average of 4.1. As in most OECD countries, the number of hospital beds per capita in **Sweden** has fallen over time, coinciding with a reduction of average length of stays in hospitals.

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 **Sweden**, the number of MRIs increased over time from about 1 per million population in 1989 to 7.9 in 1999 (latest year for which data has been reported). This is slightly above the OECD average of 7.6 MRI units per million population in 2003 (or the most recent year available in different countries). The number of CT scanners in **Sweden** as well rapidly expanded over time, up to 14.2 CT scanners per

million population in 1999. The OECD average was 17.9 in 2003. 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 for the whole population in **Sweden** stood at 80.2 years, about two and a half years above the OECD average of 77.8 years. Japan enjoyed the highest life expectancy among OECD countries with 81.8 years, followed by Iceland, Spain, Switzerland, Australia and **Sweden**.

The infant mortality rate in **Sweden**, as in other OECD countries, has fallen greatly over the past decades. It stood at 3.1 deaths per 1 000 live births in 2003, compared to the OECD average of 6.1. Only Iceland and Japan had lower infant mortality rates<sup>1</sup>.

The proportion of daily smokers among adults has shown a marked decline over the past two decades in most OECD countries. **Sweden** 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 32% in 1980 to 17.5% in 2003, the lowest rate among all OECD countries along with Canada and the United States. **Sweden** pursues a strict non-smoking policy and will be one of the first countries worldwide to prohibit indoor smoking in restaurant and other eating and drinking establishments from June 2005.

Obesity rates have increased in recent decades in all OECD countries, although there remain notable differences across countries. In 2002/3, the prevalence of obesity among adults varied from 3.2% in Japan and in Korea to 30.6% in the United States. Countries like the United Kingdom, Australia, the Slovak Republic and Mexico also showed relatively high levels of obesity among adults (over 20%)<sup>2</sup>. The obesity rate in **Sweden** (measured as a body mass index of 30 or greater) stood at 9.7% in 2003, up from 5.5% in 1989. 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 **Sweden** 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](http://www.oecd.org/health/healthdata).

For more information on OECD's work on Sweden, please visit [www.oecd.org/sweden](http://www.oecd.org/sweden).

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<sup>1</sup> 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.

<sup>2</sup> 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.